

# THE NATIONAL QUALITY FORUM

TO: NQF Members

FR: NQF Staff

RE: Voting draft for *Endorsing Preferred Practices and Performance Measures for Care Coordination: A Consensus Report*

DA: December 17, 2009

## **Background**

In May 2006, the National Quality Forum (NQF) endorsed a definition of and framework for care coordination. NQF has defined 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.” The framework specifically mentioned five key domains: Healthcare Home; Proactive Plan of Care and Follow-up; Communication; Information Systems; and Transitions or Hand-offs. In addition to endorsing a definition and framework, NQF, in its role as convener and partner in NPP has focused on care coordination.

Specifically, in November 2008, NPP deemed “care coordination” as one of six national priorities and agreed to work toward the following goals:

- Improve care and achieve quality by facilitating and carefully considering feedback from all patients regarding coordination of their care;
- Improve communication around medication information; work to reduce 30-day readmission rates;
- Work to reduce preventable ED visits by 50 percent.

In 2008, NQF undertook a project to identify and endorse a set of preferred practices and performance measures for care coordination. In considering specific practices and measures, a Steering Committee of 27 individuals representing the range of stakeholder perspectives was convened and reviewed the NQF-endorsed Framework for Care Coordination and National Priorities Partnership (NPP) goals for care coordination. The Steering Committee considered for endorsement a total of 36 practices and 78 measures as they relate to the Care Coordination Framework and the NPP goals ; it recommends 25 preferred practices and 10 performance measures for measuring and reporting care coordination. This draft report recommends that these 25 practices and 10 measures be endorsed as voluntary consensus standards.

A standardized, consensus portfolio of care coordination preferred practices can serve as the beginning of a systematic approach to care coordination and the development of performance measures that should provide the structure, process, and outcome measures required to assess progress toward the care coordination goals and to evaluate access, continuity, communication, and tracking of patients across providers and settings.

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## Comments and Revised Draft Report

The comment period for the draft report, *Endorsing Preferred Practices and Performance Measures for Care Coordination*, concluded on November 24, 2009. NQF received 464 comments from 48 organizations on the draft report, although some of the same comments were received from multiple organizations. The breakdown of the comments by Member Council is, as follows:

Consumers - 3	Health Professionals - 12
Purchasers - 3	Public Health/Community - 0
Health Plans - 4	QMRI - 4
Providers - 5	Supplier and Industry - 1
Non-members - 15	

The comments encompassed a wide variety of divergent, and sometimes conflicting, opinions for both general topics and those specific to the practices and measures. All measure-specific comments have been forwarded to the measure developers, who were invited to respond.

A table of detailed comments submitted during the review period, with responses and actions taken by the Steering Committee, is posted on the NQF voting web page.

## General Comments

Generally, the comments reflected the Steering Committee's prior deliberations on the practices and measures. The major themes of the comments for the preferred practices and performance measures included: 1) the use of the term healthcare home/medical home and acknowledging similar concepts; 2) incorporating the role of other providers of care within practices; 3) specifying additional elements within the plan of care; 4) inclusion of a condition-focused practice; 5) consideration of stratifying analyses of the measures by race, ethnicity, language, payment sources, and gender; and 6) re-review of measures not recommended. The Steering Committee and Co-chairs reviewed the comments and actions are noted in the table of comments and, in many cases, incorporated within the report.

## Comments and Their Disposition

A synthesis of the major concerns identified during the review period and actions taken are provided below. A detailed table of individual comments and their disposition is available on the NQF website.

### **Use of the term Healthcare Home/Medical Home**

Several commenters raised concerns about the consistency of the terms healthcare home and medical home throughout the report and also suggested acknowledging similar concepts lead by other provider groups such as nurses and care managers.

*Action Taken:* The report has been revised to reflect better consistency with the use of the terms healthcare home and medical home. NQF uses the broader term healthcare home as recognized by the NQF-endorsed domain for the Care Coordination Framework. The report was revised to reflect that the term medical home was only used when others used it to describe their work. In addition, concepts similar to the healthcare home, such as nurse-managed care center and accountable care organizations were acknowledged within the report.

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## **Incorporating the roles of other care providers**

Several commenters suggested including more specificity on the roles of other providers within the practices, such as mentioning the case manager, specialists, nurses, community leaders, etc.

*Action Taken:* Throughout the practices, unless the practice had been submitted by an entity and the relevant evidence provided no one care provider was singled out. Many of the practices refer to the healthcare team, which encompasses all providers of care/services.

## **Specifying additional elements within the plan of care**

Commenters suggesting including further elements within the plan of care such as social support services, functional status, and payment incentives, contingency plans.

*Action Taken:* Additional specificity was added to the practices addressing plan of care as applicable.

## **Inclusion of condition-focused practice**

Several comments were received regarding the inclusion of practice 10, which addresses the use of cardiac rehabilitation services. Many commenters suggested that this practice was too specific compared to the other preferred practices, which were more general and broadly applicable to other populations/settings.

*Action Taken:* Explanatory text has been provided within the report as to why this practice was included within the set. The Steering Committee viewed cardiac patients to be of very high-risk and therefore in greater need for care coordination services. In addition, two metrics that pair with this practice are recommended for endorsement.

## **Stratifying analysis of measures**

Several commenters suggested stratifying analysis of the measures by race, ethnicity, language, payment sources and gender.

*Action Taken:* Further clarification was provided within the report to indicate that strong consideration should be given to stratifying the analysis of measures by race, ethnicity, language, payment sources, and gender.

## **Measures not recommended**

In addition to the comments on the practices, several organizations commented on the Committee's decision to not recommend measure CC-018-09 – *Timely Case Management Assessment Rates for Pregnant Women at High Risk in Managed Care*; these organizations asked the Committee to reconsider its decision.

*Action Taken:* The Committee discussed the comments, but ultimately did *not* reverse its decision on this measure. During Committee deliberations, the measure was recommended for advancement if the following conditions could be met: (1) specify aspects of care coordination to occur during the initial assessment, (2) define the process of care plan development during the assessment and how the care plan will be shared with relevant providers, (3) specify criteria for referrals (triggers) to case management for this population with supporting evidence, (4) provide evidence to support the 15-day timeframe. The measure developer could not meet the conditions, but indicated it would take these considerations under advisement and provide updates to the measure as it evolves.

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## **NQF Member Voting**

Information for electronic voting has been sent to NQF Member organization primary contacts. Accompanying comments must be submitted by e-mail and identify submitter, organization and the specific ballot item that the comments accompany.

**Please note that voting concludes on Tuesday, January 19, 2010 at 6:00 PM (ET) - no exceptions.**

# THE NATIONAL QUALITY FORUM

## Endorsing Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report

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## 1 ENDORSING PREFERRED PRACTICES AND PERFORMANCE MEASURES FOR 2 MEASURING AND REPORTING CARE COORDINATION: A CONSENSUS REPORT

### 3 4 5 BACKGROUND

6 As the number of healthcare professionals, care settings, and treatments involved in a patient's care has  
7 increased, the coordination of care has become both more difficult and more vital. Effective care  
8 coordination ensures that patient and family needs and preferences for care are understood and, that  
9 accountable structures and processes are in place for communication and integration of a  
10 comprehensive plan of care across providers and settings. Care among many different providers must  
11 be well-coordinated to avoid waste; over-, under-, or misuse of prescribed medications and treatment  
12 regimens; and conflicting plans of care.<sup>1</sup>

13  
14 Care coordination is especially important for people with chronic conditions, such as diabetes or  
15 hypertension, who often receive care in multiple settings from numerous providers. These individuals  
16 may see up to 16 physicians a year.<sup>2</sup> In 2000, 125 million people in the United States were living with at  
17 least one chronic illness – a number that is expected to grow to 157 million by 2020. The number of  
18 individuals with multiple chronic conditions is expected to reach 81 million by 2020.<sup>3</sup> As this ever-  
19 growing group attempts to navigate our complex healthcare system and transition from one care  
20 setting to another, they often are unprepared or unable to manage their care. Incomplete or inaccurate  
21 transfer of information, poor communication, and a lack of appropriate follow-up care can lead to  
22 confusion and poor outcomes; including medication errors, and often preventable hospital  
23 readmissions and emergency department (ED) visits.

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25 In May 2006, the National Quality Forum (NQF) endorsed a definition of and framework for care  
26 coordination. NQF has defined care coordination as a “function that helps ensure that the patient's  
27 needs and preferences for health services and information sharing across people, functions, and sites  
28 are met over time.” The framework specifically mentioned five key domains: Healthcare “Home”;  
29 Proactive Plan of Care and Follow-up; Communication; Information Systems; and Transitions or Hand-  
30 offs. In addition to endorsing a definition and framework, NQF, in its role as convener and partner in  
31 the National Priorities Partnership (NPP), a national effort to set national priorities and goals, has

32 focused on care coordination. Specifically, in November 2008, NPP deemed “care coordination” as one  
33 of six national priorities and agreed to work toward the following goals:

- 34 • Improve care and achieve quality by facilitating and carefully considering feedback from all  
35 patients regarding coordination of their care;
- 36 • Improve communication around medication information; work to reduce 30-day readmission  
37 rates;
- 38 • Work to reduce preventable ED visits by 50 percent.

39 A portfolio of care coordination preferred practices and performance measures should provide the  
40 structure, process, and outcome measures required to assess progress toward the care coordination  
41 goals and evaluate access, continuity, communication, and tracking of patients across providers and  
42 settings. Given the high-risk nature of transitions in care, this work would build on ongoing efforts  
43 among the medical and surgical specialty societies to establish principles for effective patient hand-offs  
44 across clinicians and providers. Given the evolving nature of interoperable health information  
45 technology (HIT) systems, it is expected that the measurement and improvement efforts will improve  
46 over time.

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#### 48 **STRATEGIC DIRECTIONS FOR NQF**

49 NQF’s mission includes three parts: 1) setting national priorities and goals for performance  
50 improvement, 2) endorsing national consensus standards for measuring and publicly reporting on  
51 performance, and 3) promoting the attainment of national goals through education and outreach  
52 programs. As greater numbers of quality measures are developed and brought to NQF for  
53 consideration, NQF must assist stakeholders in measuring and reporting “what makes a difference”  
54 and addressing what is important to achieve the best outcomes for patients and populations. An  
55 updated Measurement Framework, reviewed by NQF Members in December 2007, promotes shared  
56 accountability and measurement across episodes of care with a focus on outcomes and patient  
57 engagement in decisionmaking coupled with measures of the healthcare process and cost/resource  
58 use. For more information, see [http://www.qualityforum.org/projects/care\\_coordination.aspx](http://www.qualityforum.org/projects/care_coordination.aspx).

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60 Several strategic directions have been identified to guide the consideration of candidate consensus  
61 standards:

- 62 • **Drive toward high performance.** Over time, the bar of performance expectations should be  
63 raised to encourage the achievement of higher levels of system performance.
- 64 • **Emphasize composites.** Composite measures provide much-needed summary information  
65 pertaining to multiple dimensions of performance and are more comprehensible to patients and  
66 consumers.
- 67 • **Move toward outcome measurement.** Outcome measures provide information of keen interest  
68 to consumers and purchasers, and when coupled with healthcare process measures, they  
69 provide useful and actionable information to providers. Outcome measures also focus attention  
70 on much-needed system-level improvements, because achieving the best patient outcomes often  
71 requires carefully designed care processes, teamwork, and coordinated action on the part of  
72 many providers.
- 73 • **Focus on disparities in all that we do.** Some of the greatest performance gaps relate to care of  
74 minority populations. Particular attention should be focused on the most relevant  
75 race/ethnicity/language/socioeconomic strata to identify relevant measures for reporting.  
76

77 The focus of this project, care coordination, is essential to meeting the challenge of a high-performing  
78 healthcare system. ~~Moreover, i~~Implementation of the practices and measures endorsed in this report  
79 can have a significant impact on the quality of care for minority and other populations, given the  
80 disproportionate impact of some chronic illnesses, such as diabetes or chronic kidney disease, in these  
81 populations. Accordingly, in analyzing adherence to the preferred practices and performance  
82 measures, strong consideration should be given to stratifying the analyses by race and ethnicity,  
83 language, payment source, and gender.  
84

## 85 PURPOSE

86 The purpose of this project was to:

- 87 • Endorse a set of preferred practices and performance measures for care coordination that are  
88 applicable across all settings of care.
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- 90 • Identify high-priority research areas to advance the evaluation of care coordination as a quality  
91 improvement tool.  
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## FRAMEWORK

The NQF-endorsed® Framework for Care Coordination served as a road map for the identification of a set of preferred practices and performance measures, as well as for the identification of areas requiring additional research or development. The framework established a conceptual model to identify and organize NQF-endorsed preferred practices and performance measures based on a set of interrelated domains that are applicable to multiple settings of care and providers of care. The framework also served as the basis to assess what is currently available and to identify areas where gaps in practices and measures exist. Guided by the framework and basic constructs of care coordination, a set of preferred practices and performance measures, which are presented in this report, should provide comprehensive evaluation and reporting tools to ensure that care is coordinated across all settings and populations. To review the framework, see [http://www.qualityforum.org/projects/care\\_coordination.aspx](http://www.qualityforum.org/projects/care_coordination.aspx).

## NQF'S CONSENSUS DEVELOPMENT PROCESS

Candidate consensus standards were solicited as part of the NQF Consensus Development Process, which included an open Call for Preferred Practices in December 2008, and an open Call for Measures in April 2009. Candidate consensus standards also were actively sought through literature reviews, suggestions from the Steering Committee, and a search of the National Quality Measures Clearinghouse. In addition, as part of NQF's ongoing measure maintenance process, one measure related to care coordination that was endorsed in 2006 was reconsidered alongside the newly submitted candidate consensus standards. A 27-person Steering Committee reflecting the diversity of the NQF membership evaluated the candidate measures and practices and made recommendations for to NQF Members for possible endorsement.

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## PREFERRED PRACTICES FOR MEASURING AND REPORTING CARE COORDINATION

Individual initiatives to improve care coordination across settings of care for diverse populations have been ongoing. In contrast to better studied areas like care transitions, systematic study of newer dimensions of the NQF-endorsed Framework for Care Coordination, like healthcare home or information systems, is relatively recent. Not unexpectedly, relatively few preferred practices were submitted in key areas of the framework. Recognizing the need to establish a meaningful foundation for future development of a set of practices with demonstrated impact on quality outcomes, the Steering Committee highlighted strong bodies of evidence, and also relied on implementation examples, widely accepted experiential data, and expert consensus in reviewing and recommending practices and their specifications.

This report endorses a set of 25 preferred practices (Table 1) that are suitable for widespread implementation and that address the domains of the NQF-endorsed Care Coordination Framework and the NPP goals. The practices are applicable and generalizable to multiple care settings, [diverse and patient populations](#), [and a broad spectrum of providers](#).

The preferred practices, while grounded in today's projects and experiments on care coordination, are intended to accelerate the evolution of preferred practices of care coordination to achieve quality and safety outcomes. In many cases, practice specifications are purposely comprehensive and futuristic or stretch goals. [The Committee recognized that for the preferred practices to achieve widespread adoption, current payment models will need to better align to incentivize these types of patient-centered approaches to care. However, payment recommendations or incentives were beyond the scope of this project and so were not addressed within the practice specifications. Additionally, other drivers of change, such as public reporting, accreditation/ certification, performance measurement, and workforce preparedness will need to be addressed as part of a comprehensive implementation strategy. As part of its work moving forward, the National Priorities Partnership is identifying high leverage drivers for each of the six priority areas--including care coordination-- and specific action steps for multiple stakeholders to take.](#)

153 The Steering Committee emphasizes the need for further research to evaluate these practices across  
154 providers and settings. Just as NQF's Safe Practices have evolved over time, this set of practices can  
155 and should be similarly improved as the evidence base expands. [The Steering Committee](#)  
156 [recommended further scrutiny of evaluation criteria applied to practices in rapidly evolving areas like](#)  
157 [care coordination. As noted below, the Committee worked diligently to balance the imperative for](#)  
158 [scientific rigor with the need to advance preferred practices and measures for care coordination.](#)  
159 [practice.](#)

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### 163 Evaluating Preferred Practices

164 The preferred practices submitted and/or developed for this project were evaluated for their adequacy  
165 using NQF-endorsed standard evaluation criteria for all practices, presented in Box A:

- 166 • *Effectiveness*: clear evidence must be presented that indicates the practice would be effective in  
167 improving outcomes;
- 168 • *Generalizability*: the practice should be able to be utilized in multiple care settings and/or for  
169 multiple types of patients;
- 170 • *Benefit*: it must be clear how the practice would improve or increase the likelihood of improving  
171 patient outcomes; and
- 172 • *Readiness*: the training, technology, and staff required for implementation of the practice are  
173 available.

174 The practices evaluated and endorsed presented differentiating levels of supportive evidence; few were  
175 rated as strong in each of evaluation criteria areas. Some practices were presented with strong bodies of  
176 research supporting effectiveness, generalizability, benefit and readiness and others were judged by the  
177 Steering Committee to have strong "face validity," i.e., they made sense and appeared to be important  
178 to experienced practitioners and researchers who study care coordination. The practices showing face  
179 validity typically were multi-component interventions with little evidence to support the detailed  
180 specification of their practice elements. Common elements were identified across these practices and  
181 developed into more generalized practice statements.

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**Box A – Criteria for Evaluation of Practices**

**Evidence of Effectiveness**

There must be clear evidence that the practice (if appropriately implemented) would be effective in improving outcomes (e.g., reduced substance use). Evidence may take various forms, including:

- research studies (syntheses) showing a direct connection between the practice and improved clinical outcomes;
- experiential data (including broad expert agreement, widespread opinion, or professional consensus) showing the practice is “obviously beneficial” or self-evident (i.e., the practice absolutely forces an improvement to occur) or organization or program data linking the practice to improved outcomes; or
- research findings or experiential data from other healthcare or nonhealthcare settings that should be substantially transferable.

**Generalizability**

The practice must be able to be utilized in multiple applicable clinical care settings (e.g., a variety of inpatient and/or outpatient settings) and/or for multiple types of patients.

**Benefit**

If the practice (determined to be effective) were more widely used, it would improve or increase the likelihood of improving patient outcomes (e.g., improved patient function). If an effective practice already is in near-universal use, its endorsement would lead to little new benefit to patients.

**Readiness**

The necessary technology and appropriately skilled staff must be available to most healthcare organizations. For this project, opportunity for measurement also was a consideration.

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**TABLE 1: RECOMMENDED PREFERRED PRACTICES FOR NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR CARE COORDINATION<sup>4</sup>**

**This information is for personal and noncommercial use only. You may not modify, reformat, copy, display, distribute, transmit, publish, license, create derivative works from, transfer, or sell any information, products, or services obtained from this document.**

Domain	Number	Practice Statement
<b>Healthcare home</b>	1	The patient shall be provided the opportunity to select the healthcare home that provides the best and most appropriate opportunities to the patient to develop and maintain a relationship with healthcare providers.
	2	Healthcare home or sponsoring organizations shall be the central point for incorporating strategies for continuity of care.
	3	The healthcare home shall develop infrastructure for managing plans of care that incorporate systems for registering, tracking, measuring, reporting, and improving essential coordinated services.
	4	The healthcare home should have policies, procedures, and accountabilities to support effective collaborations between primary care and specialist providers, including evidence-based referrals and consultations that clearly define the roles and responsibilities.
	5	The healthcare home will provide or arrange to provide care coordination services for patients at high risk for adverse health outcomes, high service use, and high costs.
<b>Proactive plan of care and follow-up</b>	6	Healthcare providers and entities should have structured and effective systems, policies, procedures, and practices to create, document, execute, and update a plan of care with every patient.
	7	A systematic process of follow-up tests, treatments, or services should be established and be informed by the plan of care.
	8	The joint plan of care should be developed and include patient education and support for self-management and resources.
	9	The plan of care should include community and nonclinical services as well as healthcare services that respond to a patient's needs and preferences and contributes to achieving the patient's goals.
	10	Healthcare organizations should use cardiac rehabilitation services to coordinate care for patients with a recent cardiovascular event, where available, appropriate, and accessible. <sup>5</sup>
<b>Communication</b>	11	The patient's plan of care should always be made available to the healthcare home team, the patient, and their designees.
	12	All healthcare home team members, including patients and their

		designees, should work within the same plan of care and share responsibility for their contributions to the plan of care and achieving the patient's goals.
	13	A program should be used that incorporates a care partner to support family and friends when caring for a hospitalized patient.
	14	Assess and document the provider's perspective of care coordination activities.
<b>Information systems</b>	15	Standardized, integrated, <del>interoperable and</del> electronic information systems <del>that have with</del> functionalities essential to care coordination <del>functions</del> , decision support, <del>and</del> quality measurement and practice improvement should be used.
	16	An electronic record system should allow the patient's health information to be accessible to caregivers at all points of care.
	17	Regional health information systems governed by public/private partnerships should enable healthcare home teams and to access all patient information.
<b>Transitions</b>	18	Decisionmaking and planning for transitions of care should involve the patient, and, according to patient preferences, family and caregivers (including the healthcare home team). Appropriate follow-up protocols should be used to assure timely understanding and endorsement of the plan for patient and their designees.
	19	Patient and their designees should participate directly in determining and preparing for ongoing care during and after transitions.
	20	Systematic care transitions programs that engage patients and families in self-management after being transferred home should be used whenever available. <sup>6</sup>
	21	The Transitional Care Model should be deployed for chronically high-risk older adults. <sup>7</sup>
	22	Healthcare organizations should develop and implement a standardized communication template for the transitions of care process, including a minimal set of core data elements that are accessible to the patient and their designee during care.
	23	Healthcare providers and healthcare organizations should implement protocols/policies for a standardized approach to all transitions of care. Policies and procedures related to transitions and the critical aspects should be included in the standardized approach.
	24	Healthcare providers and healthcare organizations should have systems in place to clarify, identify, and enhance mutual accountability (complete/confirmed communication loop) of each party involved in a

		transition of care.
	25	Healthcare organizations should evaluate the effectiveness of transition protocols and policies, as well as evaluate transition outcomes.

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**DOMAIN: HEALTHCARE HOME**

**The Problem**

During the past few years, the healthcare system has experienced increasing rates of suboptimal quality of care, and rising expenses for all patients, but especially those with comorbidities and chronic illnesses. Studies demonstrate that chronically ill patients who see several physicians are prescribed incompatible or contraindicated treatments, and/or are provided with conflicting advice.<sup>8</sup> Rehospitalization rates are also on the rise.<sup>9</sup> A recent study found that 19.6 percent and 34.0 percent<sup>10</sup> of Medicare beneficiaries who had been discharged from a hospital were rehospitalized within 30 days and 90 days, respectively. Another 67.1 percent<sup>11</sup> of patients who had been discharged with medical conditions and 51.5 percent<sup>12</sup> of those who had been discharged after surgical procedures were rehospitalized or died within the first year after discharge. In addition, costs of care are higher among this population.<sup>13</sup> The primary reason for this phenomenon is because care is not properly integrated and coordinated between healthcare practitioners.

Research clearly indicates that, through better coordination of care, the model of the medical home, offers proven opportunities to improve the quality of care for all patients, particularly those with comorbidities and chronic illnesses. The healthcare home is one of the five essential domains of the NQF-endorsed framework on care coordination. As defined by the NQF, the “healthcare home” is the usual source of care selected by the patient (such as a large or small medical group, single practitioner, a community health center or a hospital outpatient clinic). The healthcare home should function as the central point for coordinating care around the patient’s needs and preferences. The healthcare home should also coordinate between all the various team members, which include the patient, family members, other caregivers, primary care providers, specialists, other healthcare services (public and private) and non-clinical services as needed and desired by the patient.<sup>14</sup> The healthcare home also should include evidence-based strategies for all patient populations to monitor, prevent, and reduce

239 significant risk factors for adverse outcomes in areas such as mental health, and family functioning.  
240 Quality improvement efforts within the healthcare home are central to begin reducing  
241 rehospitalizations as well as costs.

242  
243 Currently, a number of terms are encompassed by the concept of -healthcare home including medical  
244 home and primary care home. Several models intended to achieve the goals of healthcare homes have  
245 been put forward in the medical, nursing and other professional communities. In this report, the term  
246 healthcare home is used as a broad umbrella term, consistent with the NQF-endorsed framework. More  
247 specific terms, including medical home or primary care home, are used when they refer to specific  
248 evidence related to them.

249  
250 Much of the supporting evidence for healthcare homes and their components has emerged from  
251 research on medical homes, i.e., physician-led organizations. Through better coordination of care,  
252 research indicates that the medical home model offers opportunities to improve the quality of care for  
253 patients, particularly those with comorbidities and chronic illness. Throughout this report, however,  
254 the NQF focuses the practices on the more comprehensive entity, the healthcare home, relying on the  
255 evidence for medical homes as the basis at this time; as implementation and additional research unfold,  
256 the practices will be refined as appropriate.~~throughout this report the terms *healthcare home* and~~  
257 ~~*medical home* are used interchangeably.~~

258  
259 Several ~~key~~ physician organizations, The American Academy of Pediatrics (AAP), the American  
260 Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) define the  
261 medical home concept as the hub for coordinating care and should coordinate between members of all  
262 teams involved.<sup>15</sup> The Patient-Centered Medical Home, endorsed by AAFP, AAP, ACP, and the  
263 American Osteopathic Association (AOA),<sup>16</sup> aims to reduce cost and emphasizes the elements of the  
264 patient and family-centered medical home,<sup>17</sup> which are:

- 265 • a personal physician,
- 266 • physician-directed medical practice,
- 267 • whole-person orientation,
- 268 • coordinated/integrated care,

- 269 • quality and safety,
- 270 • improved access, and
- 271 • payment.

272

273 ~~Other models, such as t~~The Patient Centered Medical Home (PCMH), emphasizes the central role of  
274 primary care by combining comprehensive healthcare delivery and payment reform.<sup>18</sup> The PCMH is  
275 the focus of a demonstration project launched in June 2006 by TransformMED, a subsidiary of the  
276 American Academy of Family Physicians. A pilot study of patient-centered care in 36 family medicine  
277 practices,<sup>19</sup> the objective was to measure the model’s effect on practice and patient outcomes, with an  
278 ultimate goal of improving the quality of care for patients. By integrating best practices, the PCMH  
279 allowed enhanced communication and includes a myriad of innovative practices such as open access  
280 scheduling, online appointments, and electronic visits.<sup>20</sup>

281

282 In addition to the medical home, research has shown that other similar concepts improve patient care  
283 and health outcomes, such as the nurse-managed care health centers which are nationwide and  
284 generally vulnerable populations. The focus of the nurse-managed care health centers is on the needs of  
285 communities; healthcare is offered as well as nontraditional services such as stress reduction,  
286 adolescent and neighborhood violence and drug addictions.<sup>21</sup> These centers have shown to improve  
287 medication adherence, lower rates of hospitalization and emergency room usage. Other similar  
288 concepts include accountable care organizations; Medicaid managed care program, and the Joint  
289 Commission’s initiative, primary care homes.<sup>22,23</sup>

290

291 As noted earlier, the healthcare home is a central component of the NQF-endorsed framework for care  
292 coordination. The NQF’s Framework for Care Coordination has identified the “healthcare home” as an  
293 essential component for improvement. In addition to the healthcare home serving as the usual source  
294 of care, it also should allow for a more comprehensive relationship between the patient and provider. It  
295 should serve as the point of access for communication among the patient, family, and care providers –  
296 all information about the patient’s health status and related activities should be filtered through the  
297 healthcare home – and it should promote continuous coordination for all services of care. The  
298 healthcare home also for all patient populations in areas such as mental health, and family functioning  
299 Quality improvement efforts within the healthcare home model are central to begin reducing

300 | ~~rehospitalizations as well as costs.~~ Recognizing the importance of the healthcare home to improving  
301 care coordination, five preferred practices related to the healthcare home harmonize with the efforts  
302 that are currently being done and will further enhance the field in achieving goals toward coordination  
303 of care.

