THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

The measure information you submit will be shared with NQF's Steering Committees and Technical Advisory Panels to evaluate measures against the NQF criteria of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. Four conditions (as indicated below) must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. Not all acceptable measures will be strong—or equally strong—among each set of criteria. The assessment of each criterion is a matter of degree; however, all measures must be judged to have met the first criterion, importance to measure and report, in order to be evaluated against the remaining criteria. References to the specific measure evaluation criteria are provided in parentheses following the item numbers. Please refer to the *Measure Evaluation Criteria* for more information at *www.qualityforum.org* under Core Documents. Additional guidance is being developed and when available will be posted on the NQF website.

Use the tab or arrow (↓→) keys to move the cursor to the next field (or back ←↑). There are three types of response fields:

- drop-down menus - select one response;
- check boxes – check as many as apply; and
- text fields – you can copy and paste text into these fields or enter text; these fields are not limited in size, but in most cases, we ask that you summarize the requested information.

Please note that URL hyperlinks do not work in the form; you will need to type them into your web browser.

Be sure to answer all questions. Fields that are left blank will be interpreted as no or none. Information must be provided in this form. Attachments are not allowed except when specifically requested or to provide additional detail or source documents for information that is summarized in this form. If you have important information that is not addressed by the questions, they can be entered into item #48 near the end of the form.

For questions about this form, please contact the NQF Project Director listed in the corresponding call for measures.

	CONDITIONS FOR CONSIDERATION BY NQF
	Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards.
A (A)	**Public domain or Intellectual Property Agreement signed:** IP Agreement signed and submitted (If no, do not submit) *Template for the Intellectual Property Agreement is available at* **www.qualityforum.org** *under Core Documents.*
B (B)	**Measure steward/maintenance:** Is there an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years? Yes, information provided in contact section (If no, do not submit)
C (C)	**Intended use:** Does the intended use of the measure include BOTH public reporting AND quality improvement? Yes (If no, do not submit)
D (D)	**Fully developed and tested:** Is the measure fully developed AND tested? Yes, fully developed and tested (If not tested and no plans for testing within 24 months, do not submit)

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	(for NQF staff use) **NQF Review #:** EC-014-08 **NQF Project:** National Voluntary Consensus Standards for Ambulatory Care Using Clinically Enriched Administrative Data
	MEASURE SPECIFICATIONS & DESCRIPTIVE INFORMATION
1	**Information current as of** *(date- MM/DD/YY)***:** 11/18/08
2	**Title of Measure:** Follow-Up After Hospitalization for Mental Illness
3	**Brief description of measure [1]:** This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.
4 (2a)	**Numerator Statement:** Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health pracititioner within 30 days after discharge. Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. **Time Window:** Date of discharge through 30 days after discharge **Numerator Details** (Definitions, codes with description): Include outpaitnet visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Codes to Identify Visits: CPT: 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510 HCPCS G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876 with POS: 05, 07, 11, 12, 15, 20, 22, 49, 50, 52, 53, 71, 72 CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263 with POS 52, 53 UB Revenue: 0513, 0900-0905, 0907, 0911-0917, 0919, 0510, 0515-0517, 0519-0523, 0526-0529, 077x, 0982, 0983
5 (2a)	**Denominator Statement:** Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for any mental health principal diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related

[1] Example of measure description: Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.

	condition. **Time Window:** **Denominator Details** (Definitions, codes with description): Codes to Identify Mental Health Diagnosis ICD-9-CM Diagnosis: 295–299, 300.3, 300.4, 301, 308, 309, 311–314 Codes to Identify Nonacute Care: Hospice: UB Revenue: 0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659; UB Type of Bill: 81x, 82x; POS 34 SNF: UB Revenue: 019x, UB Type of Bill: 21x, 22x; POS 31, 32 Hospital transitional care: UB Type of Bill: 18x Rehabilitation: UB Revenue: 0118, 0128, 0138, 0148, 0158 Intermediate care facility: POS 54 Respite: 0655 Residential substance abuse treatment faility: UB Revenue: 1002; POS 55 Psychatric Residential Treatment Center: HCPCS: T2048, H0017-H0019; UB Revenue: 1001; POS 56 Comprehensive Inpatient Rehabilitation Facility: POS 61
6 (2a, 2d)	**Denominator Exclusions:** Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute facility for any mental health principal diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer for codes to identify nonacute care. Non-mental health readmission or direct transfer: Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. **Denominator Exclusion Details** (Definitions, codes with description):
7 (2a, 2h)	**Stratification** Do the measure specifications require the results to be stratified? Other ► If "other" describe: This measure is stratified by product line where the information is available (Commercial, Medicaid, Medicare). **Identification of stratification variable(s):** **Stratification Details** (Definitions, codes with description):
8 (2a, 2e)	**Risk Adjustment** Does the measure require risk adjustment to account for differences in patient severity before the onset of care? No ► **If yes,** (select one) ► Is there a separate proprietary owner of the risk model? No **Identify Risk Adjustment Variables:** **Detailed risk model:** attached ☐ **OR** Web page URL:
9 (2a)	**Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☐ **OR** Web page URL: **Interpretation of Score** (*Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score*) Better quality = Higher score ► If "Other", please describe:
10 (2a. 4a,	**Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** **Data dictionary/code table** attached ☐ **OR** Web page URL: **Data Quality** (2a) *Check all that apply* ☒ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel)

4b)	☒ Data are coded using recognized data standards ☒ Method of capturing data electronically fits the workflow of the authoritative source ☒ Data are available in EHRs ☒ Data are auditable
11 (2a, 4b)	**Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply* ☒ Electronic Health/Medical Record ☐ Electronic Clinical Database, Name: ☐ Electronic Clinical Registry, Name: ☒ Electronic Claims ☐ Electronic Pharmacy data ☐ Electronic Lab data ☐ Electronic source – other, Describe: ☐ Paper Medical Record ☐ Standardized clinical instrument, Name: ☐ Standardized patient survey, Name: ☐ Standardized clinician survey, Name: ☐ Other, Describe: Instrument/survey attached ☐ **OR** Web page URL:
12 (2a)	**Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.* **Minimum sample size:** **Instructions:**
13 (2a)	**Type of Measure:** Process ► If "Other", please describe: ► If part of a composite or paired with another measure, please identify composite or paired measure
14 (2a)	**Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.* ☒ Can be measured at all levels ☐ Individual clinician (e.g., physician, nurse) ☐ Group of clinicians (e.g., facility department/unit, group practice) ☐ Facility (e.g., hospital, nursing home) ☐ Integrated delivery system ☐ Health plan ☐ Community/Population ☐ Other (*Please describe*):
15 (2a)	**Applicable Care Settings** *Check all that apply* ☐ Can be used in all healthcare settings ☒ Ambulatory Care (office/clinic) ☒ Behavioral Healthcare ☐ Community Healthcare ☐ Dialysis Facility ☐ Emergency Department ☐ EMS emergency medical services ☒ Health Plan ☐ Home Health ☐ Hospice ☐ Hospital ☐ Long term acute care hospital ☐ Nursing home/ Skilled Nursing Facility (SNF) ☐ Prescription Drug Plan ☐ Rehabilitation Facility ☒ Substance Use Treatment Program/Center ☐ Other (*Please describe*):
	IMPORTANCE TO MEASURE AND REPORT
	Note: This is a threshold criterion. If a measure is not judged to be sufficiently important to measure and report, it will not be evaluated against the remaining criteria.
16 (1a)	**Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related to this measure (see list of goals on last page)*: 2.2
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** (select one) **Summary of Evidence:** **Citations[2] for Evidence:**
18	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.*

[2] Citations can include, but are not limited to journal articles, reports, web pages (URLs).

(1b) **Summary of Evidence:** An estimated 28–30 percent of the adult U.S. population suffers from a mental or substance use disorder during the course of a year. About 5–7 percent of adults have a serious mental illness. (Kessler, 2001) A similar percentage of children—about 5–9 percent—have a serious emotional disturbance. (Friedman, 1996) Of the ten leading causes of disability worldwide in 2000 for people ages 15–44, four are psychiatric conditions and alcohol abuse. (WHO, 2001)

In 2003, approximately 1.4 million Americans were discharged from hospitals and other inpatient settings after receiving treatment for mental illness. There are several clinical reasons for ensuring adequate and timely follow-up care for patients after discharge from an institution or hospital for mental illness:
• preventing readmission
• keeping track of those who will eventually require readmission providing transitional care from inpatient to outpatient setting.

