NATIONAL QUALITY FORUM

TO: NQF Members

FR: NQF Staff

RE: Voting Draft Report: *National Voluntary Consensus Standards for Behavioral Health Phase 1*

DA: August 8, 2012

Background

Behavioral health refers to a state of mental or emotional being and choices and actions that affect wellness, as defined in the Substance Abuse Mental Health Services Administration (SAMHSA) National Behavioral Health Quality Framework (NBHQF). Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. In the United States, it is estimated that approximately 26.4 percent of the population suffers from mental illness and substance abuse.[1]

To date, NQF has endorsed a relatively small proportion of measures - approximately 45 - specific to mental health or substance abuse. This two-phase project is aimed at endorsing measures of accountability for improving the delivery of behavioral health services, achieving better behavioral health outcomes, and improving the behavioral health of the U.S. population, especially those with mental illness and substance abuse. [2]

The project was structured in two phases. This report details the evaluation of measures in the first phase, which include alcohol, tobacco, screening, medication adherence, and post care follow-up. A 25-member Steering Committee, representing a range of stakeholder perspectives, was appointed to review a total of 22 measures during this first phase, including 18 newly submitted candidate measures and 4 previously NQF endorsed measures undergoing maintenance review. The Steering Committee recommended eleven measures for endorsement, including all four maintenance measures. On June 22, 2012, the 30-day comment period concluded for the eleven recommended measures.

Comments and Revised Voting Report

NQF received five comments from three member organizations during the public and member commenting period. A table of these comments, in addition to measure submission forms and meeting materials, is posted to the Behavioral Health Project page under the Public and Member comment section.

The Steering Committee reviewed and responded to all comments received. Revisions to the draft report and the accompanying measure specifications are identified as red-line changes. (NOTE: To assist in reading, typographical errors and grammatical changes have not been red-lined.)

Comments and their Disposition

The Steering Committee reviewed each of the five comments submitted, proposing responses to both the general and measure-specific comments. Comments about specific measure specifications were also forwarded to the measure developers, who were invited to respond.

Two comments were supportive of the project and measures in general. Three commenters requested clarification regarding the following:

[1] World Health Organization (WHO), Atlas: Psychiatric Education and Training across the World 2005, Geneva, Switzerland: WHO; 2005. Available at www.who.int/mental_health/evidence/Atlas_training_final.pdf. Last accessed November 2011.
[2] Ibid.

1. Process for deferring measures (relates to #1654, 1656, 1657, 1661, 1663, 1664, 1665)
2. Endorsement of measure #0027 as an eMeasure; and
3. Committee discussion of reliability for measure #0004.

Theme 1: Process for deferring measures

A commenter expressed support for the approach of deferring the following tobacco and alcohol measures and requested clarification of the process for deferring measures.

- #1654 TOB-2 Tobacco Use Treatment Provided or Offered (and the subset measure TOB-2a Tobacco Use Treatment)
- #1656 TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge
- #1657 TOB-4 Tobacco Use: Assessing Status after Discharge
- #1661 SUB-1 Alcohol Use Screening
- #1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
- #1664 SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
- #1665 SUB-4 Alcohol and Drug Use: Assessing Status After Discharge

Action Taken: The decision for deferring measures is handled on a case-by-case basis by NQF Senior Management. As phase two of this project is expected to coincide with the developer's timeline for testing and revision of the measures, the measures were able to be deferred for completion of the endorsement process until that time.

The Steering Committee agrees that there is a need for measures in this area. Because the testing of the submitted tobacco and alcohol measures showed lower than desired reliability, the consensus of the Committee was that scientific acceptability was not met at this time.

Theme 2: Endorsement of measure #0027 as an eMeasure

One comment supported the Steering Committee's recommendation that measure #0027 Medical Assistance with Smoking and Tobacco Use Cessation (NCQA) be endorsed, but requested clarification as to whether the retooled, e-specified version of the measure will also be endorsed, as updated e-specifications were not provided by the developer.

Action Taken: The measure will only be endorsed for testing specifications that have currently been submitted and evaluated. Therefore, the e-specified version of this measure will not be considered endorsed. If, however, updated e-specifications of this measure are submitted during the annual update for the measure, the data source for the measure can be expanded to include electronic health record systems and the eMeasure specifications will be associated with the measure.

Theme 3: Committee discussion of reliability sub-criteria for measure #0004

One commenter requested clarification around the Committee's discussion of reliability regarding recommended measure #0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NCQA), noting that "the success in accounting for reliability concerns on varying terminology should be carefully considered upon future review."

Action Taken: Upon initial review of the reliability testing for measure #0004 Initiation and Engagement of Alcohol and other Drug Dependence Treatment a. Initiation b. Treatment (NCQA), the Steering Committee were concerned given the use of both "abuse" and "dependence" in the measure. However, the Committee was satisfied with the developer's explanation that the measure is broad because it intends to capture overlapping characteristics of the measure population.

Further, the measure developer intends to revisit reliability testing when the expected publication of the DSM-V occurs in May of 2013 and implementation of ICD-10-CM occurs in October 2014. In the future, when the measure has been updated to include these codes, changes may be provided to NQF during the annual update process and if considered material changes an ad hoc review can be initiated.

Harmonization of Related and Competing Measures

The Steering Committee evaluated several related measures in this phase regarding adherence to antipsychotic medication for individuals with schizophrenia, and screening, assessment and monitoring measures for individuals with schizophrenia and bipolar disease.

#1879 Adherence to Oral Antipsychotics for Individuals with Schizophrenia (CMS)

#1935 Use of Antipsychotic Medication (NCQA)

#1936 Continuity of Antipsychotic Medications for Treatment of Schizophrenia (NCQA)

The Steering Committee evaluated three similar measures related to adherence to antipsychotic medication for patients with schizophrenia (#1879 and measure pair #1935 and #1936), and agreed it was preferable to recommend a single, harmonized measure rather than multiple, overlapping measures.

As a result of the developers' work, measure #1935 has been withdrawn from consideration and measures #1936 and #1879 have been combined into one harmonized measure, #1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia, stewarded by CMS, which is now open for member vote.

#0003 Bipolar Disorder: Assessment for diabetes (Centers for Quality Assessment and Improvement in Mental Health)

#1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) (NCQA)

The Steering Committee evaluated and recommended for endorsement a new measure related to screening and assessing individuals with schizophrenia and bipolar disease for diabetes (#1932). The Steering Committee also recommended harmonization of the new measure #1932 with existing NQF endorsed measure #0003. Harmonization of the measures is requested within 12 months of endorsement.

#0057 Diabetes: Hemoglobin A1c testing (NCQA)

#0063 Diabetes: Lipid profile (NCQA)

#1934 Diabetes monitoring for people with diabetes and schizophrenia (SMD) (NCQA)

The Steering Committee evaluated a new measure on diabetes monitoring of individuals with schizophrenia (#1934). The measure addresses a subset of two existing measures for patients with a diagnosis of diabetes (#0057 and #0063). The Committee agreed that the new measure is suitable for endorsement; however, as recommended by the Steering Committee, the developer, NCQA will incorporate the new measure as subsets or target populations within the more broadly defined NQF endorsed measures (#0057 and #0063) following the member voting period and CSAC/Board reviews.

#0576 Follow-up After Hospitalization for Mental Illness (NCQA)

#1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) (NCQA)

The Steering Committee also evaluated and recommended for endorsement an existing measure and a new measure related to follow-up after hospitalization for mental illness (#0576 and #1937). The Steering Committee recommended that the developer incorporate the new measure #1937 as a subset or target population within the more broadly defined measure #0576, and the developer, NCQA agreed to do so following the member voting period and CSAC/Board reviews.

NQF Member Voting

Information for electronic voting has been sent to NQF Member organization primary contacts. Accompanying comments must be submitted via the online voting tool.

Please note that voting concludes on August 22, 2012, at 6:00 pm ET – no exceptions.

BEHAVIORAL HEALTH PHASE 1, 2012

DRAFT TECHNICAL REPORT FOR VOTING

August 8, 2012

INTRODUCTION

The Affordable Care Act (ACA) calls for the establishment of a National Strategy for Quality Improvement in Health Care to include national priorities and a strategic plan for improving the delivery of health care services, achieving better consumer outcomes, and improving the health of the U.S. population. Similarly, the Substance Abuse and Mental Health Services Administration (SAMHSA) is now advancing a national Framework for Quality Improvement in Behavioral Health Care, aimed at establishing national priorities, goals, and opportunities for: improving the delivery of behavioral health services, achieving better behavioral health outcomes, and improving the behavioral health of the U.S. population, especially those with mental illnesses and substance abuse. Behavioral health refers to a state of mental or emotional being and choices and actions that affect wellness, as defined in the Substance Abuse Mental Health Services Administration (SAMHSA) National Behavioral Health Quality Framework (NBHQF)[3]. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders.

In the United States, it is estimated that approximately 26.4 percent of the population suffers from mental illness and substance abuse.[4] While mental illness is prevalent throughout the general population, the substantial burden of disease is concentrated in the 6 percent who suffer from a serious mental illness. Such individuals are now dying 25 years earlier than the general population.[5] Although most of the years of lost life can be attributed to medical illnesses, an individual's mental health status has a significant impact on engagement in treatment of medical conditions, therapeutic response, and overall outcomes.[6]

NQF's Measure Applications Partnership (MAP)–created to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs—has been tasked by HHS to examine quality issues affecting the heterogeneous Medicare-Medicaid dual eligible beneficiary population and to provide input on an appropriate measurement strategy. The MAP identified five high-leverage opportunity areas in which measurement can have the most significant positive effects. Mental health and substance use is one of those areas, along with quality of life, screening and assessment, care coordination, and structural measures. The MAP has put forward a set of available measures considered core for use with this population. A quarter of these are related to behavioral health and include existing NQF-endorsed measures #0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, #0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention and #0576 Follow-Up After Hospitalization for Mental Illness that are undergoing endorsement maintenance review in this project.

[3] Delany PJ, Frank R. "National Behavioral Health Quality Framework Improving Health Outcomes." Presentation to the Substance Abuse and Mental Health Services Administration Advisory Councils; August 16, 2011. Available at http://store.samhsa.gov/product/National-Behavioral-Health-Quality-Framework-Improving-Health-Outcomes-Presentation-to-SAMHSA-Advisory-Councils/SMA11-PDELANY081611. Last accessed November 2011.
[4] World Health Organization (WHO), Atlas: Psychiatric Education and Training across the World 2005, Geneva, Switzerland: WHO; 2005. Available at www.who.int/mental_health/evidence/Atlas_training_final.pdf. Last accessed November 2011.
[5] Parks J, Radke A, Mazade NA, Measurement of Health Status for People with Serious Mental Illness. Alexandria, VA :National Association of State Mental Health Program Directors; 2008. Available at www.nasmhpd.org/general_files/publications/med_directors_pubs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf. Last accessed October 2011.
[6] Ibid.

To date, NQF has endorsed a relatively small proportion of measures, approximately 45, specific to mental health or substance abuse. This two-phase project is aimed at endorsing measures of accountability for improving the delivery of behavioral health services, achieving better behavioral health outcomes, and improving the behavioral health of the U.S. population, especially those with mental illness and substance abuse. [7]

In Phase I NQF seeks to endorse behavioral health measures of process, outcomes, and structure that serve as indicators of quality behavioral healthcare across all care delivery settings, including primary and specialty care. In Phase 2, NQF will seek to endorse additional measures addressing gap areas identified in Phase 1. NQF-endorsed® standards relating to behavioral healthcare that are due for endorsement maintenance also will be reviewed.

MEASURE EVALUATION

To facilitate evaluation of a large number of measures, the project was divided into two phases. In the first phase, the Behavioral Health Steering Committee reviewed candidate standards relating to tobacco and alcohol use screening and follow-up care, as well as screening and medication management for individuals with schizophrenia and bipolar disease. The committee and candidate standards were divided into three workgroups for a preliminary review of measures against the evaluation sub-criteria prior to evaluation by the entire Steering Committee. At the in-person meeting on April 17-18, 2012, the Committee evaluated eighteen new measures (two of which were ultimately combined into one measure) and four measures undergoing endorsement maintenance review against NQF's Measure Evaluation Criteria. The Committee's discussion and rating of the criteria are summarized in the evaluation tables beginning on page A-1.

TABLE 1: BEHAVIORAL HEALTH PHASE 1 SUMMARY

	MAINTENANCE	NEW	TOTAL
Measures under consideration	4	17	21
Measures deferred	0	7	7
Withdrawn from consideration	0	3	3
Recommended	4	7	11
Not recommended	0	1	1
Reasons for Not Recommending	N/A	Importance -1	

Overarching Issues

During the Steering Committee's discussion of the measures, several overarching issues emerged that were factored into Committee ratings and recommendations. These issues are discussed in detail in the following sections.

Evidence and Measure Testing (Reliability and Validity)

[7] Ibid.

The Steering Committee noted that NQF criteria have become more rigorous following the 2010 task force recommendations regarding evaluating evidence and testing. Reviewing the measures as a whole, Committee members suggested that in the future developers more clearly delineate how structure-process-outcome are linked when providing evidence to support the measures, and ensure that the testing provided can demonstrate reliability and validity of the measures.

For the sets of measures relating to tobacco use and alcohol use, the Committee strongly agreed that there is a great need for measures in this area and generally agreed the measures were important to measure and report. Because the testing of some of the newly submitted measures showed lower than desired reliability, the consensus of the Committee was that Scientific Acceptability was not met at this time. The Steering Committee recommended one measure focused on tobacco use screening in hospitals, reflecting its struggle between the desire to have a performance measure in this topic area for hospitals and concerns with the reliability of the measures. The Committee strongly encouraged the developer to continue to refine and test the measures and to re-submit them as soon as they are able. The Joint Commission has indicated that they are continuing to test the measures and will provide additional testing data to the Steering Committee on the revised measures by late 2012 or early 2013 so that the measures may then continue through the endorsement process. The measures have been deferred for further consideration until that time.

Harmonization of Related Measures

Related measures identified within this phase include: adherence to antipsychotic medication for individuals with schizophrenia, screening, assessment and monitoring measures for individuals with schizophrenia and bipolar disease. Please see the side-by-side tables of specifications in Appendix C.

#1879 Adherence to Oral Antipsychotics for Individuals with Schizophrenia (CMS)
#1935 Use of Antipsychotic Medication (NCQA)
#1936 Continuity of Antipsychotic Medications for Treatment of Schizophrenia (NCQA)

The Steering Committee evaluated three similar measures related to adherence to antipsychotic medication for patients with schizophrenia (#1879 and measure pair #1935 and #1936) and agreed it was preferable to recommend a single, harmonized measure rather than multiple, overlapping measures. There were several differences in the measures that the developers, Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA), worked together to resolve during the course of the Committee's review and during the member and public comment period; those differences are detailed below.

As a result of their work, measure #1935 has been withdrawn from consideration and measures #1936 and #1879 have been combined into one harmonized measure, #1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia stewarded by CMS, which will be voted on by the membership.

There are several differences in the measures that the developers resolved:

- *Differing target populations*. The Steering Committee recommended that a harmonized measure target individuals aged 18 years and older (as specified in #1879) rather than 25 years (as specified in #1935 and #1936). Steering Committee members alternatively suggested a separate 'first episode' measure.
    - The harmonized measure -specifies individuals aged 18 years and older, as is currently defined in #1879. A separate 'first episode' measure is not recommended at this time.

- *Differing claims for prescriptions in denominator*. There were differences in the measures on whether or not the denominator required two separate inpatient claims or one inpatient claim with a prescription for antipsychotics (#1935, #1936) or two outpatient, inpatient, emergency department setting encounters (#1879). The Steering Committee suggested including two prescription fills in the measurement period as done in #1879.
    - The harmonized measure specifies two prescription fills required in the denominator, as is currently defined in #1879.

- *Differing exclusions.* One measure excluded injectable drugs and dementia patients (#1879), while the measure pair did not (#1935 and #1936). The Committee suggested a harmonized measure include injectable drugs, and exclude dementia and pregnancy.
    - *Injectable drugs.* The developers agreed to include individuals receiving long-acting injectable medications in the harmonized measure which would make the measure applicable to a broader population of patients with schizophrenia.
    - *Dementia.* The developers agreed to retain the exclusion for dementia in #1879, and NCQA will align codes in their HEDIS measure ("Potentially harmful drug-disease interactions in the elderly: percentage of Medicare members 65 years of age and older who have a diagnosis of dementia and a prescription for tricyclic antidepressants or anticholinergic agents") to identify a dementia diagnosis.
    - *Pregnancy.* The developers determined that pregnancy is not an absolute contraindication for medication adherence, that the benefits of including this population outweighed the harms, and did not exclude pregnancy in the measures.