304

### 305 Preferred Practices

306 Five preferred practices related to optimizing care coordination through a healthcare home are  
307 recommended. The applicable care settings for these five practices include ambulatory care, ED, health  
308 plan, home care, home health services/agency, hospice, inpatient service/hospital, outpatient hospital,  
309 long-term acute care hospital, skilled nursing facility and Medicaid and Medicare home- and  
310 community-based services.

311

312 **Preferred Practice 1:** The patient shall be provided the opportunity to select the healthcare home that  
313 provides the best and most appropriate opportunities to the patient to develop and maintain a  
314 relationship with healthcare providers.

315

### 316 Additional Specifications:

- 317 • The healthcare home serves as a continuous point of contact for comprehensive and culturally  
318 competent care.
- 319 • The patient has the ability to make timely appointments with their particular primary care  
320 provider.
- 321 • The healthcare home shall work toward having in place e-visits or other forms of communication,  
322 that allow for information to be accessible and shared timely with the patient.
- 323 • The patient has the ability to participate in the decisionmaking process about their plan of care and  
324 treatment options.

325

### 326 Example Implementation Approaches:

- 327 • The National Demonstration Project integrated a set of best practices, which allowed enhanced  
328 communication, open access scheduling, online appointments, and electronic visits. This model  
329 mimics the patient centered medical home concept.<sup>24</sup>

330 • The National Nursing Centers Consortium currently represents a national network of 200 nurse-  
331 managed health centers, which are currently serving vulnerable populations across the country.  
332 These centers provide primary care, health promotion and disease prevention services for  
333 populations in urban and rural communities. Additionally, the nurse-managed health centers meet  
334 the criteria for safety-net providers as defined by the Institute of Medicine.<sup>25</sup>

335

336

337 Opportunity for Measurement:

338 • Demonstrating the established relationship between the patient and primary care provider can be  
339 shown several ways. The current most reliable measure is the Primary Care Assessment Tool,  
340 which is a global measure of primary care and incorporates questions, which can be used for  
341 measuring continuity.

342

343

344 **Preferred Practice 2:** Healthcare home or sponsoring organizations shall be the central point for  
345 incorporating strategies for continuity of care.

346

347 Additional Specifications:

- 348 • The healthcare home shall serve as the usual source of care and the coordinating hub for the  
349 patient’s medical needs.
- 350 ○ Services should be coordinated with the healthcare home for visits with multiple caregivers  
351 and/or diagnostic tests.
  - 352 ○ The capacity should be maintained to schedule appointments the same day as the  
353 patient/family requests and/or depending on the patient’s conditions.
- 354 • The healthcare home shall have access to all necessary information about the patient, as well as  
355 access to the patient during all decisionmaking processes.
- 356 • Each patient shall have an identifiable primary care provider for ongoing care.
- 357 • The patient shall have an opportunity to discuss the role of the healthcare home, identify the team  
358 members, and review their expectations of the healthcare home.
- 359 • The healthcare home shall use clinical information systems to identify and track patients.

- 360           o Accessible, clinically useful information on patients should be available to enable better  
361           comprehensive treatment for the patient.
- 362           • The healthcare home shall establish policies allowing a patient access to services and care providers  
363           during and after regular business hours.
- 364           • The healthcare home shall provide pre-visit planning and after-visit follow-up for patients.

365

366 Example Implementation Approaches:

- 367           • SoonerCare Choice serves as a primary care case management program adopted by the Oklahoma  
368           Health Care Authority. Each member of SoonerCare is provided with a primary care  
369           physician/case manager that serves as their “medical home,” and manages all of the patient’s  
370           healthcare needs from basic to specialty referrals.<sup>26</sup>

- 371           • The healthcare organizations can incorporate after-hours care mechanisms that permit urgent care  
372           by healthcare home providers (or at least someone who has access to patient-specific data).

- 373           • Minute Clinics, a system of walk-up clinics staffed by family nurse practitioners, provide rapid,  
374           efficient, cost-effective treatment at the convenience of the consumer. These clinics are the first and  
375           only retail care provider to achieve accreditation from The Joint Commission.<sup>27</sup>

376

377 Opportunity for Measurement:

- 378           • Availability of registries. Frequency of the patient visit based on whether patient attended  
379           appointment and based on patient generated appointment requests.

- 380           • Demonstrate adherence to the use of care plans, with access by the patient and family, and any  
381           authorized providers.

- 382           • Long-term resource utilization (e.g., inpatient stay; ED utilization) as a function of continuity of  
383           care compared to patients with a higher-risk for needing care coordination services. ~~low continuity  
384           populations.~~

385

386 **Preferred Practice 3:** The healthcare home shall develop infrastructure for managing plans of care that  
387 incorporate systems for registering, tracking, measuring, reporting, and improving essential  
388 coordinated services.

389

390 Additional Specifications:

391 | The plans of care established and written-documented by the healthcare team~~home~~ should encompass  
392 the following elements:

- 393 • Plans of care should be recorded in a repository that is accessible to providers of care, the patient,  
394 and their designees and updated by them at each encounter.
- 395 • Plans of care should be created, available, and updated electronically using national standardized  
396 documents that are computable, portable and enable interoperability.
- 397 • Plans of care should address, document, and allow measurement of team communication and  
398 appropriate interfaces during care, between visits, over time, and during transitions to other levels  
399 or venues of care.
- 400 • Plans of care should reflect awareness of the potential resources within the community and  
401 establish, where possible, linkages with care coordination community-based centers.
- 402 • Plans of care should produce measurements that identify defects that can be addressed by practice  
403 improvement initiatives such as access, scheduling, or communication strategies
- 404 • The plan of care document should include essential clinical data documenting the patient’s current  
405 state; including but not limited to problem lists; medication lists; allergies, risk factors; age-  
406 appropriate standardized clinical assessments and screening tests; immunization status, growth  
407 charts plotting height, weight, BMI; and structured progress notes.
  - 408 o The plan of care should also include information related to functional status, social support,  
409 caregiver status, and patient and caregiver priorities for care.
- 410 • The plan of care also should include a contingency plan for unintended circumstances related to  
411 treatment.
- 412 • The plan of care document should contain specific actions to be taken and identify the accountable  
413 entity for specific actions. Actions should be based, when available, on evidence that is referenced  
414 in the care plan and linked to specific outcomes also documented in the care plan.
- 415 • The plan of care document should align with the specific goals of the healthcare home.

416

417 Example Implementation Approaches:

- A database of ~~clinical~~medical and non~~clinical~~medical care providers is established with specific information such as services offered, cost and availability. Any pertinent licensure requirements must be provided to the healthcare home and noted in the database.
- Take Control of Your Health created by the New Jersey Department of Health and Senior Services, encourages a positive approach to self-management. The program consists of a six-week course designed to give people with chronic conditions (such as arthritis, heart disease, diabetes, emphysema, asthma, bronchitis, osteoporosis) and/or their caregivers the knowledge, skills and confidence they need to take a more active part in their health care.<sup>28</sup>

Opportunity for Measurement:

- Measure the number of provider specific referrals and outcomes of care as well as the patient/family satisfaction with care.

**Preferred Practice 4:** The healthcare home should have policies, procedures, and accountabilities to support effective collaborations between primary care and ~~specialist providers~~specialty physicians, including evidence-based referrals and consultations that clearly define the roles and responsibilities ~~of the patients, caregivers, and primary care and specialist providers.~~

Additional Specifications:

- The healthcare home and collaborating specialty practices should have policies, procedures, and tools for developing and implementing service agreements between providers to define roles and responsibilities for each party and across care settings.
- Formal specialty referral arrangements and practice service agreements will include clear guidelines regarding appropriateness of referrals and prioritizing patients to primary care, using evidence-based guidelines, when they exist.
- The healthcare home should have access to transparent information about their patient population and their medical complexity, and the services rendered by specialists and associated outcomes and costs. Implementing this will require collaboration between the healthcare home, specialists, and payers to create greater transparency that could be limited in scope to address the healthcare home

- 448 planning. Transparency agreements allow for entities to define the data and terms for sharing and  
449 exposing data and information.
- 450 • Referral communications should be structured to include evidence-based diagnosis and treatment  
451 guidelines when identifying the patient’s clinical condition.
  - 452 • Referral communications should be timely, explicitly delineating roles and responsibilities for  
453 follow-up with the healthcare home *and* with the specialist, and be transmitted in the format of an  
454 actionable care plan. The care plan and its delineated accountabilities shall be made available in real  
455 time to the patient and caregiver who will be participants in its creation.
  - 456 • The healthcare home should have tools to track referrals.
  - 457 • For patients being redirected from specialty settings, the healthcare home should have a mechanism  
458 to assure seamless access.
  - 459 • Payers should develop incentives to encourage the creation of care plans, service agreements, and  
460 use of evidence-based referral processes that result in improved outcomes.
  - 461 • Patient and provider education on availability and appropriateness of various types of referrals will  
462 be part of healthcare home orientation, including at a minimum:
    - 463 ○ Transparency and awareness of the policies and procedures regarding access to and  
464 expectations for specialty services.
    - 465 ○ Lists of specialty providers with formal practice agreements.
    - 466 ○ Procedures and policies for evaluation of activities prescribed by the care plan that are not  
467 working.
    - 468 ○ Procedures and policies for 24-hour contact information.

470 Example Implementation Approaches:

- 471 • [The Alameda County \(California\) Medical Home Project has partnered with a regional center to](#)  
472 [design a standardized referral cover sheet for providers. This cover sheet clarifies the referral](#)  
473 [process and provides pediatricians with the information they need for a successful referral.](#)<sup>29</sup>

475 Opportunity for Measurement:

- 476 • Assessing the appropriateness of referrals: primary versus specialty care
- 477 • [Measuring the redirection of patients](#)

- 478 • [Measuring whether primary and specialty care clinicians have a written co-management agreement](#)  
479 [that explicitly outlines roles and responsibilities.](#)  
480 • ~~Balance~~ measures [addressing for quality](#) outcomes  
481 • Cost of unnecessary referral care and subsequent testing generated by referral visit, including  
482 adverse events (e.g. the “cascade effect”)  
483  
484

485 **Preferred Practice 5:** The healthcare home will provide or arrange to provide care-coordination services  
486 for patients at high risk for adverse health outcomes, high service use, and high costs.  
487

488 Additional Specifications:

- 489 • Targeted assessment of the patient’s functional, cognitive, behavioral, social, [preventive health](#)  
490 [behaviors](#) and medical care needs, including relevant risk factors for adverse outcomes and high  
491 costs should be performed.  
492 • An electronic summary of the patient plan of care and risk factors should be produced and shared  
493 with the patient, caregivers, and care team within system capabilities.  
494 • Evidence-based guidelines should be used to provide patient and caregivers with options to  
495 manage their care and services, to reduce risk factors, and to achieve individual goals.  
496 • The plan of care for high-risk/high-cost patients should:  
497     o be individualized and incorporate patient and caregiver preferences and goals, [including](#)  
498 [culturally appropriate preferences and goals;](#)  
499     o incorporate findings from the targeted assessment, including relevant risk factors;  
500     o identify individual health goals the patient would like to achieve for self-management;  
501     o include evidence-based strategies to monitor, prevent, and reduce significant risk factors for  
502 adverse outcomes and avoidable use of high-cost services, e.g., intensive care, hospital  
503 admission, and readmission;  
504     o incorporate steps to coordinate transitions for patients between sites and providers of care  
505 and;

506 |       o recommend address community resources needed to meet patient and caregiver needs and  
507 |       goals, including plans for activating and monitoring the use of resources toward achieving  
508 |       patient and caregiver preferences and goals;

- 509 • Healthcare professionals responsible for providing care-coordination services for patients at high  
510 risk for adverse outcome, high-service use, and high costs will possess and demonstrate the  
511 knowledge, skills, and attitudes/competencies required to carry out these services including, but  
512 not limited to:
  - 513       o assessment of patient functional, cognitive, behavioral, social, and medical care needs,  
514       including risk factors for adverse outcome and high-cost care;
  - 515       o development of an individualized plan of care that incorporates patient and caregiver  
516 |       preferences, including those culturally appropriate as well as evidence-based treatments  
517 |       and interventions for acute and chronic health problems, and functional and social goals;
  - 518       o evidence-based interventions that promote self-management;
  - 519       o evidence-based interventions to prevent, manage, and reduce risks for adverse outcomes  
520       and preventable causes of use of high-cost services;
  - 521       o coordinate communication among providers across settings;
  - 522       o access, initiate, and evaluate the use of community resources to achieve patient and  
523       caregiver preferences and goals; and
  - 524       o evaluate the achievement of goals within the plan of care and adapt the plan of care as  
525       needed to improve goal attainment.
- 526 • A licensed healthcare professional must oversee the coordination of transitions for patients between  
527 sites and providers of care.
- 528 • Coordinates communication about the patient’s goals and healthcare action plan among the patient,  
529 caregivers, and healthcare professionals.

531 Example Implementation Approaches:

- 532 • Guided Care, a patient-centered medical home for older adults with complex health needs is a  
533 program implemented at Johns Hopkins Bloomberg School of Public Health. Guided Care has  
534 shown to improve the quality of care and reduce overall costs.<sup>30</sup>

- 535 • The National Heart Failure Training (N-HeFT) program describes itself as “a network whose  
536 mission is to create a mutually supportive environment for its members that promotes evidence-  
537 based best practices for heart failure by providing didactic sessions and preceptorships through its  
538 network of heart failure centers across the country.”<sup>31</sup> Implemented in 33 sites all over the country,  
539 the program seeks to improve the quality of care of their patients specifically in the area of  
540 mortality and hospital readmissions.
- 541 • Washington State Department of Social & Health Services, Aging and Disability Services  
542 Administration have implemented the Chronic Care Management project, with the goal of  
543 coordinating care, establishing medical homes, integrating acute and long-term healthcare, and  
544 developing client self-management skills while reducing avoidable medical expenses for high-  
545 risk/high-cost disabled adults.<sup>32</sup>

546

547 Opportunity for Measurement:

- 548 • NQF-endorsed performance measures related to chronic heart failure care, including 30-day all  
549 cause readmissions and mortality (NQF # 0229, 0330, 0505, 0521, 0535, 0551)
- 550 ○ 0229/Heart Failure 30-day Mortality
  - 551 ○ 0330/ 30-day All-cause risk standardized readmission rate following heart failure  
552 hospitalization
  - 553 ○ 0505/ 30-day All-cause risk standardized readmission rate following acute myocardial  
554 infarction (AMI) hospitalization
  - 555 ○ 0521 / Heart failure symptoms addressed
  - 556 ○ 0535/ 30-day All-cause risk standardized mortality rate following percutaneous coronary  
557 intervention
  - 558 ○ 0551/ Ace inhibitor/angiotensin receptor blocker use
- 559 • HCAHPS, ACAHPS
- 560 • Heart failure performance measures
- 561 • Minnesota Living with Heart Failure questionnaire
- 562 • Kansas City Cardiomyopathy questionnaire (KCCQ)
- 563 • NQF-endorsed CMS-OASIS measures for home care

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**DOMAIN: PROACTIVE PLAN OF CARE AND FOLLOW-UP**

**The Problem**

One of the critical constructs for effective and efficient care coordination is the plan of care, with emphasis on self-management, goals, and support. This concept is highlighted as a domain with the Care Coordination Framework—Proactive Plan of Care and Follow-up—which is defined as an established and current care plan that anticipates routine needs and actively tracks up-to-date progress on the patient and family long and short term goals.<sup>33</sup> A proactive plan of care is a central care coordinating mechanism for all patients, families, and team members.

Care that is not properly coordinated through a defined plan of care can result in especially devastating outcomes for patients with chronic disease. For example, lack of proper coordination hinders patients with cardiovascular disease (CVD) from receiving appropriate lifestyle and medication therapies (self-management), as well as increases risks for cardiovascular disease events. According to a study<sup>34</sup> conducted by the American Heart Association, out of the 80,000,000 American adults with one or more type of CVD, almost 20 percent have coronary heart disease (CHD). In 2009, the number of cases was estimated at 16,800,000<sup>35</sup> and the estimated direct and indirect cost of CHD was \$165.4 billion.<sup>36</sup>

Management of chronic diseases often varies over time; treatments and the care provided may change as the patients symptoms change.<sup>37</sup> Therefore, the plan of care becomes an increasingly important guidepost between these stages of care and self-management for the patient. In addition, the plan of care is vital during transitions of care. It often serves as the main communication document between care settings and outlines elements such as the medication list, follow-up steps, identification of care problem, and resources for nonclinical care. According to the NQF Framework for Care Coordination, the plan of care and self-management tools should encompass many other factors that contribute toward its successful implementation. These factors include the need for an organizational system or policy for refining the plan of care for every patient, jointly setting goals and managing the plan of care with the patient and family, assessing progress toward goals, a systematic process for follow-up tests, referrals, treatments, or services, and support through community and nonclinical services. Improving

595 care for patients and empowering them to take control over their conditions begins with developing a  
596 clear plan of care.

597

## 598 Preferred Practices

599 Five practices centered on improving care coordination through proactive development of a plan of  
600 care and follow-up. All practices are applicable in all healthcare settings, including ambulatory care,  
601 behavioral healthcare, community healthcare, health plan, home health, hospital, long-term acute care  
602 hospital, skilled nursing facility, and rehabilitation facility.

603

604 **Preferred Practice 6:** [Healthcare providers and entities](#) ~~The healthcare home~~ should have structured  
605 and effective systems, policies, procedures, and practices to create, document, execute, and update a  
606 plan of care with every patient.

607

### 608 Additional Specifications:

- 609 • The plan of care should be jointly created and managed by the patient, caregiver, and care provider  
610 according to their preference and the accountable provider ~~in the healthcare home~~. Elements of the  
611 plan of care should include, but are not limited to:
  - 612 ○ patient's diagnosis or problem;
  - 613 ○ environmental or social factors that may contribute to problem;
  - 614 ○ other known factors that may contribute to problem, [including assets and strengths](#);
  - 615 ○ plan of action for care to address diagnosis or problem, [including preventive care](#);
  - 616 ○ surrogate decisionmaker for patient care should be documented;
  - 617 ○ appointments for follow-up care;
  - 618 ○ self-management training and/or skills identified by the patient;
  - 619 ○ [evaluating participation and enabling engagement in activities of daily living](#); and
  - 620 ○ updated list of medications.
- 621 • The healthcare home team, which includes the patient and caregivers, shall assess progress toward  
622 goals and refine the plan of care with patient or surrogate input as needed to accommodate new  
623 information or circumstances.
- 624 • The plan of care shall remain as an integral component to all patient encounters.

- 625 • The plan of care shall be updated and involve periodic assessments as necessary at every patient  
626 encounter.
- 627 • The plan of care shall address how the patient is functioning in their environment and include  
628 assessments of medication tolerability, effectiveness, and adherence.
- 629 ○ The plan of care shall also place emphasis on improving outcomes and evidence-based  
630 interventions
- 631 • The patient shall be provided appropriate education and information for follow-up care with the  
632 healthcare home team. The healthcare home shall assess barriers to adherence with the established  
633 care plan and endeavor to address these barriers.
- 634 • The patient’s competency regarding self-management practices and skills should be assessed and  
635 considered in development and revisions of the plan of care.
- 636 • Routine assessments of the patient’s health literacy, cultural beliefs and ability/readiness to learn  
637 should be performed.
- 638

639 Example Implementation Approaches:

- 640 • None identified
- 641 • The State of New Jersey Department of Health and Senior Services has developed templates for  
642 universal child health records and care plans for children with special health care needs.<sup>38</sup>
- 643 • American Academy of Pediatrics and the National Center for Medical Home Implementation  
644 (NCMHI) have developed a communication checklist to assess how to promote patient access and  
645 quality communication using the medical home building blocks; care partnership support, clinical  
646 care information, care delivery management, resources and linkages, practice performance  
647 measurement, and payment and finance.<sup>39</sup>
- 648

649 Opportunity for Measurement:

- 650 • NQF-endorsed plan of care measures (NQF# 0021, 0251, 0262, 0321, 0323, 0383, 0384, 0385, 0386,  
651 0387)
- 652 ○ 0021/ Therapeutic Monitoring: Annual monitoring for patients on persistent  
653 medications
- 654 ○ 0251 / Vascular Access - Physician

- 655 ○ 0262 / Vascular Access – Physician (b)
- 656 ○ 0321 / Peritoneal Dialysis Adequacy/ Plan of Care
- 657 ○ 0323 / Hemodialysis Adequacy/ Plan of Care
- 658 ○ 0383/ Oncology: Plan of care for pain
- 659 ○ 0384/ Oncology: Pain Intensity Quantified
- 660 ○ 0385 / Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients
- 661 ○ 0386 / Oncology: Cancer Stage Documented
- 662 ○ 0387/ Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast
- 663 cancer

664  
665

666 **Preferred Practice 7:** A systematic process of follow-up tests, treatments, or services should be  
667 established and be informed by the plan of care.

668

669 Additional Specifications:

- 670 • Systems shall be in place to track results against patient goals.
- 671 • Tests, treatments, and services shall be coordinated for patients who receive care across providers  
672 and locations.
  - 673 ○ Interpretation of results should be appropriate and occur in a timely fashion across all venues.  
674 All venues of care also should report results and patient interventions to the healthcare home.
- 675 • Each follow-up process and/or reminder should be sent from the appropriate accountable provider  
676 in the system and should have a locus of accountability. The healthcare home for a patient must be  
677 apprised of any follow-up requested for a patient unless the patient requests otherwise.
- 678 • Reminders should be sent [to patients or their designees](#) for preventive measures, acute illness, and  
679 chronic disease management.
  - 680 ○ Reminders should be guideline based and include notifications for age-appropriate screening  
681 tests, age-appropriate immunizations, age-appropriate risk assessments [behavioral health](#)  
682 [assessments](#), and counseling.
  - 683 ○ Systems should be in place to proactively remind the patient and clinician of services needed,  
684 examples include:

- 685           ▪ patients needing pre visit planning;
- 686           ▪ patients needing clinician review or action;
- 687           ▪ patients on a particular medication;
- 688           ▪ patients needing reminders for preventive care;
- 689           ▪ patients needing reminders for specific tests; and
- 690           ▪ patients who might benefit from care management services
- 691 • Tests and other results shall be available to the patient/designee according to patient preferences  
692 and to the accountable healthcare home provider. The patient/designee and healthcare home  
693 provider shall be aware of tests, self-management data, and services specified within the plan of  
694 care. The results of tests and other data shall be readily available when needed to appropriate team  
695 members so as to avoid unnecessary duplication of services.
- 696     ○ Protocols and policies should be in place to ensure that appropriate and timely communication  
697       of tests and services is provided to the patient and designees.
- 698     ○ A process should be established for appropriate communication in responding to the results of  
699       a test.
  - 700           ▪ Diagnostic test results should be clearly interpreted and explained to the patient in an  
701           understandable manner and next steps/follow-up procedures should be reviewed.
- 702     ○ Patient information, such as current medications, consultation reports, progress notes,  
703       transitions of care reports, and test results, shall be communicated to all healthcare home team  
704       members to reduce the chance of error.
- 705     ○ At a minimum, patients should be able to explain, in their own words, the diagnosis/health  
706       problem for which they need care and instructions for prevention and/or treatment of  
707       conditions.

708

709 Example Implementation Approaches:

- 710 • None identified

711

712 Opportunity for Measurement:

- 713 • hospital readmission rates;
- 714 • preventive screening and immunization rates for target populations;

- 715 • patient satisfaction with care

716

717

718 **Preferred Practice 8:** The joint plan of care should be developed and include patient education and  
719 support for self-management and resources.

720

721 Additional Specifications:

- 722 • The joint plan of care should be developed with the patient, their designees, and the care provider.
- 723 |     ○ Inquiry should be made at each medical visit to assess patient understanding and agreement  
724 |         with planned treatment and knowledge of conditions under treatment. The agreed upon and  
725 |         written plan of care should be provided to the patient or designees according to the patient's  
726 |         preferences.
- 727 |     ○ Patient education within the joint plan of care should include education for guardians if the  
728 |         patient is a minor or incompetent.
- 729 • Readiness to change and self-management abilities should be assessed and documented in  
730 accordance with patient preferences, and where appropriate, for patients with limited competency.
- 731 • Patient's knowledge about conditions, treatments, and medications should be included in any  
732 assessment of joint plan of care. Where indicated, for full informed adherence and consent to the  
733 plan of care, the patient and their designees should be provided all relevant information to make  
734 informed decisions related to that plan.
- 735 • The patient and designees (according to patient preference or competency status) should be  
736 connected with self-management support programs that support and are aligned with the  
737 treatment plan.
- 738 • Connect the patient and their designees with classes taught by qualified instructors as necessary for  
739 informed participation in care.
- 740 • Resources necessary for informed care should be provided in the appropriate language that the  
741 patient or their designee understands and must be provided if the patient or designees expresses  
742 needs for additional materials.
- 743 • Self-monitoring tools should be considered which allow the patient to record results in the home  
744 setting where applicable.

- 745 • The plan of care should account for financial expenses the patient may incur and consider means to  
746 reduce costs to patient while seeking maximal patient benefit and patient desired outcomes.

747

748 Example Implementation Approaches:

749 • [Connected Cardiac Care<sup>40</sup>](#) is a program offered through the Center for Connected Health that aims  
750 to reduce the rehospitalization rates of patients with heart failure by educating patients about their  
751 conditions and providing self-management tools and ongoing support.

752 • [Health Dialog has developed consumer materials to assist with informed decision making, which  
753 include evidence-based information about treatment options, coaching from a neutral health  
754 professional, and an informed discussion with the treating physician.](#)<sup>41</sup>

755

756 Opportunity for Measurement:

- 757 • Process measures focused on the following elements:
- 758 ○ Patient (or designee) received written plan of care;
  - 759 ○ Patient received education about treatment and/or condition (in appropriate language);
  - 760 ○ Patient received education about self-management support programs;
  - 761 ○ Patient or designee’s preferences, readiness to change, and self-management abilities  
762 assessed;
  - 763 ○ Patient connected to classes taught by qualified instructors.