In 2003, there were an estimated 19.6 million adults aged 18 or older with SMI (serious mental illness). Rates of SMI in 2003 were highest for adults aged 18 to 25 (13.9 percent) and lowest for those aged 50 or older (5.9 percent). Rates of SMI were somewhat higher in 2003 than in 2002 for all three adult age groups, but only the increase among those aged 26 to 49 was statistically significant (9.5 percent in 2002 vs. 10.4 percent in 2003). This represents 9.2 percent of all adults and is higher than the rate of 8.3 percent in 2002. (HCUP Nationwide Inpatient Sample, 2003)

In a study conducted and published by United Behavioral Health of Georgia, results indicate that hospitalized patients who did not comply with at least one outpatient appointment after discharge were two times more likely to be rehospitalized than those who kept at least one appointment after discharge. The study found strong associations ($p<.01$) between keeping an outpatient appointment and being less likely to be rehospitalized during the third quarter of 1998 (the 270-day rehospitalization rate) and the fourth quarter of 1998 (the 365-day rehospitalization rate). A similar strong association was found for the 1998 aggregate rate of readmission. These results indicate that the positive benefit of keeping an outpatient appointment was sustained over time. (Nelson AE, 2000)

In addition to the tragedy of lost lives, mental illnesses come with a devastatingly high financial cost. In the U.S., the annual economic and indirect cost of mental illnesses is estimated to be $79 billion. In 1997, the latest year comparable data are available; the United States spent more than $1 trillion on health care, including almost $71 billion on treating mental illnesses. Mental health expenditures are predominantly publicly funded at 57 percent, compared to 46 percent of overall health care expenditures. (President's New Freedom Commission on Mental Health, 2003)

In 1996, the United States spent more than $99 billion for the direct treatment of mental disorders, as well as substance abuse, and Alzheimer's disease and other dementias. More than two-thirds of this amount ($69 billion or more than 7 percent of total health spending) was for mental health services. The indirect costs of all mental illness imposed a nearly $79 billion loss on the U.S. economy in 1990 (the most recent year for which estimates are available) (Rice & Miller, 1996). Most of that amount ($63 billion) reflects morbidity costs—the loss of productivity in usual activities because of illness. The fact that morbidity costs comprise about 80 percent of the indirect costs of all mental illness indicates an important characteristic of mental disorders: Mortality is relatively low, onset is often at a younger age, and most of the indirect costs are derived from lost or reduced productivity at the workplace, school, and home (Rupp et al., 1998).

Citations for Evidence:

Department of Health and Human Services. Mental health: a report of the Surgeon General. Bethesda, Md.: National Institute of Mental Health, 1999. (Accessed August 2, 2005, at http://www.surgeongeneral.gov/library/mentalhealth/home.html.)

Friedman RM, et al., Prevalence of Serious Emotional Disturbance in Children and Adolescents, in Mental Health, United States, 1996, ed. R.W. Manderscheid and M.A. Sonnenschein (Washington: U.S. Government Printing Office, 1996), 71–78.

HCUP Nationwide Inpatient Sample (2003). Agency for Healthcare Research and Quality. Accessed on July 9, 2005 from http://hcup.ahrq.gov/HcupNet.

Kessler RC, et al., The Prevalence and Correlates of Untreated Serious Mental Illness. Health Services Research. 2001; 36(6), Part 1: 987–1007.

Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU, Kendler KS. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. Arch Gen Psychiatry. 1994;51:8-19.

Regier DA, Kaelber CT, Rae DS, Farmer ME, Knauper B, Kessler RC, Norquist GS. Limitations of diagnostic criteria and assessment instruments for mental disorders: implications for research and policy. Arch Gen Psychiatry. 1998;55:109-115.

Rice, D. P., & Miller, L. S. (1996). The economic burden of schizophrenia: Conceptual and methodological issues, and cost estimates. In M. Moscarelli, A. Rupp, & N. Sartorious (Eds.), Handbook of mental health economics and health policy. Vol. 1: Schizophrenia (pp. 321–324). New York: John Wiley and Sons.

Rupp, A., Gause, E., & Regier, D. A. (1998). Research policy implications of cost-of-illness studies for mental disorders. British Journal of Psychiatry. Supplement,173(36), 19–25.

Substance Abuse and Mental Health Services Administration. (2004). Results from the 2003 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H–25, DHHS Publication No. SMA 04–3964). Rockville, MD. Accessed on August 2, 2005 from http://oas.samhsa.gov/NHSDA/2k3NSDUH/2k3results.htm#ch8

Wang PS, et al. Twelve-Month Use of Mental Health Services in the United States. Arch Gen Psychiatry. 2005;62:629-640.

World Health Organization, World Health Report 2001, Mental Health: New Understanding, New Hope, www.who.int/whr/2001/en

19 (1b)

Disparities *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.*

Summary of Evidence:

Citations for evidence:

20 (1c)

If measuring an Outcome Describe relevance to the national health goal/priority, condition, population, and/or care being addressed:

If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence

Summarize the evidence (including citations to source) supporting the focus of the measure as follows:

- Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit.
- Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and
  if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s).
- Structure – evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit.
- Patient experience – evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public.
- Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care.
- Efficiency– demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality.

Type of Evidence *Check all that apply*

☐ Evidence-based guideline
☐ Meta-analysis
☐ Quantitative research studies
☐ Qualitative research studies

☒ Systematic synthesis of research ☐ Other (*Please describe*):

Overall Grade for Strength of the Evidence[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*:

Summary of Evidence (*provide guideline information below*)**:** Criteria for Short-Term Treatment of Acute Psychiatric Illness (American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, 1997) The criteria provide a guideline for evaluating medical necessity and should not be interpreted to be absolute rules for determining the level of care required by a patient. Clinical judgment is as important as any factor outlined in this document. Given these caveats, this measure work-up specifically addresses levels of care for short-term treatment of acute psychiatric illness.

Outpatient Treatment Admission
Must meet each of the following:
• Symptoms due to a DSM-IV psychiatric disorder associated with subjective distress and/or a reduced level of functioning and/or impairment of developmental progression in one or more of the following areas:
• education;
• vocation;
• family; and/or
• social/peer relations.
A comprehensive, multi-axial diagnostic evaluation is required as a basis for treatment, and symptoms do not meet the criteria for a more intense level of treatment.

• Treatment is required to alleviate acute existing symptoms and/or behaviors or to prevent relapse in patients with symptoms and/or behaviors in partial or complete remission.
• The patient has demonstrated intent to form a treatment alliance and comply with treatment.
• The patient has sufficient family and/or social resources that have expressed a willingness to provide support for psychiatric treatment, or failing that, a supportive environment that can be identified for that purpose.

Outpatient Services—Continued Care
• The patient is regularly receiving individualized treatment that is implemented by licensed mental health professionals and is based on the Individualized Active Treatment Plan (IATP).
• Outpatient services are performed as determined by the IATP.
• There are regular and timely assessments and documentation of the patient's response to all treatments. Timely and appropriate modifications to the treatment plan are made that are consistent with the patient's clinical status and/or presence of new symptoms and/or information that has become evident since admission.
• A discharge plan is formulated and regularly reviewed, revised, and appropriately implemented in a timely manner. It includes specific target dates for reaching each goal designated in the discharge process, and defines the criteria for when outpatient treatment can be brought to a conclusion without significant risk to the patient.
• The active treatment interventions focus on stabilization and/or alleviation of (1) the symptoms and/or problems that necessitated admission to the program, or (2) symptoms that have emerged and/or have been identified since admission that would otherwise meet criteria for admission to outpatient services. For patients with special dependency needs, the family (or designated guardians) is actively and regularly involved in the treatment process, unless specifically contraindicated and/or impossible to implement.

[3]The strength of the body of evidence for the specific measure focus should be systematically assessed and rated, e.g., USPSTF grading system www.ahrq.gov/clinic/uspstmeth.htm: A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

	Citations for Evidence: American Academy of Child and Adolescent Psychiatry, American Psychiatric Association (1997). Criteria for Short-Term Treatment of Acute Psychiatric Illness. Accessed on August 2, 2005 via http://www.psych.org/psych_pract/criteria121503.pdf
21 (1c)	**Clinical Practice Guideline** *Cite the guideline reference; quote the specific guideline recommendation related to the measure and the guideline author's assessment of the strength of the evidence; and summarize the rationale for using this guideline over others.* **Guideline Citation:** **Specific guideline recommendation:** **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** **Rationale for using this guideline over others:**
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.* **Summary:** **Citations:**
23 (1)	**Briefly describe how this measure (as specified) will facilitate significant gains in healthcare quality related to the specific priority goals and quality problems identified above:** Reports from the Surgeon General and the President's New Freedom Commission on Mental Health stress the importance of improving mental health treatment in the United States. In addition, more recent studies to assess patterns and predictors of 12-month mental health treatment in the United States from the recently completed National Comorbidity Survey Replication found that most people with mental disorders in the United States remain either untreated or poorly treated. Interventions are needed to enhance treatment initiation and quality. Performance standards, such as those in the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services Consumer-Oriented Mental Health Report Card and those of the National Committee for Quality Assurance, could further optimize quality and monitor future interventions' impacts. (Wang PS, et al. 2005)
	SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES
	Note: Testing and results should be summarized in this form. However, additional detail and reports may be submitted as supplemental information or provided as a web page URL. If a measure has not been tested, it is only potentially eligible for time-limited endorsement.
24	**Supplemental Testing Information:** attached ☐ **OR** Web page URL:
25 (2b)	**Reliability Testing** **Data/sample:** **Analytic Method:** **Testing Results:**
26 (2c)	**Validity Testing** **Data/sample:** **Analytic Method:** **Testing Results:**
27 (2d)	**Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.*