Other:

- *Schizoaffective disorder, clarification.* The Steering Committee recommended that the developers modify specifications language to clarify that schizoaffective disorder is included in the measure. Schizoaffective disorder is included in ICD-9-CM/ICD-10-CM codes as specified in #1879 and #1936. The developers modified the wording in the specifications for the measure to ensure that it is clear that schizoaffective disorder is included.

- *Adherence methodology*. The Steering Committee recommended that the developers review the standard methods for assessing medication adherence, referencing the NQF Medication Management Report and determine whether a recommendation could be made regarding the best approach, and questioned whether the threshold of 80 percent adherence rate in the measures was optimal. The developers determined that testing shows the method of proportion of days covered (PDC) was the best approach as it has a higher face and translational validity than the standard medication possession ration (MPR), and noted that PDC has been adopted by other NQF-endorsed adherence measures as a standard methodology. The developers recommend the measure remain specified with the PDC methodology. The developers also determined that several studies link improved outcomes to adherence to antipsychotics used a threshold of 80 percent. In addition, existing NQF-endorsed adherence measures #541, #542, #543, and #545 use 80 percent as the appropriate threshold for other chronically administered medications. The developers recommend that the threshold for adherence remain at 80 percent as specified.

- *Measure pair.* Steering Committee suggested one measure rather than the #1935 and #1936 pair. The developer agreed and requested measure #1935 be removed from consideration for endorsement due to the high performance seen in their testing data.

#0003 Bipolar Disorder: Assessment for diabetes (Centers for Quality Assessment and Improvement in Mental Health)
#1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) (NCQA)

The Steering Committee evaluated and recommended for endorsement a new measure related to screening and assessing individuals with schizophrenia and bipolar disease for diabetes (#1932). The Steering Committee also recommended harmonization of the new measure #1932 with existing NQF endorsed measure #0003. Differences in the existing and new measure include:

	#0003 Bipolar Disorder: Assessment for diabetes (Centers for Quality Assessment and Improvement in Mental Health)	#1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) (NCQA)
Level of Analysis	Specified at the individual and group physician level	Specified at the plan and state level
Patient Population	Patients 18 years or older with bipolar disorder assessed for diabetes within 16 weeks after initiating treatment with an atypical medication	Patients 25 to 64 years with bipolar disorder or prescribed either an atypical or typical medication who received a diabetes screening during the measurement year
Exclusions	No exclusions	Patients are excluded if they already have diabetes
Data Source	Claims data and chart abstraction	Claims data only

The areas for harmonization include level of testing at either the individual or group clinical level vs. the state level, inclusion of those ages~~d~~ 18 and older vs. those aged 25 and older, the exclusion of patients with diabetes and the use of a combination of claims data and chart abstractions vs. claims data only. Harmonization of the measures is requested within 12 months of endorsement.

#0057 Diabetes: Hemoglobin A1c testing (NCQA)
#0063 Diabetes: Lipid profile (NCQA)
#1934 Diabetes monitoring for people with diabetes and schizophrenia (SMD) (NCQA)

The Steering Committee evaluated a new measure on diabetes monitoring of individuals with schizophrenia (#1934). The measure addresses a subset of two existing measures for patients with a diagnosis of diabetes. The Committee agreed that the new measure is suitable for endorsement; however, as recommended by the Steering Committee, the developer, NCQA will incorporate the new measure as subsets or target populations -within the more broadly defined NQF endorsed measures (#0057 and #0063) following the member voting period and CSAC/Board reviews. Please see the side-by-side tables of specifications in Appendix C.

Differences in the existing and new measures include:

	#0057 Diabetes: Hemoglobin A1c testing (NCQA)	#0063 Diabetes: Lipid profile (NCQA)	#1934 Diabetes monitoring for people with diabetes and schizophrenia (SMD) (NCQA)
Level of Analysis	Specified at the clinician, health plan, and population level	Specified at the individual and group physician level, plan, delivery system, national, regional, and state level	Specified at the population level
Patient Population	Patients 18 to 75 receiving at least one A1c test per year	Patients 18 to75 with a diagnosis of diabetes and an LDL-C test performed during the measurement year	Patients 25 to 64 with schizophrenia receiving an HbA1c test and LDL-C test during the measurement year
Exclusions	Exclude patients with a diagnosis of polycystic ovaries and patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list, who did not have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year	No exclusions	No exclusions
Data Source	Claims data and chart abstraction	Claims data and chart abstraction	Claims data only

0576 Follow-up After Hospitalization for Mental Illness (NCQA)
1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) (NCQA)

The Steering Committee also evaluated and recommended for endorsement an existing measure and a new measure related to follow-up after hospitalization for mental illness (#0576 and #1937). Differences in the existing and new measure include:

	0576 Follow-up After Hospitalization for Mental Illness (NCQA)	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) (NCQA)
Level of Analysis	Specified at the plan, clinician team and integrated delivery system, and local, nation, regional and state levels	Specified at the state level
Patient Population	Patients 6 years and older discharged from an acute inpatient setting with a principal mental health diagnosis during the measurement year, who received follow-up within 7- and 30-days of discharge	Patients 25 to 64 years of age discharged after hospitalization for treatment of schizophrenia during the measurement year, who received follow-up within 7- and 30-days of discharge
Exclusions	Certain discharge, readmission and transfer discharges that may prevent an outpatient follow-up visit from taking place	Certain discharge, readmission and transfer discharges that may prevent an outpatient follow-up visit from taking place
Data Source	Administrative claims, EHRs	Administrative claims.

The Steering Committee recommended that the developer incorporate the new measure #1937 as a subset or target population within the more broadly defined measure #0576, and the developer, NCQA, agreed to do so following the member voting period and CSAC/Board reviews. Please see the side-by-side tables of specifications in Appendix C.

Electronic Health Record Specifications
The tobacco measure #0028 Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention (AMA-PCPI) was submitted with additional electronic specifications. The specifications will undergo an eMeasure format review.

RECOMMENDATIONS FOR FUTURE MEASURE DEVELOPMENT

The Steering Committee recognized gaps in measurement in the areas of screening for alcohol and drugs, specifically using tools such as the Screening Brief Intervention and Referral to Treatment (SBIRT). Members also noted a gap in screening for post-traumatic stress disorder (PTSD) and bi-polar disorder in all patients diagnosed with depression, with an eye toward differentiating between the disorders. ***Comments are requested regarding additional gaps in measurement.***

MEASURE EVALUATION TABLES

MEASURES RECOMMENDED

Alcohol Measures

0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Maintenance Measure Description: The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. Numerator Statement: a) Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis. • If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant • If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with an AOD diagnosis (Table IET-A) within 14 days of the IESD (inclusive) – If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive) • Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment b) Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations (Table IET-B) with any AOD diagnosis (Table IET-A) within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period. • If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive). •Do not count engagement encounters that include detoxification codes (including inpatient detoxification) Denominator Statement: Members age 13 years of age and older with a medical and chemical dependency benefit who were diagnosed with a new episode of alcohol and drug dependency (AOD) during the intake period of January 1-November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD. Exclusions: Exclude members who had a claim/encounter with a diagnosis of AOD (Table IET-A) during the 60 days (2 months) before the IESD. For an inpatient IESD, use the admission date to determine the Negative Diagnosis History. For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. Exclude from the denominator members whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year. Adjustment/Stratification: No risk adjustment or risk stratification N/A Level of Analysis: Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Measure Steward: National Committee for Quality Assurance
Steering Committee In-Person April 17-18, 2012

0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact: 1b. Performance Gap 1c. Evidence)
1a. Impact: H-15; M-4; L-0; I-0 1b. Performance Gap: H-5; M-10; L-3; I-1 1c. Evidence: Y-17; N-0; I-2
Rationale:

- The Committee agreed the measure is important because it seeks to increase access and quality of care. Steering committee members raised concerns regarding the clarity of the terms used in the numerator of the measure: the terms "abuse" and "dependence" are considered very different and the measure title and description are not clear: the title lists dependence initiation but it also measures abuse, making it not a true measure of dependence and addiction needing treatment
    - The developer explained the measure is intended as an initiation and engagement measure and has been coded as such. They are currently looking into how those codes will change with the transition to ICD-10 and how abuse and dependence may be separated.
- The Committee questioned how the evidence supports the cited performance gap.
    - The developer explained the gap stratifies the population; however, the definition in the numerator may not be precise enough to be a true measure of the gap in both initiation and engagement. Steering committee members agreed there is a demonstrated performance gap.
- The Committee noted the evidence presented omits data on the capacity to identify and engage people in treatment. It does, however, show that those who are engaged have lower addiction severity index (ASI) scores over time.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-0; M-10; L-7; I-2 2b. Validity: H-0; M-13; L-3; I-3
Rationale:

- The Committee observed that when diagnoses are made in non-substance abuse clinics, there could be a high false positive rate for addiction visit types; this issue is further complicated with the inclusion of both abuse and dependence diagnoses in the measure.
- The Committee noted that the burden on providers to code the measure properly is concerning. Members were concerned about the large number of codes included in the measure, and also noted that most internists, family and primary care physicians do not routinely use the screening, brief intervention, referral and treatment (SBIRT) codes as most use the evaluation and management codes (E/M). Because the E/M codes are not included in the measure, it was a concern that many patients who should be included in the measure may not be captured with the current specifications. This variation in coding practices as well as the forthcoming DSM-V release led to some concerns with the reliability of the measure.
    - The developer explained that the intent of the broad use of codes and the broad measure was to capture the overlapping characteristics of the populations. The steering committee narrowly agreed the measure is reliable.
- The measure was field tested, presented to the CPM and incorporated into HEDIS in 2005.
- The Committee expressed a desire to see a single visit count in the measure and more data on disparities and minority groups, as well as vulnerable populations.

3. Usability: H-3; M-13; L-3; I-0
(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)*
Rationale:

- The measure is currently used for both public reporting and quality improvement.

4. Feasibility: H-2; M-15; L-2; I-0

0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented) Rationale: • The data are readily available electronically.
Steering Committee Recommendation on Overall Suitability for Endorsement: Y-14; N-5 Rationale: • The committee found this measure to be suitable for NQF endorsement as it has demonstrated it is important, reliable and valid in order to be used to measure the initiation of alcohol and drug dependence treatment. RECOMMENDATIONS: • The committee was concerned about the use of the terms "abuse" and "dependence" in the measure and the potential threats to validity and reliability posed by the difference in the use of terms. o The developer will explore how this issue may be addressed with the move from ICD-9 to ICD-10.
Public & Member Comment Comments included: • One commenter requested clarification around the Committee's discussion of reliability testing for this measure, noting that "the success in accounting for reliability concerns on varying terminology should be carefully considered upon future review." Response: • Upon initial review of reliability testing for this measure, the Steering Committee was concerned given the use of both "abuse" and "dependence" in the measure. However, the Committee was ultimately satisfied with the developer's explanation that the measure is broad because it intends to capture overlapping characteristics of the measure population. Further, the measure developer intends to revisit reliability testing when the expected publication of the DSM-V occurs in May of 2013 and the implementation of ICD-10-CM occurs in October 2014. In the future, when the measure has been updated to include these codes, changes may be provided to NQF during the annual update process, and if considered material changes, and ad hoc review can be initiated.

Tobacco Measures

0027 Medical Assistance With Smoking and Tobacco Use Cessation
Maintenance Measure Description: Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year. Numerator Statement: Component 1: Advising Smokers and Tobacco Users to Quit (ASTQ) Received advice to quit smoking Component 2: Discussing Cessation Medications (DSCM) Received discussion/recommendations on smoking cessation medications Component 3: Discussing Cessation Strategies (DSCS) Received discussion/recommendations on smoking cessation methods and strategies Denominator Statement: Patients 18 years and older who responded to the survey and indicated that they were current smokers or tobacco users Exclusions: None Adjustment/Stratification: No risk adjustment or risk stratification None

0027 Medical Assistance With Smoking and Tobacco Use Cessation

Level of Analysis: Health Plan
Type of Measure: Process
Data Source: Patient Reported Data/Survey
Measure Steward: National Committee for Quality Assurance

Steering Committee In-Person April 17-18, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact: 1b. Performance Gap 1c. Evidence)
1a. Impact: H-18; M-0; L-0; I-0 1b. Performance Gap: H-12; M-6; L-0; I-0 1c. Evidence: Y-18; N-1; I-0
Rationale:

- The importance of advising smokers to quit, offering recommendations and medication options is well established.
- The mean performance for this measure is 75 percent, demonstrating there is room for improvement.
- The evidence is based on the US Preventive Services Task Force recommendations.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-1; M-13; L-2; I-2 2b. Validity: H-3; M-14; L-1; I-1
Rationale:

- Reliability of the measure score was examined using a beta-binomial model; a method to meaningfully distinguish reliability between plans.
- The Committee was concerned about the length of time between patient-physician interaction and when the survey is distributed: errors in patient recall over the measurement year could negatively impact reliability and validity.
    - The developer stated that surveys may be administered in a rolling fashion in the future to help minimize the time between interaction and survey, and explained that there is a recall bias but it is a shared bias.
- Two groups of experts examined the validity of the measure and found it to have face validity.

3. Usability: H-6; M-11; L-1; I-1
(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)*
Rationale:

- The measure has been in use within the CAHPS survey.

4. Feasibility: H-8; M-9; L-1; I-1
(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
Rationale:

- Committee members expressed some concern regarding recall bias; in some cases physician charts reflect a discussion with patients, but patients themselves may not recall the discussion when completing the survey.
    - The developer noted the concern and responded that there is some work in progress to possibly alter the methodology of administering CAHPS for this reason.

Steering Committee Recommendation on Overall Suitability for Endorsement: Y-17; N-2
Rationale:

- The Committee found this measure to be suitable for endorsement. The medical assistance component of smoking cessation is well grounded in the USPSTF evidence and the measure is in widespread use with CAHPS.

RECOMMENDATIONS:

- The Committee was concerned about the potential for recall bias in the collection of this measure due to the potential time elapsed between physician-patient interaction and the survey.

0027 Medical Assistance With Smoking and Tobacco Use Cessation

- The developer expressed a desire to survey more frequently with the advent of new technology.

Public & Member Comment

Comments included:

- CMS expressed support for this measure, but questioned whether the retooled, e-specified version of the measure would also be considered endorsed.

Response:

- NQF clarified that the measure will only be endorsed for testing specifications that have currently been submitted and evaluated. Therefore, the e-specified version of this measure will not be considered endorsed. If, however, updated e-specifications of this measure are submitted during the annual update for the measure, the data source for the measure can be expanded to include electronic health record systems and the eMeasure specifications will be associated with the measure.

0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

Maintenance Measure

Description: Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user

Numerator Statement: Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user

*Includes use of any type of tobacco

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

Denominator Statement: All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two-year measurement period

Exclusions: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

Adjustment/Stratification: No risk adjustment or risk stratification We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

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

Measure Steward: American Medical Association - convened Physician Consortium for Performance Improvement (AMA-convened PCPI)

Steering Committee In-Person April 17-18, 2012

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

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

1a. Impact: H-19; M-0; L-0; I-0 1b. Performance Gap: H-13; M-6; L-0; I-0 1c. Evidence: Y-17; N-1; I-1

Rationale:

- The Committee agreed that this measure represents a high-impact aspect of health care
- There are suboptimal rates of asking and advising to quit, as well as prescribing pharmacotherapy
- Even though the measure has been in use since 2003, there is still an opportunity for improvement.
- Research has shown that increased counseling leads to increased quit rates; however, even brief counseling by physicians can have an impact on increasing quit rates.
- Committee members raised concerns that the two-year follow up time window is too long.
    - The developer stated a two-year follow-up window was specified to reduce burden on patients. A physician may ask patients more frequently; however, only every two years is required for the measure. It is also specified for the same

0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
clinician, as denoted by the two visit criteria.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-8; M-11; L-0; I-0 2b. Validity: H-6; M-11; L-2; I-0 Rationale: • The reliability at the average number of quality reporting events was stable, ranging from .86 to .88. • Face validity was conducted by an expert panel of 30 people.
3. Usability: H-15; M-3; L-1; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)* Rationale: • The measure has been reported as a part of the CMS PQRS program.
4. Feasibility: H-12; M-7; L-0; I-0 *(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Feasibility is acceptable using claims-based data and is expected to increase as more primary care practices incorporate electronic health records.
Steering Committee Recommendation on Overall Suitability for Endorsement: Y-19; N-0 Rationale: • The Committee found this measure suitable for endorsement. It is in widespread use with the PQRS program and despite being in use since 2003, still presents a significant opportunity for performance improvement. RECOMMENDATIONS: • Committee members expressed concern about the two-year time window and suggested additional data might aid in understanding the time window. • Committee members suggested that including testing results showing how many actual minutes of counseling are most effective would be helpful.
Public & Member Comment Comments included: • No comments were received for this measure.