764

765

766 **Preferred Practice 9:** The plan of care should include community and nonclinical services as well as  
767 healthcare services that respond to a patient’s needs and preferences and contributes to achieving the  
768 patient’s goals.

769

770 Additional Specifications:

- 771 • Healthcare providers should form partnerships with community organizations and support the  
772 development of interventions to fill the gaps of clinical and nonclinical needed services

773 • [The plan of care should recognize local, state, regional health, national resources and incorporate  
774 these into the plan.](#)

- 775 | • [The plan of care should recognize](#) ~~and~~ public health resources and incorporate these into the plan.
- 776 |     o Active awareness of community programs both clinical and nonclinical and actively engage
- 777 |     patients/family to participate in those programs.
- 778 | • The plan of care should include other nonmedical resources that may impact the medical condition.
- 779 |     o A needs assessment for the patient should be employed to assess social and environmental
- 780 |     factors that may influence care, such as housing, ~~and~~ transportation, [and activities of daily](#)
- 781 |     [living](#).
- 782 |     o Community resources (e.g., social services, community advocates, transportation services,
- 783 |     etc.) should be used to meet the needs of the patient.
- 784 |     o The healthcare home should be aware of environmental/home, lifestyle, [participation](#), and
- 785 |     other community issues and incorporate those factors into the plan of care.
- 786 |

787 | Example Implementation Approaches:

- 788 | • The MeritCare Coordinated Treatment Center in Fargo, North Dakota, works as a team with the
- 789 | patients and their families to set goals that meet everyone’s needs.<sup>42</sup> As a team, the medical
- 790 | professionals and patient designees find ways to maximize the patient’s strength and achieve the
- 791 | goals set.
- 792 | • Community Care of North Carolina is an innovative effort organized and operated by practicing
- 793 | community physicians.<sup>43</sup> In partnership with hospitals, health departments, and departments of
- 794 | social services, these community networks have improved quality and reduced cost since their
- 795 | inception a decade ago. The program is now saving the State of North Carolina at least \$160 million
- 796 | annually.
- 797 |

798 | Opportunity for Measurement:

- 799 | • Measures of adherence to medication and other treatment plans
- 800 |
- 801 |

802 **Preferred Practice 10:** Healthcare organizations should use cardiac rehabilitation services to coordinate  
803 care for patients with a recent cardiovascular event, where available, appropriate and accessible.<sup>44</sup>

804

805 Additional Specifications:

- 806 • Cardiac rehabilitation services should begin at the hospital where patients are identified after they  
807 have had a cardiovascular event, including myocardial infarction (MI), percutaneous coronary  
808 intervention (PCI), coronary artery bypass graft (CABG) surgery, stable angina, heart valve surgery,  
809 and heart transplantation.
- 810 • Eligible patients should be referred by the inpatient care team to an outpatient cardiac  
811 rehabilitation program and begin receiving those services approximately 1 to 2 weeks after hospital  
812 discharge.<sup>45</sup>
- 813 • At program entry, patients undergo an initial evaluation to identify cardiovascular and related  
814 comorbid conditions. An individualized treatment plan is then designed and implemented that  
815 includes a comprehensive program of lifestyle therapy, education, counseling, and medical  
816 treatments, all of which are done in coordination with the patient's primary medical care provider.
- 817 • Patients participate in 60-minute rehabilitation sessions 3 days a week for up to 12 weeks. During  
818 that time, program staff should monitor patients' clinical status, adherence to preventive therapies,  
819 and identify any concurrent symptoms or other concerns that may impact their cardiovascular  
820 recovery and health.
- 821 • Programs should operate in a hospital or clinic setting, where patients report for their rehabilitation  
822 sessions. Programs may also include home-based or other alternative approaches to service  
823 delivery, particularly for patients who live far from the cardiac rehabilitation centers.

824

825 Example Implementation Approaches:

- 826 • Kaiser Permanente of Colorado<sup>46</sup> (KPCO) has implemented the Collaborative Cardiac Care Service  
827 (CCCS) with the goal of improving the health of patients with coronary artery disease (CAD). The  
828 service consists of a nursing team (Kaiser Permanente Cardiac Rehabilitation program-KPCR) and a

---

<sup>1</sup>[Preferred Practice 10 demonstrates importance and has shown to improve outcomes for patients who have experienced a cardiovascular event. In addition, the two measures \(CC-019-09, CC-020-09\) pair with the practice; Cardiac Rehabilitation Patient Referral from an Inpatient Setting, Cardiac Rehabilitation Patient Referral from an Outpatient Setting.](#)

829 pharmacy team (Clinical Pharmacy Cardiac Risk Service-CPCRS) working collaboratively with  
830 patients, primary care physicians, cardiologists, and other healthcare professionals to coordinate  
831 proven cardiac risk reduction strategies for patients with CAD.

832

833 Opportunity for Measurement:

- 834 • Cardiac Rehabilitation patient referral from an inpatient setting (including among approved  
835 measures in this report)
- 836 • Cardiac rehabilitation patient referral from an outpatient setting (including among approved  
837 measures in this report)

838

839

840 **DOMAIN: COMMUNICATION**

841

842 **The Problem**

843 Communication has consistently been recognized as being vital to care coordination. Despite this  
844 recognition, however, gaps in communication between the patient and provider are still very common.  
845 Some view effective communication as time-consuming<sup>47</sup> and costly. Several other barriers to effective  
846 communication have been cited, including delays in dictation and receipt of mailed letters, difficulties  
847 in telephone contact, and incomplete communication when multiple specialists are involved.<sup>48</sup> In the  
848 case of hospital discharge summaries,<sup>49</sup> which are physician-dictated or transcribed reports, research  
849 shows that only 25% of summaries reach the patient's primary care physician.<sup>50</sup> Poor communication is  
850 linked to a decrease in continuity of care, an increase in hospital readmission<sup>51</sup> rates and adverse  
851 events, and a decline in patient safety<sup>52</sup> and poor outcomes.

852

853 Communication within the construct of care coordination consists of open dialogue between the care  
854 team members and includes the patient and family. The NQF Care Coordination Framework identifies  
855 communication as involving all healthcare home team members and working within the same shared  
856 plan of care, ready availability of consultation notes and progress reports, shared decisionmaking  
857 between with the patient and family, using various communication methodologies, and maintaining

858 | privacy with access to information. [In addition, communication strategies should involve health](#)  
859 | [literacy, translators, expert panels and direct input from patient and family.](#)

860

861 | Communication among primary care providers, hospital providers, specialists and community  
862 | resources is key for optimal care of patients.<sup>53</sup> Currently, communication has become the forefront of  
863 | many hospital programs as a vehicle to improve transitions and reduce medical errors and  
864 | rehospitalizations. Several hospitals have successfully implemented patient-centered strategies that  
865 | address gaps in communications by including a family member, caregiver, or a nurse care coordinator  
866 | in the care of a patient in the hospital. Such programs, similar to the Care Partner program, developed  
867 | by Planetree, invites the caregiver/family members to participate in care activities (ranging from  
868 | monitoring care and treatments to aiding with personal activities) and address issues that may arise  
869 | (e.g., unexpected treatments and procedures, unexplained medications, adverse reactions). The benefits  
870 | arising from enhanced communication among the care providers and the patient are evident. Improved  
871 | communication leads to a quicker reconciliation of care issues, a clearer understanding of follow-up  
872 | protocols, and ultimately better outcomes for the patient.

873

874 | Clear communication between the patient and provider is essential for effective coordination of care  
875 | and is a direct reflection on the quality of care that is provided. [In addition to “traditional” face-to-face](#)  
876 | [communication methods, alternate communication modalities increasingly are being utilized. For](#)  
877 | [example, the Department of Veterans Affairs, Office of Care Coordination Services has established a](#)  
878 | [telehealth program, delivering health-related services and information via telecommunications](#)  
879 | [technologies.](#)<sup>54</sup> The NQF set of preferred practices for communication focuses on having an open  
880 | relationship between the provider and patient and the care team sharing responsibility for  
881 | contributions to the plan of care. The four practices related to communication also include employing  
882 | the use of a care partner to help support the patient during hospitalizations.

883

884

#### 885 | Preferred Practices

886 | Four practices related to improved communication to enhance care coordination are recommended for  
887 | endorsement. All practices apply to all settings of care.

888

889 **Preferred Practice 11:** The patient’s plan of care should always be made available to the healthcare  
890 home team, the patient, and their designees.

891

892 Additional Specifications:

- 893 • [The patient’s health information is available to all healthcare home team members and is open to](#)  
894 [the patient and their designees.](#)
- 895 • [The healthcare home team ensures other healthcare entities or professionals have timely access to](#)  
896 [the plan of care, as appropriate.](#)
- 897 • Mechanisms in compliance with federal law shall be in place to protect personal privacy, yet also  
898 enable all who should have secure access to necessary information, such as the patient, the family  
899 or caregiver in the home, primary care providers, and specialists.
- 900 • A defined process and timeframe to access the plan of care should be used.
- 901 • Processes should be in place to facilitate access to the plan of care at time of request.
- 902 • Processes should be in place to identify and address obstacles encountered when accessing the plan  
903 of care.

904

905 Example Implementation Approaches:

- 906 • [Project ACT \(advancing caregiver techniques\), a study conducted by the Thomas Jefferson](#)  
907 [University, Center for Applied Research on Aging and Health is designed to help caregivers learn](#)  
908 [new ways to manage challenging behaviors common in persons with Alzheimer’s. Participants of](#)  
909 [the program receive training on several things including caregiver and memory loss, ways to](#)  
910 [manage behavior problems related to dementia, and coping strategies and ways to handle stress.](#)<sup>55</sup>

911

912 Opportunity for Measurement:

- 913 • Monitor healthcare team members and patient’s access to plan of care during clinical  
914 encounters
- 915 • Assess the portability of the electronic health record in different health care settings

916

917 **Preferred Practice 12:** All healthcare home team members, who include patients and their designees,  
918 should work within the same plan of care and share responsibility for their contributions to the plan of  
919 care and achieving the patient’s goals.

920

921 Additional Specifications:

- 922 • All practice settings have mechanisms to develop and share the plan of care that includes patient’s  
923 preferences and goals.
- 924 • Protocols and/or steps are in place to ensure that patients and designees contribute to the  
925 development of the plan of care.
  - 926 ○ Communication between the patient and care team is consistently maintained by setting up  
927 a specific time period to allow open discussions for questions and/or concerns.
  - 928 ○ The patient is actively solicited for providing input on the progress of their care.
  - 929 ○ The patient’s input is actively sought when any change in the plan of care is necessary.
- 930 • Patients and their designees are informed and have opportunities to ask questions about all  
931 relevant care options, associated risks, and benefits, and this information should be included in the  
932 plan of care.
  - 933 ○ Patients are encouraged and supported in a nonjudgmental manner to share information  
934 about their own self-management practices, including information about their medications,  
935 with their caregivers, and this information is discussed and incorporated in the care plan.

936

937 Example Implementation Approaches:

- 938 • None identified

939

940 Opportunity for Measurement:

- 941 • [Patient and caregiver awareness of mechanisms to review and discuss plan of care as well as](#)  
942 [documentation in plan of care discussions](#)~~None identified~~

943

944 **Preferred Practice 13:** A program should be used that incorporates a care partner to support family  
945 and friends when caring for a hospitalized patient.

946

947 Additional Specifications:

- 948 | • [The](#) care partner program should be developed and implemented by the accountable healthcare  
949 organization, who is also responsible for the care of the hospitalized patient.
- 950 • The care partner should be a family member, friend, or volunteer selected by the patient to  
951 participate at various times in educational, physical, psychological, and spiritual support of the  
952 patient.
- 953 • The care partner should be encouraged to be active participants in the care process and be advised  
954 to speak up with questions, especially if something does not seem right, such as unexpected tests or  
955 procedures, unexplained medications, or adverse reactions.
- 956 • Shortly after admission and with approval from the patient, the primary nurse should discuss the  
957 routine care activities that are required and establishes the caregiver's interest.
- 958     o The nurse is typically responsible for providing the necessary education about the care and  
959 monitors the caregiver's progress and comfort level with any new skills. It is important to  
960 state that care partnering is not to be seen as a replacement for nursing care, but rather as an  
961 adjunct or enhancement to care.
- 962 | • Routine care activities provided by a care partners can include, but are not limited to:
- 963     o personal care – bathing, backrubs, hair care;
- 964     o meal assistance – feeding, menu selection, encouraging, recording;
- 965     o ambulation assistance – wheelchair use, encouraging, monitoring;
- 966     o monitoring fluids and medications;
- 967     o diversional activities – reading, writing, companionship;
- 968     o treatments – mouth care, dressings, exercises;
- 969     o managing the patient's comfort;
- 970     o assisting with review of health information and treatment/care plans relevant to  
971 decisionmaking, as appropriate;
- 972     o catheter and drain care;
- 973     o safety measures; and
- 974     o suctioning.
- 975

976 Example Implementation Approaches:

977 | • Planetree, a non-profit organization, has implemented ~~the a program~~ [Care Partner Program](#),  
978 | designed to include loved ones in the healing process. The care partner acts as the family  
979 | spokesperson, family advocate, and learns skills to provide home care.<sup>56</sup>  
980 |

981 | Opportunity for Measurement:

- 982 | • Patient satisfaction and/or experience with care measures

983 |

984 |

985 | **Preferred Practice 14:** Assess and document the provider’s perspective of care coordination activities.

986 |

987 | Additional Specifications:

- 988 | • A healthcare organization or accountable entity should assess provider interactions [vis a vis care](#)  
989 | [coordination with a care coordination program](#) as it relates to patient clinical information,  
990 | information communication frequency, mode of information delivery, and external partner care  
991 | component delivery roles.

- 992 | • An assessment process should demonstrate the usefulness and convenience of patient reports by  
993 | reviewing and evaluating the following processes:

- 994 | ○ reminders that a patient needs to [schedule](#) or receive treatment, due for service,
- 995 | ○ notices that patient has had service,
- 996 | ○ aggregate feedback,
- 997 | ○ report timing,
- 998 | ○ number and frequency of reports received, and
- 999 | ○ the mode of delivery.

- 1000 | • An assessment process should assess providers’ satisfaction with care coordination by evaluating:

- 1001 | ○ how providers are informed,
- 1002 | ○ the accuracy of information about patients,
- 1003 | ○ the ability of care coordination staff to assist the provider, and
- 1004 | ○ the overall program.

- 1005 | • An assessment process should also evaluate the impact of the care coordination program on its  
1006 | ability to care for patients as well as evaluate the effects on satisfaction of current requests of:

- 1007 | ○ having to pull patient charts,

- 1008           ○ filling out forms on patients,
- 1009           ○ reimbursement for activities related to care management,
- 1010           ○ reimbursement for selected services provided, and
- 1011           ○ one-on-one consultation.
- 1012       • An assessment process should assess how care coordination affects the patient-provider
- 1013           relationship and the provider’s ability to care for their patients.
- 1014       • An assessment process should supply the program’s impact on patient’s health information by
- 1015           rating the effect of care coordination on the use of services, the patient’s health status, and health
- 1016           behaviors.
- 1017       • The provider’s assessment also should account for the views of patients and families, as gathered
- 1018           through standardized instruments (e.g., CTM-3).

1020 Example Implementation Approaches:

- 1021       • DMAA: The Care Continuum Alliance has developed a Provider Satisfaction survey, an survey
- 1022           instrument used to assess the ~~providers~~provider’s perspective of care coordination components,
- 1023           including interactions with external disease management/health management programs. Questions
- 1024           within the survey include the ~~providers~~provider’s perspective of patient reports received from
- 1025           external programs, their interactions with disease management programs and how these programs
- 1026           affect the patients’ health and the provider’s ability to manage the patient.<sup>57</sup>

1028 Opportunity for Measurement:

- 1029       • The Care Continuum Alliance survey instrument can also serve as a measure for assessing the
- 1030           provider’s perspective

1033 DOMAIN: INFORMATION SYSTEMS

1035 The Problem

1036 Comprehensive, integrated, interoperable information systems have increasingly been the focus of

1037 efforts to improve healthcare quality. The use of such information systems, including electronic health

1038 records (EHR) is gaining momentum and transforming how patient records are shared and filed.

1039 Healthcare information technology (HIT) complements the patient-provider paradigm by providing  
1040 ongoing, real-time [information that can facilitate](#) collaboration, [coordination](#) and [quality measurement](#).  
1041 [coordination](#).

1042  
1043 Information systems are defined within the NQF Care Coordination Framework as the use of  
1044 standardized, integrated electronic information systems with functionalities essential to care  
1045 coordination and available to all providers and patients. Additional characteristics of an appropriate  
1046 healthcare information system include seamless interoperability, efficient and effective integration of  
1047 patient information, decision support tools, and provider and patient reminders. [It also must](#)  
1048 [encompass consumer-accessible applications such as the web and mobile platforms](#). [Lastly, it](#) also  
1049 must support quality improvement and safety.

1050  
1051 Research demonstrates that HIT has the potential to improve healthcare providers' efficiency and  
1052 effectiveness,<sup>58</sup> and EHRs in particular are supported throughout the country, especially by U.S.  
1053 policymakers.<sup>59</sup> Other positive impacts associated with using EHRs are improvements in coordination  
1054 of care through accurate and current patient data, as well as timely access to medical history  
1055 (medications, treatments, and conditions). Currently, a minimal number of healthcare providers are  
1056 using some type of EHR: Only 17 percent of U.S. physicians<sup>60</sup> and 1.5 percent of U.S. hospitals have  
1057 information systems<sup>61</sup> of basic or comprehensive capabilities. In addition, the misuse and nonuse of  
1058 EHRs has been linked to an increase in costs, poor health outcomes, and poor patient safety due to  
1059 insufficient or poor quality of data<sup>62</sup> on the patient. A standardized approach for HIT and the essential  
1060 data elements for those systems are important for efficient and effective use.

1061  
1062 Successful deployment of healthcare information systems provides the critical link to improving care  
1063 coordination. It provides the opportunity for various systems and care settings to interact and share  
1064 vital information about the patient, which greatly contributes to timeliness and accuracy of care. NQF  
1065 fully recognizes the benefits of HIT and electronic health records, but for various reasons some barriers  
1066 still exist to widespread implementation. NQF has underway a broad spectrum of quality  
1067 improvement efforts within HIT. This set of three preferred practices is only one aspect and is intended  
1068 to serve as a starting point for the use of information systems to improve care coordination.

1069

1070 Preferred Practices

1071 Wider deployment of health information technology is important to improved care coordination. The  
1072 three practices recommended apply to all care settings.

1073  
1074 **Preferred Practice 15:** Standardized, integrated, interoperable and electronic information systems ~~that~~  
1075 have with functionalities essential to care ~~coordination~~coordinationfunctions, decision support, ~~and~~  
1076 quality measurement and practice improvement should be used.

1077  
1078 Additional Specifications:

- 1079 • Electronic information systems should be structured so that patients ~~and providers~~ have secured  
1080 access to the best and most appropriate information to guide care. ~~needed.~~
  - 1081 ○ Structured asynchronous communications should be used for care coordination functions in  
1082 methods appropriate for the recipient.
  - 1083 ○ Information systems should comply with all HIPAA privacy, security rules, and state laws  
1084 related to privacy of health information.
  - 1085 ○ The content contained within -information systems is are clearly explained and user friendly  
1086 for the patient and include web-based and mobile platform access.
  - 1087 ○ The information systems should assist patients and families in making decisions regarding  
1088 services and care.
- 1089 • Core data elements for electronic information systems should include, but not be limited to,  
1090 laboratory, imaging, referrals, medications, physical findings, plan of care, social and community  
1091 services, and self-management support.
- 1092 • Information systems should have ~~the~~ capabilities necessary to be used for tracking transitions of  
1093 care and referrals.
- 1094 • Information systems should have the capabilities to easily retrieve data for evaluation of  
1095 performance measures, transparency, information sharing (e.g., registries, population-based data),  
1096 quality improvement, cost of care, accountability, and policymaking for care coordination.
  - 1097 ○ Information systems should use industry standard terminologies and industry standard  
1098 messaging platforms necessary for information sharing between and across care delivery  
1099 settings.

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Example Implementation Approaches:

- Connecticut Community Care Inc., uses a community and institutional [electronic health record \(EHREHR\)](#) for chronically ill, high risk elderly in the community.<sup>63</sup>
- Maintain separate portals – one for the patient and one for the provider.
- Use electronic communication tools, such as e-mail or web-messaging and self-monitoring devices, as well as traditional methods.
  - Use electronic surveys or questionnaires identifying services available within an area.

Opportunity for Measurement:

- None identified

**Preferred Practice 16:** An electronic record system should allow the patient’s health ~~information~~[data](#) to be accessible to caregivers at all points of care.

Additional Specifications:

- The health information for the individual patient should be available at the point and time of care in an interoperable computable document, [while still providing privacy for sensitive information](#).
- Document structures should conform to national standards so that information can be automatically acquired and processed from multiple sources into a consolidated document and/or integrated into the EHR at the point of care.
- Structured [plans of care, care plans](#), when available, should be updated after encounters to provide a single reference source enabling and documenting coordination of care.
- Record systems should transmit computable information including: caregivers, problem list, allergies, medications, prior test results, advance directives, [plans of care care plans](#) including goals, and insurance.

- 1128 • Structured clinical document standards should have the flexibility of supporting simple or complex  
1129 structures and semantics in order to support a spectrum of electronic health records.
- 1130 • Electronic health records should be certified as to conformance with national standards.
- 1131 • Information systems should comply with all HIPAA privacy, security rules, and state laws related  
1132 to privacy of health information.

1133

1134

1135 Example Implementation Approaches:

- 1136 • Not identified

1137

1138 Opportunity for Measurement:

- 1139 • None identified

1140

1141

1142 **Preferred Practice 17:** Regional health information systems governed by public/private partnerships  
1143 should enable healthcare home teams ~~and patients and their designees~~ to access all patient information.

1144

1145 Additional Specifications:

- 1146 • Access to patient information should occur through ~~a one single~~ data exchange that still provides  
1147 privacy for the sensitive information.
- 1148 o Enable the exchange and use of health information across communities, in a private and  
1149 secure manner, for the purpose of promoting the improvement of health quality, safety, and  
1150 efficiency.
- 1151 o Information should be delivered to patients and/or providers when and where they need it so  
1152 the information could be used to make informed decisions, while also supporting privacy and  
1153 patient preferences.
- 1154 • Regional health information systems will have a structure that includes clear policies, including  
1155 involvement of a board of directors, healthcare providers, consumer representatives, and  
1156 community stakeholders to ensure care coordination is a top priority.

- 1157 | • [Information systems should comply with all HIPAA privacy, security rules, and state laws related](#)  
1158 | [to privacy of health information.](#)

1159

1160 Example Implementation Approaches:

- 1161 • The Massachusetts eHealth Collaborative, is working toward a 24- to 36-month pilot study to  
1162 demonstrate the effectiveness and practicality of implementing electronic health records for 3  
1163 communities in Massachusetts.<sup>64</sup>

1164

1165 Opportunity for Measurement:

- 1166 • None identified

1167

1168

1169 DOMAIN: TRANSITIONS

1170

1171 The Problem

1172 Transitions of care within the current system have proven to be one of the most important factors in  
1173 patient care. Every patient who is admitted to the hospital will experience a transition to another  
1174 setting (home, rehabilitation facility, skilled nursing facility, outpatient facility, etc.). It is evident that  
1175 poor transitions lead in many cases to underuse, overuse, or misuse of care.<sup>65</sup> An episode of care for a  
1176 chronic condition or serious illness may involve numerous settings, often with little communication  
1177 among the various providers and components of these settings of care.

1178

1179 NQF defines transitional care as a “hand-off” or transition between settings of care. Transitional care  
1180 should be based on a comprehensive plan of care and consist of a set of actions designed to ensure the  
1181 coordination and continuity of healthcare. In particular, the availability of healthcare professionals who  
1182 | are [accountable for transitions and who are](#) well trained in chronic care and acute care and have  
1183 | current information about the patient’s goals, preferences, and clinical status is key to successful  
1184 | transitions.<sup>66</sup>

1185

1186 | Although the implications to poor transitions of care are evident, physician practices [and other](#)  
1187 | [healthcare practitioners](#) often work in silos without accurate knowledge of prior care received,

1188 medications prescribed, or what specific problems were addressed.<sup>67</sup> Studies demonstrate that one in  
1189 five patients discharged from the hospital to home experience an adverse event and more than half of  
1190 those adverse events are drug-related events that can often be avoided or prevented.<sup>68</sup> A lack of  
1191 appropriate communication also contributes to the transitional care problems; one study found that  
1192 only 3 to 20 percent of physicians communicate key patient information between the hospital and  
1193 primary care physician.<sup>69</sup> Discharge summaries often lack the key information needed such as test  
1194 results, medication lists, patient or family counseling, follow-up steps, etc.<sup>70</sup> The emergency  
1195 department, often the point of re-entry for patients with adverse events, is a vital care setting in  
1196 transitions; communication is particularly important during this critical point. The pivotal role of the  
1197 family and caregiver during transitions is often overlooked. Family members have expressed a sense of  
1198 anxiety during transitions due to the lack of preparation, conflicting advice, confusion with different  
1199 practitioners, and a lack of input in the care plan.<sup>71</sup>

1200  
1201 A policy statement by the American College of Physicians (ACP), Society of Hospital Medicine (SHM),  
1202 Society of General Internal Medicine (SCIM), American Geriatric Society (AGS), American College of  
1203 Emergency Physicians (ACEP), and the Society for Academic Emergency Medicine (SAEM), identifies  
1204 several principles to address the quality gaps in transitions between inpatient and outpatient settings  
1205 and notes components for implementation of those principles.<sup>72</sup> The principles identified include  
1206 accountability, timely interchange of information, involvement of the patient and family member, and  
1207 standardized metrics to lead to quality improvement and accountability. In particular, the key  
1208 components for implementation are: a transition record, standard communication formats, and  
1209 communication infrastructure. The National Transitions of Care Coalition (NTOCC) also identifies  
1210 several steps for improving transitions of care; many echo those mentioned in the joint statement, but  
1211 NTOCC also notes the importance of implementing an electronic health record, increasing the use of  
1212 case management, expanding the role of the pharmacist, and implementing payment incentives.<sup>73</sup>

1213  
1214 Within the NQF Framework for Care Coordination, certain care processes during transitions deserve  
1215 particular attention: medication reconciliation, changes in the plan of care, involvement of the team  
1216 during hospitalization, timeliness, and communication between settings; the 25 NQF preferred  
1217 practices related to transitions emphasizes these components. A standardized approach to transitional

1218 care will greatly address the fragmented care within our health system, improving patient safety and  
1219 quality of care.

1220

### 1221 Preferred Practices

1222 Transitions are key leverage points for care coordination. Seven preferred practices in this domain are  
1223 recommended and are applicable to all healthcare settings.

