

# Behavioral Health and Substance Use, Fall 2017 Cycle: CDP Report

TECHNICAL REPORT

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# Behavioral Health and Substance Use, Fall 2017 Cycle

## TECHNICAL REPORT

### Executive Summary

Mental illness and substance use disorders are leading causes of disability and premature mortality in the United States. Access to quality behavioral healthcare is essential to leading a healthy, productive life. Given that one in six American adults experience a mental illness in a given year, performance measurement in this area needs to remain operational and current.<sup>1</sup>

The review and evaluation of behavioral health measures has long been a priority of the National Quality Forum (NQF), and with the ever-changing behavioral health landscape, new measures focusing on identified needs and gaps continue to come to fruition. The background and description of the previous and current projects and an overview of NQF's behavioral health portfolio are available on NQF's project webpage. This work aims to endorse measures of accountability for improving the delivery of behavioral health and substance use services and achieving better health outcomes for the U.S. population. The most recent work, detailed in this report, examines measures of continuity of care, follow-up care, antipsychotic use, medication reconciliation, and psychosocial screening in children.

Ensuring that developers continually receive relevant feedback from both NQF staff and the Committee remains a core value at NQF. During this project, two measures: 3317 *Medication Reconciliation on Admission* and 3332 *Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)* were submitted for endorsement consideration for the second time. The Committee voiced concerns that both the *Medication Reconciliation on Admission* measure (originally reviewed in 2017) and the *Psychosocial Screening Using the Pediatric Symptom Checklist-Tool* (originally reviewed in 2015) were too complex. The Committee provided the developers with tangible suggestions on improving their measures to ensure simplicity and burden reduction. Since the initial review, both of the developers worked on revising their measures to reflect the Committee's feedback, and the Committee has since recommended both for endorsement.

For this project, the Standing Committee evaluated five newly submitted measures against NQF's standard evaluation criteria. Four measures have been endorsed, and one measure was not endorsed. The four endorsed measures are:

- 3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) from Alcohol and/or Drugs (CMS)
- 3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication (CMS)
- 3317 Medication Reconciliation on Admission (CMS)
- 3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool) (Massachusetts General Hospital)

The following measure was not endorsed:

- 3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting (eCQM) (CMS)

Brief summaries of the measures reviewed appear in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in [Appendix A](#).

## Introduction

Behavioral healthcare refers to a continuum of services for individuals at risk of—or suffering from—mental, behavioral, or addictive disorders ranging from mood and anxiety disorders to substance use disorders. In the United States, approximately 44.7 million adults live with a mental illness.<sup>1</sup> In 2016, 20.1 million people aged 12 or older had a substance use disorder of which 8.2 million also had a mental disorder, also known as a co-occurring disorder.<sup>2</sup>

Behavioral health disorders are a leading cause of disabilities that contribute to rising healthcare expenditure, costing employers billions of dollars each year. Mental health and substance use disorder treatment spending from all public and private sources is expected to total \$280.5 billion in 2020—an increase from \$171.7 billion in 2009.<sup>3</sup>

While many of the illnesses and disorders that fall under the behavioral health umbrella are often chronic, people can and do recover when provided with timely, high-quality, coordinated, and evidence-based care. Proper screening and assessment of populations at risk, consistent evaluation and management of illnesses, and ongoing care have the potential to change recovery trajectories over time. Improving quality measures and shifting towards a culture of measurement-based care enhance the quality and, ultimately, the outcomes of behavioral health services.

## NQF Portfolio of Performance Measures for Behavioral Health and Substance Use Conditions

The Behavioral Health and Substance Use Standing Committee (see [Appendix C](#)) oversees NQF's portfolio of behavioral health and substance use measures; it includes measures for alcohol and drug use, care coordination, depression, medication use, tobacco, and physical health (see [Appendix B](#)). This portfolio contains 50 measures: 40 process measures, nine outcome and resource use measures, and one composite measure (see table below).

**Table 1. NQF Behavioral Health and Substance Use Portfolio of Measures**

	Process	Outcome/Resource Use	Composite
<b>Alcohol and Drug Use</b>	7	0	1
<b>Care Coordination</b>	5	0	0
<b>Depression</b>	4	5	0
<b>Medication Use</b>	8	0	0
<b>Tobacco</b>	8	0	0
<b>Physical Health</b>	8	4	0
<b>Total</b>	40	9	1

The table below contains additional measures that are related to the Behavioral Health and Substance Use portfolio that are included and evaluated in different NQF portfolios.