1651 TOB-1 Tobacco Use Screening

New Measure
Description: Hospitalized patients age 18 years and older who are screened during the hospital stay for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days. This measure is intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-2 Tobacco Use Treatment Provided or Offered (during the hospital stay); TOB-3 Tobacco Use Treatment Provided or offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)
Numerator Statement: The number of patients who were screened for tobacco use status
Denominator Statement: The number of hospitalized inpatients 18 years of age and older
Exclusions: The denominator has three exclusions:

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who a have a length of stay less than or equal to one day or greater than 120 days

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable, the measure is not stratified.
Level of Analysis: Facility, Population : National
Type of Measure: Process
Data Source: Administrative claims, Paper Records
Measure Steward: The Joint Commission

Steering Committee In-Person April 17-18, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact: 1b. Performance Gap 1c. Evidence)
1a. Impact: H-19; M-0; L-0; I-0 1b. Performance Gap: H-11; M-8; L-0; I-0 1c. Evidence: Y-17; N-2; I-0
Rationale:

- Smoking is the leading preventable cause of death in the United States.
- The performance gap ranged from 60 percent to 90 percent in the measure pilots. These numbers were specifically related to tobacco screening.
- In the 30 hospitals that participated in the testing of the measure, performance varied from 70 to 90 percent.
- Committee members agreed the gap is well documented but questioned the extent of the gap, asking whether the low rates of compliance cited are due to lack of documentation that screenings were performed.
- Screening in the outpatient setting is clearly linked to smoking cessation; however, the data analyzing the inpatient hospital setting is not as clear.
    - The developer clarified that the results of the randomized controlled trials were consistent across all of the sites included in the studies, even when stratified by inpatient and outpatient settings.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-3; M-7; L-6; I-3 2b. Validity: H-12; M-6; L-0; I-1
Rationale:

- The Committee was concerned with the reliability of the measure. The developer stated that the element specifications were unclear to abstractors, leading to a disagreement in the classification of denominator and numerator cases. Abstractors could not tell whether someone refused a screen or the screen was not offered.
    - The developer explained that 94 percent of the 131 cases were actually compliant with the measure. In this instance, the disagreement occurred for those who were not screened, rather than those who were screened. Efforts are also underway to standardize the method in which the tobacco use question is asked and how it is documented in the health record. Testing results on the revisions will be available at the end of 2012 and the developer believes increased reliability will be demonstrated.
- Committee members were concerned that the reliability issues currently demonstrated in the measure could pose problems for the field, if the measure is used for accountability rather than just internal quality improvement.
- The measure was determined to have high face validity by a panel of experts.

3. Usability: H-15; M-2; L-2; I-0
(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)*

Rationale:

- Usability was assessed as high. The Tobacco Treatment measures were noted in the recent IPPS rule for future consideration.

4. Feasibility: H-10; M-8; L-1; I-0
(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
Rationale:

- Feasibility was assessed as moderate to high; this information is routinely collected in clinical care. Committee members noted electronic collection would increase the feasibility of the measure.
    - The developer explained plans to pursue development of electronic specifications.

Steering Committee Recommendation on Overall Suitability for Endorsement: Y-16; N-3
Rationale:

- Tobacco screening is a high impact area and represents the leading cause of preventable deaths in the United States. While there was some concern regarding the reliability of the measure, the Committee agreed the measure was suitable for endorsement.

RECOMMENDATIONS:

- The Committee hopes that additional testing will demonstrate that the modified specifications resulted in improved reliability of the measure.

Public & Member Comment
Comments included:

- No comments were received for this measure.

Medication Measures

1879 Adherence to Antipsychotics for Individuals with Schizophrenia

1879 Adherence to Antipsychotics for Individuals with Schizophrenia

NOTE: This measure has now been combined with measure #1936 (Continuity of Antipsychotic Medications for Treatment of Schizophrenia). The single harmonized measure (#1879) will be stewarded by CMS.

New Measure
Description: The measure calculates the percentage of individuals 18 years of age or greater with schizophrenia who are prescribed an oral antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC) of at least 0.8 during the measurement period (12 consecutive months).
Numerator Statement: Individuals with schizophrenia who filled at least two prescriptions for any oral antipsychotic medication and have a Proportion of Days Covered (PDC) for antipsychotic medications of at least 0.8.
Denominator Statement: Individuals at least 18 years of age as of the end of the measurement period with schizophrenia with at least two claims for any oral antipsychotic medication during the measurement period (12 consecutive months).
Exclusions: We excluded the following individuals from the denominator:
EXCLUSION 1 Individuals who received an injection (including depot injections) for any antipsychotic medication during the measurement period.
EXCLUSION 2 Individuals with any diagnosis of dementia during the measurement period
Adjustment/Stratification: N/A
Level of Analysis: Clinician : Group/Practice, Population : State
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data : Pharmacy, Other
Measure Steward: Centers for Medicare and Medicaid Services

Steering Committee In-Person April 17-18, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact; 1b. Performance Gap; 1c. Evidence)
1a. Impact: H-16; M-3; L-0; I-0; 1b. Performance Gap: H-6; M-11; L-1; I-1; 1c. Evidence: Y-14, N-0, I-5
Rationale:

- This measure focuses on individuals with schizophrenia who have filled more than two antipsychotic prescriptions and have a proportion of days covered (PDC) greater than 80 percent; this is a high impact area as studies have shown individuals with schizophrenia often have poor compliance, which leads to increased rates of hospitalization.
- There appears to be a significant performance gap as many studies document poor medication compliance in individuals with schizophrenia, particulary those 18 to 44 years of age.The data presented at the state level shows that there is variation with performance ranging from 67.5 percent to 84.7 percent.
- Strong evidence was presented in support of maintenance of antipyschotic medications.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-2; M-14; L-1; I-2; 2b. Validity: H-2; M-14; L-0; I-3
Rationale:

- Reliability testing was conducted using a beta-binomial method at the state level and the measure received scores of .9, with "good" defined as greater than .7. The measure was more reliable for physician groups with greater than 45 patients with a diagnosis of schizophrenia than for those with less than 45 patients.
- Face validity of the measure was demonstrated by a 12-member expert panel that evaluated the measure and either "strongly agreed" or "agreed" that the measure appears to measure what is intended.
- Threats to validity include missing individuals paying cash for prescriptions (and therefore not being included in claims data) and missing data; however, the Committee agreed these were low threats to validity.

3. Usability: H-7; M-9; L-2; I-1
(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*
Rationale:

- The Steering Committee agreed an adherence measure at both the state population and physician group level will help providers recognize patients that are not compliant. For those populations with low adherence the measure could also be used to develop interventions for these groups.
    - The developer explained its technical expert panel was also asked to assess the usability of this measure and all

1879 Adherence to Antipsychotics for Individuals with Schizophrenia
"strongly agreed" or "agreed" the measure is highly usable.
4. Feasibility: H-2; M-13; L-3; I-1 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Data is readily available and can be drawn from electronic claims. • Committee members noted a possible susceptibility to inaccuracies as a percentage of individuals will not be accounted for, due to free drug programs. o The developer stated this issue was also raised by its technical expert panel, as free drug programs are becoming more available. The measure developer will use the input and take a closer look at this issue.
Steering Committee Recommendation for Endorsement: Y-16 ; N-3 Rationale: • The measure represents an opportunity to improve the quality of care for patients with schizophrenia and may provide empirical evidence that may be used as a basis for future interventions. The measure was assessed to be important, reliable, valid, useful and feasible. RECOMMENDATIONS: • This measure is directly competing with paired measures #1935 Use of any antipsychotic medications (NCQA) and #1936 Continuity of Antipsychotic Medications for Treatment of Schizophrenia (NCQA). The developers have agreed to harmonize the measures #1936 and #1879; the areas for harmonization include: the inclusion criteria for the population starting at 18 years and 25 years, the use of two prescription claims vs. one prescription claim, excluding dementia and including pregnancy in the population. Measure #1935 was withdrawn from consideration as part of the harmonization process.
Public & Member Comment Comments included: • CMS expressed support for the Steering Committee's evaluation of this measure and agreed with the CMS-NCQA proposed strategy for measure harmonization of measures #1879 and #1936. Developer response: • NCQA agreed to combine measures #1936 and #1879 into one single, harmonized measure. Measure #1879, stewarded by CMS, now incporates elements of both of these initially submitted measures, and is currently available for member vote.

1936 Continuity of Antipsychotic Medications for Treatment of Schizophrenia
NOTE: This measure has been combined with measure #1879 (Adherence to Oral Antipsychotics for Individuals with Schizophrenia). The single harmonized measure (#1879) will be stewarded by CMS and is currently available for member vote. This measure #1936 is therefore considered withdrawn. ~~New Measure~~ ~~Description: The percentage of individuals 25 – 64 years of age diagnosed with schizophrenia who remained on any antipsychotic medication for at least 80% of the intake period.~~ ~~Numerator Statement: The number of individuals who achieved a proportion of days covered of at least 80% for their antipsychotic medications during the intake period.~~ ~~Denominator Statement: Adults age 25 and older with a diagnosis of schizophrenia who were prescribed and remained on any antipsychotic medication during the measurement year.~~ ~~Exclusions: N/A~~ ~~Adjustment/Stratification: N/A~~ ~~Level of Analysis: Population : State~~ ~~Type of Measure: Process~~

1936 Continuity of Antipsychotic Medications for Treatment of Schizophrenia

Data Source: Administrative claims
Measure Steward: National Committee for Quality Assurance

Steering Committee In-Person April 17-18, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact; 1b. Performance Gap; 1c. Evidence)
1a. Impact: H-15; M-4; L-0; I-1; 1b. Performance Gap: H-11; M-6; L-3; I-0; 1c. Evidence: Y-18, N-0, I-2
Rationale:

- This measure was paired with #1935 Use of any antipsychotic medications (NCQA). The Steering Committee agreed continuity of antipsychotic medications for the treatment of schizophrenia is a high impact area; individuals with schizophrenia have extensive clinical needs and high cost expensitures.
- While there is a larger performance gap for Medicaid patients than for Medicare patients, overall the performance gap is very small with a mean of 93 percent.
- The Steering Committee was concerned that evidence regarding the impact of a single antipsychotic prescription is limited, but agreed sufficient evidence was presented showing that treating people consistently with the appropriate antipsychotic medications has positive patient and health system benefits.
- The Committee questioned why the measures target patients 25 and older, rather than a population beginning at 18 years.
    - The developer explained their technical advisory group recommended the age based on epidemiological evidence that a clear diagnosis of schizophrenia or schizo-affective disorder may not be possible until age 25. Age 25 was chosen to increase specificity, which in turn may have lessened the sensitivity of the measure.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-2; M-16; L-1; I-1; 2b. Validity: H-3 ; M-15 ; L-2; I-0
Rationale:

- The reliability testing for this measure was somewhat skewed by small numbers, but the task force working on the measure felt the data was reliable for the population. The measure was tested using Medicaid fee-for-service data only, through the use of Medicaid Analytic Extract (MAX) files. The developer did not have access to Medicare data, so dual-eligibles were not included, and state specific codes for behavioral healthcare were also not included as this information is not in MAX files.
- Face validity was demonstrated through the use of technical expert groups, Medicaid directors and other relevant focus groups.
- Steering committee members were concerned about the issue of over-prescribing of antipsychotics and questioned whether an optimal adherence rate is possible, particularly whether the 80 percent rate in the measure was optimal.
    - The developer stated the evidence showed the average adherence rate was approximately 64 percent--which is too low, and there was variability in rates across states.
    - The measure testing techniques and results underwent a public comment period and the majority of comments were very positive.

3. Usability: H-5; M-15; L-0; I-0
(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)
Rationale:

- The usability of the measure was assessed through a variety of focus groups including state Medicaid directors, practitioners and consumers; at those levels the measure was rated positively for quality improvement, as well as accountability purposes.
- The measure has been proposed for inclusion in HEDIS, but has not yet been included at the health plan level. The measure would be most useful for quality improvement and public reporting at the population, health plan or state levels as specified.

4. Feasibility: H-1; M-19; L-0; I-0
(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
Rationale:

- Collection of this data is a routine part of care and can be extracted from claims data.
- Steering committee members suggested that using both state level data and plan level data could improve the feasibility of

1936 Continuity of Antipsychotic Medications for Treatment of Schizophrenia
~~implementing the measure.~~ ~~o The developer explained that they are working on accessing both Medicaid and Medicare data.The feasibility of including dual-eligibles in the measure depends on the extent to which states have access to Medicare data. CMS has made strides in the past year to improving access to the Medicare data to the states so they could combine Medicaid and Medicare data.~~
~~Steering Committee Recommendation for Endorsement: Y-18; N-2~~ ~~Rationale:~~ ~~• The measure represents an opportunity to improve the quality of care for patients with schizophrenia and may provide empirical evidence which may be used as a basis for future interventions. The measure was assessed to be important, reliable, valid, useful and feasible~~ ~~RECOMMENDATIONS:~~ ~~• The measure pair directly competes with measure #1879 Adherence to Antipsychotics for Individuals with Schizophrenia (CMS).~~ ~~o The developers have agreed to harmonize the measures #1936 and #1879; the areas for harmonization include: the inclusion criteria for the population starting at 18 years and 25 years, the use of two prescription claims vs. one prescription claim, excluding dementia and including pregnancy in the population. Measure #1935, which was paired with this measure, was withdrawn from consideration as part of the harmonization process.~~
~~Public & Member Comment~~ ~~Comments included:~~ ~~• CMS expressed support for the CMS-NCQA proposed strategy for measure harmonization of measures 1879 and 1936.~~

Screening Measures

1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
New Measure Description: The percentage of individuals 25 – 64 years of age with schizophrenia or bipolar disorder, who were prescribed any antipsychotic medication, and who received a diabetes screening during the measurement year. Numerator Statement: One or more glucose or HbA1c tests performed during the measurement year. Denominator Statement: Adults age 25 years and older as of December 31 of the measurement year with schizophrenia or bipolar disorder diagnosis and who were prescribed any antipsychotic medication. Exclusions: Individuals are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify individuals with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify the eligible population, but the individual only needs to be identified by one method to be included in the measure. Pharmacy data. Individuals who were dispensed insulin or oral hypoglycemics/antihyper-glycemics during the measurement year or year before the measurement year on an ambulatory basis. Claim/encounter data. Individuals who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Codes to identify diabetes: ICD-9 CM Diagnosis: 250, 357.2, 362.0, 366.41, 648.0 Prescriptions to identify individuals with diabetes: Alpha-glucosidase inhibitors: acarbose, miglitol Amylin analogs: pramlinitide Antidiabetic combinations: glimepiride-pioglitazone, glimepiride-rosiglitazone, glipizide-metformin, glyburide-metformin, metformin-pioglitazone, metformin-rosiglitazone, metformin-sitagliptin, saxagliptin, insulin aspart, insulin aspart-insulin aspart protamine, insulin

1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications

detemir, insulin glargine, insulin glulisine, insulin inhalation, insulin isophane beef-pork, insulin isophane human, insulin isophane-insulin regular, insulin lispro, insulin lispro-insulin lispro protamine, insulin regular human, insulin zinc human
Meglitinides: nateglinide, repaglinide
Miscellaneous antidiabetic agents: exenatide, liraglutide, metformin-repaglinide, sitagliptin
Sulfonylureas: acetohexamide, chlorpropamide, glimepiride, glipizide, glyburide,
tolazamide, tolbutamide
Thiazolidinediones: pioglitazone, rosiglitazone

Codes to identify visit type:
Outpatient:
CPT: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
UB Revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient:
CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
UB Revenue: 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
UB Revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987
ED:
CPT: 99281-99285
UB Revenue: 045x, 0981
Adjustment/Stratification: N/A
Level of Analysis: Health Plan/Population: State
Type of Measure: Process
Data Source: Administrative Claims
Measure Steward: National Committee for Quality Assurance

Steering Committee In-Person April 17-18, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact; 1b. Performance Gap; 1c. Evidence)
1a. Impact: H-15; M-4; L-0; I-0; 1b. Performance Gap: H-15; M-5; L-0 I-0; 1c. Evidence: Y-,12 N-1, I-7
Rationale:

- The Steering Committee agreed the measure addresses a high impact area as individuals with schizophrenia or bipolar disorder have nearly two times the risk for diabetes due to use of antipsychotic medications.
- The Committee was concerned the measure included only schizophrenia and bipolar patients when patients with other diagnoses may be appropriate to include as well.
    - The developer explained the focus is due to the particular risk of the target population, who tend to use the medication for a long time period. On average individuals with schizophrenia and bipolar disease die 25 years earlier than the general population.
- A gap in performance was shown at the state level where the mean value per state was 12.1 percent, and the maximum was 28 percent - individuals with schizophrenia or bipolar are not screened for diabetes as often as they should be.
- The Steering Committeed agreed that the there was strong evidence to support the measure.
- Committee members expressed an interest in seeing additional evidence to explore whether or not additional diagnoses should be included in the measure, such as a body mass index or the presence of metabolic syndrome.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-13; M-0; L-5; I-2; 2b. Validity: H-14; M-0; L-5; I- 1
Rationale:

- The Steering Committee was concerned by the one-year measurement time window, asking whether more periodic screening should be specified.
    - The developer stated that this timeframe was also reviewed by their technical expert panel, which noted the earlier

1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
test is often used a baseline, and then measured again once the individual has been on the medication. • The Committee agreed the reliability results showed good test/retest capability. Overall, 4 of the 16 states in the test had no change in performance across the quartiles. State performance for this measure correlated at .33 level and accounted for 11 percent of the variance in the 2008 scores. • The measure demonstrated face validity through the use of a technical expert panel and focus groups. The developers also looked at how the measure related to hospitalization, and found that there was a higher hospitalization rate in the states that had lower screening rates. States that performed at the bottom quartile had approximately 24 percent of their enrollees with schizophrenia hospitalized compared to 18 percent in the states that were in the top quartile of performance for this measure.
3. Usability: H-4; M-14; L-1; I- 0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The Committee agreed the measure is usable.
4. Feasibility: H-4; M-15; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The Committee agreed the measure was feasible as it relies on administrative claims data.
Steering Committee Recommendation for Endorsement: Y-13; N-7 Rationale: • The measure represents an opportunity to improve the quality of care for patients with schizophrenia and bipolar disorder and may provide empirical evidence which may be used as a basis for future interventions. The measure was assessed to be important, reliable, valid, useful and feasible. Recommendations: • It was recommended that this measure be harmonized with existing NQF endorsed measure #0003 Bipolar Disorder: Assessment for Diabetes (Centers for Quality Assessment and Improvement in Mental Health). The areas for harmonization include level of testing at either the individual or group clinical level vs. the state level, inclusion of those ages 18 and older vs. those 25 and older, the exclusion of patients with diabetes and the use of claim and chart abstractions vs. claim data only.
Public & Member Comment Comments included: • No comments were received for this measure.