	Summary of Evidence supporting exclusion(s): **Citations for Evidence:** **Data/sample:** **Analytic Method:** **Testing Results:**
28 (2e)	**Risk Adjustment Testing** *Summarize the testing used to determine the need (or no need) for risk adjustment and the statistical performance of the risk adjustment method.* **Data/sample:** **Analytic Method:** **Testing Results:** ►**If outcome or resource use measure not risk adjusted, provide rationale:**
29 (2g)	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*) **Data/sample:** **Analytic Method:** **Results:** This measure has been previously field tested using both administrative and medical record data. Field-testing of this measure indicated that the data sources required for data capture are accurate, reproducible and valid.
30 (2f)	**Provide Measure Results from Testing or Current Use** Results from current use **Data/sample:** This measure is based on administrative data. **Methods to identify statistically significant and practically/meaningfully differences in performance:** **Results:** This measure is reported by plans across all three product lines: commercial, Medicare, and Medicaid. For Rate 1 (7-day rate): In 2007 health plan performance was 55.6 percent, 37.0 percent, and 42.5 percent for commercial, Medicare and Medicaid plans respectively. In 2006 the performance was 56.7 percent, 36.5 percent, and 39.1 percent. For Rate 2 (30-day rate): In 2007 commercial plan performance was 74.0 percent, Medicare plan performance was 54.4 percent, and 61.0 percent for Medicaid plans. In 2006 performance across the plan types was 75.8 percent, 55.8 percent and 57.7 percent respectively.
31 (2h)	**Identification of Disparities** ►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:** ►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale:
	USABILITY
32 (3)	**Current Use** In use **If in use, how widely used** Nationally ► If "other," please describe: ☒ Used in a public reporting initiative, name of initiative: NCQA's State of Healthcare Quality Report

	Sample report attached ☐ **OR** Web page URL: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf
33 (3a)	**Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **Data/sample:** **Methods:** **Results:**
34 (3b, 3c)	**Relation to other NQF-endorsed™ measures** ►Is this measure similar or related to measure(s) already endorsed by NQF (on the same topic or the same target population)? *Measures can be found at www.qualityforum.org under Core Documents.* *Check all that apply* ☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic ☐ Other measure(s) for same target population ☒ No similar or related measures **Name of similar or related NQF-endorsed™ measure(s):** **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one) ►If not fully harmonized, provide rationale: **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:**
	FEASIBILITY
35 (4a)	**How are the required data elements generated?** *Check all that apply* ☐ Data elements are generated concurrent with and as a byproduct of care processes during care delivery (e.g., blood pressure or other assessment recorded by personnel conducting the assessment) ☐ Data elements are generated from a patient survey (e.g., CAHPS) ☒ Data elements are generated through coding performed by someone other than the person who obtained the original information (e.g., DRG or ICD-9 coding on claims) ☐ Other, Please describe:
36 (4b)	**Electronic Sources** All data elements ►**If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:** ►**Specify the data elements for the electronic health record:**
37 (4c)	**Do the specified exclusions require additional data sources beyond what is required for the other specifications?** No ►**If yes, provide justification:**
38 (4d)	**Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure:** **Describe how could these potential problems be audited:** **Did you audit for these potential problems during testing?** (select one) **If yes, provide results:**
39 (4e)	**Testing feasibility** Describe what have you learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: The measure has face validity in that it appears to measure the ability of providers to provide a first step in the continuity of care for patients who are released from inpatient settings after treatment for mental

	illness. Additionally, groups like the American Managed Behavioral Health Association (AMBHA) and the American College of Mental Health Administration (ACMHA) recognize the validity of the measurement as an important indicator of continuity of care.
	CONTACT INFORMATION
40	**Web Page URL for Measure Information** *Describe where users (implementers) should go for more details on specifications of measures, or assistance in implementing the measure.* **Web page URL:** www.ncqa.org
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Philip **MI:** **Last Name:** Renner **Credentials (MD, MPH, etc.):** MBA **Organization:** National Committee for Quality Assurance **Street Address:** 1100 13th Street NW, Suite 1000 **City:** Washington **State:** DC **ZIP:** 20005 **Email:** renner@ncqa.org **Telephone:** 202-955-5192 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext:
44	**Measure Steward Point of Contact** **If different than IP Owner Contact** *Identifies the organization that will take responsibility for updating the measure and assuring it is consistent with the scientific evidence and current coding schema; the steward of the measure may be different than the developer.* **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext
	ADDITIONAL INFORMATION
45	**Workgroup/Expert Panel involved in measure development** Workgroup/panel used ►If workgroup used, describe the members' role in measure development: This advisory plan supported NCQA staff in the development of behavioral health measures that address important behavioral health issues that align with clinical practices and guidelines and are feasible for health plans to report. ►Provide a list of workgroup/panel members' names and organizations: Behavioral Health Measurement Advisory Panel Joann Albright, PhD, Magellan Behavioral Health John Bartlett, MD, The Avisa Group Bruce Bobbitt, PhD, LP, United Behavioral Health Audrey Burnam, PhD, RAND Vijay Ganju, PhD, National Association of State Mental Health Program Directors (NASMHPD) Research Institute Eric Goplerud, PhD, George Washington University Katherine Grimes, MD, MPH, Neighborhood Health Plan of Boston Richard Hermann, MD, MS, Tufts-New England Medical Center Constance Horgan, ScD, Brandeis University John Ludden, MD, Tufts University Medical School David Mrazek, MD, FRC Psych, Mayo Clinic Harold Pincus, MD, Columbia University Mike Quirk, PhD (Chair), Group Health Cooperative of Puget Sound Sarah Wattenberg, LCSW-C (Liaison), Center for Substance Abuse Treatment, Substance Abuse & Mental Health Services Administration (SAMHSA)

46	**Measure Developer/Steward Updates and Ongoing Maintenance** Year the measure was first released: 1994 Month and Year of most recent revision: April 2006 What is the frequency for review/update of this measure? Once a measure is publicly reported it undergoes an in depth re-evaluation process approximately every three years. The measure specifications are reviewed annually to refine and update measure algorithms. When is the next scheduled review/update for this measure?
47	**Copyright statement/disclaimers:** These performance measures were developed and are owned by the National Committee for Quality Assurance ("NCQA"). These performance measures are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures. NCQA holds a copyright in these measures and can rescind or alter these measures at any time. Users of the measures shall not have the right to alter, enhance, or otherwise modify the measures and shall not disassemble, recompile, or reverse engineer the source code or object code relating to the measures. Anyone desiring to use or reproduce the measures without modification for a noncommercial purpose may do so without obtaining any approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA. ©2008 National Committee for Quality Assurance, all rights reserved. Note: Performance measures developed by NCQA for CMS may look different from the measures solely created and owned by NCQA for NCQA.
48	**Additional Information:**
49	**I have checked that the submission is complete and any blank fields indicate that no information is provided.** ☒
50	**Date of Submission** (*MM/DD/YY*)**:** 11/18/08

PATIENT & FAMILY ENGAGEMENT

PRIORITY STATEMENT: Engage Patients and Their Families in Managing Their Health and Making Decisions About Their Care

1.1. All providers will routinely solicit and publicly report on their patients' perspectives of care

1.2. All providers will work collaboratively with their patients to assist them in making informed decisions about treatment options consistent with their values and preferences

POPULATION HEALTH

PRIORITY STATEMENT: IMPROVE THE HEALTH OF THE U.S. POPULATION

2.1. The population will be up to date on all high-priority age- and gender-appropriate evidence-based clinical preventive services

2.2. The population will receive recommended evidence-based interventions to improve targeted healthy lifestyle behaviors

2.3. All communities will demonstrate a 10% improvement in their community index of health

2.4. Americans will have all recommended high priority healthy lifestyle behaviors under control

SAFETY

PRIORITY STATEMENT: IMPROVE THE SAFETY OF THE U.S. HEALTH CARE SYSTEM

3.1. All providers will drive all preventable healthcare-associated infections (HAI) to zero

3.2. All providers will drive the incidence of preventable NQF Serious Reportable Events (SRE) to zero

3.3. All hospitals will reduce preventable and premature mortality rates to best-in-class

3.4. All hospitals and their community partners will reduce 30-day mortality rates following hospitalization for select conditions to best-in-class