1224

1225 **Preferred Practice 18:** Decisionmaking and planning for transitions of care should involve the patient,  
1226 and, according to patient preferences, family and caregivers (including the healthcare home team).

1227 Appropriate follow-up protocols should be used to assure timely understanding and endorsement of  
1228 the plan for patient and their designees.

1229

### 1230 Additional Specifications:

- 1231 • Healthcare home team has current information and resources that assist the patient and their  
1232 designees in making the best decisions about transitions, especially for post acute care or long-term  
1233 care.
  - 1234 ○ Information resources should be provided to the patient and their designees, which include  
1235 available services, eligibility, costs, and comparative data for those services.
- 1236 • The patient, family, and caregivers should be actively involved in decisionmaking for transitions of  
1237 care.
- 1238 • The healthcare home team, patient, and their designees should collaboratively develop a plan for  
1239 transitions of care.
- 1240 • Appropriate follow-up protocols for transitions of care should be used by the healthcare home  
1241 team.
- 1242 • All resources provided to the patient should be offered in the patient's primary written and spoken  
1243 language, [including American Sign Language, as appropriate](#).

1244

### 1245 Example Implementation Approaches:

- 1246 • The California Healthcare Foundation's program, Better Chronic Disease Care focuses on  
1247 improving quality of life for patients with chronic disease, by expanding the number the providers

1248 who effectively care for patients with chronic conditions, increase participation of patients and  
1249 families, and promote appropriate care toward end of life.<sup>74</sup>

1250  
1251 Opportunity for Measurement:

- 1252 • Assess the patient, family and caregivers involvement in decision making for transitions of care.

1253  
1254  
1255 **Preferred Practice 19:** Engage patient and their designees to determine and prepare for ongoing care  
1256 during and after transitions.

1257  
1258 Additional Specifications:

- 1259 • Appropriate patient education should be used during transitions of care.
- 1260 • Use programs to engage patients and families on self-management practices during transition of  
1261 care.
- 1262 • The patient and all parties accountable for the patient's care should be provided the appropriate  
1263 information during transitions of care.
- 1264 • Preparations for transitions of care and ongoing care should include aspects of care at home, when  
1265 appropriate.
- 1266 • Fully inform patient of clinical options and engage patient in decisionmaking.
- 1267 • Self-management practices should be shared by the patient with the family and healthcare team.
- 1268 • Medication lists and patient education of medication use should be evaluated appropriately before  
1269 transitioning to another care setting.

1270  
1271 Example Implementation Approaches:

- 1272 • Not identified

1273  
1274 Opportunity for Measurement:

- 1275 • [Assessment of the quality of the patient education materials, the skills of the self-management](#)  
1276 [coach, and whether or not the patient was able to absorb and retain the information received](#)
- 1277 • [Assessment of patient preparation and engagement for ongoing care](#)

- 1278 • NQF-endorsed readmission measures (NQF# 0330, 0329, 0337, 0549, 0335, 0505, 0506)
- 1279 ○ 0329 / All-Cause Readmission Index
- 1280 ○ 0330/ 30-day all-cause risk standardized readmission rate following heart failure
- 1281 hospitalization
- 1282 ○ 0335 / PICU Unplanned Readmission Rate
- 1283 ○ 0337 / Review of Unplanned PICU Readmissions
- 1284 ○ 0505/ 30-day all-cause risk standardized readmission rate following acute myocardial
- 1285 infarction (AMI) hospitalization
- 1286 ○ 0506 / 30-day All-Cause Risk Standardization Readmission rate following pneumonia
- 1287 hospitalization
- 1288 ○ 0549 / Pharmacotherapy Management of COPD Exacerbation (PCE)

1291 | **Preferred Practice 20:** Systematic care transitions programs that engage patients and families in self-  
1292 management after being transferred home should be used whenever available.<sup>75</sup>

1294 Additional Specifications:

- 1295 • The care transitions program is low cost and low intensity and should focus on four areas:
- 1296 medication self-management, use of a dynamic patient-centered record, timely primary
- 1297 care/specialty care follow-up, and what to do when access is a problem and knowledge of red flags
- 1298 that indicate a worsening in their condition and how to respond.
- 1299 • The care transitions program should be a minimum of 4 weeks and incorporate skill building
- 1300 exercises and resource tools.
- 1301 • Key self-management skills should be identified, including skills needed to assert a more active role
- 1302 in the patient’s care.
- 1303 | • A care transitions coach<sup>†</sup> should be introduced to provide the additional support to the patient and
- 1304 family caregivers, particularly for patients who are at high-risk for adverse outcomes and/or
- 1305 readmissions.

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<sup>†</sup> [Transition coaches typically are registered nurses, advanced practice nurses, or masters-level social workers. The transitions coach is not intended to fix common transition related problems, but rather serve as a model for how patient and families can address these problems themselves.](#)

1306

1307           o The transition coach assists in learning and developing care transition self-management  
1308           skills.

1309 • Transition coach and patient simulate next steps care, including role play for upcoming encounters  
1310       with other caregivers.

1311

1312 Example Implementation Approaches:

1313 • None identified

1314

1315 Opportunity for Measurement:

1316 • NQF-endorsed readmission measures

1317 • NQF-endorsed 3-Item Care Transitions Measure (Measure is recommended for continued  
1318       endorsement as a component of this project)

1319

1320

1321 | **Preferred Practice 21:** [TheA](#) Transitional Care Model should be deployed for chronically high-risk  
1322       older adults.<sup>76</sup>

1323

1324 Additional Specifications:

1325 | [TheA](#) Transitional Care Model should include the following elements:

1326 • A Transitional Care Nurse (TCN)<sup>77</sup> should be used as the primary coordinator of care to assure  
1327       continuity of care across the entire episode:

1328           o TCN should be used for in-hospital assessments, preparations, and development of an  
1329           evidenced-based plan of care;

1330           o TCN should be used for regular home visits and ongoing telephone support through an  
1331           average of two months after discharge;

1332 • Continuity of medical care between the hospital and primary care physicians facilitated by the TCN  
1333       accompanying patient at least for the first follow-up visits;

1334 • Comprehensive, holistic focus on each patient’s needs, including the reason for the primary  
1335       hospitalization as well as other complicating or coexisting events;

- 1336 • Active engagement of patients and family caregivers including education and support;
- 1337 • Emphasis on early identification and response to healthcare risks and symptoms to achieve longer-
- 1338 term positive outcomes and avoid adverse and untoward events that lead to hospital readmissions;
- 1339 • Multidisciplinary approach that includes the patient, family, and formal caregivers as part of a
- 1340 team;
- 1341 • Physician-nurse collaboration; and
- 1342 • Communication to, between, and among the patient, family, and informal caregivers, and
- 1343 healthcare providers and professionals.

1344

1345 Every patient enrolled in the Transitional Care Model should receive individualized care based the  
1346 following elements:

- 1347 • The following patient visit schedule is used by the TCN:
  - 1348 ○ In the hospital within 24 hours of enrollment;
  - 1349 ○ Daily throughout the hospitalization;
  - 1350 ○ In the home within 24 to 48 hours of discharge from the hospital;
  - 1351 ○ At least weekly during the first month;
  - 1352 ○ At least semi-monthly through the duration of the intervention
- 1353 • In-Hospital Visits with Patients:
  - 1354 ○ The TCN conducts a comprehensive assessment of the patient’s health status and defines
  - 1355 priority needs and services for the patient and family caregiver(s) throughout the patient’s
  - 1356 stay.
  - 1357 ○ The TCN also collaborates with the physicians and other members of the healthcare team to
  - 1358 streamline the plan of care and to design and coordinate follow-up care based on the
  - 1359 comprehensive assessment and goals identified by the patient.
- 1360 • Home Visits with Patients:
  - 1361 ○ The TCN initiates telephone contact with the patient, as needed, and in each week an in-
  - 1362 person visit is not scheduled.
  - 1363 ○ The nurses are available to the patients and their family/caregivers by telephone from 8 am
  - 1364 to 8 pm Monday through Friday and 8 am to noon on weekends.

- 1365           ○ An explicit, personalized plan for emergency care during those hours when the TCN is
- 1366           unavailable is prepared for each patient and their family caregivers.
- 1367       • The TCN accompanies the patient on his/her first visit with the physician post-discharge and on
- 1368       subsequent visits, if needed.
- 1369       • Immediately following the visit with the physician, the nurse also assists patients and family
- 1370       caregivers in understanding the primary care physician’s instructions.
- 1371       • The following elements should take place following a transition from TCM:
- 1372           ○ the TCN assures continuity of care and ongoing commitment to the patient’s self-
- 1373           management goals through communication with the primary care provider who will
- 1374           continue to follow the patient.
- 1375           ○ A transition summary prepared by the TCN is provided to patients and primary care
- 1376           providers, which include the patients’ goals, progress in meeting these goals and ongoing or
- 1377           unresolved issues with the plan of care.
- 1378       • TCM substitutes for visiting nurse services except in those cases in which patients require
- 1379       specialized services such as wound care or intravenous therapy.

1380  
1381 Example Implementation Approaches:

- 1382       • [The Transitional Care Model is currently fully implemented within the University of Pennsylvania](#)
- 1383       [Health System.](#)<sup>78</sup>

1384  
1385 Opportunity for Measurement:

- 1386       • [Transitional care model assessment measures coupled with readmission measures](#)
- 1387       • NQF-endorsed 30-day readmission rate measures for heart failure, myocardial infarction, and
- 1388       pneumonia;
- 1389       • NQF-endorsed 3-item Care Transitions Tool (CTM-3)
- 1390       • 6-month and 12-month readmission rates; and
- 1391       • Time to first hospital readmission.

1392  
1393

1394 **Preferred Practice 22:** Healthcare organizations should develop and implement a standardized  
1395 communication template for the transitions of care process, including a minimal set of core data  
1396 elements that are accessible to the patient during care.

1397

1398 Additional Specifications:

- 1399 • Organizations should specifically identify the appropriate steps of communication and elements to  
1400 ensure accuracy during transitions. These include, but are not limited to:
  - 1401 ○ patient identifiers such as patient name, medical record number, and date of birth;
  - 1402 ○ names of physicians, other providers, and key contacts;
  - 1403 ○ important medical history, such as diagnosis, current condition, treatments, time-sensitive  
1404 issues; and
  - 1405 ○ clear opportunities to ask and respond to questions.
- 1406 • Core data elements should accompany the patient during all transitions of care, appropriate to the  
1407 type of transition and accessible throughout the transition.
- 1408 • The core data elements should include, but are not limited to:
  - 1409 ○ [clinical status](#);
  - 1410 ○ medication lists;
  - 1411 ○ functional status;
  - 1412 ○ medical diagnosis and significant health problems;
  - 1413 ○ patient and caregiver priorities for care;
  - 1414 ○ preferences relevant to the transition;
  - 1415 ○ treatments/procedures completed within the setting;
  - 1416 ○ all treatments (durable medical equipment [DME], medications, therapies) including post-  
1417 transitions treatments should clearly be identified;
  - 1418 ○ relevant past medical history; and
  - 1419 ○ advance directive status.
- 1420 • Follow-up information such as appointments and changes in medication should be included  
1421 during transitions.
- 1422 • An electronic summary care record for every transition in care should be produced and shared  
1423 with the patient and care team within system capabilities.<sup>79</sup>

- 1424 • The plan of care should be visibly accessible and communicated appropriately during transitions.
- 1425 • Clinical information should be provided, documented, and reviewed with the next
- 1426 provider/contact person of care for the patient.
- 1427 • All parties caring for the patient should be aware of important clinical information that may
- 1428 impact care.

1429

1430 Example Implementation Approaches:

- 1431 • The National Transition of Care Coalition has developed several tools to assist consumers during
- 1432 transitions of care.<sup>80</sup>
  - 1433 ○ Taking Care of My Health Care is a consumer tool developed to guide patients and their
  - 1434 caregivers in preparing for physicians visits; what kinds of information should be received
  - 1435 and what kinds of questions should be asked.
  - 1436 ○ Transitions of care checklist provides a detailed description of effective patient transfer
  - 1437 between practice settings

1438

1439 Opportunity for Measurement:

- 1440 • Process measures: data template completed, transferred in targeted timeframe, reviewed with
- 1441 receiving provider in targeted timeframe, reviewed with patient at transition
- 1442 • Outcomes: medication errors, hospital admission, readmission

1443

1444

1445 **Preferred Practice 23:** Healthcare providers and healthcare organizations should implement

1446 protocols/policies for a standardized approach to all transitions of care. Policies and procedures

1447 related to transitions and the critical aspects should be included in the standardized approach.

1448

1449 Additional Specifications:

- 1450 • During all transitions, standardized information should include elements such as information
- 1451 transfer, follow-up, and communications.
- 1452 ○ Standardized information should be utilized for transitions and for chronically high-risk
- 1453 patients

- 1454 • Standardized approaches should include internal and external transfers.
- 1455 • Healthcare organizations should use specific elements of discharge:
  - 1456 ○ Comprehensive assessments with specific language (current state of patient during
  - 1457 transition). Discharge summaries should be communicated with the patient in a clear and
  - 1458 understandable format.
- 1459 • A clear plan should be developed and implemented for management of clinical symptoms and
- 1460 establishing a contact for emergencies.
- 1461 • Decisions regarding post-acute referrals should include the healthcare team, patient, family and/or
- 1462 caregivers.
- 1463 • Goal setting with the patient, family, and caregivers should be developed and reviewed during all
- 1464 transitions of care.
- 1465 • At a minimum, patients should be able to explain, in their everyday words, the diagnosis/health
- 1466 problem for which they need care and instructions for prevention and/or treatment of conditions.
- 1467 • “Teach back” should begin early in the process of patient care decisionmaking to ensure that
- 1468 patients have time to understand and think about their care options and transitions.

1469

1470 Example Implementation Approaches:

- 1471 • Structured computable documents are now being developed to address transitions of care. Their
- 1472 use, when available, will facilitate automation, result in administrative simplification, and enhance
- 1473 the effectiveness and measurability of protocols.

1474

1475 Opportunity for Measurement:

- 1476 • Assess and monitor the care plan and implementation of the plan
- 1477 • Assessment of condition status, level of control and functional status compared to previous periods

1478

1479

1480 **Preferred Practice 24:** Healthcare providers and healthcare organizations should have systems in place

1481 to clarify, identify, and enhance mutual accountability (complete/confirmed communication loop) of

1482 each party involved in a transition of care.

1483

1484 Additional Specifications:

- 1485 • Healthcare organizations should establish defined roles and responsibilities of the sender and  
1486 receiver during transitions/hand offs.
- 1487 • A documented receipt of information should be provided during transitions.
- 1488 • Healthcare organizations should have policies and procedures in place to identify the care provider  
1489 for the patient during transitions of care.
- 1490 • Healthcare organizations should routinely assess the transitions/hand-off process and evaluate the  
1491 patient’s satisfaction with transitions of care.

1492

1493 Example Implementation Approaches:

- 1494 • Improve communication between specialist and primary care clinicians to reduce unnecessary  
1495 duplicate testing, improve medication safety, etc. Readmission and medication errors are major  
1496 issues.

1497

1498 Opportunity for Measurement:

- 1499 • CTM-3 (NQF-endorsed) and CTM-15 are applicable.
- 1500 • NCQA’s provider practice connections systems tool contains some questions about communication  
1501 loops and measures the capacity for “closing the communication loop.”

1502

1503

1504 **Preferred Practice 25:** Healthcare organizations should evaluate the effectiveness of transition  
1505 protocols and policies, as well as evaluate transition outcomes.

1506

1507 Additional Specifications:

- 1508 • Evaluate adherence to transition policies and protocols.
- 1509 • Evaluations of transitions of care should include:
  - 1510 ○ rates of adverse events defined and determined by local risk assessments;
  - 1511 ○ rates of avoidable readmissions; and

- patient's satisfaction with transitions of care (Healthcare organizations should routinely assess the transitions/hand-off process and evaluate the patient's satisfaction with transitions of care).

Example Implementation Approaches:

- None identified

Opportunity for Measurement:

- [Patient satisfaction/patient experience with care during transitions \(i.e. HCAHPS family of surveys\)](#)
- Rates of adverse events related to poor transitions of care
- Readmission rates

**RELATIONSHIP TO OTHER NQF-ENDORSED PREFERRED PRACTICES**

This report does not represent the entire scope of NQF work relevant to the quality of care for care coordination. Through other projects, NQF has endorsed several preferred practices addressing the domains of the NQF-endorsed Care Coordination Framework and the National Priorities Partnership (NPP) goals for care coordination.

**NQF-endorsed Safe Practices Related to Care Coordination<sup>81</sup>**

**Safe Practice 12: Patient Care Information**

Ensure that care information is transmitted and appropriately documented in a timely manner and in a clearly understandable form to patients [and appropriate family and caregivers](#) and to all of the patient's healthcare providers/professionals, within and between care settings, who need that information to provide continued care.

**Safe Practice 15: Discharge Systems**

1542 A “discharge plan” must be prepared for each patient at the time of hospital discharge, and a concise  
1543 discharge summary must be prepared for and relayed to the clinical caregiver accepting responsibility  
1544 for post-discharge care in a timely manner. Organizations must ensure that there is confirmation of  
1545 receipt of the discharge information by the independent licensed practitioner who will assume the  
1546 responsibility for care after discharge.

1547  
1548 **[Safe Practice 18: Pharmacist Leadership Structures and Systems](#)**  
1549 [Pharmacy leaders should have an active role on the administrative leadership team that reflects their](#)  
1550 [authority and accountability for medication management systems performance across the organization.](#)  
1551

1552 **Safe Practice 17: Medication Reconciliation**  
1553 The Healthcare organization must develop, reconcile, and communicate an accurate patient medication  
1554 list throughout the continuum of care.

1555  
1556  
1557 **NQF-endorsed Cultural Competency Practices Related to Care Coordination<sup>82</sup>**  
1558

1559 **Cultural Competency Preferred Practice 14**  
1560 Maintain sufficient resources for communicating with patients in their primary written and spoken  
1561 languages through qualified and competent interpreter resources, such as competent bilingual or  
1562 multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting  
1563 services, credentialed volunteers, and others, to ensure timely and high-quality communication.

1564  
1565 **Cultural Competency Preferred Practice 23**  
1566 Develop and implement a comprehensive care plan that addresses cultural concerns.

1567  
1568 **Cultural Competency Preferred Practice 26**  
1569 Use culturally appropriate care coordination services that take into consideration the cultural diversity  
1570 of the populations seeking healthcare.

1571  
1572 **Cultural Competency Preferred Practice 43**  
1573 Assess and improve patient- and family-centered communication on an ongoing basis.

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## AREAS FOR FURTHER RESEARCH

There is significant need for research on each of the core domains of care coordination and their link to quality and safety outcomes. As noted earlier in this report, the quality of evidence supporting the recommended practices varied greatly. Although a few of the practices have undergone extensive testing and have strong support in each of the areas for evaluation, the majority of practices were recommended primarily on their face validity and were purposely included to establish a foundation and direction for future research.

### Practices recommended for further research

- Patient and family support and empowerment and active engagement in care coordination.
- Operationalization and measurement of core elements of the healthcare home and their relationship to quality and safety outcomes.
- Strategies for enhancing coordination between the healthcare home and community resources and services
- Identification of elements of a plan of care essential for care coordination and associated outcomes.
- Alternative practices for transitional care involving different combinations of health team members and preparation.
- Cost-effective strategies for using and linking data repositories to support care coordination

1598 PERFORMANCE MEASURES FOR MEASURING AND REPORTING CARE COORDINATION QUALITY  
1599

1600 This report presents 10 performance measures for care coordination, including 1 measure  
1601 recommended for continued endorsement (Table 2) to expand NQF's portfolio of measures for  
1602 continuity of care, communication, transitions, information systems, and the healthcare home. The  
1603 purpose of these proposed consensus standards is to improve the quality of healthcare – via  
1604 accountability and public reporting – by standardizing the quality measurement for transitions of care,  
1605 patient engagement and involvement with care plans, information systems, and the role of the setting  
1606 in which the patient receives their usual source of care. As noted for each measure in Table 2, the  
1607 proposed consensus standards are intended for use at various levels of analysis, including individual  
1608 clinicians, groups, plans, systems, and populations.

1609  
1610 Evaluating Care Coordination Performance Measures

1611 A Call for Measures solicited “performance measures that address the aspects of care coordination that  
1612 ensure the patient’s needs and preferences for health services and information-sharing across people,  
1613 functions, and care sites are met over time.” In addition, measures were solicited to address the NPP  
1614 goals for care coordination, the key domains of the NQF-endorsed® Care Coordination Framework,  
1615 and targeted areas, such as effectiveness of transitions, patient’s participation in and understanding of  
1616 the plan of care, and care coordination for patients with multiple comorbidities. Seven measure  
1617 developers submitted 77 individual measures for consideration in a variety of topic areas. Many of the  
1618 measures submitted for this project were focused on office visits, specific-conditions, referrals, and care  
1619 management. The Steering Committee carefully considered these constructs when evaluating them as  
1620 valid measures for care coordination. Definition and general premises used by the Steering Committee  
1621 to guide their evaluation of measures are summarized below.

1622  
1623 The Steering Committee used the definition of care coordination in the NQF-endorsed Framework of  
1624 Care Coordination as the foundation for its discussion and decision making about submitted measures.

1625 “Care coordination is a function that helps ensure that the patient’s needs and preferences for  
1626 health services and information sharing across people, functions, and sites are met over time to  
1627 achieve improved outcomes.”<sup>83</sup>

1628

1629 The Steering Committee applied these general premises in their review of submitted measures:

- 1630 • Care coordination is relevant for *all* patients – e.g., all patients need some aspects of care  
1631 coordination; and
- 1632 • Care coordination exists on a continuum according to patient/family need and risk. Higher-risk  
1633 patients/families often require more intense, more rapid, more comprehensive – more  
1634 coordinated – care than low-risk patients/families.
- 1635 • Patient and/or family surveys of their experience with the processes and outcomes of care  
1636 coordination efforts are essential to measure the safety, effectiveness, efficiency, and timeliness  
1637 of care coordination in an equitable fashion. Patient and/or family surveys should be  
1638 administered within close proximity to the healthcare event.
- 1639 • As the point of intersection of the general universe of care processes and outcomes, care  
1640 coordination theoretically might be linked to most other care processes and outcomes. For the  
1641 purposes of this project the Steering Committee focused its attention on aspects of the practices  
1642 and measures that were consistent with NQF framework and the NPP goals for care  
1643 coordination and for which there is stronger evidence linking care coordination to processes  
1644 and outcomes.

1645

1646 Finally, the Steering Committee identified several “gray” areas in which the relevance of submitted  
1647 measures to the definition and endorsed Care Coordination framework was unclear. These areas  
1648 included disease specific measures, office visits, referral and consultation measures, and care  
1649 management measures. The Steering Committee developed and consistently applied the following set  
1650 of guidelines in these areas to ensure consistency and focus:

- 1651 • To be relevant to care coordination, measures that address specific diseases (e.g., asthma,  
1652 diabetes) should address aspects of care for these populations that cross providers and settings.  
1653 For this initial work on care coordination measures, measures that address specific diseases  
1654 were not recommended for endorsement, when they focused solely on treatment guidelines for  
1655 these conditions.
- 1656 • To be relevant to care coordination, measures that address frequency or timing of office visits  
1657 need to address care coordination activities within the visit, e.g., development of a plan of care

59

1658 to be used across settings, medication reconciliation, structures for sharing of the plan of care  
1659 across settings. For this initial work on care coordination measures, measures that address  
1660 office visits were not recommended for endorsement when they focused solely on appointment  
1661 making or keeping.

- 1662 • To be relevant to care coordination, measures that address consultations and referrals between  
1663 providers and settings should address care coordination activities across these providers and  
1664 settings, e.g., communication between referring and receiving provider, closing feedback gaps  
1665 between providers and settings. For this initial work on care coordination measures, measures  
1666 that address consultation and referrals were not recommended for endorsement when they  
1667 focused solely on making or keeping consultation appointments.
- 1668 • To be relevant to care coordination, measures that address case management for at-risk or high  
1669 risk populations should address the care coordination needs of patient populations at risk for  
1670 adverse clinical and cost outcomes. For this initial work on care coordination measures,  
1671 measures that address case management were evaluated as a part of – and not distinct from nor  
1672 separately labeled from – care coordination measures and were not recommended for  
1673 endorsement when they were limited to one setting or one payment model.

1674  
1675 In addition, several candidate measures focused on evidence-based referrals; the Steering Committee  
1676 considered these measures as out of scope for care coordination and recommended reviewing the  
1677 evidence required to evaluating evidence-based referral measures. This set of measures will be  
1678 reviewed and evaluated in a subsequent project.

#### 1679 1680 Measure Evaluation

1681 The Care Coordination Steering Committee evaluated the candidate measures against the standard  
1682 NQF criteria (revised August 2008):

- 1683 • importance to measure and report – a threshold criterion;
- 1684 • scientific acceptability of the measure properties;
- 1685 • usability; and
- 1686 • feasibility.

1687  
1688 The Steering Committee also was asked to consider NQF’s four strategic issues during its deliberations:

- 1689 • driving toward high performance;
- 1690 • emphasis on composite measures;
- 1691 • moving toward outcomes measures; and
- 1692 • consideration of disparities.
- 1693
- 1694

**TABLE 2: RECOMMENDED MEASURES FOR NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR CARE COORDINATION**

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Measure Title	Measure ID <sup>a</sup>	Measure Description and Review Number <sup>b</sup>	Level of Analysis	IP Owners <sup>c</sup>
Cardiac rehabilitation patient referral from an inpatient setting	XXXX	Percentage of patients admitted to a hospital with a primary diagnosis of an acute myocardial infarction or chronic stable angina or who during hospitalization have undergone coronary artery bypass (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery (CVS), or cardiac transplantation who are referred to an early outpatient cardiac rehabilitation/secondary prevention program. (CC-019-09)	Individual Clinician Health Plan Group of Clinicians Facility Integrated delivery Systems	ACC/AHA Task Force
Cardiac rehabilitation patient referral from an outpatient setting	XXXX	Percentage of patients evaluated in an outpatient setting who in the previous 12 months have experienced an acute myocardial infarction or chronic stable angina or who have undergone coronary artery bypass (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery (CVS), or cardiac transplantation, who have not already participated in an early outpatient cardiac rehabilitation/secondary prevention program for the qualifying event, and who are referred to an outpatient cardiac rehabilitation/secondary prevention program.	Individual Clinician Health Plan Group of Clinicians Facility Integrated delivery Systems	ACC/AHA Task Force

		<b>(CC-020-09)</b>		
Patients with a transient ischemic event or visit who had a follow-up office visit	XXXX	Patient(s) with a recent emergency room encounter for a transient cerebral ischemic event who had any physician visit within 14 days of the acute event. <b>(CC-050-09)</b>	All levels	Ingenix
Biopsy follow-up	XXXX	Percentage of patients who are undergoing a biopsy whose biopsy results have been reviewed by the biopsying physician and communicated to the primary care physician and patient. <b>(CC-071-09)</b>	All levels	AAD
Reconciled medication list received by discharged patients (inpatient discharges to home/self care or any other site of care)	XXXX	Percentage of patients, regardless of age, discharged from an inpatient 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. <b>(CC-073-09)</b>	Facility Integrated delivery systems	AMA PCPI
Transition record with specified elements received by discharged patients (inpatient discharges to home/self care or any other site of care)	XXXX	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements. <b>(CC-074-09)</b>	Facility Integrated delivery systems	AMA PCPI
Timely transmission of transition record (inpatient discharges to home/self care or any other site of care)	XXXX	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record	Facility Integrated delivery systems	AMA PCPI

		was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge. <b>(CC-075-09)</b>		
Transition record with specified elements received by discharged patients (emergency department discharges to ambulatory care [home/self care])	XXXX	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home healthcare, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements. <b>(CC-076-09)</b>	Facility Integrated delivery systems	AMA PCPI
Melanoma continuity of care - recall system	XXXX	Percentage of patients with a current diagnosis of melanoma or a history of melanoma who were entered into a recall system with the date for the next complete physical skin exam specified, at least once within the 12-month reporting period. <b>(CC-078-09)</b>	Individual Clinician Group of Clinicians	AMA PCPI/AAD/NCQA
3-Item Care Transitions Measure (CTM-3) <sup>d</sup>	0228	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions	Facility	University of Colorado Health Sciences Center

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1703 <sup>a</sup> Upon NQF endorsement, each measure receives a unique NQF measure ID number.