1927 Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
New Measure Description: The percentage of individuals 25 – 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication who received a cardiovascular health screening during the measurement year. Numerator Statement: One or more LDL-C screenings. Denominator Statement: Adults age 25 and older as of December 31 of the measurement year with a diagnosis of schizophrenia or bipolar disorder who were prescribed any antipsychotic medication. Exclusions: Individuals are excluded from the denominator if they were discharged alive for a coronary artery bypass graft or percutaneous coronary intervention (these events may occur in the measurement year or year prior to the measurement year), or diagnosed with ischemic vascular disease (this diagnosis must appear both the measurement year and the year before the measurement year), chronic heart failure, or had a prior myocardial infarction (identified in the measurement year or as far back as possible). Adjustment/Stratification: N/A Level of Analysis: Health Plan; Population: State

1927 Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications

Type of Measure: Process
Data Source: Administrative Claims
Measure Steward: National Committee for Quality Assurance

Steering Committee In-Person April 17-18, 2012

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

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)
1a. Impact: H-7; M-9; L-2; I-1; 1b. Performance Gap: H-8; M-7; L-2; I-2; 1c. Evidence: Y-8, N-3, I-7
Evidence Exception *(expert opinion was systematically assessed with agreement that the benefits of the measured process or structure to patients greatly outweigh the potential harms, there is exceptional and compelling reason that the measure should be considered further)* Y-10, N-8
Rationale:

- The Steering Committee agreed the measure addresses a high impact area, as individuals with schizophrenia or bipolar disorder are at a greater risk for cardiovascular disease due to lifestyle risk factors, and high non-treatment rates for hyperlipidemia among people with schizophrenia.
- Committee members questioned why cholesterol was the focus rather than tobacco use--the main risk factor for cardiovascular disease in people with mental illness--and obesity.
    - The developer responded that the focus on cholesterol as a risk factor is due to the availability of data from claims.
- The Committee noted that there was overall poor performance with little variation – the 25th percentile was 42 percent, the median was 46 percent, the 75th percentile was 51 percent. The research submitted shows that patients in this population receive cholesterol screening 25 percent less often than the general population, which demonstrates a significant performance gap.
- The Committee noted a lack of evidence regarding the relationship between adherence and desired outcome or improved treatment/diagnosis.
    - The developer stated that there is not a great deal of specific empirical data on patients with schizophrenia and LDL screening for schizophrenics, but there is good evidence of high rates of cardiovascular disease unrecognized in schizophrenics – which demonstrates the need for such a measure.
- The Committee agreed the measure did not meet the evidence criterion, but an exception was warranted as the benefits to patients of screening outweighed potential harm. The measure is a state measure intended to help improve systems, and clearly this population is at higher risk. Screening is a necessary step along the way to improving the health of this population.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-0; M-14; L3-; I-0; 2b. Validity: H-0; M-13; L-3; I-2
Rationale:

- The Committee noted potential difficulties of having individuals with schizophrenia or bipolar fast prior to LDL testing, which is usually done with a panel of other cholesterol tests (HDL, VLDL, LDL) that do require the patient to fast.
- The Steering Committee found the reliability testing in the measure was clear, using data from 16 states of the 22 states. The states that were not included were due to small sample size in the denominator. The reliability testing was based on the stability of performance at the state level and 56 percent of the states found no change between two years. The correlation of the data was moderate at .43.
- The measure's validity was assessed by establishing face validity from the review done by multi-stakeholder technical advisory groups, state Medicaid health commissioners and focus groups from several organizations. Concurrent validity was based on correlation with other quality indicators related to screening, which was found to be high, along with the ED use for schizophrenia.
    - The measure developer explained that there is a negative relationship between screenings, and there was an assumption that ED use for schizophrenics may be an adverse event. The potential threats to validity were not examined.

3. Usability: H-1; M-12; L-5; I-0

1927 Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The Committee agreed this measure was usable.
4. Feasibility: H-0; M-12; L-6; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The Committee agreed moderate feasibility is demonstrated; however, expressed concerns regarding required patient fasting prior to testing and a trend toward co-pays for lab results, the cost of which may discourage patients from being tested.
Steering Committee Recommendation for Endorsement: Y-10; N-8 Rationale: • The measure was assessed to be important, reliable, valid, useful and feasible. The Committee invoked the evidence exception for this measure. RECOMMENDATION: • The Steering Committee suggested that capturing obesity, nicotine use in addition to LDL in the measure would strengthen the measure. However, due to the lack of evidence and limited availability of data, the use of LDL screening can be used as a baseline for measuring cardiovascular health for those with schizophrenia and bipolar disorder.
Public & Member Comment Comments included: • No comments were received for this measure.

1933 Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia
New Measure Description: The percentage of individuals 25 – 64 years of age with a schizophrenia diagnosis and a diagnosis of cardiovascular disease who received a cardiovascular health monitoring test (LDL-C) during the measurement year. Numerator Statement: One or more LDL-C tests performed during the measurement year. Denominator Statement: Adults 25 years and older as of December 31 of the measurement year with a diagnosis of schizophrenia and cardiovascular disease. Exclusions: N/A Adjustment/Stratification: N/A Level of Analysis: Health Plan, Population: State Type of Measure: Process Data Source: Administrative Claims Measure Steward: National Committee for Quality Assurance
Steering Committee In-Person April 17-18, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-10; M-7; L-1; I-0; 1b. Performance Gap: H-6; M-11;L-0; I-1; 1c. Evidence: Y-15, N-1, I-2 Rationale: • This measure addresses a high impact area. • This measure was modeled from the general population HEDIS measure monitoring individuals with established cardiovascular disease, the only difference is the denominator population, which is comprised of schizophrenics with cardiovascular disease. The data shows a 26 percent higher rate for monitoring in the general population versus monitoring in the schizophrenic population. •
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

1933 Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia
2a. Reliability: H-1; M-13; L-4; I-0; 2b. Validity: H-;2 M-15; L-2; I-0 Rationale: • The Committee agreed the reliability of the measure was demonstrated by the testing. • The measure's validity was assessed by establishing face validity from the review done by multi-stakeholder technical advisory groups, state Medicaid health commissioners and focus groups from several organizations. Concurrent validity was based on correlation with other quality indicators related to monitoring. • The Committee noted the same concerns with usability as they did in #1927, noting potential difficulties of individuals with schizophrenia or bipolar fasting prior to LDL testing, which is usually done with a panel of other cholesterol tests (HDL, VLDL, LDL) that do require the patient to fast.
3. Usability: H-2; M-12; L-4; I- 0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The Steering Committee agreed this measure was usable.
4. Feasibility: H-1; M-12; L-5; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The Committee agreed feasibility is demonstrated; however, expressed concerns regarding required patient fasting prior to testing and a trend toward co-pays for lab results, the cost of which may discourage patients from being tested.
Steering Committee Recommendation for Endorsement: Y-16; N-2 Rationale: • The measure was assessed to be important, reliable, valid, useful and feasible.
Public & Member Comment Comments included: • No comments were received for this measure.

1934 Diabetes monitoring for people with diabetes and schizophrenia
Description: The percentage of individuals 25 – 64 years of age with schizophrenia and diabetes who received diabetes monitoring as specified by an HbA1c test and LDL-C test during the measurement year. Numerator Statement: One or more HbA1c tests and one or more LDL-C tests performed during the measurement year. Denominator Statement: Adults age 25 years and older as of December 31 of the measurement year with a schizophrenia and diabetes diagnosis. Exclusions: N/A Adjustment/Stratification: N/A Level of Analysis: Population : State Type of Measure: Process Data Source: Administrative Claims Measure Steward: National Committee for Quality Assurance
Steering Committee In-Person April 17-18, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-10; M-6; L-; I-; 1b. Performance Gap: H-8; M-8; L-0; I-0; 1c. Evidence: Y-13, N-1, I-2 Rationale: • This measure addresses a high impact area as studies cite that one-third of individuals with both diabetes and schizophrenia do not receive treatment. • This measure was based on the HEDIS measure that focuses on monitoring of individuals with a diagnosis of diabetes but focuses on a subset of patients who also have a diagnosis of schizophrenia. The performance rate found within the diabetes measure was 70 to 80 percent, while the rate of the subset of patients who also have schizophrenia was 50 percent.

1934 Diabetes monitoring for people with diabetes and schizophrenia
• The Committee discussed the possibility of this measure being included as a strata within the existing NQF-endorsed measure #0057 Diabetes: Hemoglobin A1c testing (NCQA). A key difference between the two measures is the diabetes measure includes individuals 18 to 75 years of age and the measure before the Committee includes those 25 to 64 years of age. The developer is willing to reconcile the measures.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-1; M-15; L-1; I-0; 2b. Validity: H-1; M-15; L-1; I-0 Rationale: • The Committee agreed reliability of the measure was demonstrated. • Face validity was assessed by multi-stakeholder technical advisory groups, state Medicaid health commissioners and focus groups from several organizations. Concurrent validity was based on high correlation with other quality indicators related to monitoring.
3. Usability: H-0; M-17; L-0; I- 0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The Steering Committee agreed this measure was usable.
4. Feasibility: H-1; M-15; L-1; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The Committee agreed feasibility is demonstrated; however, expressed concerns regarding required patient fasting prior to testing and a trend toward co-pays for lab results, the cost of which may discourage patients from being tested.
Steering Committee Recommendation for Endorsement: Y-17; N-0 Rationale: • The measure was assessed to be important, reliable, valid, useful and feasible. RECOMMENDATIONS: • The Steering Committee discussed the possibility of this measure being included as a strata within the existing NQF-endorsed measure #0057 Diabetes: Hemoglobin A1c testing (NCQA) and #0063 Diabetes: Lipid profile (NCQA). o NCQA will incorporate the new measure as a subset or target population within the more broadly defined NQF endorsed measures (#0057 and #0063) following the member voting period and CSAC/Board review.
Public & Member Comment Comments included: • No comments were received for this measure.

Post Care Follow-up Measures

1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
New Measure Description: The percentage of discharges for individuals 25 – 64 years of age who were hospitalized for treatment of schizophrenia and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. •The percentage of individuals who received follow-up within 30 days of discharge •The percentage of individuals who received follow-up within 7 days of discharge Numerator Statement: 30-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Denominator Statement: Adults 25 – 64 years of age of December 31 of the measurement year Discharged alive from an acute

1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
inpatient setting (including acute care psychiatric facilities) with a principal schizophrenia diagnosis. Exclusions: Schizophrenia readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a schizophrenia 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. 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 non-acute facility for a schizophrenia 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. 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 non-acute facility for a non-mental health principal diagnosis. These discharges are excluded from the measure because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place. Adjustment/Stratification: N/A Level of Analysis: Population : State Type of Measure: Process Data Source: Administrative claims Measure Steward: National Committee for Quality Assurance
Steering Committee In-Person April 17-18, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-6; M-7; L-1; I-0; 1b. Performance Gap: H-10; M-4; L-0; I-0; 1c. Evidence: Y-13, N-1, I-0 Rationale: • The Committee believes this measure addresses a high impact area, as individuals with schizophrenia have high cost healthcare expenditures and typically lack follow-up post hospitalization. • This measure demonstrates a high performance gap area, as evidence shows that follow-up is a significant problem for individuals with schizophrenia compared to the general population.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-8; M-6; L-0; I-0; 2b. Validity: H-5; M-8; L-0; I-0 Rationale: • The Committee agreed the measure demonstrated reliability and validity: o The developer conducted an analysis of test-retest reliability for state results to assess the reliability of state-level performance. Stability over time was tested by computing quartiles of performance based on the state distribution for each measure and assigning each state a score reflecting performance relative to other states in the distribution during the measurement years 2007 and 2008. The developer also reported Pearson correlations measuring the association between 2007 and 2008 measure performance for the 16 states with data. o The measure showed good to modest test-retest reliability with no change in performance quartile between 2007 and 2008. Performance was correlated at r=0.173 and r=.202, respectively, for 7- and 30-day follow-up, indicating that 2007 performance on this measure accounted for 3% and 4%, respectively of the variance in 2008 scores. o The developer demonstrated face validity, as the Technical Advisory Group overseeing development of the measure and focus groups deemed the measures important, usable and feasible to collect. Concurrent validity, as beneficiaries in the lowest performing states had higher rates of schizophrenia related hospitalization, comparing 7 and 30 day rates; and concurrent and discriminant validity, as the 7-day follow-up measure was correlated with 30-day follow-up measure (r=.495). Additionally, the 7- and 30-day follow-up measure was correlated with high antipsychotic continuity (r=.103 and r=.153, respectively).
3. Usability: H-3; M-10; L-0; I-1 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The measure is easily understood and was rated as meaningful, understandable, and useful for public reporting by participants in focus groups. Those groups included representatives from State Medicaid programs, for whom the measure is intended to be used for public reporting, and quality improvement and benchmarking.

1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
4. Feasibility: H-7; M-6; L-0; I-1 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Performance data are captured in claims/encounter systems. • The Committee noted there may be difficulty following up with individuals due to socioeconomic issues such as homelessness or living in group housing, which is difficult to capture in administrative data. • The Committee noted poverty, crime and living in unsafe neighborhoods all play a role in the difficulty to ensure adequate follow up with these patients.
Steering Committee Recommendation for Endorsement: Y-13; N-1 Rationale: • This is an important area for measurement, as there are few measures of quality related to follow up and transition of care over time particularly in this population. Recommendation: • The Steering Committee discussed the possibility of including this measure as strata within the existing NQF-endorsed measure #0576 Follow-Up After Hospitalization for Mental Illness (NCQA). o NCQA agreed to incorporate the new measure #1937 as a subset or target population within the more broadly defined measure #0576 following the member voting period and CSAC/Board reviews.
Public & Member Comment Comments included: • No comments were received for this measure.

0576 Follow-Up After Hospitalization for Mental Illness
Maintenance Measure Description: 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. Numerator Statement: Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. 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 a 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 re-hospitalization might not be for a selected mental health disorder, it is probably for a related condition. 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 non-acute facility for a 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 to Table FUH-B for codes to identify non-acute care. Non-mental health readmission or direct transfer: Exclude discharges in which the patient was transferred directly or readmitted within m0 days after discharge to an acute or non-acute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables MPT-A and MPT-B. These discharges are excluded from the measure because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

0576 Follow-Up After Hospitalization for Mental Illness

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 non-acute 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 non-acute 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 non-acute facility for a non-mental health principal diagnosis. These discharges are excluded from the measure because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Adjustment/Stratification: N/A
Level of Analysis: Clinician : Team, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record
Measure Steward: National Committee for Quality Assurance

Steering Committee In-Person April 17-18, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact; 1b. Performance Gap; 1c. Evidence)
1a. Impact: H-6; M-7; L-1; I-0; 1b. Performance Gap: H-10; M-4; L-0; I-0; 1c. Evidence: Y-13, N-1, I-0
Rationale:

- The Committee believes this measure addresses a high impact area, as individuals with schizophrenia have high cost healthcare expenditures and typically lack follow-up post hospitalization.
- The measure has been reported in HEDIS for 10 years, the average performance rate at seven days is 45 to 50 percent. Over time, the rate has improved but the Medicaid rates remain very low. At 30 days the rate is closer to 70 percent.
- The Committee agreed the evidence presented demonstrates that outcomes are poorer when follow up does not occur.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-8; M-6; L-0; I-0; 2b. Validity: H-5; M-8; L-0; I-0
Rationale:

- The Steering Committee agreed reliability and validity of the measure was demonstrated.
    - The developer used a beta-binomial approach to estimate reliability using a 0.0 to 1.0 reliability score, where a minimum reliability score of 0.7 is used to indicate sufficient signal strength to discriminate performance between accountable entities. The results for the percentage of members who received follow-up within 30 days of discharge were 0.949 or better for Commercial, Medicaid and Medicare populations, and the results for members who received follow-up within 7 days of discharge were 0.95 or better for the three populations.
    - The measure was written, field-tested, and presented to the CPM and incorporated into HEDIS in 1994

3. Usability: H-3; M-10; L-0; I-1
(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*
Rationale:

- The measure is easily understood and currently in use for public reporting, regulatory accreditation programs, qualty improvement, benchmarking, external benchmarking over multiple organizations and then internal quality improvement within a specific organization.
- The Committee noted that if the measure received continued endorsement, the developer should review its usefulness for additional populations.