PALLIATIVE CARE

PRIORITY STATEMENT: GUARANTEE APPROPRIATE AND COMPASSIONATE CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESSES

4.1. All providers will identify, document, and effectively treat physical symptoms (e.g. pain, shortness of breath, constipation, others) at levels acceptable to patients with a life-limiting illness

4.2. All providers will effectively address the psychosocial and spiritual needs of patients with life-limiting illnesses and their families according to their preferences

4.3. All eligible patients will receive high quality palliative care and hospice services

CARE COORDINATION

PRIORITY STATEMENT: ENSURE PATIENTS RECEIVE WELL-COORDINATED CARE ACROSS ALL PROVIDERS, SETTINGS, AND LEVELS OF CARE

5.1. All providers will accurately and completely reconcile medications across the continuum of care (i.e. admission, transfer within and between care providers, discharge, and outpatient appointments) and ensure communication with the next provider of services

5.2. All inpatient and outpatient providers will assess the patient's perspective of the coordination of their care using a validated care coordination survey tool

5.3. All providers will reduce 30-day all-cause readmission rates resulting from poorly coordinated care to best-in-class

5.4. All providers will reduce preventable emergency department (i.e. those that could be avoided with timely access to primary care) visits resulting from poorly coordinated care by 50%

PATIENT-FOCUSED CARE

PRIORITY STATEMENT: GUARANTEE HIGH VALUE CARE ACROSS ACUTE AND CHRONIC EPISODES

6.1. All patients will receive high-value care over the course of their acute or chronic illness

OVERUSE

PRIORITY STATEMENT: ELIMINATE WASTE WHILE ENSURING THE DELIVERY OF APPROPRIATE CARE

7.1. Reduce wasteful and inappropriate care for the top ten targeted areas by 50%

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

The measure information you submit will be shared with NQF's Steering Committees and Technical Advisory Panels to evaluate measures against the NQF criteria of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. Four conditions (as indicated below) must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. Not all acceptable measures will be strong—or equally strong—among each set of criteria. The assessment of each criterion is a matter of degree; however, all measures must be judged to have met the first criterion, importance to measure and report, in order to be evaluated against the remaining criteria. References to the specific measure evaluation criteria are provided in parentheses following the item numbers. Please refer to the *Measure Evaluation Criteria* for more information at *www.qualityforum.org* under Core Documents. Additional guidance is being developed and when available will be posted on the NQF website.

Use the tab or arrow (↓→) keys to move the cursor to the next field (or back ←↑). There are three types of response fields:

- drop-down menus - select one response;
- check boxes – check as many as apply; and
- text fields – you can copy and paste text into these fields or enter text; these fields are not limited in size, but in most cases, we ask that you summarize the requested information.

Please note that URL hyperlinks do not work in the form; you will need to type them into your web browser.

Be sure to answer all questions. Fields that are left blank will be interpreted as no or none. Information must be provided in this form. Attachments are not allowed except when specifically requested or to provide additional detail or source documents for information that is summarized in this form. If you have important information that is not addressed by the questions, they can be entered into item #48 near the end of the form.

For questions about this form, please contact the NQF Project Director listed in the corresponding call for measures.

	CONDITIONS FOR CONSIDERATION BY NQF
	Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards.
A (A)	*Public domain or Intellectual Property Agreement signed:* *IP Agreement signed and submitted* *(If no, do not submit)* *Template for the Intellectual Property Agreement is available at www.qualityforum.org under Core Documents.*
B (B)	*Measure steward/maintenance: Is there an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years?* *Yes, information provided in contact section (If no, do not submit)*
C (C)	*Intended use: Does the intended use of the measure include BOTH public reporting AND quality improvement? Yes (If no, do not submit)*

D (D)	*Fully developed and tested: Is the measure fully developed AND tested? Yes, fully developed and tested (If not tested and no plans for testing within 24 months, do not submit)*

EC-032-08

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THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

	(for NQF staff use) NQF Review #: EC-032-08 NQF Project: National Voluntary Consensus Standards for Ambulatory Care Using Clinically Enriched Administrative Data
	MEASURE SPECIFICATIONS & DESCRIPTIVE INFORMATION
1	*Information current as of (date- MM/DD/YY):* 6/19/09
2	*Title of Measure:* Bipolar antimanic agent
3	**Brief description of measure [1]:** This measure identifies the percentage of patients with newly diagnosed bipolar disorder who have received at least 1 prescription for a mood-stabilizing agent during the measurement year.
4 (2a)	**Numerator Statement:** Patients in the denominator who have received at least 1 prescription for a mood-stabilizing agent during the measurement year **Time Window:** See Below **Numerator Details** (Definitions, codes with description): >=1 claim for "Mood stabilizers" from diagnosis of bipolar disorder to end of measurement year

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mood stabilizers (Medispan Drug)

Type	GPI Code	Description
GPI	59070070000303	Risperidone Tab 0.25 MG
GPI	59070070000306	Risperidone Tab 0.5 MG
GPI	59070070000310	Risperidone Tab 1 MG
GPI	59070070000320	Risperidone Tab 2 MG
GPI	59070070000330	Risperidone Tab 3 MG
GPI	59070070000340	Risperidone Tab 4 MG
GPI	59070070002010	Risperidone Soln 1 MG/ML
GPI	59070070007220	Risperidone Orally Disintegrating Tab 0.5 MG
GPI	59070070007230	Risperidone Orally Disintegrating Tab 1 MG
GPI	59070070007240	Risperidone Orally Disintegrating Tab 2 MG
GPI	59070070007250	Risperidone Orally Disintegrating Tab 3 MG
GPI	59070070007260	Risperidone Orally Disintegrating Tab 4 MG
GPI	59070070101910	Risperidone Microspheres For Inj 12.5 MG
GPI	59070070101920	Risperidone Microspheres For Inj 25 MG
GPI	59070070101930	Risperidone Microspheres For Inj 37.5 MG
GPI	59070070101940	Risperidone Microspheres For Inj 50 MG
GPI	59100010100305	Haloperidol Tab 0.5 MG
GPI	59100010100310	Haloperidol Tab 1 MG
GPI	59100010100315	Haloperidol Tab 2 MG
GPI	59100010100320	Haloperidol Tab 5 MG
GPI	59100010100325	Haloperidol Tab 10 MG
GPI	59100010100330	Haloperidol Tab 20 MG
GPI	59100010102900	Haloperidol Powder

[1] Example of measure description: Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.

GPI	59100010201305	Haloperidol Lactate Oral Conc 2 MG/ML
GPI	59100010202005	Haloperidol Lactate Inj 5 MG/ML
GPI	59100010302010	Haloperidol Decanoate IM Soln 50 MG/ML
GPI	59100010302020	Haloperidol Decanoate IM Soln 100 MG/ML
GPI	59152020000310	Clozapine Tab 12.5 MG
GPI	59152020000320	Clozapine Tab 25 MG
GPI	59152020000325	Clozapine Tab 50 MG
GPI	59152020000330	Clozapine Tab 100 MG
GPI	59152020000340	Clozapine Tab 200 MG
GPI	59152020007210	Clozapine Orally Disintegrating Tab 12.5 MG
GPI	59152020007220	Clozapine Orally Disintegrating Tab 25 MG
GPI	59152020007230	Clozapine Orally Disintegrating Tab 100 MG
GPI	59153070100310	Quetiapine Fumarate Tab 25 MG
GPI	59153070100314	Quetiapine Fumarate Tab 50 MG
GPI	59153070100320	Quetiapine Fumarate Tab 100 MG
GPI	59153070100330	Quetiapine Fumarate Tab 200 MG
GPI	59153070100340	Quetiapine Fumarate Tab 300 MG
GPI	59153070100350	Quetiapine Fumarate Tab 400 MG
GPI	59153070107520	Quetiapine Fumarate Tab SR 24HR 200 MG
GPI	59153070107530	Quetiapine Fumarate Tab SR 24HR 300 MG
GPI	59153070107540	Quetiapine Fumarate Tab SR 24HR 400 MG
GPI	59157060000305	Olanzapine Tab 2.5 MG
GPI	59157060000310	Olanzapine Tab 5 MG
GPI	59157060000315	Olanzapine Tab 7.5 MG
GPI	59157060000320	Olanzapine Tab 10 MG
GPI	59157060000330	Olanzapine Tab 15 MG
GPI	59157060000340	Olanzapine Tab 20 MG
GPI	59157060002120	Olanzapine For IM Inj 10 MG
GPI	59157060007210	Olanzapine Orally Disintegrating Tab 5 MG
GPI	59157060007220	Olanzapine Orally Disintegrating Tab 10 MG
GPI	59157060007230	Olanzapine Orally Disintegrating Tab 15 MG
GPI	59157060007240	Olanzapine Orally Disintegrating Tab 20 MG
GPI	59200025100305	Fluphenazine HCl Tab 1 MG
GPI	59200025100310	Fluphenazine HCl Tab 2.5 MG
GPI	59200025100315	Fluphenazine HCl Tab 5 MG
GPI	59200025100320	Fluphenazine HCl Tab 10 MG
GPI	59200025101005	Fluphenazine HCl Elixir 2.5 MG/5ML
GPI	59200025101320	Fluphenazine HCl Oral Conc 5 MG/ML
GPI	59200025102005	Fluphenazine HCl Inj 2.5 MG/ML
GPI	59200025302005	Fluphenazine Decanoate Inj 25 MG/ML
GPI	59200045000305	Perphenazine Tab 2 MG
GPI	59200045000310	Perphenazine Tab 4 MG
GPI	59200045000315	Perphenazine Tab 8 MG
GPI	59200045000320	Perphenazine Tab 16 MG
GPI	59200045001350	Perphenazine Conc 16 MG/5ML
GPI	59200080100305	Thioridazine HCl Tab 10 MG
GPI	59200080100310	Thioridazine HCl Tab 15 MG
GPI	59200080100315	Thioridazine HCl Tab 25 MG
GPI	59200080100320	Thioridazine HCl Tab 50 MG
GPI	59200080100325	Thioridazine HCl Tab 100 MG
GPI	59200080100330	Thioridazine HCl Tab 150 MG
GPI	59200080100335	Thioridazine HCl Tab 200 MG