1704 <sup>b</sup> Review number.

1705 <sup>c</sup> Intellectual property owner(s). For the most current specifications and supporting information, please refer to  
1706 the IP owner:

1707 AAD - American Academy of Dermatology ([www.aad.org](http://www.aad.org))

1708 ACC/AHA Task Force ([www.americanheart.org](http://www.americanheart.org))

1709 AMA PCPI - American Medical Association (AMA)-convened Physician Consortium for Performance  
1710 Improvement ([www.ama-assn.org](http://www.ama-assn.org))

1711 Ingenix ([www.ingenix.com](http://www.ingenix.com))

1712 NCQA - National Committee for Quality Assurance ([www.ncqa.org](http://www.ncqa.org))

1713 <sup>d</sup>NQF-endorsed measure, reviewed for continued endorsement

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## 1716 RECOMMENDED MEASURES

1717 Although NQF sought measures across all domains of the NQF-endorsed framework, ultimately only  
1718 measures in two of the six domains – proactive plan of care and follow-up and transitions – are  
1719 recommended.

1720

1721 Framework Domain: Proactive Plan of Care and Follow-up

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1723 The Care Coordination Steering Committee recommends five measures under this framework domain.

1724

### 1725 **CC-019-09 Cardiac Rehabilitation Patient Referral from an Inpatient Setting (ACC/AHA Task Force)**

1726 This performance measure is designed to be used for referral of inpatients to an outpatient cardiac  
1727 rehabilitation program, while proposed consensus standard CC-020-09, Cardiac Rehabilitation Patient  
1728 Referral from an Outpatient Setting, is a related measure that is designed for referral of outpatients to  
1729 an outpatient cardiac rehabilitation program. This measure examines the percentage of patients  
1730 admitted to a hospital with a primary diagnosis of an acute myocardial infarction or chronic stable  
1731 angina or who during hospitalization have undergone coronary artery bypass (CABG) surgery, a  
1732 percutaneous coronary intervention (PCI), cardiac valve surgery (CVS), or cardiac transplantation who  
1733 are referred to an early outpatient cardiac rehabilitation/secondary prevention program. The  
1734 specifications are well detailed and capture the right steps of care coordination for cardiac  
1735 rehabilitation. The field of cardiology is currently involved in many registries and studies for  
1736 improving outcomes; the Action Registry mentioned in the specifications is a database developed in  
1737 collaboration with the American Heart Association (AHA) and the American College of Cardiology  
1738 (ACC). This registry captures many data elements, including information on the cardiac rehabilitation  
1739 centers available for each patient. ACC, AHA, and the American Association of Cardiovascular and  
1740 Pulmonary Rehabilitation (AACVPR) have collaborated to include this performance measure in their  
1741 registries and are working to provide tools to hospitals to help them with the collection, assessment,  
1742 and reporting of this measure.

1743

1744 In its review, the Committee did raise concerns about the denominator and the exclusions, which  
1745 excluded patients who refuse rehabilitation care and those who do not have insurance. In addition, the

1746 Committee discussed the feasibility of the “Action Registry” database used for collecting the  
1747 specifications of the measure. A concern was also raised about whether hospitals that do not participate  
1748 in the registry and that may not be equipped with an EHR will be able to implement this measure. At  
1749 the request of the Committee, the developer clarified that the patient population and exclusions list was  
1750 modified to include patient’s referrals to outpatient cardiac rehabilitation from an inpatient  
1751 rehabilitation facility.

1752  
1753 The data elements for this measure will be made publicly available by all hospitals as a core measure,  
1754 and any hospital will have the capabilities to collect data on this standard, analyze the data, and make  
1755 them available for public reporting.

1756  
1757 **CC-020-09 Cardiac Rehabilitation Patient Referral from an Outpatient Setting (ACC/AHA Task**  
1758 **Force)**

1759 This process measure reports the percentage of patients evaluated in an outpatient setting who in the  
1760 previous 12 months have experienced an acute myocardial infarction or chronic stable angina or who  
1761 have undergone coronary artery bypass (CABG) surgery, a percutaneous coronary intervention (PCI),  
1762 cardiac valve surgery (CVS), or cardiac transplantation, who have not already participated in an early  
1763 outpatient cardiac rehabilitation/secondary prevention program for the qualifying event, and who are  
1764 referred to an outpatient cardiac rehabilitation/secondary prevention program. The focus of this  
1765 measure captures a population that is particularly vulnerable – those patients who do not go to an early  
1766 outpatient cardiac rehabilitation program. The specifications of this measure are well detailed and  
1767 address important steps of care coordination. This measure also contributes to the appropriateness of  
1768 guidelines for cardiac rehabilitation.

1769  
1770 The Committee expressed concerns about the definition of the outpatient setting and variability of the  
1771 access to data, which may depend on the setting. Additionally, the exclusions of the measure included  
1772 patients who are not going to the cardiac rehabilitation programs; the underlying cause for this is  
1773 important to understand in order to change outcomes. Finally, the Committee felt that the care  
1774 coordination loop among the outpatient setting, the primary care physician, and the patient’s  
1775 successful enrollment and completion of the program should be addressed. At the request of the  
1776 Committee, the developer clarified the denominator and exclusion criteria. In addition, the numerator

1777 details specified communication between the healthcare provider and the patient to recommend and  
1778 carry out a referral order to an early outpatient cardiac rehabilitation program. The developer noted  
1779 that the measure demands clear referral and coordination of care from an outpatient to inpatient  
1780 setting.

1781  
1782 **CC-050-09 Patients with a Transient Ischemic Event ER Visit who had a Follow-up Office Visit**  
1783 **(Ingenix)**

1784 This measure examines the number of patient(s) with a recent emergency room encounter for a  
1785 transient cerebral ischemic event and who had any physician visit within 14 days of the acute event. It  
1786 provides a reasonable indication that care coordination has occurred and has a timeliness component.  
1787 The Committee viewed this measure as an important component to addressing the continuity of care to  
1788 ensure that a patient is actually seen by a care provider, and not limited to measuring that an  
1789 appointment was made. The measure also provides continuity with the other consensus standards  
1790 endorsed by NQF that focus on emergency room visits. This measure also has the potential to address  
1791 the first incidence with a transient ischemic attack, which could capture a significant population.  
1792 Lastly, the timeframe component is intended to minimize the potential for a full stroke.

1793  
1794 The Committee requested clarification on the specifications of this measure, specifically, the activities  
1795 that take place during the emergency room visit and the follow-up office visit; measuring the activities  
1796 of these processes is truly what demonstrates care coordination. It was noted that the specifications  
1797 designate diagnosis codes that the follow-up office visit is related to an ischemic event and the  
1798 proposed timeframe should meet guidelines for appropriate care. At the request of the Committee, the  
1799 developer provided further testing data for the reliability and validity of the measure and confirmed  
1800 diagnosis codes for the office visit. The timeframe for the measure was changed from a 30-day period  
1801 to a 14-day period.

1802  
1803 **CC-071-09 Biopsy Follow-up (American Academy of Dermatology)**

1804 This process measure focuses on the percentage of patients who are undergoing a biopsy, whose  
1805 biopsy results have been reviewed by the biopsying physician, and have been communicated to the  
1806 primary care provider and the patient. This measure incorporates the critical feedback loops integral to  
1807 care coordination, i.e., the measure extends beyond the act of reviewing the biopsy to communication  
1808 of results to the primary provider and patient.

1809

1810 Coordination between the specialist and the primary care provider is very important; this measure  
1811 address a critical patient-safety issue. Poor follow-up after a laboratory test presents one of the main  
1812 reasons for medical errors in care. This measure specifies the important communication loop between  
1813 the specialist, the primary care physician, and the patient, and it appropriately addresses patient safety  
1814 and continuity of care.

1815

1816 In its initial review, The Steering Committee noted that this measure focused more on biopsy review,  
1817 rather than the communication of results central to care coordination. Initial specifications reviewed by  
1818 the Committee lacked components addressing follow-up with the patient or primary care provider. The  
1819 Committee noted the importance of addressing the problem that often tests are ordered and not  
1820 performed and/or results from tests are not provided to the providers. The communication loop  
1821 between the biopsy physician, the primary care provider, and the patient is critical and should be  
1822 addressed.

1823

1824 At the request of the Committee, the developer provided data related to the reliability and validity  
1825 testing and revised the description and numerator of the standard to include more specificity for  
1826 communication between all care providers and the patient.

1827

1828 **CC-078-09 Melanoma Continuity of Care - Recall System (AMA PCPI/AAD/NCQA)**

1829 This is a structural measure which looks at the percentage of patients with a current diagnosis of  
1830 melanoma or a history of melanoma who were entered into a recall system with the date for the next  
1831 complete physical skin exam specified, at least once within the 12-month reporting period. The  
1832 Committee acknowledged the importance and face validity of the recall system, but that alone was not  
1833 sufficient to measure care coordination. The Committee noted that this measure demonstrated good  
1834 follow-up procedures, rather than care coordination. It also felt that the specifications should address  
1835 the important subset of patients who do not return for follow-up skin examinations. At the request of  
1836 the Committee, the developer provided clarification to the specifications of the measure to include  
1837 reminder systems for patients who missed an appointment.

1838

1839 Framework Domain: Transitions

1840  
1841 The Care Coordination Steering Committee recommends five measures under this framework domain:  
1842  
1843 Measures CC-073-09, CC-074-09 and CC-075-09 are recommended as a bundled set to be considered  
1844 together. These three measures address three essential and interrelated components of the discharge  
1845 transition for all patients: (1) provision of a reconciled medication list to patients and/or caregivers at  
1846 hospital discharge, (2) provision of the transition plan of care to the patient and/or caregivers at  
1847 hospital discharge, and (3) provision of the transition plan of care to the receiving provider(s) at  
1848 hospital discharge.

1849  
1850 **CC-073-09 Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to**  
1851 **Home/Self Care or Any Other Site of Care) (AMA PCPI)**

1852 This process measure is the first measure in the bundle and examines the percentage of patients,  
1853 regardless of age, discharged from an inpatient facility to home or any other site of care, or their  
1854 caregiver(s), who received a reconciled medication list at the time of discharge including, at a  
1855 minimum, medications in the specified categories.

1856 The bundled set of measures are closely related but also have interdependent aspects of the transition  
1857 in care for patients discharged from an inpatient facility and are recommended as a bundled set of  
1858 measures, which will achieve better outcomes when implemented together. The importance of patient  
1859 education on medication reconciliation processes was viewed as important by the Committee, which  
1860 also suggested having a medication list sequenced over a period of time rather than having a simple list  
1861 of medications. Overall the Committee concluded that the three measures combined encompass core  
1862 aspects of care coordination, are well specified. This measure, in and of itself, harmonizes with the Joint  
1863 Commission's National Patient Safety Goals for medication reconciliation.

1864  
1865 **CC-074-09 Transition Record with Specified Elements Received by Discharged Patients (Inpatient**  
1866 **Discharged to Home/Self Care or Any Other Site of Care) (AMA PCPI)**

1867 The second measure in the bundle, a process measure, focuses on the percentage of patients, regardless  
1868 of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who  
1869 received a transition record (and with whom a review of all included information was documented) at  
1870 the time of discharge including, at a minimum, all of the specified elements. Although the Committee  
1871 recognized that this measure is integral to care coordination, it had some concerns about appointing  
1872 someone to complete the transition record.

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**CC-075-09 Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care) (AMA PCPI)**

The third measure in this bundle focuses on the percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge. Evidence to support the timeframe of 24 hours was discussed, along with the suggestion for documentation to be provided at both discharge and receiving facilities.

**CC-076-09 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care]) (AMA PCPI)**

This process measure focuses on the percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home healthcare, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements. The Committee felt that the measure is integral to care coordination and was well specified. It also aligns well with the goals of care coordination presented in the NQF-endorsed Framework for Care Coordination.

**MEASURES RECOMMENDED FOR CONTINUED ENDORSEMENT**

**0228/3-Item Care Transition Measure (CTM-3) University of Colorado Health Sciences Center**

This survey instrument measures the quality of preparation for care transitions. Utilization of the measure was well-known to the Committee in a variety of settings and populations; it has undergone extensive testing with most sample sizes over 200. Overall the Committee felt this measure is well specified and should continue to remain within the NQF portfolio.

**MEASURES NOT RECOMMENDED**

The Steering Committee did not recommend measures for a variety of reasons. The primary reasons for not recommending measures were:

- the measure did not pass the ‘importance to measure and report’ criteria as it relates to care coordination;
- the measure focused more on the standard of care/treatment guidelines rather than care coordination;

1907 • the measure was missing the integral component of closing the communication loop between  
 1908 providers; and

1909 • the measure lack sufficient evidence to support its reliability and validity.

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1911 The measures not recommended and the rationale related to the NQF endorsement criteria and/or  
 1912 comparisons to similar measures are described in Table 3.

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**TABLE 3: MEASURES NOT RECOMMENDED**

<b>Measures</b>	<b>Reason for Not Recommending</b>
CC-001-09 Average Caseload for Members with Diabetes in Case Management in Managed Care (New York State Department of Health)	Importance: Will not have a big impact as a consensus standard for measuring and reporting care coordination. Operational difficulties were identified, specifically attaining the right level of caseload per case manager. Measure does not specify what the caseload should be; therefore, the outcome could be severe if the caseload was too high.
CC-002-09 Diabetic Care-BP Outcome Measure for Members in Managed Care (New York State Department of Health)	Importance: Measure does not fit within the scope of care coordination for this project and will not have a big impact as a consensus standard for measuring and reporting care coordination. Specifications do not focus on how this measure would coordinate with other parts of the patient’s medical or healthcare home process; narrowly focused on blood pressure.
CC-003-09 Diabetes Care-Service Measures for Members in Managed Care (New York State Department of Health)	Importance: Measure is more of a standard of care within case management, rather than a measure of care coordination; it focuses on the quality of case management services and following clinical guidelines, which does not give an indication of whether a patient receives coordination of care.
CC-004-09 Timely Case Management Assessment Rate for Members with Diabetes in Managed Care (New York State Department of Health)	Importance: The concept of timeliness is important but, in the case of this measure, there is no evidence to support its importance to care coordination.
CC-005-09 Case Management Enrollment Rate for Members with Diabetes in Managed Care (New York State Department of Health)	Importance: No evidence to support the importance of this measure to care coordination.
CC-006-09 Medication	Scientific Acceptability: The reliability and validity testing was not provided and the

Adherence for Members with Diabetes in Managed Care (New York State Department of Health)	extent of care coordination was not specified. The denominator focuses only on people who have completed both the pre- and postassessments, which can contribute to selection bias. This measure looks more at the functionality of case management, which is not the same as care coordination, and it does not display any links to real outcomes or to the provider.
CC-007-09 Emergency Room Visits for Members with Diabetes in Managed Care (New York State Department of Health)	Scientific Acceptability and Feasibility: The measure uses self-report data instead of claims data. Flexibility is given to the health plans for identifying triggers and how the data are reported. Interoperability is a concern; without clear specifications of the criteria for case management, it would be difficult to interpret the data if each measure user applies its own criteria and risk adjustment.
CC-008-09 Graduation Rates for Members with Diabetes in Case Management in Managed Care (New York State Department of Health)	Importance: Measure does not fit within the scope of care coordination and would not provide any significant impact as an outcome measure in the context of the framework or as a consensus standard for measuring and reporting care coordination.
CC-009-09 Hospital Admission Rates for Members with Diabetes in Managed Care (New York State Department of Health)	Scientific Acceptability and Feasibility: The measure uses self-report data instead of claims data. The focus is on a single population within managed care. Interoperability is a concern; without clear specifications of the criteria for case management, it would be difficult to interpret the data if each measure user applies its own criteria and risk adjustment.
CC-010-09 Trigger Rates for Members with Diabetes in Managed Care (New York State Department of Health)	Scientific Acceptability: Measure did not provide sufficient specifications of care coordination activities, such as creating a plan of care with patient/designee, self-management skills, communication between case management and primary care provider. The focus of the measure is on triggering managed care for patients with diabetes as part of the process in managed care that leads into assessment and further care. The measure needs more conceptual work (e.g., identify trigger factors).
CC-011-09 Average Length of Stay in an Intensive Care Unit for Infants of Women in Case Management in managed care (New York State Department of Health)	Importance: Measure does not fit within the scope of care coordination; evidence provided is not sufficient to show that this is an indicator of quality. Measure is an indicator of case management quality but is dependent on comorbidities.
CC-012-09 Case Management Enrollment Rate for Pregnant Women at High Risk in Managed Care (New York State Department of Health)	Scientific Acceptability and Feasibility: The measure does not specify who qualifies as a high-risk patient, and standardization should be included for comparative services. The measure specifies triggering patients for enrollment in case management, but triggering alone does not provide insight into the process of care coordination.
CC-013-09 Crude Low Birth Weight Rate for	Scientific Acceptability, Usability, and Feasibility: The denominator excluded individuals who remove themselves from case management; this exclusion is

Members in High Risk Case Management in Managed Care (New York State Department of Health)	important. Measure is unique to the managed care population, which makes it less useful. The measure permits the use of self-reported data and hospital records but does not address whether the results are compatible.
CC-014-09 Intensive Care Unit Admission Rate for Infants of Women in Case Management in Managed Care (New York State Department of Health)	Scientific Acceptability and Feasibility: Does not specify communication between obstetrician and the primary care physician, which is a strong indicator of proper care coordination and improved outcomes. Care management is not the appropriate entity to bring prepartum obstetrics management decisionmaking and postpartum pediatric decisionmaking together.
CC-015-09 Average Caseload with Members in High Risk OB Case Management in Managed Care (New York State Department of Health)	Importance: Measure will not add value for the purpose of measuring and reporting care coordination; most women go for a postpartum visit.
CC-016-09 Trigger Rates of Members with High Risk OB in Managed Care (New York State Department of Health)	Scientific Acceptability: Measure is more appropriate as a referral measure, rather than a measurement of care coordination. Focus is only on the managed care population and has limited utility. Measure developer should consider studying how triggers might lead to future interventions or care coordination activities.
CC-017-09 Postpartum Care Visits Rate for Pregnant Women in case Management in Managed Care (New York State Department of Health)	Importance: Not within the scope of care coordination; focuses on the standard of care, not coordinating care. Measure showed to be an outcome of coordinated case management.
CC-018-09 Timely Case Management Assessment Rates for Pregnant Women at High Risk in Managed Care (New York State Department of Health)	Scientific Acceptability: Specifications not clear on which aspects of care coordination occurred during the initial assessment. The process of how women will be triggered for case management is not provided. Additional evidence to support the specific 15-day timeframe as important to improved outcomes was not provided.
CC-021-09 Cardiac Rehabilitation/Secondary Prevention (CR) Program Structure-Based Measurement Set to Set Safety Standards for CR Programming (ACC/AHA Task Force)	Importance: Not within the scope of care coordination; focuses on the standard of care/ guideline, rather than on coordinating care. Measure may serve as a source for effective care.
CC-022-09 Cardiac Rehabilitation/Secondary	Importance: Measure is a component of a certification process the AACVPR for cardiac rehabilitation programs and not a measure of care coordination. The risk

Prevention (CR) Program Measurement Set to Assess Risk for Adverse Cardiovascular Events (ACC/AHA Task Force)	assessment is not part of care coordination, but a part of healthcare home or the initial provider's responsibility, and therefore antecedent to it. Lack of evidence that this particular set of criteria translates into a better outcome or better experiences for the patient.
CC-023-09 Cardiac Rehabilitation/Secondary Prevention (CR) Measurement Set to Assure Individualized Assessment and Evaluation of Modifiable Cardiovascular Risk Factors, Development of Individualized Interventions, and Communication With Other Healthcare Providers (ACC/AHA Task Force)	Importance: Measure is a component of a certification process the AACVPR uses for cardiac rehabilitation programs and is not a measure of care coordination. The risk assessment is not part of care coordination, rather a part of healthcare home or the initial provider's responsibility, and therefore antecedent to it. Lack of evidence that this particular set of criteria translates into a better outcome or better experiences for the patient.
CC-024-09 Cardiac Rehabilitation/Secondary Prevention (CR) Program Measurement Set Related to Monitoring Response to Therapy and Documenting Program Effectiveness (ACC/AHA Task Force)	Importance: Measure was not shown to be important to measure and report for care coordination. Effectiveness of the measure depends on the number of patients admitted to the program, as opposed to those in need of such a program.
CC-025-09 Patient(s) 65 years of age and older that received a high-risk medication. (Ingenix)	Usability: Harmonization issues with existing HEDIS measures.
CC-028-09 Patient(s) with diabetes who had an office visit in past 6 reported months (Ingenix)	Scientific Acceptability: Measure specifications only examine the occurrence of an office visit, which is not an accurate measure for care coordination. Measure should provide more specificity on the care coordination activities that take place during the office visit and demonstrate how care was coordinated, such as creating the plan of care for use across settings or transfer of information to another setting.
CC-029-09 Patient(s) with asthma who had an office visit in past 6 reported months (Ingenix)	Scientific Acceptability: Not within the scope of care coordination. Measure addresses office visits and should provide more specificity on the care coordination activities that took place during the office visit and demonstrate how care was coordinated, such as creating the plan of care for use across settings or transfer of information to another setting.
CC-030-09 Asthma office	Scientific Acceptability: Specifications of the measure do not show care coordination

visit for patients with poorly controlled disease (Ingenix)	components, which could consist of transfer of information and developing a care plan. Measure does not define 'poorly controlled,' particularly within an asthma population; definition would help differentiate between well-controlled and poorly controlled patients.
CC-032-09 Patient(s) with hypertension who had an annual physician visit (Ingenix)	Scientific Acceptability: Measure constitutes an annual visit, but there was no specification requiring documentation of coordinated care (e.g., that a care plan was developed and implemented to show that care coordination actually took place).
CC-035-09 Migraine office visit for patients with poorly controlled disease (Ingenix)	Scientific Acceptability: Measure only tracks office visits and does not specify whether this measure tracked people in the emergency department with frequent migraines who had an office visit or have <i>not</i> had an office visit in the past 6 months. Measure should specify the care coordination activities that took place during the office visit.
CC-037-09 Annual serum creatinine for patients with chronic kidney failure (Ingenix)	Importance: Measure addresses guidelines/standards of care (lab tests on a schedule), not coordination of care. Focus of measure should be on linking the patient with activities that produce better outcomes.
CC-038-09 Annual hemoglobin/hematocrit for patients with moderate Chronic Kidney Disease (CKD), severe CKD, or kidney failure (Ingenix)	Importance: Measure was not within scope of care coordination. Measure addresses guidelines/standards of care (lab tests on a schedule), not coordination of care. Focus of measure should be on linking the patient with activities that produce better outcomes.
CC-039-09 Annual serum calcium for patients with moderate CKD, severe CKD, or kidney failure. (Ingenix)	Importance: Measure was not within scope of care coordination. Measure addresses guidelines/standards of care (lab tests on a schedule), not coordination of care. Focus of measure should be on linking the patient with activities that produce better outcomes.
CC-040-09 Annual serum phosphorus for patients with moderate CKD, severe CKD, or kidney failure (Ingenix)	Importance: Measure was not within scope of care coordination. Measure addresses guidelines/standards of care (lab tests on a schedule), not coordination of care. Focus of measure should be on linking the patient with activities that produce better outcomes.
CC-042-09 Annual serum PTH for patients with severe kidney disease or kidney failure (Ingenix)	Importance: Measure was not within scope of care coordination. Measure addresses guidelines/standards of care (lab tests on a schedule), not coordination of care. Focus of measure should be on linking the patient with activities that produce better outcomes.
CC-043-09 Annual LDL cholesterol for patients with chronic kidney disease (Ingenix)	Importance: Measure was not within scope of care coordination. Measure addresses guidelines/standards of care (lab tests on a schedule), not coordination of care. Focus of measure should be on linking the patient with activities that produce better outcomes.
CC-044-09 Annual HDL	Importance: Measure was not within scope of care coordination. Measure addresses

cholesterol for patients with chronic kidney disease (Ingenix)	guidelines/standards of care (lab tests on a schedule), not coordination of care. Focus of measure should be on linking the patient with activities that produce better outcomes.
CC-045-09 Annual triglyceride for patients with chronic kidney disease (Ingenix)	Importance: Measure demonstrates a standard of care, not care coordination.
CC-047-09 Annual urine protein/ microalbumin for selected patients with chronic kidney failure. (Ingenix)	Importance: Measure was not within scope of care coordination. Measure addresses guidelines/standards of care (lab tests on a schedule), not coordination of care. Focus of measure should be on linking the patient with activities that produce better outcomes.
CC-049-09 Patients with bariatric surgery who had complications. (Ingenix)	Importance: Measure is an outcome measure of bariatric surgery and does not fit within the scope of care coordination for this project. This measure will be reviewed with the NQF project focused on patient outcomes.
CC-056-09 Patient(s) with a CABG procedure who received a beta-blocker. (Ingenix)	Importance: Measure does not fit within the scope of care coordination; it focuses on a standard of care, rather than a measure for care coordination. Measure specifications do not document whether the medication was filled and continued after discharge.
CC-057-09 Patient(s) with a CABG procedure who received a lipid-lowering agent. (Ingenix)	Importance: Measure does not fit within the scope of care coordination; it focuses on a standard of care, rather than a measure for care coordination. Measure specifications do not document whether the medication was filled and continued after discharge.
CC-058-09 Patient(s) with a CABG procedure who had a postoperative stroke. (Ingenix)	Importance: Measure does not fit within the scope of care coordination for this project; it is measuring a complication of surgery. This measure will be reviewed with the NQF project focused on patient outcomes.
CC-072-09 High-Risk Medication Monitoring (American Academy of Dermatology)	Scientific Acceptability and Feasibility: Measure does not demonstrate the importance of using a recall system in managing/monitoring patients on high-risk medications. The measure does not specify who is responsible for the monitoring – whether it is the primary care physician or the pharmacist? Additionally, the feasibility of all primary care providers prescribing the high-risk drugs is problematic and burdensome.
CC-077-09 NYU ED Algorithm (NYU)	Feasibility: Insufficient information about the methodology was provided and the measure does not demonstrate use in a variety of settings. Measure was viewed as more of a health services/research care delivery/ health policy measure and not a provider-level measure of the quality of care coordination.