4. Feasibility: H-7; M-6; L-0; I-1
(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
Rationale:

- There may be difficulty following up with individuals due to socioeconomic issues such as homelessness or living in group housing, which is difficult to capture in administrative data.
- The Committee noted poverty, crime and living in unsafe neighborhoods all play a role in the difficulty to ensure adequate

0576 Follow-Up After Hospitalization for Mental Illness
follow up with these patients.
Steering Committee Recommendation for Endorsement: Y-13; N-1 Rationale: • There are few measures of quality related to follow up and transition of care over time. This measure has been in use over 10 years and addresses a population for which follow-up is critical. Recommendation: • The Steering Committee discussed the possibility of including #1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) (NCQA) as strata for the schizophrenic population within this measure. o NCQA agreed to incorporate the new measure #1937 as a subset or target population within the more broadly defined measure #0576 following the member voting period and CSAC/Board reviews. • Committee members suggested highly vulnerable groups who receive disparate care, including the fragile elderly, should be included in the measure, and extending the target age beyond 64 should be considered.
Public & Member Comment Comments included: • No comments were received for this measure.

MEASURES NOT RECOMMENDED

Emergency Department Utilization

1938 Emergency department utilization for mental health conditions by people with schizophrenia
Description: The percentage of individuals 25 – 64 years of age with a schizophrenia diagnosis who had an emergency department admission for mental health. Numerator Statement: An admission to the ED with a mental health diagnosis. Denominator Statement: Adults 25 – 64 years of age as of December 31 of the measurement year with a schizophrenia diagnosis. Exclusions: N/A Adjustment/Stratification: N/A Level of Analysis: Population: State, Health Plan Type of Measure: Process Data Source: Administrative claims Measure Steward: National Committee for Quality Assurance
Steering Committee In-Person April 17-18, 2012
1. Importance to Measure and Report: The measure did not meet the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-0; M-1; L-4; I-11; b. Performance Gap: H-; M-; L-; I-; 1c. Evidence: Y-, N-, I- Rationale: • The measure seeks to demonstrate the rate at which patients with schizophrenia utilize the emergency department; however, it is unknown whether or not the visit has a positive or negative affect on the outcome. • The evidence appears contradictory because the relative rates of emergency department utilization may be reflective of either inappropriate use or demonstrate barriers to care. The increased use of services may be driven by either increased severity of mental illness and medical disorders. o The measure developer stated that the purpose of the measure was to use the rates to understand how to potentially avoid hospitalizations. • The Steering Committee believes this measure may be more appropriate as a measure used to gauge disengagement rather than using this as an accountability measure for comparison across states. • This measure may have the unintended consequence of showing overutilization of emergency departments by schizophrenics and could possibly negatively impact reimbursement if they are deemed unncessary. This may discourage patients with a

1938 Emergency department utilization for mental health conditions by people with schizophrenia
diagnosis of schizophrenia from seeking care. • Because the measure did not pass the impact subcriteria, the remaining subcriteria for importance were not evaluated.
Steering Committee Recommendation for Endorsement: Y-; N- Rationale: • The measure did not pass the Importance to Measure and Report criteria. RECOMMENDATIONS: • A measure related to follow-up after an emergency department visit might better address the concerns this measure attempts to resolve.
Public & Member Comment Comments included: • No comments were received for this measure.

MEASURES DEFERRED

Endorsement decisions for seven tobacco and alcohol related Joint Commission measures have been deferred to the second phase of the Behavioral Health project. The measures passed the Importance to Measure and Report criterion, but the consensus of the Committee was that scientific acceptability was not met at this time. The Joint Commission has indicated that they are continuing to test the measures and will provide additional test data to the Steering Committee on the revised measures by late 2012 or early 2013 so that the measures may complete the endorsement process. The measures have been deferred for further consideration until that time. The seven deferred measures include:

- #1654 TOB-2 Tobacco Use Treatment Provided or Offered (and the subset measure TOB-2a Tobacco Use Treatment)
- #1656 TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge
- #1657 TOB-4 Tobacco Use: Assessing Status after Discharge
- #1661 SUB-1 Alcohol Use Screening
- #1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
- #1664 SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
- #1665 SUB-4 Alcohol and Drug Use: Assessing Status After Discharge

WITHDRAWN FROM CONSIDERATION

Measure #1926 Cervical cancer screening for women with schizophrenia (NCQA) was withdrawn prior to Steering Committee review. In the time between submission and review, the U.S. Preventative Services Task Force (USPSTF) issued new recommendations regarding cervical cancer screening for women. The NCQA is currently reevaluating the overall cervical cancer screening measure #0032 Cervical Cancer Screening (NCQA), as well as #1926 Cervical cancer screening for women with schizophrenia (NCQA), which focuses specifically

on women with schizophrenia. NCQA plans to resubmit the measure after it has been reevaluated to be consistent with the updated USPSTF guidelines.

The Steering Committee evaluated three similar measures related to adherence to antipsychotic medication for patients with schizophrenia (#1879 and measure pair #1935 and #1936), and agreed it was preferable to recommend a single, harmonized measure rather than multiple, overlapping measures.

As a result of the developers' work, measures #1935 and #1936 have been withdrawn from consideration. Measures #1936 and #1879 have been combined into one harmonized measure, #1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia, stewarded by CMS, which is now open for member vote.

APPENDIX A - MEASURE SPECIFICATIONS

	0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Status	Maintenance, Original Endorsement: Aug 10, 2009
Steward	National Committee for Quality Assurance
Description	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). URL http://www.ncqa.org/tabid/370/default.aspx
Level	Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Behavioral Health/Psychiatric : Outpatient, Emergency Medical Services/Ambulance, Hospital/Acute Care Facility
Numerator Statement	a) Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis. • If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant • If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with an AOD diagnosis (Table IET-A) within 14 days of the IESD (inclusive) – If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive) • Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment b) Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations (Table IET-B) with any AOD diagnosis (Table IET-A) within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period. • If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive). •Do not count engagement encounters that include detoxification codes (including inpatient detoxification)
Numerator Details	Time Window: 44 days after diagnosis. Table IET-A: Codes to Identify AOD Dependence ICD-9-CM Diagnosis 291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1 Table IET-B: Codes to Identify Outpatient, Intensive Outpatient and Partial Hospitalization Visits CPT: 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510 HCPCS: G0155, G0176, G0177, G0396, G0397, G0409-G0411, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012 UB Revenue: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983 CPT: 90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876

	0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	WITH POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72 CPT: 90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255 WITH POS: 52, 53 Table IET-C: Codes to Identify Detoxification Visits HCPCS: H0008-H0014 ICD-9-CM Procedure:94.62, 94.65, 94.68 UB Revenue: 0116, 0126, 0136, 0146, 0156 Table IET-D: Codes to Identify ED Visits CPT: 99281-99285 UB Revenue: 045x, 0981 Table IET-E: Codes to Identify AOD Procedures ICD-9-CM Procedure: 94.61, 94.63, 94.64, 94.66, 94.67, 94.69
Denominator Statement	Members age 13 years of age and older with a medical and chemical dependency benefit who were diagnosed with a new episode of alcohol and drug dependency (AOD) during the intake period of January 1-November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.
Denominator Details	Time Window: The Intake Period, which is January 1 through November 15 of the measurement year. For commercial, Medicaid and Medicare product lines, and for members with a medical and chemical dependency benefit who meet the continuous enrollment criteria of 60 days prior to the index episode start date through 44 days after the index episode start date. Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following. • An outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with a diagnosis of AOD (Table IET-A) • A detoxification visit (Table IET-C) • An ED visit (Table IET-D) with a diagnosis of AOD (Table IET-A) • An inpatient discharge with a diagnosis of AOD as identified by either of the following. – An inpatient facility code in conjunction with a diagnosis of AOD (IET-A) – An inpatient facility code in conjunction with an AOD procedure code (IET-E) For members with more than one episode of AOD, use the first episode. For members whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge. Select the IESD. Test for Negative Diagnosis History and calculate continuous enrollment. Members must be continuously enrolled without any gaps 60 days (2 months) before the IESD through 44 days after the IESD.
Exclusions	Exclude members who had a claim/encounter with a diagnosis of AOD (Table IET-A) during the 60 days (2 months) before the IESD. For an inpatient IESD, use the admission date to determine the Negative Diagnosis History. For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. Exclude from the denominator members whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.
Exclusion Details	Exclude members who had a claim/encounter with a diagnosis of AOD (Table IET-A) during the 60 days (2 months) before the IESD. Table IET-A: Codes to Identify AOD Dependence ICD-9-CM Diagnosis 291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. Step 2. Search administrative systems to identify numerator events for all members in the eligible population. Step 3. Calculate the rate.
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	0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Disclaimer	1100 13th Street, NW, Suite 1000 Washington, DC 20005 These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

	0027 Medical Assistance With Smoking and Tobacco Use Cessation
Status	Maintenance, Original Endorsement: 10-Aug-09
Steward	National Committee for Quality Assurance
Description	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.
Type	Process
Data Source	Patient Reported Data/Survey CAHPS Health Plan Survey 4.0H, Adult Version; Medicare CAHPS URL https://www.cahps.ahrq.gov/default.asp
Level	Health Plan
Setting	Ambulatory Care : Clinician Office, Other In addition to clinician visits, some respondents may recall other contacts with clinicians or health plans (e.g. smoking cessation classes)
Numerator Statement	Component 1: Advising Smokers and Tobacco Users to Quit (ASTQ) Received advice to quit smoking Component 2: Discussing Cessation Medications (DSCM) Received discussion/recommendations on smoking cessation medications Component 3: Discussing Cessation Strategies (DSCS) Received discussion/recommendations on smoking cessation methods and strategies
Numerator Details	Time Window: This measure is collected annually via patient survey using the CAHPS 4.0H, Adult Version (Commercial and Medicaid Product lines) and Medicare CAHPS survey. For Commercial and Medicaid product lines: Advising Smokers and Tobacco Users to Quit: The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider. CAHPS question: Q46. In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan? Discussing Smoking Cessation Medications The number of members in the denominator who indicated that medication to assist with quitting smoking was recommended or discussed. CAHPS question: Q47. In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication. Discussing Cessation Strategies The number of members in the denominator who indicated that their doctor or health provider recommended or discussed methods and strategies other than medication to assist with quitting smoking. CAHPS question: Q48. In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helping, individual group counseling, or cessation program.

	0027 Medical Assistance With Smoking and Tobacco Use Cessation
	Response Options for all questions: Never, Sometimes, Usually, Always For the Medicare Product line: Advising Smokers or Tobacco Users to Quit The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider CAHPS question: Q58. In the last 6 months, on how many visits were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan? Response Options for all questions: Never, Sometimes, Usually, Always
Denominator Statement	Patients 18 years and older who responded to the survey and indicated that they were current smokers or tobacco users
Denominator Details	Time Window: 1 year For the Commercial and Medicaid Product Lines: Number of members who responded to the survey and indicated that they were current tobacco users and supplied an answer to the next survey question on advice to quit. Member response choices must be as follows to be included in the denominator: Do you now smoke cigarettes or use tobacco every day, some days, or not at all? Response Choices: Every day, Some days, Not at all, Don´t know Response must = Every day OR Some days In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan? Response Choices: Never, Sometimes, Usually, Always Response must = Never OR Sometimes OR Usually OR Always For the Medicare Product Lines: The number of members who responded to the survey and indicated that they were current smokers or tobacco users and had one or more visits during the measurement year, and supplied an answer to the next survey question on advice to quit.. The member responses must be as follows to be included in the denominator: Do you now smoke cigarettes or use tobacco every day, some days, or not at all? Response choices: Never, Sometimes, Usually, Always Response must = Every day or Some days In the last 6 months, on how many visits were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan? Response choices: Never, Sometimes, Usually, Always Response must = Never OR Sometimes OR Usually OR Always The Medicare results for the Advising Smokers and Tobacco Users to Quit Rate requires a minimum denominator of at least 30 responses.
Exclusions	None
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	None
Type Score	Rate/proportion better quality = higher score
Algorithm	For the commercial and Medicaid product lines, rolling averages are calculated using the formula Rate = (Year 1 Numerator + Year 2 Numerator)/(Year 1 Denominator + Year 2 Denominator) If the denominator is less than 100, NCQA assigns a measure result of NA If the denominator is 100 or more, NCQA calculates the result. If the health plan did not report results for the current year (Year 2), NCQA assigns a measure result of NA If the health plan did not report results in the prior year (Year 1), but reports results for the current year and achieves a denominator of 100 or more, NCQA calculates a rate; if the denominator is less than 100, NCQA assigns a measure result of N/A.

	0027 Medical Assistance With Smoking and Tobacco Use Cessation
	For the Medicare product line, this is collected by the Centers for Medicare & Medicaid Services through the Medicare CAHPS Survey. This is collected on an annual basis. Rate = Year 1 Numerator / Year 2 Denominator
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	0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
Status	Maintenance, Original Endorsement: 10-Aug-09
Steward	American Medical Association - convened Physician Consortium for Performance Improvement (AMA-convened PCPI) Other organizations: The measure was developed by a multi-disciplinary, cross-speciality work group representing all key stakeholders and including representation from the following specialties, most of whom were sponsored by their medical specialty society: family medicine, internal medicine, geriatric medicine, gastroenterology, general surgery, colon & rectal surgery, infectious disease, radiology, cardiology, obstetrics & gynecology, emergency medicine, preventive medicine, occupational medicine, nursing, psychology, occupational therapy, chiropractics, dietetics, optometry.
Description	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Paper Medical Records Not applicable. Attachment NQF_Submission_Tobacco.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient, Other Occupational Therapy Evaluation
Numerator Statement	Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user *Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy
Numerator Details	Time Window: Once during measurement period For Electronic Health Record specifications - See attached for PCPI eSpecification; HQMF eMeasure under development For Claims/Administrative specifications - CPT II 1036F: Current tobacco non-user OR CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation counseling (intervention counseling, pharmacotherapy, or both), if identified as a tobacco user OR CPT Category I code-Smoking and tobacco-use cessation counseling *The following codes are applicable if the patient screened positive for smoking/tobacco use and counseling was provided.. 99406: Smoking/tobacco counseling 3-10 minutes 99407: Smoking/tobacco counseling greater than 10 minutes
Denominator Statement	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two-year measurement period
Denominator Details	Time Window: 24 consecutive months Note: for certain implementation programs that cannot support a 2 year measurement period, the measure can be reported within a 12 month period with a 24 month look back for the numerator details. For Electronic Health Record specifications - See attached for PCPI eSpecification; HQMF eMeasure under development For Claims/Administrative specifications - CPT E/M Service code:

	0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
	Two visits during the two year measurement period 99201, 99202, 99203, 99204, 99205 (Office/other outpatient services-new patient) 99212, 99213, 99214,99215 (Office/other outpatient services-established patient) 97003, 97004 (Occupational therapy evaluations) 90801, 90802 (Psychiatric diagnostic or evaluative interview) 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815 (Psychiatric therapeutic procedures-office or other outpatient) 90845, 90862, (Other Psychotherapy) 96150, 96151, 96152 (Health and Behavior Assessment/Intervention) OR CPT E/M Service Code: One preventive care visit during the two year measurement period 99385, 99386, 99387 (Initial comprehensive preventive medicine-new patient) 99395, 99396, 99397 (Initial comprehensive preventive medicine-established patient) 99401, 99402, 99403, 99404 (Preventive medicine, Individual Counseling) 99411, 99412 (Preventive medicine, Group Counseling) 99420 (Other preventive medicine services-administration and interpretation of health risk assmt) 99429 (Unlisted preventive) OR G-codes for annual wellness visit G0438, G0439
Exclusions	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0028, exceptions may include medical reason(s) (eg, limited life expectancy) for not screening for tobacco use. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For Electronic Health Record specifications - See attached for PCPI eSpecification; HQMF eMeasure under development For Claims/Administrative specifications - CPT II 4004F–1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, or other medical reason)
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets

	0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
	any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) (eg, limited life expectancy)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in data dictionary/code table attachment 2a1.30.
Copyright/ Disclaimer	Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians. These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures. Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures. THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND © 2008 American Medical Association. All Rights Reserved Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications. THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND. CPT® contained in the Measures specifications is copyright 2007 American Medical Association. See copyright statement above.