GPI	59250015000305	Aripiprazole Tab 2 MG
GPI	59250015000310	Aripiprazole Tab 5 MG
GPI	59250015000320	Aripiprazole Tab 10 MG
GPI	59250015000330	Aripiprazole Tab 15 MG
GPI	59250015000340	Aripiprazole Tab 20 MG
GPI	59250015000350	Aripiprazole Tab 30 MG
GPI	59250015002020	Aripiprazole Oral Solution 1 MG/ML
GPI	59250015002050	Aripiprazole IM Inj 9.75 MG/1.3ML (7.5 MG/ML)
GPI	59250015007220	Aripiprazole Orally Disintegrating Tab 10 MG
GPI	59250015007230	Aripiprazole Orally Disintegrating Tab 15 MG
GPI	59400015006910	Carbamazepine (Antipsychotic) Cap SR 12HR 100 MG
GPI	59400015006920	Carbamazepine (Antipsychotic) Cap SR 12HR 200 MG
GPI	59400015006930	Carbamazepine (Antipsychotic) Cap SR 12HR 300 MG
GPI	59400085100120	Ziprasidone HCl Cap 20 MG
GPI	59400085100130	Ziprasidone HCl Cap 40 MG
GPI	59400085100140	Ziprasidone HCl Cap 60 MG
GPI	59400085100150	Ziprasidone HCl Cap 80 MG
GPI	59400085202120	Ziprasidone Mesylate For Inj 20 MG (Base Equivalent)
GPI	59500010100103	Lithium Carbonate Cap 150 MG
GPI	59500010100105	Lithium Carbonate Cap 300 MG
GPI	59500010100110	Lithium Carbonate Cap 600 MG
GPI	59500010100305	Lithium Carbonate Tab 300 MG
GPI	59500010100405	Lithium Carbonate Tab CR 300 MG
GPI	59500010100410	Lithium Carbonate Tab CR 450 MG
GPI	59500010102900	Lithium Carbonate Powder
GPI	59500010202010	Lithium Citrate Oral Soln 8 mEq/5ML
GPI	62995002500110	Olanzapine-Fluoxetine HCl Cap 3-25 MG
GPI	62995002500120	Olanzapine-Fluoxetine HCl Cap 6-25 MG
GPI	62995002500125	Olanzapine-Fluoxetine HCl Cap 6-50 MG
GPI	62995002500140	Olanzapine-Fluoxetine HCl Cap 12-25 MG
GPI	62995002500145	Olanzapine-Fluoxetine HCl Cap 12-50 MG
GPI	72500010100605	Divalproex Sodium Tab Delayed Release 125 MG
GPI	72500010100610	Divalproex Sodium Tab Delayed Release 250 MG
GPI	72500010100615	Divalproex Sodium Tab Delayed Release 500 MG
GPI	72500010106820	Divalproex Sodium Cap Sprinkle 125 MG
GPI	72500010107520	Divalproex Sodium Tab SR 24 HR 250 MG
GPI	72500010107530	Divalproex Sodium Tab SR 24 HR 500 MG
GPI	72500020101205	Valproate Sodium Syrup 250 MG/5ML
GPI	72500020102020	Valproate Sodium Inj 100 MG/ML
GPI	72500030000105	Valproic Acid Cap 250 MG
GPI	72500030006505	Valproic Acid Cap Delayed Release 125 MG
GPI	72500030006510	Valproic Acid Cap Delayed Release 250 MG
GPI	72500030006520	Valproic Acid Cap Delayed Release 500 MG
GPI	72600020000305	Carbamazepine Tab 200 MG
GPI	72600020000505	Carbamazepine Chew Tab 100 MG
GPI	72600020001810	Carbamazepine Susp 100 MG/5ML
GPI	72600020002900	Carbamazepine Powder
GPI	72600020006910	Carbamazepine Cap SR 12HR 100 MG
GPI	72600020006920	Carbamazepine Cap SR 12HR 200 MG
GPI	72600020006930	Carbamazepine Cap SR 12HR 300 MG
GPI	72600020007410	Carbamazepine Tab SR 12HR 100 MG
GPI	72600020007420	Carbamazepine Tab SR 12HR 200 MG

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	GPI 72600020007440 Carbamazepine Tab SR 12HR 400 MG GPI 72600040000310 Lamotrigine Tab 25 MG GPI 72600040000330 Lamotrigine Tab 100 MG GPI 72600040000335 Lamotrigine Tab 150 MG GPI 72600040000340 Lamotrigine Tab 200 MG GPI 72600040006420 Lamotrigine Tab 25 MG (35) Starter Kit GPI 72600040006430 Lamotrigine Tab 25 MG (42) & 100 MG (7) Starter Kit GPI 72600040006435 Lamotrigine Tab 25 MG (84) & 100 MG (14) Starter Kit GPI 72600040007205 Lamotrigine Tab Disp 2 MG GPI 72600040007210 Lamotrigine Tab Disp 5 MG GPI 72600040007220 Lamotrigine Tab Disp 25 MG GPI 72600046000310 Oxcarbazepine Tab 150 MG GPI 72600046000320 Oxcarbazepine Tab 300 MG GPI 72600046000340 Oxcarbazepine Tab 600 MG GPI 72600046001820 Oxcarbazepine Susp 300 MG/5ML (60 MG/ML) GPI 72600075000310 Topiramate Tab 25 MG GPI 72600075000320 Topiramate Tab 50 MG GPI 72600075000330 Topiramate Tab 100 MG GPI 72600075000340 Topiramate Tab 200 MG GPI 72600075006820 Topiramate Sprinkle Cap 15 MG GPI 72600075006830 Topiramate Sprinkle Cap 25 MG
5 (2a)	**Denominator Statement:** Patients newly diagnosed as having bipolar disorder earlier than 30 days before the end of the measurement year **Time Window:** See Below **Denominator Details** (Definitions, codes with description): -Age >=18 years old as of the end of the measurement year -AND newly diagnosed with "bipolar disorder" {defined by [>=2 outpatient claims for 'bipolar disorder' -OR >=1 inpatient claims for 'bipolar disorder' with the 1st claim occuring during the measurement year but earlier than 30 days before end of measurement year, saving the earliest claim as the onset date} -AND no claims for 'bipolar disorder prior' to the onset date -AND >=1 Inpatient or ER claim for 'Bipolar Acute mania or depression' during the measurement year -AND has Rx eligibility from onset date of bipolar disorder to end of measurement year -AND has member eligibility for 2 yrs prior to the end of the measurement year. **Bipolar Acute mania or depression (Diagnosis)** ========== Type Code Description --- ICD9 29600 BIPLR I D/O SINGLE MANIC EPIS UNS ICD9 29601 BIPLR I D/O SINGLE MANIC EPIS MILD ICD9 29602 BIPLR I D/O SINGLE MANIC EPIS MOD ICD9 29603 BIPLR I D/O 1 MANIC EPIS NO PSYCHOT ICD9 29604 BIPLR I D/O 1 MANIC EPIS W/PSYCHOT ICD9 29610 MANIC DISORDER RECUR EPIS UNSPEC ICD9 29611 MANIC DISORDER RECURRENT EPIS MILD ICD9 29612 MANIC DISORDER RECURRENT EPIS MOD ICD9 29613 MANIC RECUR D/O EPIS SEVERE ICD9 29614 RECUR MANIC-SEV W PSYCHO ICD9 29620 MAJ DPRSV D/O SINGLE EPIS UNSPEC ICD9 29621 MAJ DPRSV DISORDER SINGLE EPIS MILD ICD9 29622 MAJ DPRSV DISORDER SINGLE EPIS MOD ICD9 29623 MAJ DEPRESS D/O 1 EPIS SEVERE