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1918

1919 **MEASURES DEFERRED**

1920 When reviewing the candidate standards, there was much discussion on the proposed measures that  
1921 were focused on evidence-based referrals. The measures within these groups will be deferred until they  
1922 can be reviewed in the context that is more applicable to the measures. Specifically, NQF will look into  
1923 the level of evidence required to endorse evidence-based referral measures as a class and evaluate these  
1924 measures in a subsequent project.

1925  
1926 The standards below present a focus on evidence-based referrals:

- 1927 • **CC-026-09 CHF Cardiology Consultation (Ingenix)**  
1928 Patient(s) with heart failure and 2 or more recent heart failure ER encounters or hospitalizations  
1929 that had cardiology consultation in last 24 reported months.
- 1930 • **CC-027-09 Atrial Fibrillation Cardiology Consultation (Ingenix)**  
1931 Patient(s) with atrial fibrillation and evidence of problematic atrial fibrillation control that had  
1932 cardiology consultation in last 12 reported months.
- 1933 • **CC-031-09 Asthmatics with problematic asthma control who had specialty consultation**  
1934 **(Ingenix)**  
1935 Patient(s) exhibiting problematic asthma control who had pulmonary or allergy consultation in  
1936 last 12 reported months.
- 1937 • **CC-033-09 Patient with problematic COPD control who had pulmonary consultation**  
1938 **(Ingenix)**  
1939 Patient(s) exhibiting problematic COPD control who had pulmonary consultation in last 12  
1940 reported months.
- 1941 • **CC-034-09 Psychiatry consultation for patients with severe depression (Ingenix)**  
1942 Patient(s) with evidence of severe depression that had psychiatric consultation in last 3 reported  
1943 months.
- 1944 • **CC-036-09 Patients with poor migraine control who had specialty consultation (Ingenix)**  
1945 Patient(s) with one or more hospitalizations for migraines that had neurology or anesthesiology  
1946 consultation in last 6 reported months.

- 1947 • **CC-041-09 CKD nephrology consultation for patients with severe kidney disease or kidney**  
1948 **failure (Ingenix)**
- 1949 Patient(s) with severe chronic kidney disease or kidney failure that had nephrology  
1950 consultation in last 12 reported months.
- 1951 • **CC-046-09 Nephrology consultation for patients with CKD and other specific diagnosis**  
1952 **(Ingenix)**
- 1953 Patient(s) with chronic kidney disease and specific indications that had nephrology consultation  
1954 in last 12 reported months.
- 1955 • **CC-048-09 Patient with poor epilepsy control with had a neurology consultation (Ingenix)**
- 1956 Patient(s) with one or more hospitalizations or two or more emergency room encounters for  
1957 epilepsy that had neurology consultation in last 3 reported months.
- 1958 • **CC-051-09 Patients hospitalized with an acute cerebral ischemic event that had a specialty**  
1959 **consultation (Ingenix)**
- 1960 Patient(s) with a recent hospitalization for an acute cerebral ischemic event that had neurology,  
1961 neurosurgery, vascular surgery or thoracic surgery consultation during the hospitalization or  
1962 within 30 days of discharge.
- 1963 • **CC-052-09 Gastroenterology consultation for patients on simple chronic medication regimens**  
1964 **for inflammatory bowel disease (Ingenix)**
- 1965 Patient(s) taking certain medications for inflammatory bowel disease treatment that had  
1966 gastroenterology consultation in last 12 reported months.
- 1967 • **CC-053-09 Gastroenterology consultation for patients on complex treatment regimens or**  
1968 **chronic corticosteroid therapy for inflammatory bowel disease (Ingenix)**
- 1969 Patient(s) with complex inflammatory bowel disease treatment regimens or chronic  
1970 corticosteroid therapy that had gastroenterology consultation in last 6 reported months.
- 1971 • **CC-054-09 Gastroenterology consultation for patients hospitalized or received ER care for**  
1972 **inflammatory bowel disease (Ingenix)**

- 1973 Patient(s) with inflammatory bowel disease complications that had gastroenterology  
 1974 consultation in last 3 reported months.
- 1975 • **CC-055-09 Patient(s) with newly diagnosed with breast cancer who received prompt specialty  
 1976 care (Ingenix)**
- 1977 Patient(s) newly diagnosed with breast cancer that received radiation or chemotherapy  
 1978 treatment, or had medical oncology or radiation oncology consultation within 90 days of the  
 1979 diagnostic procedure.
- 1980 • **CC-059-09 Baseline audiologic assessment for ototoxicity (Audiology Quality Consortium)**  
 1981 Percentage of patients age 1 month and older referred for a baseline comprehensive audiologic  
 1982 assessment prior to the administration of a prescribed ototoxic medication(s) or therapeutic  
 1983 agent(s).
- 1984 • **CC-060-09 Audiologic monitoring for ototoxicity (Audiology Quality Consortium)**  
 1985 Percentage of patients age 1 month and older referred for an audiologic monitoring protocol  
 1986 subsequent to the administration of a prescribed ototoxic medication(s) or therapeutic agent(s).
- 1987 • **CC-061-09 Baseline vestibular assessment for vestibulotoxicity (Audiology Quality  
 1988 Consortium)**
- 1989 Percentage of patients age 3 years and older referred for a baseline comprehensive vestibular  
 1990 assessment prior to the administration of a prescribed vestibulotoxic medication(s) or  
 1991 therapeutic agent(s).
- 1992 • **CC-062-09 Vestibular monitoring for vestibulotoxicity (Audiology Quality Consortium)**  
 1993 Percentage of patients age 3 years and older referred for a vestibular monitoring protocol  
 1994 subsequent to the administration of a prescribed vestibulotoxic medication(s) or therapeutic  
 1995 agent(s).
- 1996 • **CC-063-09 Referral for otologic evaluation for patients with visible congenital or traumatic  
 1997 deformity of the ear (Audiology Quality Consortium)**
- 1998 Percentage of patients age birth and older referred to a physician (preferably a physician  
 1999 specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic  
 2000 evaluation after presenting with a visible congenital or traumatic deformity of the ear.

- 2001 • **CC-064-09 Referral for otologic evaluation for patients with a history of active drainage from**  
 2002 **the ear within the previous 90 days (Audiology Quality Consortium)**  
 2003 Percentage of patients referred to a physician (preferably a physician specially trained in  
 2004 disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after  
 2005 presenting with a history of active drainage from the ear within the previous 90 days.
- 2006 • **CC-065-09 Referral for otologic evaluation for patients with a history of sudden or rapidly**  
 2007 **progressive hearing loss (Audiology Quality Consortium)**  
 2008 Percentage of patients age birth and older referred to a physician (preferably a physician  
 2009 specially trained in disorders of the ear) for an otologic evaluation immediately following an  
 2010 audiologic evaluation after presenting with a history of sudden or rapidly progressive hearing  
 2011 loss.
- 2012 • **CC-066-09 Referral for otologic evaluation for patients with acute or chronic dizziness**  
 2013 **(Audiology Quality Consortium)**  
 2014 Percentage of patients referred to a physician (preferably a physician specially trained in  
 2015 disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after  
 2016 presenting with acute or chronic dizziness.
- 2017 • **CC-067-09 Referral for otologic evaluation for patients with a unilateral hearing loss**  
 2018 **(Audiology Quality Consortium)**  
 2019 Percentage of patients referred to a physician (preferably a physician specially trained in  
 2020 disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after  
 2021 presenting with a unilateral hearing loss.
- 2022 • **CC-068-09 Referral for otologic evaluation for patients who present with a conductive**  
 2023 **hearing loss or air-bone gap (Audiology Quality Consortium)**  
 2024 Percentage of patients age birth and older referred to a physician (preferably a physician  
 2025 specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic  
 2026 evaluation after presenting with a conductive hearing loss or air-bone gap.
- 2027 • **CC-069-09 Referral for otologic evaluation for patients with evidence of impacted cerumen**  
 2028 **accumulation or a foreign body in the ear canal (Audiology Quality Consortium)**

2029 Percentage of patients age birth and older referred to a physician (preferably a physician  
2030 specially trained in disorders of the ear) for an otologic evaluation subsequent or prior to an  
2031 audiologic evaluation after presenting with an accumulation of cerumen or a foreign body that  
2032 causes symptoms, prevents a needed assessment of the ear canal/tympanic membrane or audio  
2033 vestibular system, or both.

2034 • **CC-070-09 Referral for otologic evaluation for patients with pain or discomfort in the ear**  
2035 **(Audiology Quality Consortium)**

2036 Percentage of patients referred to a physician (preferably a physician specially trained in  
2037 disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after  
2038 presenting with pain or discomfort in the ear.

2039  
2040 **RELATIONSHIP TO OTHER NQF-ENDORSED CONSENSUS STANDARDS**

2041 This report does not represent the entire scope of NQF work relevant to the quality of care for care  
2042 coordination. NQF has endorsed several consensus standards addressing the domains of the NQF-  
2043 endorsed Care Coordination Framework and the National Priorities Partnership (NPP) goals for care  
2044 coordination.

2045 The previously endorsed measures addressing the domains of the NQF-endorsed Care Coordination  
2046 Framework are as follows:

2047 NQF-endorsed measures related to care coordination and the healthcare home:

- 2048 • 0494/Medical Home System Survey (National Committee for Quality Assurance)

2049  
2050 NQF-endorsed measures related to care coordination and proactive plan of care:

- 2051 • 0021/Therapeutic monitoring: Annual monitoring for patients on persistent medications  
2052 National Committee for Quality Assurance
- 2053 • 0251/Vascular Access- Physician (KCQA)
- 2054 • 0262/Vascular Access - Physician (b) (KCQA)
- 2055 • 0321/Peritoneal Dialysis Adequacy/Plan of Care (AMA PCPI)
- 2056 • 0323/Hemodialysis Adequacy/Plan of Care (AMA PCPI)
- 2057 • 0383/Oncology: Plan of Care for Pain - Medical Oncology and Radiation Oncology (paired  
2058 with 0384) (AMA PCPI)

- 2059 • 0384/Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired  
2060 with 0383) (AMA PCPI)
- 2061 • 0385/Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients (AMA PCPI)
- 2062 • 0386/Oncology: Cancer Stage Documented (AMA PCPI)
- 2063 • 0387/Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer  
2064 (AMA PCPI)
- 2065 • 0441 / Assessed for Rehabilitation (The Joint Commission)
- 2066
- 2067 NQF- endorsed measures related to care coordination and communication:
- 2068 • 0005/CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist  
2069 Care Surveys) (AHRQ)
- 2070 • 0006 CAHPS Health Plan Survey v 4.0 - Adult questionnaire (AHRQ)
- 2071 • 0007/NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H) (NCQA)
- 2072 • 0009/CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement (AHRQ)
- 2073 • 0166/HCAHPS (AHRQ)
- 2074 • 0291/ Administrative Communication (University of Minnesota Rural Health Research Center)
- 2075 • 0292/Vital Signs (University of Minnesota Rural Health Research Center)
- 2076 • 0293/Medication Information (University of Minnesota Rural Health Research Center)
- 2077 • 0294/Patient Information (University of Minnesota Rural Health Research Center)
- 2078 • 0295 Physician Information (University of Minnesota Rural Health Research Center)
- 2079 • 0296/Nursing Information (University of Minnesota Rural Health Research Center)
- 2080 • 0297/Procedures and Tests (University of Minnesota Rural Health Research Center)
- 2081 • 0381/Oncology: Treatment Summary Documented and Communicated – Radiation Oncology  
2082 (AMA PCPI)
- 2083
- 2084 NQF-endorsed measures related to care coordination and information systems:
- 2085 • 0488/Adoption of Health Information Technology (CMS)

2086 • 0490/The ability to use health information technology to perform care management at the point  
2087 of care (CMS)

2088 • 0491/Tracking of clinical results between visits (CMS)

2089

2090 NQF-endorsed measures related to care coordination and transitions:

2091 • 0097/Medication Reconciliation (NCQA, AGS, AMA)

2092 • 0526/Timely Initiation of Care (CMS)

2093

2094 NQF previously endorsed measures addressing the NPP goal for care coordination, reducing 30-day  
2095 readmission rates/hospitalizations:

2096 • 0329/All-Cause Readmission Index (risk adjusted) (United Health Group - Ho, Sam)

2097 • 0330/30-Day All-Cause Risk Standardized Readmission Rate Following Heart Failure  
2098 Hospitalization (risk adjusted) (CMS - McGann, Paul E)

2099 • 0335/PICU Unplanned Readmission Rate (National Association of Children's Hospitals and  
2100 Related Institutions - Schwalenstocker, Ellen)

2101 • 0336/Review of Unplanned PICU Readmissions (National Association of Children's Hospitals  
2102 and Related Institutions - Schwalenstocker, Ellen)

2103 • 0505/30-day all-cause risk standardized readmission rate following acute myocardial infarction  
2104 (AMI) hospitalization (CMS)

2105 • 0506/30-day all-cause risk standardized readmission rate following pneumonia hospitalization  
2106 (CMS)

2107

## 2108 RECOMMENDATIONS TO ACCOMPANY THE MEASURES

2109 Several Steering Committee recommendations were made to accompany the set of measures:

2110

2111 • **Care Coordination encompasses several steps over an episode of care.** A standard should  
2112 measure more than one step of that care. Coordination not only consists of movement from point A  
2113 to point B, it also is more systematic and should be patient centered. The communication loop

- 2114 between the specialist, primary care provider, and the patient should address appropriately and  
 2115 include clear documentation to show follow-up has happened.
- 2116 • **Structured framework for office visits as they relate to care coordination.** Among the many steps  
 2117 of care coordination, an office visit and referral are often components that happen within care.  
 2118 Creating a structure framework with the components/activities needed during an office visit to  
 2119 ensure care coordination.
  - 2120 • **Patient experience and involvement with care.** The patient should be involved in every step of  
 2121 care and measurement should include demonstrating the use of care plans, patient education about  
 2122 treatment and/or conditions, self-management support programs.
  - 2123 • **Pairing future transition measures with the NQF-endorsed CTM-3 measure.**
  - 2124 • **Long-term resource utilization (e.g., inpatient stay; ED utilization) as a function of continuity of  
 2125 care compared to low-continuity populations.**

2126

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2130

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2215 **NOTES**

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## **Appendix A - Specifications of the National Voluntary Consensus Standards for Care Coordination**

The following table presents descriptive specifications for each of the proposed National Voluntary Consensus Standards for Care Coordination.

All information presented has been derived directly from measure sources/developers without modification or alteration (except when the measure developer agreed to such modification during the NQF Consensus Development Process) and is current as of December 2009.

All NQF-endorsed voluntary consensus standards are open source, meaning they are fully accessible and disclosed.

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## Appendix A - Specifications of the National Voluntary Consensus Standards for Care Coordination

Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
<b>Cardiac Rehabilitation Patient Referral From an Inpatient Setting</b>	Measure ID#: XXXX  Review #: CC-019-09	© ACCF/ AHA Task Force	<b>Numerator Statement</b> Number of eligible patients with a qualifying event/diagnosis who have been referred to an outpatient cardiac rehabilitation program prior to hospital discharge, or who have a documented medical or patient-oriented reason why such a referral was not made. (Note: the program may include a traditional program based on face-to-face interactions or training sessions or may include other options such as home-based approaches. If alternative methods are used, they should be designed to meet	<b>Denominator Statement</b> All hospitalized patients in the reporting period hospitalized with a qualifying cardiovascular disease event who do not meet any of the exclusion criteria.  <b>Denominator Details</b> Qualifying cardiovascular disease events including the following: (1) acute myocardial infarction (defined by standardized criteria on the basis of cardiac pain, electrocardiographic data, and biomarker levels, (2) coronary artery bypass graft (CABG) surgery, (3) chronic stable angina (characterized	<b>Denominator Exclusions</b> Exclusion criteria include documentation of one of more of the following barriers to cardiac rehabilitation participation: (1) Patient factors (patient to be discharged to a nursing care facility for long term care, for example), (2) Medical factors (patient deemed by provider to have a medically unstable, life-threatening condition, for example), (3) Health care system factors (no cardiac rehabilitation program available within 60 minutes of travel time from the patient's home, for example).	<ul style="list-style-type: none"> <li>• Electronic Health/Medical Record</li> <li>• Electronic Clinical Registry - National Cardiovascular Data Registry (NCDR), ACTION-Get With the Guidelines Inpatient Registry</li> <li>• Electronic Claims</li> <li>• Paper Medical Record</li> </ul>

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>appropriate safety standards.)</p> <p><b>Numerator Details</b>  A referral is defined as an official communication between the healthcare provider and the patient to recommend and carry out a referral order to an early outpatient cardiac rehabilitation program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an early outpatient cardiac rehabilitation program. This also includes written or electronic communication between the healthcare provider or healthcare system and the cardiac rehabilitation program that includes the patient's</p>	<p>as a deep, poorly localized chest or arm discomfort that is reproducibly associated with physical exertion or emotional stress and is relieved promptly (i.e., less than 5 min) with rest and/or the use of sublingual nitroglycerin (NTG) , (4) cardiac valve surgery (surgical repair or replacement of the aortic, mitral, pulmonic or tricuspid valves), and (5) cardiac transplantation. Patients with a qualifying event who are to be discharged for a short-term stay in an inpatient medical rehabilitation facility are still expected to be referred to an outpatient cardiac rehabilitation program by the in-patient team during the index hospitalization.</p>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>enrollment information for the program. A hospital discharge summary or office note may be potentially formatted to include the necessary patient information to communicate to the cardiac rehabilitation program [the patient's cardiovascular history, testing, and treatments, for instance.] All communications must maintain appropriate confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act (HIPAA).</p> <p><i>Detailed specifications and coding are available in Attachment 2</i></p>	<p>This referral should be reinforced by the care team at the medical rehabilitation facility.</p> <p><i>Detailed specifications and coding are available in Attachment 2</i></p>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
Cardiac Rehabilitation Patient Referral From an Outpatient Setting	Measure ID#: XXXX Review #: CC-020-09	© ACCF/AHA Task Force	<p><b>Numerator Statement</b> Number of patients in an outpatient practice who have had a qualifying event/diagnosis in the previous 12 months who have been referred to an outpatient cardiac rehabilitation/secondary prevention program. (Note: the program may include a traditional program based on face-to-face interactions or training sessions or may include other options such as home-based approaches. If alternative methods are used, they should be designed to meet appropriate safety standards.)</p>	<p><b>Denominator Statement</b> Number of patients in an outpatient clinical practice who have had a qualifying cardiovascular event in the previous 12 months, who do not meet any of the exclusion criteria, and who have not participated in an out-patient cardiac rehabilitation program since the cardiovascular event.</p> <p><b>Denominator Details</b> Qualifying cardiovascular disease events including the following: (1) acute myocardial infarction (defined by standardized criteria on the basis of cardiac pain, electrocardiographic data, and biomarker levels, (2) coronary artery bypass graft (CABG) surgery, (3) chronic</p>	<p><b>Denominator Exclusions:</b> Exclusion criteria include documentation of one of more of the following barriers to cardiac rehabilitation participation: (1) Patient factors (patient resides in a long-term nursing care facility, for example), (2) Medical factors (patient deemed by provider to have a medically unstable, life-threatening condition), (3) Health care system factors (no cardiac rehabilitation program available within 60 minutes of travel time from the patient's home, for example).</p> <p>The out-patient setting where this measure would apply includes the</p>	<ul style="list-style-type: none"> <li>• Electronic Health/Medical Record</li> <li>• Electronic Clinical Registry - National Cardiovascular Data Registry (NCDR), ACTION-Get With the Guidelines Inpatient Registry</li> <li>• Electronic Claims Paper Medical Record</li> </ul>

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p><b>Numerator Details:</b>            A referral is defined as an official communication between the healthcare provider and the patient to recommend and carry out a referral order to an early outpatient cardiac rehabilitation program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an early outpatient cardiac rehabilitation program. This also includes written or electronic communication between the healthcare provider or healthcare system and the cardiac rehabilitation program that includes the patient's enrollment information for the program. A hospital discharge summary or office</p>	<p>stable angina (characterized as a deep, poorly localized chest or arm discomfort that is reproducibly associated with physical exertion or emotional stress and is relieved promptly (i.e., less than 5 min) with rest and/or the use of sublingual nitroglycerin (NTG)), (4) cardiac valve surgery (surgical repair or replacement of the aortic, mitral, pulmonic or tricuspid valves), and (5) cardiac transplantation.</p> <p><i>Detailed specifications and coding are available in Attachment 2</i></p>	<p>outpatient practice setting of the clinician who provides the primary cardiovascular-related care for the patient. In general, this would be the patient's cardiologist, but in some cases it might be a family physician, internist, nurse practitioner, or other healthcare provider.</p>	

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			note may be potentially formatted to include the necessary patient information to communicate to the cardiac rehabilitation program [the patient's cardiovascular history, testing, and treatments, for instance.] According to standards of practice for cardiac rehabilitation programs, care coordination communications are sent to the referring provider, including any issues regarding treatment changes, adverse treatment responses, or new non-emergency condition (new symptoms, patient care questions, etc.) that need attention by the referring provider. These communications also include a progress report			

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>once the patient has completed the program. All communications must maintain appropriate confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act (HIPAA).</p> <p><i>Detailed specifications and coding are available in Attachment 2</i></p>			
<b>Patients with a transient ischemic event ER visit that had a follow up office visit</b>	<b>Measure ID#:</b> XXXX  <b>Review #:</b> CC-050-09	© Ingenix	<b>Numerator Statement</b> Create a POST period from the day after the initiating Facility Event (i.e., the ER encounter for the transient cerebral ischemic event) through 14 days after the	<b>Denominator Statement</b> For condition confirmation, patients must meet the following criteria:  1. All males or females that are 18 years or older at the	<b>Denominator Exclusions</b> None	<ul style="list-style-type: none"> <li>Electronic Claims</li> </ul>

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			initiating Facility Event AND During the POST period, did the patient have any professional encounter (code set PR0107, RV0107) with any diagnosis  (Note: Will allow non-physician encounters (e.g., nurse practitioner and physician assistance encounters) to count toward numerator compliance as long as the provider(s) has submitted one of the face-to-face encounter codes (e.g., 99213) listed in our code set.)  <b>Numerator Detail:</b>  See Attachment 1	end of the report period  2. Patient must have been continuously enrolled:  Medical benefits throughout the 12 months prior to the end of the report period  AND  Pharmacy benefit plan for 6 months prior to the end of the report period  Note: The standard enrollment break logic allows unlimited breaks of no more than 45 days and no breaks greater than 45 days.  3. Either one of the following (A or B):  A. The patient is listed on		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				<p>the Disease Registry Input File for this condition, if a Disease Registry Input File is available. Note: Disease Registry is NOT a required input file.</p> <p>B. During the 24 months prior to the end of the report period, patient has 2 or more that are at least 14 days apart of the following services, where the diagnosis is Occlusive Vascular Disease OR Stroke, non-hemorrhagic OR Transient cerebral ischemia (code set DX0110, DX0146, DX0149):</p> <ul style="list-style-type: none"> <li>• Professional Encounter (code set PR0107, RV0107)</li> <li>• Professional Supervision (code set</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				PR0108) <ul style="list-style-type: none"> <li>• Facility Event - Confinement/ Admission</li> <li>• Facility Event - Emergency Room</li> <li>• Facility Event - Outpatient Surgery</li> </ul> <p>In addition, for this measure, the patient must meet the following criteria:</p> <p>Create multiple temporary events for transient cerebral ischemic event.</p> <p>Set Episode Start Date to the date of service of any claim (i.e. initiating event) for the service and diagnosis stated below during the following window of time: 365 days prior to the end of the report period through 30</p>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				<p>days prior to the end of the report period</p> <p>Facility Event - Emergency Room AND</p> <p>The primary diagnosis on the claim was: Transient cerebral ischemia (code set DX0149)</p> <p><b>Denominator Details</b> See Attachment 1</p>		
Biopsy Follow-up	<p>Measure ID#: XXXX</p> <p>Review #: CC-071-09</p>	© American Academy of Dermatology	<p><b>Numerator Statement</b></p> <p>Patients who are undergoing a biopsy whose biopsy results have been reviewed by the biopsying physician and communicated to the primary care physician and the patient, denoted by entering said physician's initials into a log, as well as by documentation in the</p>	<p><b>Denominator Statement</b></p> <p>All patients undergoing a biopsy</p> <p><b>Denominator Details</b></p> <p>Not available at this time</p>	<p><b>Denominator Exclusions</b></p> <p>Patients not undergoing a biopsy</p>	<ul style="list-style-type: none"> <li>Paper Medical Record</li> </ul>

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>patient's medical record.</p> <p><b>Numerator Details</b> Not available at this time</p>			
<p><b>Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)</b></p>	<p><b>Measure ID#:</b> XXXX</p> <p><b>Review #:</b> CC-073-09</p>	<p>© AMA-PCPI</p>	<p><b>Numerator Statement</b> 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:</p> <p>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</p>	<p><b>Denominator Statement</b> 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.</p> <p><b>Denominator Details</b> The denominator may be identified using UB-04 claims data: UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital, Inpatient, Admit through</p>	<p><b>Denominator Exclusions</b> Patients who died Patients who left against medical advice (AMA) or discontinued care</p>	<ul style="list-style-type: none"> <li>• Electronic Health/Medical Record</li> <li>• Paper Medical Record</li> <li>• Hybrid, electronic data collection supplemented with medical record abstraction</li> </ul>