	0576 Follow-Up After Hospitalization for Mental Illness
Status	Maintenance, Original Endorsement: 4-Dec-09
Steward	National Committee for Quality Assurance
Description	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.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). URL http://www.ncqa.org/tabid/370/default.aspx
Level	Clinician : Team, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Behavioral Health/Psychiatric : Inpatient, Behavioral Health/Psychiatric : Outpatient
Numerator Statement	Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

	0576 Follow-Up After Hospitalization for Mental Illness
Numerator Details	Time Window: Date of discharge through 30 days after discharge Include outpatient 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: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255 with POS 52, 53 The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes. UB Revenue: 0513, 0900-0905, 0907, 0911-0917, 0919, Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table FUH-A. UB Revenue: 0510, 0515-0517, 0519-0523, 0526-0529, 077x, 0982, 0983
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 a 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 condition. 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 a 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 to Table FUH-B 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. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables MPT-A and MPT-B. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Denominator Details	Time Window: The measurement year For commercial, Medicaid and Medicare product lines, and for members with a medical and mental health benefit who meet the continuous enrollment criteria of the date of discharge through 30 days after discharge. Codes to Identify Mental Health Diagnosis ICD-9-CM Diagnosis: 295–299, 300.3, 300.4, 301, 308, 309, 311–314 Table FUH0B: 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, 28x; 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 facility: UB Revenue: 1002; POS 55 Psychiatric Residential Treatment Center: HCPCS: T2048, H0017-H0019; UB Revenue: 1001; POS 56 Comprehensive Inpatient Rehabilitation Facility: POS 61 Other nonacute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)
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.

	0576 Follow-Up After Hospitalization for Mental Illness
	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.
Exclusion Details	Use Codes identified in Table FUH-B in 2a1.7. Denominator Details.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. Step 2. Search administrative systems to identify numerator events for all members in the eligible population. Step 3. Calculate the rate.
Copyright/ Disclaimer	© 2012 by the National Committee for Quality Assurance 1100 13th Street, NW, Suite 1000 Washington, DC 20005 These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

	1651 TOB-1 Tobacco Use Screening
Status	New Submission
Steward	The Joint Commission
Description	Hospitalized patients age 18 years and older who are screened during the hospital stay for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days. This measure is intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-2 Tobacco Use Treatment Provided or Offered (during the hospital stay); TOB-3 Tobacco Use Treatment Provided or offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)
Type	Process
Data Source	Administrative claims, Paper Records Each data element in the data dictionary includes suggested data sources. The Joint Commission developed a web-based data collection tool that was used by hospitals and for reliability testing during the pilot test. When the measures are made part of Th Attachment Tobacco Treatment Data Dictionary.doc
Level	Facility, Population : National
Setting	Behavioral Health/Psychiatric : Inpatient, Hospital/Acute Care Facility
Numerator Statement	The number of patients who were screened for tobacco use status
Numerator Details	Time Window: Episode of care The patients in the numerator (those who were screened for tobacco use status) are a subset of the denominator. The data element "Tobacco Use Status" is used to screen or examine methodologically in order to make a separation into different groups. "Tobacco Use Status" is the only data element used to calculate the numerator. There are 14 allowable values that address the various tobacco products or combinations thereof and the volume used as well as the timeframe of use. Notes for abstraction are included along with suggested data sources. Full specifications can be viewed on the Joint Commission web site at the following link: http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/
Denominator	The number of hospitalized inpatients 18 years of age and older

	1651 TOB-1 Tobacco Use Screening
Statement	
Denominator Details	Time Window: Episode of care Four data elements are used to calculate the denominator: Admission Date, Birthdate, Discharge Date and Cognitive Impairment. 1. Admission Date - this is used to define the length of stay and to calculate the patient age 2. Birthdate - this data element calculates the patient age by subtracting the birthdate from the admission date. Patients less than 18 are excluded from the population 3. Discharge Date - this data element is used to calculate the hospital length of stay and exclude patients with a length of stay (LOS) of less than or equal to one day and those with LOS greater than 120 days. 4. Cognitive Impairment - Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for tobacco and alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss). Temporary cognitive impairment due to acute substance use such as overdose or acute intoxication does not meet the definition of cognitive impairment. This is a yes/no data element.
Exclusions	The denominator has three exclusions: • Patients less than 18 years of age • Patients who are cognitively impaired • Patients who a have a length of stay less than or equal to one day or greater than 120 days
Exclusion Details	The patient age in years is equal to the admission date minus the birthdate. The month and day portion of the admission date and birthdate are used to yield the most accurate age. If the patient age is less than 18 years the patient is not in the population. Length of stay (LOS) in days is equal to the discharge date minus the admission date. If the LOS is greater than 120 days or equal to or less than 1 day, the patient is not in the population. If the patient is determined to be cognitively impaired when initially assessed and cannot be screened and answer reliably for tobacco use and the data element is answered with a "yes" value, the patient will not be in the population. Again, temporary cognitive impairment due to acute substance use such as overdose or acute intoxication will require another assessment later in the stay.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
Stratification	Not Applicable, the measure is not stratified.
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure. 2. Calculate Patient Age. Patient Age, in years, is equal to the Admission Date minus the Birthdate. Use the month and day portion of admission date and Birthdate to yield the most accurate age. Only cases with valid Admission Date and Birthdate will pass the front end edits into the measure specific algorithms. 3. Check Patient Age a. If Patient Age is less than 18 years, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. b. If Patient Age is equal to or older than 18 years, continue processing and proceed to calculate Length of Stay. 4. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date. 5. Check Length of Stay a. If Length of Stay is equal to or less than 1 day, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. b. If Length of Stay is more than 1 day, continue processing and proceed to check Cognitive Impairment status. 6. Check Cognitive Impairment a. If Cognitive Impairment is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b. If Cognitive Impairment equals Yes, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. c. If Cognitive Impairment equals No, continue processing and proceed to Tobacco Use Status. 7. Check Tobacco Use Status a. If Tobacco Use Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

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	b. If Tobacco Use Status equals 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14 the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing. c. If Tobacco Use Status equals 8, the case will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing. Attachment TOB1.docx
Copyright/ Disclaimer	The Specifications Manual for National Hospital Inpatient Quality Measures (Specifications Manual) is the result of the collaborative efforts of the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission to publish a uniform set of national hospital quality measures. A primary objective of this collaborative effort is to promote and enhance the utility of these measures for all hospitals. No royalty or use fee is required for copying or reprinting this manual, but the following are required as a condition of usage: 1) disclosure that the Specifications Manual is periodically updated, and that the version being copied or reprinted may not be up-to-date when used unless the copier or printer has verified the version to be up-to-date and affirms that, and 2) users participating in the QIO supported initiatives, the Hospital Inpatient Quality Reporting Program, and Joint Commission accreditation; including performance measures systems; are required to update their software and associated documentation based on the published manual production timelines. Example Acknowledgement: The Specifications Manual for National Hospital Inpatient Quality Measures [Version xx, Month, Year] is the collaborative work of the Centers for Medicare & Medicaid Services and The Joint Commission. The Specifications Manual is periodically updated by the Centers for Medicare & Medicaid Services and The Joint Commission. Users of the Specifications Manual for National Hospital Inpatient Quality Measures must update their software and associated documentation based on the published manual production timelines.

	1879 Adherence to Antipsychotics for Individuals with Schizophrenia
Status	New Submission
Steward	Centers for Medicare and Medicaid Services Other organizations: RAND Corporation: Soeren Mattke, DSc, Senior Scientist and Elizabeth Sloss, PhD. University of Florida College of Pharmacy: Almut Winterstein, PhD, Associate Professor, Department of Pharmaceutical Outcomes and Ploicy, College of Pharmacy
Description	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Pharmacy, Other
Level	Clinician : Group/Practice, Population : State
Setting	Ambulatory Care : Clinician Office, Behavioral Health/Psychiatric : Outpatient
Numerator Statement	Individuals with schizophrenia or schizoaffective disorder who filled at least two prescriptions for any antipsychotic medication and have a Proportion of Days Covered (PDC) for antipsychotic medications of at least 0.8.
Numerator Details	Time Window: We define this as any time during the measurement period (12 consecutive months). The numerator is defined as individuals with a PDC of 0.8 or greater. The PDC is calculated as follows: PDC NUMERATOR: The PDC numerator is the sum of the days covered by the days' supply of all antipsychotic prescriptions. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescriptions with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are prescriptions for the same drug (generic name or 10-digit generic product identifier [GPI]) on the same date of service, keep the prescription with the largest days' supply. If prescriptions for the same drug (generic name or GPI) overlap, then adjust the latest prescription start date to be the day

	1879 Adherence to Antipsychotics for Individuals with Schizophrenia
	after the previous fill has ended. PDC DENOMINATOR: The PDC denominator is the number of days from the first prescription date through the end of the measurement period, or death date, whichever comes first.
Denominator Statement	Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder with at least two claims for any antipsychotic medication during the measurement period (12 consecutive months).
Denominator Details	Time Window: We define this as any time during the measurement period (12 consecutive months). IDENTIFICATION OF SCHIZOPHRENIA Individuals with schizophrenia or schizoaffective disorder are identified by having a diagnosis of schizophrenia within the inpatient or outpatient claims data. Individuals must have: At least two encounters with a diagnosis of schizophrenia with different dates of service in an outpatient setting, emergency department setting, or nonacute inpatient setting during the measurement period; Or At least one encounter with a diagnosis of schizophrenia in an acute inpatient setting during the measurement period. CODES USED TO IDENTIFY SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER DIAGNOSIS: ICD-9-CM: 295.xx ICD-10-CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9 CODES USED TO IDENTIFY ENCOUNTER TYPE: OUTPATIENT SETTING Current Procedural Terminology (CPT)*: 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510 HCPCS: G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 UB-92 revenue: 0510,0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983, 077x, 090x, 091x OR CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 UB-92 revenue: 0961 WITH Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 EMERGENCY DEPARTMENT SETTING CPT: 99281-99285 UB-92 revenue: 045x, 0981 OR

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	CPT: 90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291 UB-92 revenue: 0961 WITH POS: 23 NONACUTE INPATIENT SETTING CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 HCPCS: H0017-H0019, T2048 UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x, 1000, 1001, 1003-1005 OR CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291 UB-92 revenue: 0961 WITH POS: 31, 32, 56 ACUTE INPATIENT SETTING UB-92 revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987,080x OR CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 UB-92 revenue: 0961 WITH POS: 21, 51 *CPT ©2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. The following are the oral antipsychotic medications by Class for the denominator. The route of administration includes all oral formulations of the medications listed below. TYPICAL ANTIPSYCHOTIC MEDICATIONS: chlorpromazine fluphenazine haloperidol loxapine molindone

	1879 Adherence to Antipsychotics for Individuals with Schizophrenia
	perphenazine perphenazine-amitriptyline pimozide prochlorperazine thioridazine thiothixene trifluoperazine ATYPICAL ANTIPSYCHOTIC MEDICATIONS: aripiprazole asenapine clozapine olanzapine olanzapine-fluoxetine iloperidone lurasidone paliperidone quetiapine risperidone ziprasidone The following are the long-acting (depot) injectable antipsychotic medications by Class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below. TYPICAL ANTIPSYCHOTIC MEDICATIONS: fluphenazine decanoate (J2680) haloperidol decanoate (J1631) ATYPICAL ANTIPSYCHOTIC MEDICATIONS: olanzapine pomoate (J2358) paliperidone palmitate (J2426) risperidone microspheres (J2794) Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long acting (depot) injectable antipsychotic medications billed under Part D and Part B: fluphenazine decanoate (J2680) – 28 days' supply haloperidol decanoate (J1631) – 28 days' supply olanzapine pomoate (J2358) – 28 days' supply paliperidone palmitate (J2426) – 28 days' supply risperidone microspheres (J2794) – 14 days' supply
Exclusions	We excluded the following individuals from the denominator: EXCLUSION Individuals with any diagnosis of dementia during the measurement period
Exclusion Details	EXCLUSION Individuals with any diagnosis of dementia are identified with the diagnosis codes listed below. CODES USED TO IDENTIFY DEMENTIA: ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 291.2, 294.10, 294.11, 330.1, 331.0, 331.19, 331.82 ICD-10-CM: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03, F05, F10.27,

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	G30.0, G30.1, G30.8, G30.9, G31.09, G31.83
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Depending on the operational use of the measure, measure results will be stratified by: State Physician Group* Age – Divided into 6 categories: 18-24, 25-44, 45-64, 65-74, 75-84, 85+ years Race/Ethnicity Dual Eligibility *See attachment referenced in Sec 2.a.1.21 for the physician group attribution methodology used for this measure.
Type Score	Rate/proportion
Algorithm	Adherence to antipsychotic medications for individuals with schizophrenia is calculated as follows: Obtain Medicare administrative claims data and related files as described in detail in Section 2a1.26. Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder with at least two claims for any antipsychotic medication during the measurement period (12 consecutive months). Create Denominator: 1. Pull individuals who are 18 or older as of January 1 of the measurement period. 2. Include individuals who were continuously enrolled in Part D coverage during the measurement year, with no more than a 1-month gap in enrollment during the measurement year. 3. Include individuals who had no more than a 1-month gap in Part A enrollment, no more than a 1-month gap in Part B enrollment, and no more than 1 month of HMO [Health Maintenance Organization] enrollment during the current measurement year (fee-for-service [FFS] individuals only). 4. Of those individuals identified in Step 3, keep individuals who had at least 2 encounters with a diagnosis of schizophrenia with different dates of service in an outpatient setting, emergency department setting, or nonacute inpatient setting during the measurement period; Or Individuals who had at least 1 encounter with a diagnosis of schizophrenia in an acute inpatient setting during the measurement period. 5. For the individuals identified in Step 4, extract Part D claims for any antipsychotic medication during the measurement period. 6. Of the individuals identified in Step 5, exclude those who did not have at least 2 claims for any antipsychotic medication on different dates of service (identified by having at least 2 Part D claims with the specific codes) during the measurement year. 7. Exclude those individuals with a diagnosis of dementia during the measurement period. Numerator: Individuals with schizophrenia or schizoaffective disorder who filled at least two prescriptions for any antipsychotic medication and have a Proportion of Days Covered (PDC) for antipsychotic medications of at least 0.8. Of the individuals in the denominator, calculate the PDC for each individual according to the following methods: 1. Determine the individual's measurement period, defined as the number of days from the index date through the end of the measurement period, or death, whichever comes first. The index date is the date of the first prescription in the measurement period. 2. Within the measurement period, count the days the individual was covered by at least one antipsychotic drug based on the

	1879 Adherence to Antipsychotics for Individuals with Schizophrenia
	prescription fill date and days of supply. a. Pull Part D antipsychotic claims for individuals in the denominator. Attach the drug ID and the generic name to the dataset. b. Sort and de-duplicate claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name or 10-digit generic product identifier [GPI]) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply. c. Calculate the number of days covered by antipsychotic drug therapy per individual. i. For prescriptions with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. ii. If prescriptions for the same drug (generic name or GPI) overlap, then adjust the latest prescription start date to be the day after the previous fill has ended. iii. If prescriptions for different drugs (different generic names or GPIs) overlap, do not adjust the prescription start date. 3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's measurement period found in Step 1. An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf. The algorithm regarding the physician group attribution is provided in the attachment below in Section 2a1.21.
Copyright/ Disclaimer	Not Applicable, the measure is in the public domain.