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ICD9	29624 MAJ DEPRESS 1 EPIS SEVR W/PSYCHOT
ICD9	29630 MAJ DPRSV D/O RECUR EPIS UNSPEC
ICD9	29631 MAJ DPRSV DISORDER RECUR EPIS MILD
ICD9	29632 MAJOR DPRSV DISORDER RECUR EPIS MOD
ICD9	29633 MJR DEPRESS D/O RECUR EPIS-SEVERE
ICD9	29634 MJR DEPRES D/O RECUR EPIS-PSYCHOTIC
ICD9	29640 BIPLR I MOST RECENT EPIS MANIC UNS
ICD9	29641 BIPLR I MOST RECENT EPIS MANIC MILD
ICD9	29642 BIPLR I MOST RECENT EPIS MANIC MOD
ICD9	29643 BP I MOST RECNT MNIC SEV NO PSYCHOT
ICD9	29644 BP I MOST RECENT MNIC SEV W/PSYCHOT
ICD9	29650 BIPLR I MOST RECENT EPIS DPRSD UNS
ICD9	29651 BIPLR I MOST RECENT EPIS DPRSD MILD
ICD9	29652 BIPLR I MOST RECENT EPIS DPRSD MOD
ICD9	29653 BIPLR I RECENT DPRSD SEV NO PSYCHOT
ICD9	29654 BIPLR I RECENT DPRSD SEV W/PSYCHOT
ICD9	29660 BIPLR I MOST RECENT EPIS MIX UNS
ICD9	29661 BIPLR I MOST RECENT EPIS MIX MILD
ICD9	29662 BIPLR I MOST RECENT EPIS MIX MOD
ICD9	29663 BIPLR I RECENT MIX SEV W/O PSYCHOT
ICD9	29664 BIPLR I RECENT MIX SEV W/PSYCHOT

bipolar disorder (Diagnosis)

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Type	Code	Description
ICD9	2960	BIPLR I DISORDER SINGLE MANIC EPIS
ICD9	29600	BIPLR I D/O SINGLE MANIC EPIS UNS
ICD9	29601	BIPLR I D/O SINGLE MANIC EPIS MILD
ICD9	29602	BIPLR I D/O SINGLE MANIC EPIS MOD
ICD9	29603	BIPLR I D/O 1 MANIC EPIS NO PSYCHOT
ICD9	29604	BIPLR I D/O 1 MANIC EPIS W/PSYCHOT
ICD9	29605	BIPLR I D/O 1 MNIC EPIS PART REMISS
ICD9	29606	BIPLR I D/O 1 MNIC EPIS FULL REMISS
ICD9	2961	MANIC DISORDER, RECURRENT EPISODE
ICD9	29610	MANIC DISORDER RECUR EPIS UNSPEC
ICD9	29611	MANIC DISORDER RECURRENT EPIS MILD
ICD9	29612	MANIC DISORDER RECURRENT EPIS MOD
ICD9	29613	MANIC RECUR D/O EPIS SEVERE
ICD9	29614	RECUR MANIC-SEV W PSYCHO
ICD9	29615	MNIC D/O RECUR EPIS PART/UNS REMISS
ICD9	29616	MANIC D/O RECUR EPIS FULL REMISSION
ICD9	2964	BIPLR I D/O MOST RECENT EPIS MANIC
ICD9	29640	BIPLR I MOST RECENT EPIS MANIC UNS
ICD9	29641	BIPLR I MOST RECENT EPIS MANIC MILD
ICD9	29642	BIPLR I MOST RECENT EPIS MANIC MOD
ICD9	29643	BP I MOST RECNT MNIC SEV NO PSYCHOT
ICD9	29644	BP I MOST RECENT MNIC SEV W/PSYCHOT
ICD9	29645	BIPLR I RECENT MNIC PART/UNS REMISS
ICD9	29646	BIPLR I RECENT MANIC FULL REMISS
ICD9	2965	BIPLR I D/O MOST RECENT EPIS DPRSD
ICD9	29650	BIPLR I MOST RECENT EPIS DPRSD UNS
ICD9	29651	BIPLR I MOST RECENT EPIS DPRSD MILD
ICD9	29652	BIPLR I MOST RECENT EPIS DPRSD MOD
ICD9	29653	BIPLR I RECENT DPRSD SEV NO PSYCHOT
ICD9	29654	BIPLR I RECENT DPRSD SEV W/PSYCHOT
ICD9	29655	BIPLR I RECENT DPRSD PART/UNS REMIS
ICD9	29656	BIPLR I RECENT DPRSD FULL REMISS
ICD9	2966	BIPLR I D/O MOST RECENT EPIS MIX
ICD9	29660	BIPLR I MOST RECENT EPIS MIX UNS
ICD9	29661	BIPLR I MOST RECENT EPIS MIX MILD
ICD9	29662	BIPLR I MOST RECENT EPIS MIX MOD
ICD9	29663	BIPLR I RECENT MIX SEV W/O PSYCHOT
ICD9	29664	BIPLR I RECENT MIX SEV W/PSYCHOT

	ICD9 29665 BIPLR I RECENT MIX PART/UNS REMISS ICD9 29666 BIPLR I RECENT EPIS MIX FULL REMISS ICD9 2967 BIPLR I D/O MOST RECENT EPIS UNSPEC ICD9 2968 OTHER&UNSPECIFIED BIPOLAR DISORDERS ICD9 29680 BIPOLAR DISORDER UNSPECIFIED ICD9 29681 ATYPICAL MANIC DISORDER ICD9 29689 OTHER&UNSPECIFIED BIPOLAR DISORDERS
6 (2a, 2d)	**Denominator Exclusions:** None **Denominator Exclusion Details** (Definitions, codes with description):
7 (2a, 2h)	**Stratification** Do the measure specifications require the results to be stratified? No ► If "other" describe: **Identification of stratification variable(s):** **Stratification Details** (Definitions, codes with description):
8 (2a, 2e)	**Risk Adjustment** Does the measure require risk adjustment to account for differences in patient severity before the onset of care? No ► **If yes,** (select one) ► Is there a separate proprietary owner of the risk model? No **Identify Risk Adjustment Variables:** **Detailed risk model:** attached ☐ **OR** Web page URL:
9 (2a)	**Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☒ **OR** Web page URL: **Interpretation of Score** (*Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score*) Better quality = Higher score ► If "Other", please describe:
10 (2a. 4a, 4b)	**Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** Diagnosis, Pharmacy Claims **Data dictionary/code table** attached ☒ see numerator and denominator detail **OR** Web page URL: **Data Quality** (2a) *Check all that apply* ☐ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel) ☒ Data are coded using recognized data standards ☐ Method of capturing data electronically fits the workflow of the authoritative source ☐ Data are available in EHRs ☒ Data are auditable
11 (2a, 4b)	**Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply* ☐ Electronic Health/Medical Record ☐ Electronic Clinical Database, Name: ☐ Electronic Clinical Registry, Name: ☒ Electronic Claims ☒ Electronic Pharmacy data ☐ Electronic Lab data ☐ Electronic source – other, Describe: ☐ Paper Medical Record ☐ Standardized clinical instrument, Name: ☐ Standardized patient survey, Name: ☐ Standardized clinician survey, Name: ☐ Other, Describe: Instrument/survey attached ☐ **OR** Web page URL:
12 (2a)	**Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.* **Minimum sample size:** 10 **Instructions:** We have developed a hierarchical logistic regression model with expert biostatisticians at the Johns Hopkins School of Public Health that enables one to produce a probability distribution around a point estimate of the "quality score" for a given physician. This model has shown that there is no minimum sample size that is required to produce a quality score which has a comparatively "tight" probability distribution. Rather, the number of required observations depends on how a given physician performs on particular measures compared to how all other MDs perform on those measures. We