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge.</p> <p>* Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed</p> <p>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</p>	<p>Discharge Claim)</p> <ul style="list-style-type: none"> <li>• 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim)</li> <li>• 0114 (Hospital, Inpatient, Last Claim)</li> <li>• 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim)</li> <li>• 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim)</li> <li>• 0214 (Skilled Nursing-Inpatient, Interim, Last Claim)</li> <li>• 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim)</li> <li>• 0224 (Skilled</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>that caused an allergic reaction or adverse event and were therefore discontinued.</p> <p>Time Window: Each time a patient is discharged from an inpatient facility</p> <p><b>Numerator Details:</b> Numerator Details to be obtained through medical record abstraction. See Retrospective data collection tool in measure worksheet document for numerator details.</p> <p>Definitions specific to Measure #CC-073-09:</p> <ul style="list-style-type: none"> <li>For the purposes of this measure, “medications” includes prescription, over-</li> </ul>	<p>Nursing- Interim, Last Claim)</p> <ul style="list-style-type: none"> <li>0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)</li> <li>0284 (Skilled Nursing-Swing Beds, Interim, Last Claim)</li> </ul> <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> <li>01 (Discharged to home care or self care (routine discharge)</li> <li>02 (Discharged/transferred to a short term general hospital for inpatient care)</li> <li>03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>the-counter, and herbal products. Generic and proprietary names should be provided for each medication, when available.</p> <ul style="list-style-type: none"> <li>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</li> </ul>	<p>certification in anticipation of skilled care)</p> <ul style="list-style-type: none"> <li>04 (Discharged/transferred to an intermediate care facility)</li> <li>05 Discharged/transferred to a designated cancer center or children's hospital</li> <li>06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)</li> <li>43 (Discharged/transferred to a federal health care facility)</li> <li>50 (Hospice - home)</li> <li>51 (Hospice - medical facility (certified))</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>AND any allergic reactions are identified.</p> <p>Detailed specifications with coding can be found at <a href="http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml">http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml</a></p>	<p>providing hospice level of care)</p> <ul style="list-style-type: none"> <li>• 61 (Discharged/transferred to hospital-based Medicare approved swing bed)</li> <li>• 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)</li> <li>• 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))</li> <li>• 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)</li> <li>• 65</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				(Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) <ul style="list-style-type: none"> <li>• 66</li> </ul> (Discharged/transferred to a Critical Access Hospital (CAH)) <ul style="list-style-type: none"> <li>• 70</li> </ul> (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): <ul style="list-style-type: none"> <li>• 0131 (Hospital Outpatient, Admit through Discharge Claim)</li> <li>• 0134 (Hospital Outpatient, Interim, Last Claim)</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				AND UB-04 (Form Locator 42 - Revenue Code): <ul style="list-style-type: none"> <li>• 0762 (Hospital Observation)</li> <li>• 0490 (Ambulatory Surgery)</li> <li>• 0499 (Other Ambulatory Surgery)</li> </ul> AND Discharge Status (Form Locator 17) <ul style="list-style-type: none"> <li>• 01 (Discharged to home care or self care (routine discharge))</li> <li>• 02 (Discharged/transferred to a short term general hospital for inpatient care)</li> <li>• 03 (Discharged/transferred to skilled nursing facility)</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				(SNF) with Medicare certification in anticipation of skilled care) <ul style="list-style-type: none"> <li>• 04</li> </ul> (Discharged/transferred to an intermediate care facility) <ul style="list-style-type: none"> <li>• 05</li> </ul> Discharged/transferred to a designated cancer center or children's hospital <ul style="list-style-type: none"> <li>• 06</li> </ul> (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) <ul style="list-style-type: none"> <li>• 43</li> </ul> (Discharged/transferred to a federal health care facility) <ul style="list-style-type: none"> <li>• 50 (Hospice - home)</li> <li>• 51 (Hospice -</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				medical facility (certified) providing hospice level of care) <ul style="list-style-type: none"> <li>• 61 (Discharged/transferred to hospital-based Medicare approved swing bed)</li> <li>• 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)</li> <li>• 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))</li> <li>• 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				<ul style="list-style-type: none"> <li>• 65 (Discharged/ transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)</li> <li>• 66 (Discharged/ transferred to a Critical Access Hospital (CAH))</li> <li>• 70 (Discharged/ transferred to another type of health care institution not defined elsewhere in this code list)</li> </ul> <p>Detailed specifications with coding can be found at <a href="http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance">http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance</a></p>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				<a href="#">improvement/pcpi-measures.shtml</a>		
Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care) (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Measure ID#: XXXX  Review #: CC-074-09	© AMA-PCPI	<p><b>Numerator Statement:</b> Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements:</p> <p>Inpatient Care</p> <ul style="list-style-type: none"> <li>Reason for inpatient admission, AND</li> <li>Major procedures and tests performed during inpatient stay and summary of results, AND</li> <li>Principal diagnosis at discharge</li> </ul> <p>Post-Discharge/ Patient Self-Management</p>	<p><b>Denominator Statement:</b> 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.</p> <p>Time Window: Each time a patient is discharged from an inpatient facility.</p> <p><b>Denominator Details:</b> UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> <li>0111 (Hospital, Inpatient, Admit through Discharge Claim)</li> <li>0121 (Hospital, Inpatient - Medicare Part B</li> </ul>	<p><b>Denominator Exclusions:</b> Patients who died Patients who left against medical advice (AMA) or discontinued care</p>	<ul style="list-style-type: none"> <li>Electronic Health/Medical Record</li> <li>Paper Medical Record</li> <li>Hybrid, electronic data collection supplemented with medical record abstraction</li> </ul>

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<ul style="list-style-type: none"> <li>• Current medication list, AND</li> <li>• Studies pending at discharge (eg, laboratory, radiological), AND</li> <li>• Patient instructions Advance Care Plan</li> <li>• Advance directives or surrogate decision maker documented OR Documented reason for not providing advance care plan</li> <li>Contact Information/Plan for Follow-up Care</li> <li>• 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND</li> <li>• Contact information for obtaining results of studies pending at discharge, AND</li> <li>• Plan for follow-up care, AND</li> </ul>	only, Admit through Discharge Claim) <ul style="list-style-type: none"> <li>• 0114 (Hospital, Inpatient, Last Claim)</li> <li>• 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim)</li> <li>• 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim)</li> <li>• 0214 (Skilled Nursing-Inpatient, Interim, Last Claim)</li> <li>• 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim)</li> <li>• 0224 (Skilled Nursing- Interim, Last Claim)</li> <li>• 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)</li> <li>• 0284 (Skilled</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<ul style="list-style-type: none"> <li>Primary physician, other health care professional, or site designated for follow-up care</li> </ul> <p>Time Window: Each time a patient is discharged from an inpatient facility.</p> <p><b>Numerator Details:</b> Numerator Details to be obtained through medical record abstraction. See Retrospective data collection tool in measure worksheet document for numerator details.</p> <p>Definitions specific to Measure #CC-074-09: a. Transition record: a core,</p>	<p>Nursing-Swing Beds, Interim, Last Claim) AND Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> <li>01 (Discharged to home care or self care (routine discharge)</li> <li>02 (Discharged/transferred to a short term general hospital for inpatient care)</li> <li>03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)</li> <li>04 (Discharged/transferred to an intermediate care facility)</li> <li>05 Discharged/transferred to a designated cancer center or</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in a printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.</p> <p>b. Current medication list: all medications to be taken by patient after discharge, including all continued and new medications</p>	<p>children's hospital</p> <ul style="list-style-type: none"> <li>• 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)</li> <li>• 43 (Discharged/transferred to a federal health care facility)</li> <li>• 50 (Hospice - home)</li> <li>• 51 (Hospice - medical facility (certified) providing hospice level of care)</li> <li>• 61 (Discharged/transferred to hospital-based Medicare approved swing bed)</li> <li>• 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>c. Advance directives: eg, written statement of patient wishes regarding future use of life-sustaining medical treatment</p> <p>d. Documented reason for not providing advance care plan: documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care</p>	<ul style="list-style-type: none"> <li>• 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))</li> <li>• 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)</li> <li>• 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)</li> <li>• 66 (Discharged/transferred to a Critical Access Hospital (CAH))</li> <li>• 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)</li> </ul> <p>OR</p>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.</p> <p>e. Contact information/plan for follow-up care: For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the "receiving" facilities.</p> <p>f. Plan for follow-up care: may include any post-discharge therapy needed</p>	<p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> <li>• 0131 (Hospital Outpatient, Admit through Discharge Claim)</li> <li>• 0134 (Hospital Outpatient, Interim, Last Claim)</li> </ul> <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> <li>• 0762 (Hospital Observation)</li> <li>• 0490 (Ambulatory Surgery)</li> <li>• 0499 (Other Ambulatory Surgery)</li> </ul> <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> <li>• 01 (Discharged to home care or self care)</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			(eg, oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc.  g. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional.  Detailed specifications with coding can be found at <a href="http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-">http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-</a>	(routine discharge) <ul style="list-style-type: none"> <li>• 02</li> </ul> (Discharged/transferred to a short term general hospital for inpatient care) <ul style="list-style-type: none"> <li>• 03</li> </ul> (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) <ul style="list-style-type: none"> <li>• 04</li> </ul> (Discharged/transferred to an intermediate care facility) <ul style="list-style-type: none"> <li>• 05</li> </ul> Discharged/transferred to a designated cancer center or children's hospital <ul style="list-style-type: none"> <li>• 06</li> </ul> (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<a href="#">improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml</a>	<ul style="list-style-type: none"> <li>• 43 (Discharged/transferred to a federal health care facility)</li> <li>• 50 (Hospice – home)</li> <li>• 51 (Hospice - medical facility (certified) providing hospice level of care)</li> <li>• 61 (Discharged/transferred to hospital-based Medicare approved swing bed)</li> <li>• 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)</li> <li>• 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))</li> <li>• 64 (Discharged/transferred to a nursing facility certified</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				under Medicaid but not certified under Medicare) <ul style="list-style-type: none"> <li>• 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)</li> <li>• 66 (Discharged/transferred to a Critical Access Hospital (CAH))</li> <li>• 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)</li> </ul> Detailed specifications with coding can be found at <a href="http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-">http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-</a>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				<a href="http://consortium-performance-improvement/pcpi-measures.shtml">consortium-performance-improvement/pcpi-measures.shtml</a>		
<b>Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)</b>	Measure ID#: XXXX  Review #: CC-075-09	© AMA-PCPI	<p><b>Numerator Statement:</b> Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge</p> <p>Time Window: Each time a patient is discharged from an inpatient facility</p> <p><b>Numerator Details:</b> Numerator Details to be obtained through medical record abstraction. See Retrospective data collection tool in measure worksheet document for</p>	<p><b>Denominator Statement:</b> 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</p> <p>Time Window: Each time a patient is discharged from an inpatient facility.</p> <p><b>Denominator Details:</b> UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> <li>• 0111 (Hospital, Inpatient, Admit through Discharge Claim)</li> <li>• 0121 (Hospital, Inpatient - Medicare Part B</li> </ul>	<p><b>Denominator Exclusions:</b> Patients who died Patients who left against medical advice (AMA) or discontinued care</p>	<ul style="list-style-type: none"> <li>• Electronic Health/Medical Record</li> <li>• Paper Medical Record</li> <li>• Hybrid, electronic data collection supplemented with medical record abstraction</li> </ul>

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>numerator details.</p> <p>Definitions specific to Measure # CC-075-09:</p> <p>a. Transition record: a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in a printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable</p>	<p>only, Admit through Discharge Claim)</p> <ul style="list-style-type: none"> <li>• 0114 (Hospital, Inpatient, Last Claim)</li> <li>• 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim)</li> <li>• 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim)</li> <li>• 0214 (Skilled Nursing-Inpatient, Interim, Last Claim)</li> <li>• 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim)</li> <li>• 0224 (Skilled Nursing- Interim, Last Claim)</li> <li>• 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)</li> <li>• 0284 (Skilled</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>to patient.</p> <p>b. Transmitted: transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).</p> <p>c. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional Detailed specifications with coding can be found at</p>	<p>Nursing-Swing Beds, Interim, Last Claim) AND Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> <li>•01 (Discharged to home care or self care (routine discharge)</li> <li>•02(Discharged/ transferred to a short term general hospital for inpatient care)</li> <li>•03(Discharged/ transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)</li> <li>•04(Discharged/ transferred to an intermediate care facility)</li> <li>•05(Discharged/ transferred to a designated cancer center or children’s hospital)</li> <li>•06(Discharged/ transferred to home under care of</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<a href="http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml">http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml</a>	organized home health service org. in anticipation of covered skilled care) <ul style="list-style-type: none"> <li>•43(Discharged/transferred to a federal health care facility)</li> <li>•50 (Hospice - home)</li> <li>•51 (Hospice - medical facility (certified) providing hospice level of care)</li> <li>•61(Discharged/transferred to hospital-based Medicare approved swing bed)</li> <li>•62(Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)</li> <li>•63(Discharged/transferred to a Medicare certified long term care hospital (LTCH))</li> <li>•64(Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				<ul style="list-style-type: none"> <li>•65(Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)</li> <li>•66(Discharged/transferred to a Critical Access Hospital (CAH))</li> <li>•70(Discharged/transferred to another type of health care institution not defined elsewhere in this code list)</li> </ul> <p>OR</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> <li>•0131 (Hospital Outpatient, Admit through Discharge Claim)</li> <li>•0134 (Hospital Outpatient, Interim, Last Claim)</li> </ul> <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				<ul style="list-style-type: none"> <li>•0762 (Hospital Observation)</li> <li>•0490 (Ambulatory Surgery)</li> <li>•0499 (Other Ambulatory Surgery)</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>Discharge Status (Form Locator 17)</li> <li>•01 (Discharged to home care or self care (routine discharge))</li> <li>•02(Discharged/transferred to a short term general hospital for inpatient care)</li> <li>•03(Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)</li> <li>•04(Discharged/transferred to an intermediate care facility)</li> <li>•05(Discharged/transferred</li> </ul>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				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		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				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) Detailed specifications with coding can be found at <a href="http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance">http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance</a>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
				<a href="#">improvement/pcpi-measures.shtml</a>		
Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care])	Measure ID#: XXXX  Review #: CC-076-09	© AMA-PCPI	<b>Numerator Statement</b> Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: <ul style="list-style-type: none"> <li>• Major procedures and tests performed during ED visit, AND</li> <li>• Principal diagnosis at discharge OR chief complaint, AND</li> <li>• Patient instructions, AND</li> <li>• Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND</li> <li>• List of new medications</li> </ul>	<b>Denominator Statement</b> All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health  <b>Denominator Details</b> UB-04 (Form Locator 4 - Type of Bill): <ul style="list-style-type: none"> <li>• 0131 (Hospital, Outpatient, Admit through Discharge Claim)</li> </ul> AND UB-04 (Form Locator 42 - Revenue Code): <ul style="list-style-type: none"> <li>• 0450 - Emergency Room</li> </ul> AND UB-04 (Form Locator 17 -	<b>Denominator Exclusions</b> Patients who died Patients who left against medical advice (AMA) or discontinued care Patients who declined receipt of transition record	<ul style="list-style-type: none"> <li>• Electronic Health/Medical Record</li> <li>• Paper Medical Record</li> <li>• Hybrid, electronic data collection supplemented with medical record abstraction</li> </ul>

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each.</p> <p><b>Numerator Details</b>            Numerator Details to be obtained through medical record abstraction. See Retrospective data collection tool in measure worksheet document for numerator details.</p> <p>Definitions specific to Measure #CC-076-09:</p> <p>a. Transition record (for ED discharges): a core, standardized set of data</p>	<p>Discharge Status):</p> <ul style="list-style-type: none"> <li>• 01 - Discharged to home care or self care (routine discharge)</li> <li>• 06 - Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care</li> </ul> <p>Detailed specifications with coding can be found at <a href="http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml">http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml</a></p>		

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in written, printed, or electronic format. Electronic format may be provided only if acceptable to patient.</p> <p>b. Primary physician or other health care professional designated for follow-up care: may be primary care physician (PCP), medical specialist, or other physician or health care professional. If no physician, other health care professional, or site designated or available, patient may be provided with information on alternatives for obtaining</p>			

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>follow-up care needed, which may include a list of community health services/other resources.</p> <p>Detailed specifications with coding can be found at <a href="http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml">http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml</a></p>			
<b>Melanoma Continuity of Care - Recall System</b>	<p><b>Measure ID#:</b> XXXX</p> <p><b>Review #:</b> CC-078-09</p>	© AMA-PCPI/AAD/NCQA	<p><b>Numerator Statement</b> Patients whose information is entered, at least once within a 12 month period, into a recall system* that includes:</p> <ul style="list-style-type: none"> <li>• A target date for the next complete physical skin</li> </ul>	<p><b>Denominator Statement</b> All patients with a current diagnosis of melanoma or a history of melanoma.</p> <p><b>Denominator Details</b> All patients, regardless of age, with a current diagnosis melanoma or history of melanoma ICD-9</p>	<p><b>Denominator Exclusions</b> Documentation of system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another provider) Append modifier to CPT Category II codes: 7010F-</p>	<ul style="list-style-type: none"> <li>• Claims</li> <li>• Medical Record</li> <li>• Electronic Health/Medical Record</li> <li>• Hybrid, electronic data collection supplemented with medical record</li> </ul>

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			exam , <u>AND</u> • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment  <b>Numerator Details</b> Patient information entered into a recall system that includes target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments (7010F) OR Documentation of a system reason(s) for not entering patient's information into a recall system (eg, melanoma being monitored by another physician provider) (7010F with 3P) OR Recall system	diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82  AND  CPT E/M codes: 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245	3P	abstraction

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Care Coordination						
Measure Title	Measure Numbers	IP Owners	Numerator	Denominator	Exclusions	Data Source
			<p>not utilized, reason not otherwise specified (7010F with 8P)*<i>To satisfy this measure, the recall system must be linked to a process to notify patients when their next physical exam is due and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and must include the following elements at a minimum: patient identifier, patient contact information, cancer diagnosis(es), dates(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.</i></p>			

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## Attachment 1 – Specifications of the National Voluntary Consensus Standards for Care Coordination

The following tables present descriptive code sets for care coordination measure CC-050-09.

### DIAGNOSIS CODE SETS:

Code Set	Code Set Description	Diagnosis Code	Diagnosis Code Description
DX0110	Occlusive Vascular Disease	433	OCCLUSION AND STENOSIS OF PRECEREBRAL ARTERIES*
DX0110	Occlusive Vascular Disease	433.0	OCCLUSION AND STENOSIS OF BASILAR ARTERY*
DX0110	Occlusive Vascular Disease	433.00	OCCLUSION&STENOS BASILAR ART W/O MENTION INFARCT
DX0110	Occlusive Vascular Disease	433.01	OCCLUSION&STENOSIS BASILAR ARTERY W/INFARCT
DX0110	Occlusive Vascular Disease	433.1	OCCLUSION AND STENOSIS OF CAROTID ARTERY*
DX0110	Occlusive Vascular Disease	433.10	OCCLUSION&STENOS CAROTID ART W/O MENTION INFARCT
DX0110	Occlusive Vascular Disease	433.11	OCCLUSION&STENOSIS CAROTID ARTERY W/INFARCT
DX0110	Occlusive Vascular Disease	433.2	OCCLUSION AND STENOSIS OF VERTEBRAL ARTERY*
DX0110	Occlusive Vascular Disease	433.20	OCCLUSION&STENOS VERT ART W/O MENTION INFARCT
DX0110	Occlusive Vascular Disease	433.21	OCCLUSION&STENOSIS VERTEBRAL ARTERY W/INFARCT

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Code Set	Code Set Description	Diagnosis Code	Diagnosis Code Description
DX0110	Occlusive Vascular Disease	433.3	OCCLUSION&STENOSIS MULTIPLE&BILAT PRECERBRL ART*
DX0110	Occlusive Vascular Disease	433.30	OCCL&STENOS MX&BILAT PRECERBRL ART W/O INFARCT
DX0110	Occlusive Vascular Disease	433.31	OCCL&STENOS MX&BILAT PRECERBRL ART W/INFARCT
DX0110	Occlusive Vascular Disease	433.8	OCCLUSION&STENOSIS OTHER SPEC PRECEREBRAL ARTERY*
DX0110	Occlusive Vascular Disease	433.80	OCCL&STENOS OTH SPEC PRECERBRL ART W/O INFARCT
DX0110	Occlusive Vascular Disease	433.81	OCCL&STENOS OTH SPEC PRECERBRL ART W/INFARCT
DX0110	Occlusive Vascular Disease	433.9	OCCLUSION&STENOSIS UNSPEC PRECEREBRAL ARTERY*
DX0110	Occlusive Vascular Disease	433.90	OCCL&STENOS UNS PRECERBRL ART W/O INFARCT
DX0110	Occlusive Vascular Disease	433.91	OCCLUSION&STENOS UNSPEC PRECERBRL ART W/INFARCT
DX0110	Occlusive Vascular Disease	434	OCCLUSION OF CEREBRAL ARTERIES*
DX0110	Occlusive Vascular Disease	434.0	CEREBRAL THROMBOSIS*
DX0110	Occlusive Vascular Disease	434.00	CEREBRAL THROMBOSIS WITHOUT MENTION INFARCT
DX0110	Occlusive Vascular Disease	434.01	CEREBRAL THROMBOSIS WITH CEREBRAL INFARCTION
DX0110	Occlusive Vascular Disease	434.1	CEREBRAL EMBOLISM*
DX0110	Occlusive Vascular Disease	434.10	CEREBRAL EMBOLISM WITHOUT MENTION INFARCT

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Code Set	Code Set Description	Diagnosis Code	Diagnosis Code Description
DX0110	Occlusive Vascular Disease	434.11	CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
DX0110	Occlusive Vascular Disease	434.9	UNSPECIFIED CEREBRAL ARTERY OCCLUSION*
DX0110	Occlusive Vascular Disease	434.90	UNSPEC CERBRL ART OCCLUSION W/O MENTION INFARCT
DX0110	Occlusive Vascular Disease	434.91	UNSPECIFIED CEREBRAL ARTERY OCCLUSION W/INFARCT
DX0146	Stroke, non-hemorrhagic	436	ACUTE BUT ILL-DEFINED CEREBROVASCULAR DISEASE
DX0149	Transient cerebral ischemia	435	TRANSIENT CEREBRAL ISCHEMIA*
DX0149	Transient cerebral ischemia	435.0	BASILAR ARTERY SYNDROME
DX0149	Transient cerebral ischemia	435.1	VERTEBRAL ARTERY SYNDROME
DX0149	Transient cerebral ischemia	435.2	SUBCLAVIAN STEAL SYNDROME
DX0149	Transient cerebral ischemia	435.3	VERTEBROBASILAR ARTERY SYNDROME
DX0149	Transient cerebral ischemia	435.8	OTHER SPECIFIED TRANSIENT CEREBRAL ISCHEMIAS
DX0149	Transient cerebral ischemia	435.9	UNSPECIFIED TRANSIENT CEREBRAL ISCHEMIA

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## PROCEDURE CODE SETS:

Code Set	Code Set Description	Procedure Code	Category	Procedure Code Description
PR0107	Professional encounter	99201	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99202	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99203	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99204	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

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PR0107	Professional encounter	99205	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99211	CPT	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
PR0107	Professional encounter	99212	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99213	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

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PR0107	Professional encounter	99214	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99215	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99217	CPT	Observation care discharge day management (This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.]
PR0107	Professional encounter	99218	CPT	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity.

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PR0107	Professional encounter	99219	CPT	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity.
PR0107	Professional encounter	99220	CPT	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity.
PR0107	Professional encounter	99221	CPT	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
PR0107	Professional encounter	99222	CPT	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

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PR0107	Professional encounter	99223	CPT	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.
PR0107	Professional encounter	99231	CPT	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.
PR0107	Professional encounter	99232	CPT	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.
PR0107	Professional encounter	99233	CPT	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

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PR0107	Professional encounter	99234	CPT	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.
PR0107	Professional encounter	99235	CPT	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.
PR0107	Professional encounter	99236	CPT	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.
PR0107	Professional encounter	99238	CPT	Hospital discharge day management; 30 minutes or less
PR0107	Professional encounter	99239	CPT	Hospital discharge day management; more than 30 minutes

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PR0107	Professional encounter	99241	CPT	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99242	CPT	Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99243	CPT	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99244	CPT	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

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PR0107	Professional encounter	99245	CPT	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99251	CPT	Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.
PR0107	Professional encounter	99252	CPT	Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.
PR0107	Professional encounter	99253	CPT	Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

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PR0107	Professional encounter	99254	CPT	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.
PR0107	Professional encounter	99255	CPT	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.
PR0107	Professional encounter	99261	CPT	Follow-up inpatient consult
PR0107	Professional encounter	99262	CPT	Follow-up inpatient consult
PR0107	Professional encounter	99263	CPT	Follow-up inpatient consult
PR0107	Professional encounter	99271	CPT	Confirmatory consultation
PR0107	Professional encounter	99272	CPT	Confirmatory consultation
PR0107	Professional encounter	99273	CPT	Confirmatory consultation
PR0107	Professional encounter	99274	CPT	Confirmatory consultation
PR0107	Professional encounter	99275	CPT	Confirmatory consultation

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PR0107	Professional encounter	99281	CPT	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
PR0107	Professional encounter	99282	CPT	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
PR0107	Professional encounter	99283	CPT	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
PR0107	Professional encounter	99284	CPT	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
PR0107	Professional encounter	99285	CPT	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

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## THE NATIONAL QUALITY FORUM

PR0107	Professional encounter	99301	CPT	Nursing facility care
PR0107	Professional encounter	99302	CPT	Nursing facility care
PR0107	Professional encounter	99303	CPT	Nursing facility care
PR0107	Professional encounter	99304	CPT	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.
PR0107	Professional encounter	99305	CPT	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes with the patient and/or family or caregiver.
PR0107	Professional encounter	99306	CPT	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.