	1927 Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
Status	New Submission
Steward	National Committee for Quality Assurance Other organizations: Mathematica Policy Research, Inc.
Description	The percentage of individuals 25 – 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication who received a cardiovascular health screening during the measurement year.
Type	Process
Data Source	Administrative claims Not applicable.
Level	Population : State
Setting	Other Any outpatient setting represented with Medicaid claims data
Numerator Statement	One or more LDL-C screenings.
Numerator Details	Time Window: The measurement year. One or more LDL-C screenings performed during the measurement year defined by the following: CPT: 80061, 83700, 83701, 83704, 83721 CPT Category II: 3048F, 3049F, 3050F LOINC: 2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2
Denominator Statement	Adults age 25 and older as of December 31 of the measurement year with a diagnosis of schizophrenia or bipolar disorder who were prescribed any antipsychotic medication.
Denominator Details	Time Window: The measurement year. -Medicaid beneficiaries 25 – 64 years of age as of December 31 of the measurement year -Two separate claims with schizophrenia or bipolar disorder as a primary diagnosis or one inpatient claim with schizophrenia or bipolar disorder as a primary diagnosis

	1927 Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
Exclusions	Individuals are excluded from the denominator if they were discharged alive for a coronary artery bypass graft or percutaneous coronary intervention (these events may occur in the measurement year or year prior to the measurement year), or diagnosed with ischemic vascular disease (this diagnosis must appear both the measurement year and the year before the measurement year), chronic heart failure, or had a prior myocardial infarction (identified in the measurement year or as far back as possible.).
Exclusion Details	Coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI). Individuals discharged alive for CABG or PCI in the measurement year or the year prior to the measurement year. Refer to (Table–E) and use codes for PCI and CABG only. CABG cases should be from inpatient claims/encounters only. Include all cases of PCI, regardless of setting (e.g., inpatient, outpatient, ED). Ischemic vascular disease (IVD). Individuals who met at least one of the following criteria during both the measurement year and the year before the measurement year. Criteria need not be the same across both years. -At least one outpatient visit (Table–F) with an IVD diagnosis (Table–E), or -At least one acute inpatient claim/encounter (Table–F) with an IVD diagnosis (Table–E) Chronic heart failure (CHF). Individuals who had at least one encounter, in any setting, with a code to identify CHF. Refer to (Table–E) and use codes for CHF only. Look as far back as possible in the member's history through December 31 of the measurement year. Prior Myocardial infarction (MI). Individuals who had at least one encounter, in any setting, with any code to identify MI (Table–E). Look as far back as possible in the member's history through December 31 of the measurement year. Table – E: Codes to identify AMI, PCI, CABG, and CHF: CABG (include only inpatient claims): CPT: 33510-33514, 33516-33519, 33521-33523, 33533-33536 HCPCS: S2205-S2209 ICD-9-CM Procedure: 36.1, 36.2 PCI: CPT: 92980, 92982, 92995 HCPCS: G0290 ICD-9-CM Procedure: 00.66, 36.06, 36.07 CHF: ICD-9-CM Diagnosis: 428 IVD: ICD-9-CM Diagnosis: 411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 440.4, 444, 445 Table –F: Codes to identify visit type: Outpatient: CPT: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456 UB Revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983 Acute Inpatient: CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 UB Revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Determine the eligible population. The eligible population is all individuals who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. 2. Search administrative systems to identify numerator events for all individuals in the eligible population. 3. Calculate the rate.
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	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
Status	New Submission
Steward	National Committee for Quality Assurance Other organizations: Mathematica Policy Research, Inc.
Description	The percentage of individuals 25 – 64 years of age with schizophrenia or bipolar disorder, who were prescribed any antipsychotic medication, and who received a diabetes screening during the measurement year.
Type	Process
Data Source	Administrative claims Not applicable.
Level	Population : State
Setting	Other Any outpatient setting represented with Medicaid claims data
Numerator Statement	One or more glucose or HbA1c tests performed during the measurement year.
Numerator Details	Time Window: The measurement year. One or more diabetes screenings during the measurement year defined by the following: Glucose Test: CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 HbA1c Test: 83036, 83037 CPT Category II: 3044F, 3045F, 3046F LOINC: 4548-4, 4549-2, 17856-6, 59261-8, 62388-4
Denominator Statement	Adults age 25 years and older as of December 31 of the measurement year with a schizophrenia or bipolar disorder diagnosis and who were prescribed any antipsychotic medication.
Denominator Details	Time Window: The measurement year. -Medicaid beneficiaries 25 – 64 years of age as of December 31 of the measurement year -Two separate claims with schizophrenia or bipolar disorder as a primary diagnosis or one inpatient claim with schizophrenia or bipolar disorder as a primary diagnosis
Exclusions	Individuals are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify individuals with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify the eligible population, but the individual only needs to be identified by one method to be included in the measure. Pharmacy data. Individuals who were dispensed insulin or oral hypoglycemics/antihyper-glycemics during the measurement year or year before the measurement year on an ambulatory basis. Claim/encounter data. Individuals who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Codes to identify diabetes: ICD-9 CM Diagnosis: 250, 357.2, 362.0, 366.41, 648.0 Prescriptions to identify individuals with diabetes: Alpha-glucosidase inhibitors: acarbose, miglitol Amylin analogs: pramlinitide Antidiabetic combinations: glimepiride-pioglitazone, glimepiride-rosiglitazone, glipizide-metformin, glyburide-metformin, metformin-pioglitazone, metformin-rosiglitazone, metformin-sitagliptin, saxagliptin, insulin aspart, insulin aspart-insulin aspart protamine, insulin detemir, insulin glargine, insulin glulisine, insulin inhalation, insulin isophane beef-pork, insulin isophane human, insulin isophane-insulin regular, insulin lispro, insulin lispro-insulin lispro protamine, insulin regular human, insulin zinc human Meglitinides: nateglinide, repaglinide Miscellaneous antidiabetic agents: exenatide, liraglutide, metformin-repaglinide, sitagliptin Sulfonylureas: acetohexamide, chlorpropamide, glimepiride, glipizide, glyburide, tolazamide, tolbutamide Thiazolidinediones: pioglitazone, rosiglitazone Codes to identify visit type: Outpatient: CPT: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-

	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
	99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456 UB Revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983 Nonacute inpatient: CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 UB Revenue: 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x Acute inpatient: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 UB Revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987 ED: CPT: 99281-99285 UB Revenue: 045x, 0981
Exclusion Details	There are two ways to identify individuals with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify the eligible population, but the individual only needs to be identified by one method to be included in the measure. Pharmacy data. Individuals who were dispensed insulin or oral hypoglycemics/antihyper-glycemics during the measurement year or year before the measurement year on an ambulatory basis. Claim/encounter data. Individuals who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Codes to identify diabetes: ICD-9 CM Diagnosis: 250, 357.2, 362.0, 366.41, 648.0 Prescriptions to identify individuals with diabetes: Alpha-glucosidase inhibitors: acarbose, miglitol Amylin analogs: pramlinitide Antidiabetic combinations insulin: glimepiride-pioglitazone, glimepiride-rosiglitazone, glipizide-metformin, glyburide-metformin, metformin-pioglitazone metformin-rosiglitazone metformin-sitagliptin, Saxagliptin, insulin aspart, insulin aspart-insulin aspart protamine, insulin detemir, insulin glargine, insulin glulisine, insulin inhalation, insulin isophane beef-pork, insulin isophane human, insulin isophane-insulin regular, insulin lispro, insulin lispro-insulin lispro protamine, insulin regular human, insulin zinc human Meglitinides: nateglinide, repaglinide Miscellaneous antidiabetic agents: exenatide, liraglutide, Metformin-repaglinide sitagliptin Sulfonylureas: acetohexamide, chlorpropamide, glimepiride, glipizide, glyburide tolazamide, tolbutamide Thiazolidinediones: pioglitazone, rosiglitazone Codes to identify visit type: Outpatient: CPT: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456; UB Revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983 Nonacute inpatient: CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337; UB Revenue: 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x Acute inpatient: CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291; UB Revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987 ED: CPT: 99281-99285; UB Revenue: 045x, 0981
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Determine the eligible population. The eligible population is all individuals who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. 2. Search administrative systems to identify numerator events for all individuals in the eligible population. 3. Calculate the rate.
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	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
Disclaimer	1100 13th Street, NW, Suite 1000 Washington, DC 20005

	1933 Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia
Status	New Submission
Steward	National Committee for Quality Assurance Other organizations: Mathematica Policy Research, Inc.
Description	The percentage of individuals 25 – 64 years of age with a schizophrenia diagnosis and a diagnosis of cardiovascular disease who received a cardiovascular health monitoring test (LDL-C) during the measurement year.
Type	Process
Data Source	Administrative claims Not applicable.
Level	Population : State
Setting	Other Any outpatient setting represented with Medicaid claims data
Numerator Statement	One or more LDL-C tests performed during the measurement year.
Numerator Details	Time Window: The measurement year. Codes to identify monitoring test: CPT: 80061, 83700, 83701, 83704, 83721 CPT Category II: 3048F, 3049F, 3050F LOINC: 2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2
Denominator Statement	Adults 25 years and older as of December 31 of the measurement year with a diagnosis of schizophrenia and cardiovascular disease.
Denominator Details	Time Window: The measurement year. -Medicaid beneficiaries 25 – 64 years of age as of December 31 of the measurement year -Two separate claims with schizophrenia as a primary diagnosis or one inpatient claim with schizophrenia or as a primary diagnosis in the measurement year and diagnosis
Exclusions	Not applicable.
Exclusion Details	Not applicable.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Determine the eligible population. The eligible population is all individuals who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. 2. Search administrative systems to identify numerator events for all individuals in the eligible population. 3. Calculate the rate.
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	1934 Diabetes monitoring for people with diabetes and schizophrenia
Status	New Submission
Steward	National Committee for Quality Assurance Other organizations: Mathematica Policy Research, Inc.

	1934 Diabetes monitoring for people with diabetes and schizophrenia
Description	The percentage of individuals 25 – 64 years of age with schizophrenia and diabetes who received diabetes monitoring as specified by an HbA1c test and LDL-C test during the measurement year.
Type	Process
Data Source	Administrative claims Not applicable.
Level	Population : State
Setting	Other Any outpatient setting represented with Medicaid claims data
Numerator Statement	One or more HbA1c tests and one or more LDL-C tests performed during the measurement year.
Numerator Details	Time Window: The measurement year. One or more HbA1c tests and one or more LDL-C tests performed during the measurement year defined by the following: Codes to identify HbA1c Test: CPT: 83036, 83037 CPT Category II: 3044F, 3045F, 3046F Codes to identify LDL-C screening: CPT: 80061, 83700, 83701, 83704, 83721 CPT Category II: 3048F, 3049F, 3050F
Denominator Statement	Adults age 25 years and older as of December 31 of the measurement year with a schizophrenia and diabetes diagnosis.
Denominator Details	Time Window: The measurement year. -Medicaid beneficiaries 25 – 64 years of age as of December 31 of the measurement year -Two separate claims with schizophrenia as a primary diagnosis or one inpatient claim with schizophrenia or as a primary diagnosis in the measurement year and diagnosis
Exclusions	Not applicable.
Exclusion Details	Not applicable.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Determine the eligible population. The eligible population is all individuals who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. 2. Search administrative systems to identify numerator events for all individuals in the eligible population. 3. Calculate the rate.
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	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
Status	New Submission
Steward	National Committee for Quality Assurance Other organizations: Mathematica Policy Research, Inc.
Description	The percentage of discharges for individuals 25 – 64 years of age who were hospitalized for treatment of schizophrenia and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. •The percentage of individuals who received follow-up within 30 days of discharge •The percentage of individuals who received follow-up within 7 days of discharge
Type	Process

	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
Data Source	Administrative claims Not applicable.
Level	Population : State
Setting	Other Any outpatient setting represented with Medicaid claims data
Numerator Statement	30-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
Numerator Details	Time Window: The measurement year. Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner: 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, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner: CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876 WITH POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72 CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255 WITH POS: 52, 53 The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes: UB Revenue: 0513, 0900-0905, 0907, 0911-0917, 0919 Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code: 0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983.
Denominator Statement	Adults 25 – 64 years of age of December 31 of the measurement year Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal schizophrenia diagnosis.
Denominator Details	Time Window: The measurement year. -Medicaid beneficiaries age 25 years and older as of December 31 of the measurement year; no upper age limit -Two separate claims with schizophrenia as a primary diagnosis or one inpatient claim with schizophrenia as a primary diagnosis and a prescription
Exclusions	Schizophrenia readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a schizophrenia 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. 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 a schizophrenia 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. 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.
Exclusion Details	Exclude discharges followed by readmission or direct transfer to a nonacute facility for a schizophrenia 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. 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:

	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
	UB Revenue: 019x ; UB Type of Bill: 21x, 22x, 28x ; POS: 31, 32 Hospital transitional care, swing bed or rehabilitation: UB Type of Bill: 18x Rehabilitation: UB Revenue: 0118, 0128, 0138, 0148, 0158 Respite: UB Revenue: 0655 Intermediate care facility: POS: 54 Residential substance abuse treatment facility: UB Revenue: 1002 POS: 55 Psychiatric residential treatment center; HCPCS: T2048, H0017-H0019 UB Revenue: 1001 POS: 56 Comprehensive inpatient rehabilitation facility: POS: 61
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Determine the eligible population. The eligible population is all individuals who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. 2. Search administrative systems to identify numerator events for all individuals in the eligible population. 3. Calculate the rate.
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APPENDIX B – STEERING COMMITTEE

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Medical Director, National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

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Colleen Barry, MPP, PhD
Associate Professor, Johns Hopkins Bloomberg School of Public Health

Caroline Carney-Doebbeling, MD, MSc, FAPM
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Mady Chalk, PhD
Director, Treatment Research Institute

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APPENDIX C – RELATED MEASURE COMPARISON TABLES

Comparison of NQF #0003 and NQF #1932

	0003 Bipolar Disorder: Assessment for diabetes	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
Steward	Center for Quality Assessment and Improvement in Mental Health	National Committee for Quality Assurance
Description	Percentage of patients treated for bipolar disorder who are assessed for diabetes within 16 weeks after initiating treatment with an atypical antipsychotic agent.	The percentage of individuals 25 – 64 years of age with schizophrenia or bipolar disorder, who were prescribed any antipsychotic medication, and who received a diabetes screening during the measurement year.
Type	Process	Process
Data Source	Administrative claims, Paper Records	Administrative claims Not applicable.
Level	Clinician : Group/Practice, Clinician : Individual	Population : State
Setting	Ambulatory Care : Clinician Office, Behavioral Health/Psychiatric : Outpatient	Other Any outpatient setting represented with Medicaid claims data
Numerator Statement	Assessment for diabetes must include documentation of one of the following: • Reference in chart that test was ordered and results or information about results was obtained OR • Lab results filed in chart or available in patient's electronic medical record Reference: Tests used to screen/assess for diabetes: Preferred Fasting plasma glucose; Non-fasting plasma glucose; Glucose tolerance Also Accepted: Glycosylated hemoglobin (Hb A1c; glycated hemoglobin) Random glucose AND Timeframe: Test results/information from test conducted within 16 weeks after the initiation of a second generation atypical antipsychotic agent OR	One or more glucose or HbA1c tests performed during the measurement year.

	0003 Bipolar Disorder: Assessment for diabetes	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
	Measurement EXCLUSION FROM COMPLIANCE Issues Numerator criteria not applicable and exclusion from compliance as stated below: 1.Dcumentation by physician that test was not clinically indicated for this patient OR 2Documentation that test was requested but patient failed to comply with request to obtain test	
Numerator Details	Time Window:	Time Window: The measurement year. One or more diabetes screenings during the measurement year defined by the following: Glucose Test: CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 HbA1c Test: 83036, 83037 CPT Category II: 3044F, 3045F, 3046F LOINC: 4548-4, 4549-2, 17856-6, 59261-8, 62388-4
Denominator Statement	Patients 18 years of age or older with an initial or new episode of bipolar disorder AND Documentation of a diagnosis of bipolar disorder; to include at least one of the following: • Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms OR	Adults age 25 years and older as of December 31 of the measurement year with a schizophrenia or bipolar disorder diagnosis and who were prescribed any antipsychotic medication.