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	recommend that a minimum of 10 observations be required, however, because of the normality assumptions that underlies the model and for public "face validity". Alternatively, to satisfy current NCQA standards, a minimum of 30 observations could be required.
13	**Type of Measure:** Process ► If "Other", please describe:
(2a)	► If part of a composite or paired with another measure, please identify composite or paired measure
14	**Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.*
(2a)	☐ Can be measured at all levels ☒ Individual clinician (e.g., physician, nurse) ☒ Group of clinicians (e.g., facility department/unit, group practice) ☐ Facility (e.g., hospital, nursing home) ☒ Integrated delivery system ☒ Health plan ☒ Community/Population ☐ Other (*Please describe*):
15	**Applicable Care Settings** *Check all that apply*
(2a)	☐ Can be used in all healthcare settings ☒ Ambulatory Care (office/clinic) ☐ Behavioral Healthcare ☒ Community Healthcare ☐ Dialysis Facility ☐ Emergency Department ☐ EMS emergency medical services ☒ Health Plan ☐ Home Health ☐ Hospice ☐ Hospital ☐ Long term acute care hospital ☐ Nursing home/ Skilled Nursing Facility (SNF) ☐ Prescription Drug Plan ☐ Rehabilitation Facility ☐ Substance Use Treatment Program/Center ☐ Other (*Please describe*):
	IMPORTANCE TO MEASURE AND REPORT
	Note: This is a threshold criterion. If a measure is not judged to be sufficiently important to measure and report, it will not be evaluated against the remaining criteria.
16	**Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related*
(1a)	*to this measure (see list of goals on last page)*: 5.4,6.1
17	**If not related to NPP goal, identify high impact aspect of healthcare** (select one)
(1a)	**Summary of Evidence:** **Citations[2] for Evidence:**
18	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.*
(1b)	**Summary of Evidence:** Numerator Denominator Measure 44 58 76% **Citations for Evidence:** RHI testing experience
19	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.*
(1b)	**Summary of Evidence:** Not applicable **Citations for evidence:**
20	**If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed:
(1c)	

Deleted: ¶ Numerator ... [1]

Deleted: RHI client experience

[2] Citations can include, but are not limited to journal articles, reports, web pages (URLs).

	If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence *Summarize the evidence (including citations to source) supporting the focus of the measure as follows:* • Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit. • Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s). • Structure – evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit. • Patient experience – evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public. • Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care. • Efficiency– demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality. **Type of Evidence** *Check all that apply* ☒ Evidence-based guideline ☐ Quantitative research studies ☐ Meta-analysis ☐ Qualitative research studies ☒ Systematic synthesis of research ☐ Other (*Please describe*): **Overall Grade for Strength of the Evidence**[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*: **Summary of Evidence** (*provide guideline information below*)**:** **Citations for Evidence:** See question #21 below
21 (1c)	**Clinical Practice Guideline** *Cite the guideline reference; quote the specific guideline recommendation related to the measure and the guideline author's assessment of the strength of the evidence; and summarize the rationale for using this guideline over others.* **Guideline Citation:** American Psychiatric Association. Practice guideline for the treatment of patients with bipolar disorder (revision). Am J Psychiatry. 2002 Apr;159(4 Suppl):1-50. **Specific guideline recommendation:** The first-line pharmacological treatment for more severe manic or mixed episodes is the initiation of either lithium plus an antipsychotic or valproate plus an antipsychotic [I]. For less ill patients, monotherapy with lithium, valproate, or an antipsychotic such as olanzapine may be sufficient [I]. The first-line pharmacological treatment for bipolar depression is the initiation of either lithium [I] or lamotrigine [II]. Antidepressant monotherapy is not recommended [I] The medications with the best empirical evidence to support their use in maintenance treatment include lithium [I] and valproate [I]; possible alternatives include lamotrigine [II] or carbamazepine or oxcarbazepine [II]. **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** Class ratings are embedded in the quoted text above in brackets.

[3]The strength of the body of evidence for the specific measure focus should be systematically assessed and rated, e.g., USPSTF grading system www.ahrq.gov/clinic/uspstmeth.htm: A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

	[I] Recommended with substantial clinical confidence. [II] Recommended with moderate clinical confidence. Authors cite many randomized-controlled trials. The rating generally would correspond to a USPSTF rating of high certainty of net benefit. **Rationale for using this guideline over others:** The APA is the authoritative source in this area.
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.* **Summary:** No significant controversy **Citations:**
23 (1)	**Briefly describe how this measure (as specified) will facilitate significant gains in healthcare quality related to the specific priority goals and quality problems identified above:**
	SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES
	Note: Testing and results should be summarized in this form. However, additional detail and reports may be submitted as supplemental information or provided as a web page URL. If a measure has not been tested, it is only potentially eligible for time-limited endorsement.
24	**Supplemental Testing Information:** attached ☐ **OR** Web page URL:
25 (2b)	**Reliability Testing** **Data/sample:** We have tested this measure on several patient populations, including, in total, more than 30 million people enrolled in 18 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in more than 5 million health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both. **Analytic Method:** The validity of a physician quality score describes how accurately it estimates the true value. Reliability is the stability or consistency of an estimator from one data set to the next. Both are important in assessing the performance of the quality score. We have used the following measure as an indication of the reliability of each of our measures: 1 minus [(the variance of the posterior distribution of the physician quality score) divided by (the variance of the true physician quality score)], which is the reduction in the variance of a doctor's performance score (posterior distribution) obtained by using his or her performance data, expressed as a fraction of the total variance before any data is collected. **Testing Results:** The reliability of a physician quality score depends on the number of observations available for a given physician, how the physician performs relative to all other physician, and the overall variance in physician quality scores. As a result, reliability varies with the population of MDs in whom the measure is used. In our experience, reliability is in the range of 0.5 to >0.7.
26 (2c)	**Validity Testing** **Data/sample:** We have tested this measure on several patient populations, including, in total, more than 30 million people enrolled in 18 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in more than 5 million health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both. **Analytic Method:** We have employed several approaches to ensure the validity of this measure: 1) we've ensured that the technical specifications for this measure are valid reflections of the underlying clinical practice guideline; 2) we have obtained feedback on the validity of the measure from several physician panels that were assembled by either Care Focused Purchasing or the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative, or both, and 3) we have systematically collected feedback from physicians and health plan members to whom we have sent messages regarding this measure.

	Testing Results: This measure is considered to be valid by the physician panels that have reviewed it. (More information regarding the panels is provided elsewhere in this document.) In addition, the measure has been considered to be valid by the medical directors of 17 different health plans. In addition, the fact that thousands of physicians have received results based on this measure without indicating that they don't believe the measure is valid attests to its validity.
27 (2d)	**Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.* **Summary of Evidence supporting exclusion(s):** n/a **Citations for Evidence:** **Data/sample:** **Analytic Method:** **Testing Results:**
28 (2e)	**Risk Adjustment Testing** *Summarize the testing used to determine the need (or no need) for risk adjustment and the statistical performance of the risk adjustment method.* **Data/sample:** **Analytic Method:** **Testing Results:** ►**If outcome or resource use measure not risk adjusted, provide rationale:**
29 (2g)	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*) **Data/sample:** **Analytic Method:** **Results:**
30 (2f)	**Provide Measure Results from Testing or Current Use** (select one) **Data/sample:** **Group Insurance Commission (GIC):** In 2003, the Massachusetts Group Insurance Commission GIC launched the Clinical Performance Improvement initiative, requiring health plans under contract with the GIC to incorporate provider "tiering"—differential payments based on value—into their GIC product. For this initiative, RHI evaluates physician performance on a set of quality measures using administrative claims data from approximately 2.2 million health plan members. **Methods to identify statistically significant and practically/meaningfully differences in performance:** We have developed a hierarchical logistic regression model with expert biostatisticians at the Johns Hopkins School of Public Health that enables one to produce a probability distribution around a point estimate of the "quality score" for a given physician. This model has shown that there is no minimum sample size that is required to produce a quality score which has a comparatively "tight" probability distribution. Rather, the number of required observations depends on how a given physician performs on particular measures compared to how all other MDs perform on those measures. We recommend that a minimum of 10 observations be required, however, because of the normality assumption that underlies the model and for public "face validity". We have employed this statistical approach in the MD quality profiling we performed on the experience of more than 2 million members of 6 health plans participating in the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative in 2008. **Results:** Numerator Denominator Measure