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PR0107	Professional encounter	99307	CPT	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes with the patient and/or family or caregiver.
PR0107	Professional encounter	99308	CPT	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes with the patient and/or family or caregiver.
PR0107	Professional encounter	99309	CPT	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes with the patient and/or family or caregiver.
PR0107	Professional encounter	99310	CPT	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes with the patient and/or family or caregiver.
PR0107	Professional encounter	99311	CPT	Nursing fac care, subseq

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PR0107	Professional encounter	99312	CPT	Nursing fac care, subseq
PR0107	Professional encounter	99313	CPT	Nursing fac care, subseq
PR0107	Professional encounter	99315	CPT	Nursing facility discharge day management; 30 minutes or less
PR0107	Professional encounter	99316	CPT	Nursing facility discharge day management; more than 30 minutes
PR0107	Professional encounter	99318	CPT	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 30 minutes with the patient and/or family or caregiver.
PR0107	Professional encounter	99341	CPT	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99342	CPT	Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

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PR0107	Professional encounter	99343	CPT	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99344	CPT	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99345	CPT	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99347	CPT	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

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PR0107	Professional encounter	99348	CPT	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99349	CPT	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99350	CPT	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
PR0107	Professional encounter	99381	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
PR0107	Professional encounter	99382	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)

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PR0107	Professional encounter	99383	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
PR0107	Professional encounter	99384	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
PR0107	Professional encounter	99385	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
PR0107	Professional encounter	99386	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
PR0107	Professional encounter	99387	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
PR0107	Professional encounter	99391	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
PR0107	Professional encounter	99392	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)

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PR0107	Professional encounter	99393	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
PR0107	Professional encounter	99394	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
PR0107	Professional encounter	99395	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
PR0107	Professional encounter	99396	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
PR0107	Professional encounter	99397	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
PR0107	Professional encounter	99401	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
PR0107	Professional encounter	99402	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
PR0107	Professional encounter	99403	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes

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PR0107	Professional encounter	99404	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
PR0107	Professional encounter	99411	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
PR0107	Professional encounter	99412	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
PR0107	Professional encounter	99420	CPT	Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)
PR0107	Professional encounter	99429	CPT	Unlisted preventive medicine service
PR0107	Professional encounter	S0270	HCPCS	Physician management of patient home care, standard monthly case rate (per 30 days)
PR0107	Professional encounter	S0271	HCPCS	Physician management of patient home care, hospice monthly case rate (per 30 days)
PR0107	Professional encounter	S0272	HCPCS	Physician management of patient home care, episodic care monthly case rate (per 30 days)
PR0107	Professional encounter	S0273	HCPCS	Physician visit at member's home, outside of a capitation arrangement
PR0108	Professional supervision	99321	CPT	Rest home visit, new patient
PR0108	Professional supervision	99322	CPT	Rest home visit, new patient
PR0108	Professional supervision	99323	CPT	Rest home visit, new patient

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PR0108	Professional supervision	99324	CPT	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.
PR0108	Professional supervision	99325	CPT	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.
PR0108	Professional supervision	99326	CPT	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.
PR0108	Professional supervision	99327	CPT	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

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PR0108	Professional supervision	99328	CPT	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.
PR0108	Professional supervision	99331	CPT	Rest home visit, est pat
PR0108	Professional supervision	99332	CPT	Rest home visit, est pat
PR0108	Professional supervision	99333	CPT	Rest home visit, est pat
PR0108	Professional supervision	99334	CPT	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.
PR0108	Professional supervision	99335	CPT	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

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PR0108	Professional supervision	99336	CPT	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.
PR0108	Professional supervision	99337	CPT	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.
PR0108	Professional supervision	99339	CPT	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, wit
PR0108	Professional supervision	99340	CPT	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, wit

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PR0108	Professional supervision	99371	CPT	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brie
PR0108	Professional supervision	99372	CPT	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (
PR0108	Professional supervision	99373	CPT	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or len
PR0108	Professional supervision	99374	CPT	Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adj
PR0108	Professional supervision	99375	CPT	Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adj

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PR0108	Professional supervision	99377	CPT	Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
PR0108	Professional supervision	99378	CPT	Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more
PR0108	Professional supervision	99379	CPT	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
PR0108	Professional supervision	99380	CPT	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

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PR0108	Professional supervision	99441	CPT	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
PR0108	Professional supervision	99442	CPT	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
PR0108	Professional supervision	99443	CPT	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
PR0108	Professional supervision	99444	CPT	Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network
PR0108	Professional supervision	G0179	HCPCS	Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period
PR0108	Professional supervision	G0180	HCPCS	Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period
PR0108	Professional supervision	G0181	HCPCS	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

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PR0108	Professional supervision	G0182	HCPCS	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
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# THE NATIONAL QUALITY FORUM

## REVENUE CODE SETS:

Code Set	Code Set Description	Revenue Code	Revenue Code Description
RV0107	Professional encounter	0510	Clinic-General
RV0107	Professional encounter	0511	Clinic-Chronic Pain Center
RV0107	Professional encounter	0512	Clinic-Dental Clinic
RV0107	Professional encounter	0513	Clinic-Psychiatric Clinic
RV0107	Professional encounter	0514	Clinic-OB/GYN Clinic
RV0107	Professional encounter	0515	Clinic-Pediatric Clinic
RV0107	Professional encounter	0516	Clinic-Urgent Care Clinic
RV0107	Professional encounter	0517	Clinic-Family Practice Clinic
RV0107	Professional encounter	0519	Clinic-Other Clinic
RV0107	Professional encounter	0520	Freestanding Clinic-General
RV0107	Professional encounter	0521	Freestanding Clinic-Clinic visit by member to RHC/FQHC
RV0107	Professional encounter	0522	Freestanding Clinic-Home visit by RHC/FQHC Practitioner
RV0107	Professional encounter	0523	Freestanding Clinic-Family Practice Clinic
RV0107	Professional encounter	0524	Freestanding Clinic-Visit by RHC/FQHC Practitioner to a Member in a Covered Part A Stay at SNF

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Code Set	Code Set Description	Revenue Code	Revenue Code Description
RV0107	Professional encounter	0525	Freestanding Clinic-Visit by RHC/FQHC Practitioner to a Member in a SNF (Not in a Covered Part A Stay) or NF or ICF MR or Other Residential Facility
RV0107	Professional encounter	0526	Freestanding Clinic-Urgent Care Clinic
RV0107	Professional encounter	0528	Freestanding Clinic-Visit by RHC/FQHC Practitioner to Other Non-RHC/FQHC Site (e.g. Scene of Accident)
RV0107	Professional encounter	0529	Freestanding Clinic-Other Freestanding Clinic
RV0107	Professional encounter	0981	Professional Fees (Extension of 096X and 097X)-Emergency Room
RV0107	Professional encounter	0983	Professional Fees (Extension of 096X and 097X)-Clinic

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## Attachment 2 – Specifications of the National Voluntary Consensus Standards for Care Coordination

The following tables present descriptive (denominator) code sets for care coordination measure CC-019-09

### Notes:

- Additional CPT II codes may be required to identify the numerator and any applicable measure exclusions (patient, medical or health system factors), depending on how the measure is implemented.
- We have included ICD 9 Procedure codes where applicable. Depending on how the measure is implemented (i.e., facility-level reporting vs. provider-level reporting) these codes may or may not be needed.

All hospitalized patients in the reporting period hospitalized with a qualifying event/diagnosis (acute myocardial infarction (AMI) or chronic stable angina (CSA), or who during hospitalization have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation) who do not meet any of the exclusion criteria (patient factors, medical factors, health care system factors).

### A. Codes for all patients with a principal discharge diagnosis of Acute Myocardial Infarction:

ICD-9-CM	Description: Acute Myocardial Infarction
410.00	Anterolateral wall, acute myocardial infarction-episode of care unspecified
410.01	Anterolateral wall, acute myocardial infarction-initial episode
410.10	Other anterior wall, acute myocardial infarction-episode of care unspecified
410.11	Other anterior wall, acute myocardial infarction-initial episode
410.20	Inferolateral wall, acute myocardial infarction-episode of care unspecified

# THE NATIONAL QUALITY FORUM

ICD-9-CM	Description: Acute Myocardial Infarction
410.21	Inferolateral wall, acute myocardial infarction-initial episode
410.30	Inferoposterior wall, acute myocardial infarction-episode of care unspecified
410.31	Inferoposterior wall, acute myocardial infarction-initial episode
410.40	Other inferior wall, acute myocardial infarction-episode of care unspecified
410.41	Other inferior wall, acute myocardial infarction-initial episode
410.50	Other lateral wall, acute myocardial infarction-episode of care unspecified
410.51	Other lateral wall, acute myocardial infarction-initial episode
410.60	True posterior wall, acute myocardial infarction-episode of care unspecified
410.61	True posterior wall, acute myocardial infarction-initial episode
410.70	Subendocardial, acute myocardial infarction-episode of care unspecified (NSTEMI)
410.71	Subendocardial, acute myocardial infarction-initial episode (NSTEMI)
410.80	Other specified sites, acute myocardial infarction-episode of care unspecified
410.81	Other specified sites, acute myocardial infarction-initial episode
410.90	Unspecified site, acute myocardial infarction-episode of care unspecified
410.91	Unspecified site, acute myocardial infarction-initial episode
410.00	Anterolateral wall, acute myocardial infarction-episode of care unspecified
410.01	Anterolateral wall, acute myocardial infarction-initial episode
410.10	Other anterior wall, acute myocardial infarction-episode of care unspecified

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## THE NATIONAL QUALITY FORUM

ICD-9-CM	Description: Acute Myocardial Infarction
410.11	Other anterior wall, acute myocardial infarction-initial episode
410.20	Inferolateral wall, acute myocardial infarction-episode of care unspecified
410.21	Inferolateral wall, acute myocardial infarction-initial episode
410.30	Inferoposterior wall, acute myocardial infarction-episode of care unspecified
410.31	Inferoposterior wall, acute myocardial infarction-initial episode
410.40	Other inferior wall, acute myocardial infarction-episode of care unspecified
410.41	Other inferior wall, acute myocardial infarction-initial episode
410.50	Other lateral wall, acute myocardial infarction-episode of care unspecified
410.51	Other lateral wall, acute myocardial infarction-initial episode
410.60	True posterior wall, acute myocardial infarction-episode of care unspecified
410.61	True posterior wall, acute myocardial infarction-initial episode
410.70	Subendocardial, acute myocardial infarction-episode of care unspecified (NSTEMI)
410.71	Subendocardial, acute myocardial infarction-initial episode (NSTEMI)
410.80	Other specified sites, acute myocardial infarction-episode of care unspecified
410.81	Other specified sites, acute myocardial infarction-initial episode
410.90	Unspecified site, acute myocardial infarction-episode of care unspecified
410.91	Unspecified site, acute myocardial infarction-initial episode

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### B. Codes for all patients with a principal discharge diagnosis of Chronic Stable Angina:

ICD-9-CM	Description: Chronic Stable Angina
413	Angina Pectoris
413.9	Other and unspecified angina pectoris

### C. Codes for all patients who have undergone Coronary Artery Bypass Graft Surgery during the hospitalization:

ICD-9-CM	CPT	Description: CABG Surgery
36.10		Aortocoronary bypass for heart revascularization, not otherwise specified
36.11		(Aorto)coronary bypass of one coronary artery
36.12		(Aorto)coronary bypass of two coronary arteries
36.13		(Aorto)coronary bypass of three coronary arteries
36.14		(Aorto)coronary bypass of four or more coronary arteries
36.15		Single internal mammary-coronary artery bypass
36.16		Double internal mammary-coronary artery bypass
36.17		Abdominal-coronary artery bypass
36.19		Other bypass anastomosis for heart revascularization
36.2		Heart revascularization by arterial implant
	33503	Repair of anomalous coronary artery from pulmonary artery origin; by graft, without cardiopulmonary bypass
	33504	Repair of anomalous coronary artery from pulmonary artery origin; by graft, with cardiopulmonary bypass
	33505	Repair of anomalous coronary artery from pulmonary artery origin; with construction of intrapulmonary artery tunnel (Takeuchi procedure)
	33508	Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to code for primary procedure)

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## THE NATIONAL QUALITY FORUM

ICD-9-CM	CPT	Description: CABG Surgery
	33510	Coronary artery bypass, vein only; single coronary venous graft
	33511	Coronary artery bypass, vein only; two coronary venous grafts
	33512	Coronary artery bypass, vein only; three coronary venous grafts
	33513	Coronary artery bypass, vein only; four coronary venous grafts
	33514	Coronary artery bypass, vein only; five coronary venous grafts
	33516	Coronary artery bypass, vein only; six or more coronary venous grafts
	33517	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for arterial graft)
	33518	Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (List separately in addition to code for arterial graft)
	33519	Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (List separately in addition to code for arterial graft)
	33521	Coronary artery bypass, using venous graft(s) and arterial graft(s); four venous grafts (List separately in addition to code for arterial graft)
	33522	Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (List separately in addition to code for arterial graft)
	33523	Coronary artery bypass, using venous graft(s) and arterial graft(s); six or more venous grafts (List separately in addition to code for arterial graft)
	33530	Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (List separately in addition to code for primary procedure)
	33533	Coronary artery bypass, using arterial graft(s); single arterial graft
	33534	Coronary artery bypass, using arterial graft(s); two coronary arterial grafts
	33535	Coronary artery bypass, using arterial graft(s); three coronary arterial grafts
	33536	Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts
	33542	Myocardial resection (eg, ventricular aneurysmectomy)
	33545	Repair of postinfarction ventricular septal defect, with or without myocardial resection
	33572	Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)
	33999	Unlisted procedure, cardiac surgery
	35500	Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure

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ICD-9-CM	CPT	Description: CABG Surgery
		(List separately in addition to code for primary procedure)
	35600	Harvest of upper extremity artery, one segment, for coronary artery bypass procedure

**D. Codes for all patients who have undergone Percutaneous Coronary Intervention (PCI) during the hospitalization:**

ICD-9-CM	CPT	Description: PCI
00.66		Percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy
36.01		Single vessel percutaneous transluminal coronary angioplasty [ptca] or coronary atherectomy without mention of thrombolytic agent
36.02		Single vessel percutaneous transluminal coronary angioplasty [ptca] or coronary atherectomy with mention of thrombolytic agent
36.05		Multiple vessel percutaneous transluminal coronary angioplasty [ptca] or coronary atherectomy performed during the same operation, with or without mention of thrombolytic agent
36.06		Insertion of non-drug-eluting coronary artery stent(s)
	92980	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel
	92981	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel
	G0290	Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel
	G0291	Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel
	92982	Percutaneous transluminal coronary balloon angioplasty, single vessel
	92984	Percutaneous transluminal coronary balloon angioplasty, each additional vessel
	92995	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel
	92996	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel

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## E. Codes for all patients who have undergone Heart Valve Surgery during the hospitalization:

ICD-9-CM	CPT	Description: Heart Valve Surgery
35.00		Closed heart valvotomy, unspecified valve
35.01		Closed heart valvotomy, aortic valve
35.02		Closed heart valvotomy, mitral valve
35.03		Closed heart valvotomy, pulmonary valve
35.04		Closed heart valvotomy, tricuspid valve
35.10		Open heart valvuloplasty, without replacement, unspecified valve
35.11		Open heart valvuloplasty of aortic valve without replacement
35.12		Open heart valvuloplasty of mitral valve without replacement
35.13		Open heart valvuloplasty of pulmonary valve without replacement
35.14		Open heart valvuloplasty of tricuspid valve without replacement
35.20		Replacement of unspecified heart valve
35.21		Replacement of aortic valve with tissue graft
35.22		Other replacement of aortic valve
35.23		Replacement of mitral valve with tissue graft
35.24		Other replacement of mitral valve
35.25		Replacement of pulmonary valve with tissue graft
35.26		Other replacement of pulmonary valve
35.27		Replacement of tricuspid valve with tissue graft
35.28		Other replacement of tricuspid valve
35.31		Operations on papillary muscle
35.32		Operations on chordae tendineae
35.33		Annuloplasty
		<b>Aortic Valve</b>
	33400	Valvuloplasty, aortic valve; open, with cardiopulmonary bypass
	33401	Valvuloplasty, aortic valve; open, with inflow occlusion
	33403	Valvuloplasty, aortic valve; using transventricular dilation, with cardiopulmonary bypass

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ICD-9-CM	CPT	Description: Heart Valve Surgery
	33414	Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract
	33415	Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis
	33416	Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)
	33414	Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract
	33415	Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis
	33416	Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)
	33417	Aortoplasty (gusset) for supraaortic stenosis
		<b>Mitral Valve</b>
	33420	Valvotomy, mitral valve; closed heart
	33422	Valvotomy, mitral valve; open heart, with cardiopulmonary bypass
	33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass;
	33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring
	33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring
		<b>Tricuspid Valve</b>
	33463	Valvuloplasty, tricuspid valve; without ring insertion
	33464	Valvuloplasty, tricuspid valve; with ring insertion
	33465	Replacement, tricuspid valve, with cardiopulmonary bypass
	33468	Tricuspid valve repositioning and plication for Ebstein anomaly
		<b>Pulmonary Valve</b>
	33470	Valvotomy, pulmonary valve, closed heart; transventricular
	33471	Valvotomy, pulmonary valve, closed heart; via pulmonary artery
	33472	Valvotomy, pulmonary valve, open heart; with inflow occlusion
	33474	Valvotomy, pulmonary valve, open heart; with cardiopulmonary bypass
	33476	Right ventricular resection for infundibular stenosis, with or without commissurotomy
	33478	Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection
		<b>Miscellaneous</b>
	33496	Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)
	33600	Closure of atrioventricular valve (mitral or tricuspid) by suture or patch

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ICD-9-CM	CPT	Description: Heart Valve Surgery
	33602	Closure of semilunar valve (aortic or pulmonary) by suture or patch
		<b>Aortic Valve</b>
	33404	Construction of apical-aortic conduit
	33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)
	33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve
	33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp
	33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)
	33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)
		<b>Mitral Valve</b>
	33430	Replacement, mitral valve, with cardiopulmonary bypass
		<b>Tricuspid Valve</b>
	33465	Replacement, tricuspid valve, with cardiopulmonary bypass
		<b>Pulmonary Valve</b>
	33475	Replacement, pulmonary valve
		<b>Aortic Valve</b>
	33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve
		<b>Mitral Valve</b>
	33430	Replacement, mitral valve, with cardiopulmonary bypass
		<b>Tricuspid Valve</b>
	33465	Replacement, tricuspid valve, with cardiopulmonary bypass
		<b>Pulmonary Valve</b>
	33404	Construction of apical-aortic conduit
	33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)
	33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve
	33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp

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**F. Codes for all patients who have undergone Cardiac Transplantation during the hospitalization:**

ICD-9-CM	CPT	Description: Heart Transplantation
	33945	Heart Transplantation
	33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy

**G. One of the following during the measurement period (measure should be assessed at each hospital discharge):**

ICD-9-CM	CPT	Description: Discharge encounter visits
	99238	Hospital discharge day management; 30 minutes or less
	99239	Hospital discharge day management; more than 30 minutes

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## Attachment 3 – Specifications of the National Voluntary Consensus Standards for Care Coordination

The following tables present descriptive (denominator) code sets for care coordination measure CC-020-09.

**NOTE:** Additional CPT II codes may be required to identify the numerator and any applicable measure exclusions (patient, medical or health system factors) depending on how the measure is implemented.

All patients evaluated in the outpatient setting during the reporting period who have a qualifying event/ diagnosis (chronic stable angina (CSA), or who during the past 12 months have had an acute myocardial infarction (AMI) or have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation) who do not meet any of the exclusion criteria (patient factors, medical factors, health care system factors) and who have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program.

### A. Codes for all patients with a diagnosis of Acute Myocardial Infarction within the past 12 months:

ICD-9-CM	Description: Acute Myocardial Infarction
410.00	Anterolateral wall, acute myocardial infarction-episode of care unspecified
410.01	Anterolateral wall, acute myocardial infarction-initial episode
410.10	Other anterior wall, acute myocardial infarction-episode of care unspecified
410.11	Other anterior wall, acute myocardial infarction-initial episode
410.20	Inferolateral wall, acute myocardial infarction-episode of care unspecified
410.21	Inferolateral wall, acute myocardial infarction-initial episode

## THE NATIONAL QUALITY FORUM

ICD-9-CM	Description: Acute Myocardial Infarction
410.30	Inferoposterior wall, acute myocardial infarction-episode of care unspecified
410.31	Inferoposterior wall, acute myocardial infarction-initial episode
410.40	Other inferior wall, acute myocardial infarction-episode of care unspecified
410.41	Other inferior wall, acute myocardial infarction-initial episode
410.50	Other lateral wall, acute myocardial infarction-episode of care unspecified
410.51	Other lateral wall, acute myocardial infarction-initial episode
410.60	True posterior wall, acute myocardial infarction-episode of care unspecified
410.61	True posterior wall, acute myocardial infarction-initial episode
410.70	Subendocardial, acute myocardial infarction-episode of care unspecified (NSTEMI)
410.71	Subendocardial, acute myocardial infarction-initial episode (NSTEMI)
410.80	Other specified sites, acute myocardial infarction-episode of care unspecified
410.81	Other specified sites, acute myocardial infarction-initial episode
410.90	Unspecified site, acute myocardial infarction-episode of care unspecified
410.91	Unspecified site, acute myocardial infarction-initial episode
410.00	Anterolateral wall, acute myocardial infarction-episode of care unspecified
410.01	Anterolateral wall, acute myocardial infarction-initial episode
410.10	Other anterior wall, acute myocardial infarction-episode of care unspecified
410.11	Other anterior wall, acute myocardial infarction-initial episode

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## THE NATIONAL QUALITY FORUM

ICD-9-CM	Description: Acute Myocardial Infarction
410.20	Inferolateral wall, acute myocardial infarction-episode of care unspecified
410.21	Inferolateral wall, acute myocardial infarction-initial episode
410.30	Inferoposterior wall, acute myocardial infarction-episode of care unspecified
410.31	Inferoposterior wall, acute myocardial infarction-initial episode
410.40	Other inferior wall, acute myocardial infarction-episode of care unspecified
410.41	Other inferior wall, acute myocardial infarction-initial episode
410.50	Other lateral wall, acute myocardial infarction-episode of care unspecified
410.51	Other lateral wall, acute myocardial infarction-initial episode
410.60	True posterior wall, acute myocardial infarction-episode of care unspecified
410.61	True posterior wall, acute myocardial infarction-initial episode
410.70	Subendocardial, acute myocardial infarction-episode of care unspecified (NSTEMI)
410.71	Subendocardial, acute myocardial infarction-initial episode (NSTEMI)
410.80	Other specified sites, acute myocardial infarction-episode of care unspecified
410.81	Other specified sites, acute myocardial infarction-initial episode
410.90	Unspecified site, acute myocardial infarction-episode of care unspecified
410.91	Unspecified site, acute myocardial infarction-initial episode

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### B. Codes for all patients with a diagnosis of Chronic Stable Angina within the past 12 months:

ICD-9-CM	Description: Chronic Stable Angina
413	Angina Pectoris
413.9	Other and unspecified angina pectoris

### C. Codes for all patients who have undergone Coronary Artery Bypass Graft Surgery within the past 12 months:

CPT	Description: CABG Surgery
33503	Repair of anomalous coronary artery from pulmonary artery origin; by graft, without cardiopulmonary bypass
33504	Repair of anomalous coronary artery from pulmonary artery origin; by graft, with cardiopulmonary bypass
33505	Repair of anomalous coronary artery from pulmonary artery origin; with construction of intrapulmonary artery tunnel (Takeuchi procedure)
33508	Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to code for primary procedure)
33510	Coronary artery bypass, vein only; single coronary venous graft
33511	Coronary artery bypass, vein only; two coronary venous grafts
33512	Coronary artery bypass, vein only; three coronary venous grafts
33513	Coronary artery bypass, vein only; four coronary venous grafts
33514	Coronary artery bypass, vein only; five coronary venous grafts
33516	Coronary artery bypass, vein only; six or more coronary venous grafts
33517	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for arterial graft)
33518	Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (List separately in addition to code for arterial graft)
33519	Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (List separately in addition to code for arterial graft)
33521	Coronary artery bypass, using venous graft(s) and arterial graft(s); four venous grafts (List separately in addition to code for arterial graft)

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CPT	Description: CABG Surgery
33522	Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (List separately in addition to code for arterial graft)
33523	Coronary artery bypass, using venous graft(s) and arterial graft(s); six or more venous grafts (List separately in addition to code for arterial graft)
33530	Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (List separately in addition to code for primary procedure)
33533	Coronary artery bypass, using arterial graft(s); single arterial graft
33534	Coronary artery bypass, using arterial graft(s); two coronary arterial grafts
33535	Coronary artery bypass, using arterial graft(s); three coronary arterial grafts
33536	Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts
33542	Myocardial resection (eg, ventricular aneurysmectomy)
33545	Repair of postinfarction ventricular septal defect, with or without myocardial resection
33572	Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)
33999	Unlisted procedure, cardiac surgery
35500	Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure)
35600	Harvest of upper extremity artery, one segment, for coronary artery bypass procedure

### D. Codes for all patients who have undergone Percutaneous Coronary Intervention (PCI) within the past 12 months:

CPT	Description: PCI
92980	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel
92981	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel
G0290	Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

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G0291	Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel
92982	Percutaneous transluminal coronary balloon angioplasty, single vessel
92984	Percutaneous transluminal coronary balloon angioplasty, each additional vessel
92995	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel
92996	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel

### E. Codes for all patients who have undergone Heart Valve Surgery within the past 12 months:

CPT	Description: Heart Valve Surgery
	<b>Aortic Valve</b>
33400	Valvuloplasty, aortic valve; open, with cardiopulmonary bypass
33401	Valvuloplasty, aortic valve; open, with inflow occlusion
33403	Valvuloplasty, aortic valve; using transventricular dilation, with cardiopulmonary bypass
33414	Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract
33415	Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis
33416	Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)
33414	Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract
33415	Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis
33416	Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)
33417	Aortoplasty (gusset) for supraaortic stenosis
	<b>Mitral Valve</b>
33420	Valvotomy, mitral valve; closed heart
33422	Valvotomy, mitral valve; open heart, with cardiopulmonary bypass
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass;
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring
33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring
	<b>Tricuspid Valve</b>
33463	Valvuloplasty, tricuspid valve; without ring insertion

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CPT	Description: Heart Valve Surgery
33464	Valvuloplasty, tricuspid valve; with ring insertion
33465	Replacement, tricuspid valve, with cardiopulmonary bypass
33468	Tricuspid valve repositioning and plication for Ebstein anomaly
	<b>Pulmonary Valve</b>
33470	Valvotomy, pulmonary valve, closed heart; transventricular
33471	Valvotomy, pulmonary valve, closed heart; via pulmonary artery
33472	Valvotomy, pulmonary valve, open heart; with inflow occlusion
33474	Valvotomy, pulmonary valve, open heart; with cardiopulmonary bypass
33476	Right ventricular resection for infundibular stenosis, with or without commissurotomy
33478	Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection
	<b>Miscellaneous</b>
33496	Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)
33600	Closure of atrioventricular valve (mitral or tricuspid) by suture or patch
33602	Closure of semilunar valve (aortic or pulmonary) by suture or patch
	<b>Aortic Valve</b>
33404	Construction of apical-aortic conduit
33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve
33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)
33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)
	<b>Mitral Valve</b>
33430	Replacement, mitral valve, with cardiopulmonary bypass
	<b>Tricuspid Valve</b>
33465	Replacement, tricuspid valve, with cardiopulmonary bypass
	<b>Pulmonary Valve</b>
33475	Replacement, pulmonary valve
	<b>Aortic Valve</b>

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CPT	Description: Heart Valve Surgery
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve
	<b>Mitral Valve</b>
33430	Replacement, mitral valve, with cardiopulmonary bypass
	<b>Tricuspid Valve</b>
33465	Replacement, tricuspid valve, with cardiopulmonary bypass
	<b>Pulmonary Valve</b>
33404	Construction of apical-aortic conduit
33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve
33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp

### F. Codes for all patients who have undergone Cardiac Transplantation within the past 12 months:

CPT	Description: Heart Transplantation
33945	Heart Transplantation
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy

### G. One of the following outpatient visits during the measurement period:

CPT	Description: Outpatient encounter visits
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

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CPT	Description: Outpatient encounter visits
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided

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CPT	Description: Outpatient encounter visits
	consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99241	Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99243	Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes

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CPT	Description: Outpatient encounter visits
	face-to-face with the patient and/or family.
99245	Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

**EXCLUDE:** All patients with a qualifying event/diagnosis who have not already participated in a cardiac rehabilitation/secondary prevention program since the qualifying event/diagnosis:

CPT	Description: Early outpatient (Phase 2) cardiac rehabilitation sessions
93798	Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)
93797	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)