	0003 Bipolar Disorder: Assessment for diabetes	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
	• Diagnosis or Impression or "working diagnosis" documented in chart indicating bipolar disorder OR • Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and documentation that this information is used to establish or substantiate the diagnosis AND Documentation of treatment with an atypical antipsychotic agent. (See reference list below) Note: It is not the intent to indicate preferred pharmacotherapy. The reference list is inclusive of those atypical antipsychotic medications that are reasonably construed to be appropriate in accordance with current guidelines. (Reference list of medications also included in data collection form) Atypical Antipsychotic Agents • aripiprazole • quetiapine • clozapine • risperidone • olanzapine • ziprasidone • olanzapine-fluoxetine (combination) None. New diagnosis" or a "new episode," is defined as cases where the patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the out-patient care of a physician.	
Denominator Details	Time Window: Patients 18 years of age or older with an initial or new episode of bipolar disorder AND Documentation of a diagnosis of bipolar disorder; to include at least one of the following: • Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms OR	Time Window: The measurement year. -Medicaid beneficiaries 25 – 64 years of age as of December 31 of the measurement year -Two separate claims with schizophrenia or bipolar disorder as a primary diagnosis or one inpatient claim with schizophrenia or bipolar disorder as a primary diagnosis

	0003 Bipolar Disorder: Assessment for diabetes	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
	• Diagnosis or Impression or "working diagnosis" documented in chart indicating bipolar disorder OR • Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and documentation that this information is used to establish or substantiate the diagnosis AND Documentation of treatment with an atypical antipsychotic agent. (See reference list below) Note: It is not the intent to indicate preferred pharmacotherapy. The reference list is inclusive of those atypical antipsychotic medications that are reasonably construed to be appropriate in accordance with current guidelines. (Reference list of medications also included in data collection form) Atypical Antipsychotic Agents • aripiprazole • quetiapine • clozapine • risperidone • olanzapine • ziprasidone • olanzapine-fluoxetine (combination) None. New diagnosis" or a "new episode," is defined as cases where the patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the out-patient care of a physician.	
Exclusions	None.	Individuals are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify individuals with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify the eligible population, but the individual only needs to be identified by one method to be included in the measure. Pharmacy data. Individuals who were dispensed insulin or oral

	0003 Bipolar Disorder: Assessment for diabetes	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
		hypoglycemics/antihyper-glycemics during the measurement year or year before the measurement year on an ambulatory basis. Claim/encounter data. Individuals who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Codes to identify diabetes: ICD-9 CM Diagnosis: 250, 357.2, 362.0, 366.41, 648.0 Prescriptions to identify individuals with diabetes: Alpha-glucosidase inhibitors: acarbose, miglitol Amylin analogs: pramlinitide Antidiabetic combinations: glimepiride-pioglitazone, glimepiride-rosiglitazone, glipizide-metformin, glyburide-metformin, metformin-pioglitazone, metformin-rosiglitazone, metformin-sitagliptin, saxagliptin, insulin aspart, insulin aspart-insulin aspart protamine, insulin detemir, insulin glargine, insulin glulisine, insulin inhalation, insulin isophane beef-pork, insulin isophane human, insulin isophane-insulin regular, insulin lispro, insulin lispro-insulin lispro protamine, insulin regular human, insulin zinc human Meglitinides: nateglinide, repaglinide Miscellaneous antidiabetic agents: exenatide, liraglutide, metformin-repaglinide, sitagliptin Sulfonylureas: acetohexamide, chlorpropamide, glimepiride, glipizide, glyburide,

	0003 Bipolar Disorder: Assessment for diabetes	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
		tolazamide, tolbutamide Thiazolidinediones: pioglitazone, rosiglitazone Codes to identify visit type: Outpatient: CPT: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456 UB Revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983 Nonacute inpatient: CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 UB Revenue: 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x Acute inpatient: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 UB Revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987 ED: CPT: 99281-99285 UB Revenue: 045x, 0981
Exclusion Details		There are two ways to identify individuals with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify the eligible population, but the individual only needs to be identified by one method to be included in the

	0003 Bipolar Disorder: Assessment for diabetes	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
		measure. Pharmacy data. Individuals who were dispensed insulin or oral hypoglycemics/antihyper-glycemics during the measurement year or year before the measurement year on an ambulatory basis. Claim/encounter data. Individuals who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Codes to identify diabetes: ICD-9 CM Diagnosis: 250, 357.2, 362.0, 366.41, 648.0 Prescriptions to identify individuals with diabetes: Alpha-glucosidase inhibitors: acarbose, miglitol Amylin analogs: pramlinitide Antidiabetic combinations insulin: glimepiride-pioglitazone, glimepiride-rosiglitazone, glipizide-metformin, glyburide-metformin, metformin-pioglitazone metformin-rosiglitazone metformin-sitagliptin, Saxagliptin, insulin aspart, insulin aspart-insulin aspart protamine, insulin detemir, insulin glargine, insulin glulisine, insulin inhalation, insulin isophane beef-pork, insulin isophane human, insulin isophane-insulin regular, insulin lispro, insulin lispro-insulin lispro protamine, insulin regular human, insulin zinc human Meglitinides: nateglinide, repaglinide

	0003 Bipolar Disorder: Assessment for diabetes	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
		Miscellaneous antidiabetic agents: exenatide, liraglutide, Metformin-repaglinide sitagliptin Sulfonylureas: acetohexamide, chlorpropamide, glimepiride, glipizide, glyburide tolazamide, tolbutamide Thiazolidinediones: pioglitazone, rosiglitazone Codes to identify visit type: Outpatient: CPT: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456; UB Revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983 Nonacute inpatient: CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337; UB Revenue: 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x Acute inpatient: CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291; UB Revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987 ED: CPT: 99281-99285; UB Revenue: 045x, 0981
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification Not applicable.
Stratification		Not applicable.
Type Score		Rate/proportion better quality = higher score

	0003 Bipolar Disorder: Assessment for diabetes	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
Algorithm		1. Determine the eligible population. The eligible population is all individuals who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. 2. Search administrative systems to identify numerator events for all individuals in the eligible population. 3. Calculate the rate.
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:	5.1 Identified measures: 0003 : Bipolar Disorder: Assessment for diabetes 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The denominator for this measure includes bipolar disorder and schizophrenia while the NQF-endorsed measure only includes bipolar disorder. This measure includes an older population (25 years versus 18 years) as the ability to properly diagnose may become more apparent in older patients. The NQF-endorsed measure has a higher data collection burden as that measure is collected by claims and chart data while this measure is collected through claims only. The NQF-endorsed measure includes only atypical antipsychotics, while this measure includes both typical and atypical medications. Evidence suggests that both types of medications may increase the risk of diabetes (Gianfrancesco et al., 2002). Gianfrancesco, F.D., Grogg, A.L., Mahmoud, R.A., et al. (2002). Differential effects of risperidone, olanzapine, clozapine, and conventional antipsychotics on type 2 diabetes: findings from a large health plan database. J Clin Psychiatry, 63, 920-30.

	0003 Bipolar Disorder: Assessment for diabetes	1932 Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
		5b.1 If competing, why superior or rationale for additive value: The denominator for this measure includes bipolar disorder and schizophrenia while the NQF-endorsed measure only includes bipolar disorder. This measure includes an older population (25 years versus 18 years) as the ability to properly diagnose may become more apparent in older patients. The NQF-endorsed measure may have a higher data collection burden as that measure is collected by claims and chart data, while this measure is collected through claims data only. The NQF-endorsed measure includes only atypical antipsychotics, while this measure includes both typical and atypical medications. Evidence suggests that both types of medications may increase the risk of diabetes (Gianfrancesco et al., 2002). Gianfrancesco, F.D., Grogg, A.L., Mahmoud, R.A., et al. (2002). Differential effects of risperidone, olanzapine, clozapine, and conventional antipsychotics on type 2 diabetes: findings from a large health plan database. J Clin Psychiatry, 63, 920-30.

Comparison of NQF #0057, #0063, and #1934

	0057 Diabetes: Hemoglobin A1c testing	0063 Diabetes: Lipid profile	1934 Diabetes monitoring for people with diabetes and schizophrenia
Steward	National Committee for Quality Assurance	National Committee for Quality Assurance	National Committee for Quality Assurance
Description	Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year	Percentage of adult patients with diabetes aged 18-75 years receiving at least one lipid profile (or ALL component tests)	The percentage of individuals 25 – 64 years of age with schizophrenia and diabetes who received diabetes monitoring as specified by an HbA1c test and LDL-C test during the measurement year.
Type	Process	Process	Process

	0057 Diabetes: Hemoglobin A1c testing	0063 Diabetes: Lipid profile	1934 Diabetes monitoring for people with diabetes and schizophrenia
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records	Administrative claims	Administrative claims Not applicable.
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State	Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State	Population : State
Setting	Ambulatory Care : Clinician Office	Ambulatory Care : Clinician Office	Other Any outpatient setting represented with Medicaid claims data
Numerator Statement	One or more HbA1c tests performed during the measurement year.	An LDL-C test performed during the measurement year.	One or more HbA1c tests and one or more LDL-C tests performed during the measurement year.
Numerator Details	Time Window: The measurement year Administrative Claims: CPT codes: 83036, 83037; CPT Category II: 3044F, 3045F, 3046F; LOINC: 4548-4, 4549-2, 17856-6 Medical Record Documentation: At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result. Notation of the following in the medical record may be counted: -A1c	Time Window: The measurement year (one calendar year) Documentation in the medical record must include, at a minimum, a note indicating the date on which the LDL-C test was performed and the result	Time Window: The measurement year. One or more HbA1c tests and one or more LDL-C tests performed during the measurement year defined by the following: Codes to identify HbA1c Test: CPT: 83036, 83037 CPT Category II: 3044F, 3045F, 3046F Codes to identify LDL-C screening: CPT: 80061, 83700, 83701, 83704, 83721

	0057 Diabetes: Hemoglobin A1c testing	0063 Diabetes: Lipid profile	1934 Diabetes monitoring for people with diabetes and schizophrenia
	-HbA1c -Hemoglobin A1c -Glycohemoglobin A1c -HgbA1c		CPT Category II: 3048F, 3049F, 3050F
Denominator Statement	Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through: •Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available). •A Diagnosis of Diabetes on the Problem List or at least two visits with diabetes listed as a diagnosis. Presentation of Codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three digit code is listed, it is valid as a three-, four- or five-digit code. When necessary, a code may be specified with an "x" which represents a required digit. For example ICD-9 CM diagnosis code 640.0x means that a fifth digit is required, but the fifth digit could be any	Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).	Adults age 25 years and older as of December 31 of the measurement year with a schizophrenia and diabetes diagnosis.

	0057 Diabetes: Hemoglobin A1c testing	0063 Diabetes: Lipid profile	1934 Diabetes monitoring for people with diabetes and schizophrenia
	number allowed by the coding manual.		
Denominator Details	Time Window: The measurement year Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through: Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available). A Diagnosis of Diabetes on the Problem List or at least two visits with diabetes listed as a diagnosis. Presentation of Codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three digit code is listed, it is valid as a three-, four- or five-digit code. When necessary, a code may be specified with an "x" which represents a required digit. For example ICD-9 CM diagnosis code 640.0x means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.	Time Window: The measurement year Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through: Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available). A Diagnosis of Diabetes on the Problem List or at least two visits with diabetes listed as a diagnosis. Presentation of Codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three digit code is listed, it is valid as a three-, four- or five-digit code. When necessary, a code may be specified with an "x" which represents a required digit. For example ICD-9 CM diagnosis code 640.0x means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.	Time Window: The measurement year. -Medicaid beneficiaries 25 – 64 years of age as of December 31 of the measurement year -Two separate claims with schizophrenia as a primary diagnosis or one inpatient claim with schizophrenia or as a primary diagnosis in the measurement year and diagnosis
Exclusions	Exclude patients with a diagnosis of polycystic ovaries	Exclude patients with a diagnosis of polycystic ovaries	Not applicable.

	0057 Diabetes: Hemoglobin A1c testing	0063 Diabetes: Lipid profile	1934 Diabetes monitoring for people with diabetes and schizophrenia
	on the problem list who did not have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list who did not have a diagnosis of diabetes on the problem list during the measurement year or the year prior to the measurement year.	on the problem list who did not have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list who did not have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year.	
Exclusion Details	N/A	N/A	Not applicable.
Risk Adjustment	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification Not applicable.
Stratification			Not applicable.
Type Score			Rate/proportion better quality = higher score
Algorithm			1. Determine the eligible population. The eligible population is all individuals who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. 2. Search administrative systems to identify numerator events for all individuals in the eligible population. 3. Calculate the rate.

	0057 Diabetes: Hemoglobin A1c testing	0063 Diabetes: Lipid profile	1934 Diabetes monitoring for people with diabetes and schizophrenia
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:	5.1 Identified measures: 0057 : Diabetes: Hemoglobin A1c testing 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The NQF-endorsed measure includes adults age 18 – 75 years of age who have received one or more HbA1c tests. This measure is focused on serious mental illness and includes patients with schizophrenia who are 25 years or older who have received an HbA1c and LDL-C test. The age cutoff for this measure was set at 25 years as diagnostic clarity may be more favorable in older patients with schizophrenia. The NQF-endorsed measure may have a higher data collection burden as the measure is specified to use claims, paper chart, or electronic medical records, while this measure strictly uses claims data. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

Comparison of NQF #0576 and #1937

	0576 Follow-up After Hospitalization for Mental Illness	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
Steward	National Committee for Quality Assurance	National Committee for Quality Assurance
Description	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.	The percentage of discharges for individuals 25 – 64 years of age who were hospitalized for treatment of schizophrenia and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. •The percentage of individuals who received follow-up within 30 days of discharge •The percentage of individuals who received follow-up within 7 days of discharge
Type	Process	Process
Data Source	Administrative claims, Electronic Clinical Data: Electronic Health Record	Administrative claims
Level	Health Plan, Clinician: Team, Integrated Delivery System, Population: County or city, National, Regional, State	Population : State
Setting	Ambulatory Care: Clinician Office/Clinic, Urgent Care, Behavioral Health: Psychiatrist, Outpatient	Other: Any outpatient setting represented with Medicaid claims data.
Numerator Statement	Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.	30-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
Numerator Details	Time Window: Date of discharge through 30 days after discharge Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Codes to Identify Visits:	Time Window: The measurement year. Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner: CPT: 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-

	0576 Follow-up After Hospitalization for Mental Illness	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
	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: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255 with POS 52, 53 The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes. UB Revenue: 0513, 0900-0905, 0907, 0911-0917, 0919, Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table FUH-A. UB Revenue: 0510, 0515-0517, 0519-0523, 0526-0529, 077x, 0982, 0983	99220, 99241-99245, 99341- 99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510 HCPCS: G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner: CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876 WITH POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72 CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255 WITH POS: 52, 53 The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes: UB Revenue: 0513, 0900-0905, 0907, 0911-0917, 0919

	0576 Follow-up After Hospitalization for Mental Illness	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
		Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code: 0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983.
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.	Adults 25 – 64 years of age of December 31 of the measurement year Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal schizophrenia diagnosis.
Denominator Details	Time Window: The measurement year. For commercial, Medicaid and Medicare product lines, and for members with a medical and mental health benefit who meet the continuous enrollment criteria of the date of discharge through 30 days after discharge. Codes to Identify Mental Health Diagnosis ICD-9-CM Diagnosis: 295–299, 300.3, 300.4, 301, 308, 309, 311–314 Table FUH0B: 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, 28x; POS 31, 32	Time window: The measurement year. -Medicaid beneficiaries age 25 years and older as of December 31 of the measurement year -Two separate claims with schizophrenia as a primary diagnosis or one inpatient claim with schizophrenia as a primary diagnosis and a prescription for any antipsychotic medication in the measurement year -10 months continuous enrollment during the measurement year -Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal schizophrenia diagnosis on or between January 1 and December 1 of the measurement year. -The denominator for this measure is based on discharges. Include all discharges for individuals who have

	0576 Follow-up After Hospitalization for Mental Illness	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
	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 facility: UB Revenue: 1002; POS 55 Psychiatric Residential Treatment Center: HCPCS: T2048, H0017-H0019; UB Revenue: 1001; POS 56 Comprehensive Inpatient Rehabilitation Facility: POS 61 Other nonacute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)	more than one discharge on or between January 1 and December 1 of the measurement year. Codes to Identify Schizophrenia Diagnosis: ICD-9-CM Diagnosis: 295 ICD-10-CM Diagnosis: F20, F25.9
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.	Schizophrenia readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a schizophrenia diagnosis within the 30-day followup period, count only the readmission discharge or the discharge from the facility to which the member was transferred. 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 a schizophrenia 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. 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

	0576 Follow-up After Hospitalization for Mental Illness	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
		measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Exclusion Details	Use Codes identified in Table FUH-B in 2a1.7. Denominator Details.	Exclude discharges followed by readmission or direct transfer to a nonacute facility for a schizophrenia 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. 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, 28x ; POS: 31, 32 Hospital transitional care, swing bed or rehabilitation: UB Type of Bill: 18x Rehabilitation: UB Revenue: 0118, 0128, 0138, 0148, 0158 Respite:

	0576 Follow-up After Hospitalization for Mental Illness	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
		UB Revenue: 0655 Intermediate care facility: POS: 54 Residential substance abuse treatment facility: UB Revenue: 1002 POS: 55 Psychiatric residential treatment center; HCPCS: T2048, H0017-H0019 UB Revenue: 1001 POS: 56Comprehensive inpatient rehabilitation facility: POS: 61
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	Not applicable	Not applicable
Type Score	Rate/proportion	Rate/proportion
Algorithm	Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. Step 2. Search administrative systems to identify numerator events for all members in the eligible population.	1. Determine the eligible population. The eligible population is all individuals who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. 2. Search administrative systems to identify numerator events for all individuals in

	0576 Follow-up After Hospitalization for Mental Illness	1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
	Step 3. Calculate the rate.	the eligible population. 3. Calculate the rate.
Submission items	5.1. If there are related measures (either same measure focus or target population) or competing measures (both the same measure focus and same target population), list the NQF # and title of all related and/or competing measures: N/A 5b.1. If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible): N/A	5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized? No 5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden: The age cutoff for this measure was set at 25 years as diagnostic clarity is more favorable in older patients with schizophrenia. The NQF-endorsed measure is specified for health plans, while this new measure is specified for state populations. The NQF-endorsed measure may have a higher data collection burden as the measure is specified to use claims or electronic medical records, while this new measure strictly uses claims data.