	195 233 83.69%
31 (2h)	**Identification of Disparities** ►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:** ►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale:
	USABILITY
32 (3)	*Current Use In use If in use, how widely used Regionally ► If "other," please describe:* ☒ *Used in a public reporting initiative, name of initiative: Group Insurance Commission of Massachusetts, Clinical Performance Improvement Initiative* *Sample report attached* ☐ *OR Web page URL:*
33 (3a)	**Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **Data/sample:** **Methods:** **Results:**
34 (3b, 3c)	**Relation to other NQF-endorsed™ measures** ►Is this measure similar or related to measure(s) already endorsed by NQF (on the same topic or the same target population)? *Measures can be found at www.qualityforum.org under Core Documents.* *Check all that apply* ☐ Have not looked at other NQF measures ☒ Other measure(s) on same topic ☐ Other measure(s) for same target population ☐ No similar or related measures **Name of similar or related NQF-endorsed™ measure(s):** **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one) ►If not fully harmonized, provide rationale: **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** This measure can be used exclusively with enriched administrative data
	FEASIBILITY
35 (4a)	*How are the required data elements generated? Check all that apply* ☐ *Data elements are generated concurrent with and as a byproduct of care processes during care delivery (e.g., blood pressure or other assessment recorded by personnel conducting the assessment)* ☐ *Data elements are generated from a patient survey (e.g., CAHPS)* ☒ *Data elements are generated through coding performed by someone other than the person who obtained the original information (e.g., DRG or ICD-9 coding on claims)* ☐ *Other, Please describe:*
36 (4b)	*Electronic Sources None* ►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:* ►*Specify the data elements for the electronic health record:*
37 (4c)	*Do the specified exclusions require additional data sources beyond what is required for the other specifications? No*

	►*If yes, provide justification:*
38 (4d)	*Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure: As with any type of clinical performance measure, and with any source of data used to operationalize the measure, there will be some instances in which the data used to compute the measure are incomplete or inaccurate. We try to minimize the impact of such errors or omissions through the way we have constructed the technical specifications for the measure. There is no data source for performance measurement that is completely accurate. Two studies have shown that physician performance tends to be better when assessed using claims data compared to via chart abstraction.* *Describe how could these potential problems be audited: Potential data errors of omission or commission could be audited through chart abstraction, or feedback from physicians and patients. However, as mentioned above, each of these alternative sources of information also are susceptible to error and thus are not true gold standards.* *Did you audit for these potential problems during testing? Yes If yes, provide results: Through feedback from physicians whose performance has been evaluated*
39 (4e)	*Testing feasibility Describe what have you learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:*
	CONTACT INFORMATION
40	*Web Page URL for Measure Information Describe where users (implementers) should go for more details on specifications of measures, or assistance in implementing the measure.* *Web page URL: www.resolutionhealth.com*
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Alan **MI:** **Last Name:** Lefkowitz **Credentials (MD, MPH, etc.):** **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** alefkowitz@resolutionhealth.com **Telephone:** 240-295-5834 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext:
44	**Measure Steward Point of Contact** **If different than IP Owner Contact** *Identifies the organization that will take responsibility for updating the measure and assuring it is consistent with the scientific evidence and current coding schema; the steward of the measure may be different than the developer.* **First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext:
	ADDITIONAL INFORMATION
45	**Workgroup/Expert Panel involved in measure development** Workgroup/panel used ►If workgroup used, describe the members' role in measure development: Over the past several years, two formal workgroups -- one organized by the Care Focused Purchasing initiative and one organized by

	the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative -- and several ad hoc experts have provided useful input to our measure development and refinement processes. In each case, we have provided the Work Group Members with details regarding each of our performance measures and members of the work group (not always all members) have provided feedback on the validity of the clinical practice guideline underlying the measure and suggestions regarding potential ways to improve the technical specifications for the measure. In some instances, we have eliminated measures based on feedback from the work groups. In other instances, work group members have proposed new measures. We try to get feedback from work group members and selected clinical experts on an annual basis. ►Provide a list of workgroup/panel members' names and organizations: **Care Focused Purchasing Clinical Advisory Panel** Bobbie Berg -BCBS -IL Dow Briggs - BCBS- AL Joe Calderella - Cigna Carl Cameron - Preferred Care Steven Goldberg – Humana Tom James – Humana Don Liss – Aetna Catherine MacLean – WellPoint Zak Ramadan-Jradi – Regence Fred Volkman – Avidyn Health Constance Hwang – Resolution Health Darren Schulte - Resolution Health Earl Steinberg – Resolution Health **Massachusetts Group Insurance Commission Physician Advisory Panel** Jim Glauber – Neighborhood Health Plan Lyn Laurenco - Neighborhood Health Plan Anton Dodek - Tufts Barbara Chase - Fallon Jonathan Scott Coblyn – Brigham and Women's Hospital Tom Ebert - Health New England Elaine Wilson - Harvard Pilgrim Health Care Jennifer St. Thomas – Tufts Jennifer Lavigne – Fallon Michael O'Shea - Baycare Health Neil Minkoff - Harvard Pilgrim Health Care Paul Mendis- Neighborhood Health Plan Bob Jordan - Neighborhood Health Plan Bob Sorrenti – Unicare Constance Williams – Unicare Laura Syron - Neighborhood Health Plan Susan Tiffany – Unicare Constance Hwang – Resolution Health Darren Schulte - Resolution Health Earl Steinberg – Resolution Health David Gregg – Mercer Russ Robinson - Mercer
46	*Measure Developer/Steward Updates and Ongoing Maintenance* *Year the measure was first released: 2007* *Month and Year of most recent revision: October 2008* *What is the frequency for review/update of this measure? Annual Review* *When is the next scheduled review/update for this measure? Summer 2009*
47	**Copyright statement/disclaimers:** Copyright © 2008 – Resolution Health, Inc. All rights reserved. The material submitted is confidential and proprietary. No use of this material is permitted other than in accordance with the Agreement with Measure Stewards between National Quality Forum and Resolution

	Health, Inc.
48	**Additional Information:** None
49	**I have checked that the submission is complete and any blank fields indicate that no information is provided.** ☒
50	**Date of Submission** (*MM/DD/YY*)**:** 10/31/2008

PATIENT & FAMILY ENGAGEMENT

PRIORITY STATEMENT: Engage Patients and Their Families in Managing Their Health and Making Decisions About Their Care

1.1. All providers will routinely solicit and publicly report on their patients' perspectives of care

1.2. All providers will work collaboratively with their patients to assist them in making informed decisions about treatment options consistent with their values and preferences

POPULATION HEALTH

PRIORITY STATEMENT: IMPROVE THE HEALTH OF THE U.S. POPULATION

2.1. The population will be up to date on all high-priority age- and gender-appropriate evidence-based clinical preventive services

2.2. The population will receive recommended evidence-based interventions to improve targeted healthy lifestyle behaviors

2.3. All communities will demonstrate a 10% improvement in their community index of health

2.4. Americans will have all recommended high priority healthy lifestyle behaviors under control

SAFETY

PRIORITY STATEMENT: IMPROVE THE SAFETY OF THE U.S. HEALTH CARE SYSTEM

3.1. All providers will drive all preventable healthcare-associated infections (HAI) to zero

3.2. All providers will drive the incidence of preventable NQF Serious Reportable Events (SRE) to zero

3.3. All hospitals will reduce preventable and premature mortality rates to best-in-class

3.4. All hospitals and their community partners will reduce 30-day mortality rates following hospitalization for select conditions to best-in-class

PALLIATIVE CARE

PRIORITY STATEMENT: GUARANTEE APPROPRIATE AND COMPASSIONATE CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESSES

4.1. All providers will identify, document, and effectively treat physical symptoms (e.g. pain, shortness of breath, constipation, others) at levels acceptable to patients with a life-limiting illness

4.2. All providers will effectively address the psychosocial and spiritual needs of patients with life-limiting illnesses and their families according to their preferences

4.3. All eligible patients will receive high quality palliative care and hospice services

CARE COORDINATION

PRIORITY STATEMENT: ENSURE PATIENTS RECEIVE WELL-COORDINATED CARE ACROSS ALL PROVIDERS, SETTINGS, AND LEVELS OF CARE

5.1. All providers will accurately and completely reconcile medications across the continuum of care (i.e. admission, transfer within and between care providers, discharge, and outpatient appointments) and ensure communication with the next provider of services

5.2. All inpatient and outpatient providers will assess the patient's perspective of the coordination of their care using a validated care coordination survey tool

5.3. All providers will reduce 30-day all-cause readmission rates resulting from poorly coordinated care to best-in-class

5.4. All providers will reduce preventable emergency department (i.e. those that could be avoided with timely access to primary care) visits resulting from poorly coordinated care by 50%

PATIENT-FOCUSED CARE

PRIORITY STATEMENT: GUARANTEE HIGH VALUE CARE ACROSS ACUTE AND CHRONIC EPISODES

6.1. All patients will receive high-value care over the course of their acute or chronic illness

OVERUSE

PRIORITY STATEMENT: ELIMINATE WASTE WHILE ENSURING THE DELIVERY OF APPROPRIATE CARE

7.1. Reduce wasteful and inappropriate care for the top ten targeted areas by 50%

Numerator	Denominator	Measure
75	94	79.79%
54	65	83.08%
5	6	83.33%
32	36	88.89%
8	9	88.89%
21	23	91.30%