**Table 2. NQF Measures in Other Portfolios**

NQF #/Title	Process	Outcome/ Resource Use	Composite	NQF Topic Area Portfolio
2860 Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)		X		All-Cause Admissions and Readmissions
0008 Experience of Care and Health Outcomes (ECHO) Survey		X		Patient Experience and Function
0726 Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)		X		Patient Experience and Function
2483 Gains in Patient Activation (PAM) Scores at 12 Months		X		Patient Experience and Function
2967 CAHPS® Home- and Community-Based Services Measures		X		Patient Experience and Function
2111 Antipsychotic Use in Persons with Dementia	X			Neurology
2337 Antipsychotic Use in Children Under 5 Years Old	X			Patient Safety
2020 Adult Current Smoking Prevalence		X		Prevention and Population Health
2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics	X			Pediatric Performance Measures
2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	X			Pediatric Performance Measures
2803 Tobacco Use and Help with Quitting Among Adolescents	X			Pediatric Performance Measures
2806 Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department	X			Pediatric Performance Measures
<b>Total</b>	<b>6</b>	<b>6</b>	<b>0</b>	

## Behavioral Health and Substance Use Measure Evaluation

On January 19, 24, and February 6, 2018, the Behavioral Health and Substance Use Standing Committee evaluated five new measures against [NQF's standard evaluation criteria](#).

**Table 3. Behavioral Health and Substance Use Measure Evaluation Summary**

	Maintenance	New	Total
Measures under consideration	0	5	5
Measures recommended for endorsement	0	4	4
Measures not recommended for endorsement	0	1	1
Reasons for not recommending	Importance – N/A Scientific Acceptability – N/A Overall – N/A Competing Measure – N/A	Importance – 1 Scientific Acceptability – 0 Overall – 0 Competing Measure – 0	

### Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the [Quality Positioning System \(QPS\)](#). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on November 28, 2017 and closed on March 30, 2018. One comment was submitted and shared with the Committee prior to the measure evaluation meetings ([Appendix F](#)).

### Comments Received After Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on March 30, 2018. Following the Committee’s evaluation of the measures under consideration, NQF received 23 comments from eight organizations (including six member organizations) and individuals pertaining to the draft report and the measures under consideration. All comments for each measure under consideration have been summarized in [Appendix A](#).

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support (‘support’ or ‘do not support’) for each measure submitted for endorsement consideration to inform the Committee’s recommendations. Three NQF members provided their expression of support.

### Overarching Themes

During the discussion of the measures, the Standing Committee considered three overarching themes. These themes are discussed below and are not repeated in detail with each individual measure.

#### *Increase of Behavioral Health Measures for Medicaid*

The Committee evaluated several new measures specified for state Medicaid agencies and applauded the addition of measures to assess quality of behavioral healthcare in the Medicaid population. Medicaid is a major source of insurance coverage for low-income Americans, and is the only source of funding for some specialized behavioral health services. Medicaid spending for people with behavioral health diagnoses was nearly four times higher (\$13,303 vs. \$3,564) than spending for enrollees without

behavioral health conditions, respectively.<sup>4</sup> Due to the high level of spending on behavioral healthcare and the prevalence of mental health conditions in the Medicaid populations, the Committee highlighted the need for additional endorsed measures in this area to assess quality of care and promote accountability.<sup>4</sup>

### *Optimizing Access to Continuity of Care*

The Committee noted that follow-up care depends on access to care, particularly for individuals with mental illness and substance use disorders. The Committee noted that many individuals struggle with access and often do not have appropriate continuity of care or follow-up. The Committee emphasized the importance of considering flexible access methods in measurement whether it be via telehealth, same day appointments, or through pharmacotherapy.

### *Screening and Follow-Up*

The Committee discussed the small evidence base for both universal screening and early follow-up leading to improved outcomes. It recognized that while there is a dearth of evidence for long-term improvement, screening does lead to higher follow-up rates, which in the case of the measures under consideration, lead to appropriate clinical cascades. In parallel, several Committee members noted that not screening in the case of psychosocial screening in pediatrics could potentially lead to more harm. Similarly, the Committee agreed that timely follow-up for individuals who have been discharged from detox does reduce morbidity.

## Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in [Appendix A](#).

### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) from Alcohol and/or Drugs (Mathematica Policy Research): Endorsed**

**Description:** Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy) within 7 or 14 days after discharge. This measure is reported across all detoxification settings; **Measure Type:** Process; **Level of Analysis:** Population: Regional and State; **Setting of Care:** Inpatient/Hospital; Outpatient Services; **Data Source:** Claims

Detoxification is a medical intervention that manages an individual safely through acute withdrawal from alcohol and/or drugs. Not getting patients into treatment after detox is a missed opportunity to connect them to the treatment system, and studies show that having continuity of care after detox is associated with better outcomes. This newly proposed process measure focuses on the percentage of discharges from a detoxification episode for adult Medicaid beneficiaries, age 18-64, that were followed by a treatment service for substance use disorder—including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy)—within 7 or 14 days after discharge. The Committee questioned why the measure does not include same day visits. The developer agreed that



same day visits are important, but stated that administrative data used to calculate the measure make it difficult, if not impossible, to identify same day visits. Additionally, there were questions from the Committee focused on the receipt of Naloxone in an emergency event or the receipt of a 30-day prescription and how those events are factored into the measure. The developer agreed that ensuring appropriate continuity of care for both situations is very important but reiterated that this measure strictly focuses on the continuity of care that occurred within 7 or 14 days after detox. The Committee recommended the inclusion of same day visits as well as telehealth in a future iteration of this measure. Overall, the Committee agreed that while this is a new measure and not currently in use, they anticipate that states will use it to monitor and improve quality of care provided for Medicaid beneficiaries with alcohol and/or drug use disorders. The Committee recommended this measure for endorsement.

### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication (Mathematica Policy Research): Endorsed**

**Description:** Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication; **Measure Type:** Process; **Level of Analysis:** Population: Regional and State; **Setting of Care:** Outpatient Services; **Data Source:** Claims

People with severe mental illness have a considerably shorter lifespan than the general population. This excess mortality is mainly due to physical illness, unhealthy lifestyle, and disparities in healthcare access. Despite the positive impact antipsychotics medications have on mental health, these drugs can also contribute to the risk of physical morbidity and mortality.<sup>5</sup> Timely follow-up with a provider following the prescription of an antipsychotic medication is an essential first step to ensure treatment effectiveness, dose modification, and elimination of any barriers to treatment adherence. This newly proposed process measure seeks to ensure the timely follow-up and care for individuals with serious mental illness who have been newly prescribed an antipsychotic medication. The Committee questioned why the measure does not include telemedicine. The developer noted that codes for telephone follow-up are included per the recommendation of its clinical workgroup; however, specific telehealth codes are not included in the measure specifications, as the measure was developed and tested prior to the introduction of specific telehealth codes. Committee members noted that the measure only captured whether a visit happened, but did not specify the contents of the visit. There was some concern that checking a box indicating that a follow-up visit occurred does not measure the quality and efficacy of the follow-up visit. The developer explained that due to limitations in Medicaid claims, it is difficult to capture what happens in a follow-up beyond a claim that the event took place. The Committee agreed that any type of health monitoring is important and follow-up supports adherence. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for endorsement.

### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting (eCQM) (CMS): Not Endorsed**

**Description:** Proportion of inpatient hospitalizations for patients 65 years of age and older who receive an order for antipsychotic medication therapy; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Inpatient/Hospital; **Data Source:** Electronic Health Records

Antipsychotics are often used “off-label” as a method of treating individuals in an acute state of confusion, despite conflicting evidence.<sup>6</sup> This newly proposed process measure seeks to address potential inappropriate use of antipsychotics in inpatient hospital settings and the potentially unnecessary continuation of the intervention post-discharge. The Committee expressed concern about the evidence for exclusions missing in the measure as specified, specifically the absence of hospitalized elderly patients who were previously on an antipsychotic for depression but did not have a diagnosis of the denominator exclusions of schizophrenia, Tourette’s syndrome, bipolar disorder, or Huntington’s Disease. The Committee was also concerned about the lack of clarity for the numerator exclusion of patients who are “threatening harm to self or others.” In addition, the Committee was concerned that the evidence lacked benchmarks to determine what constitutes appropriate ordering of antipsychotics. The Committee did not recommend the measure for NQF endorsement because it did not pass criterion 1a Evidence to Support the Measure Focus. The Committee agreed that inappropriate antipsychotic prescribing in the elderly is an important topic to measure, and requested that the developer consider updating the measure specifications to address their concerns specific to benchmarking, time and nature of antipsychotic ordering, and exclusions.

### **3317 Medication Reconciliation on Admission (Health Services Advisory Group, Inc.): Endorsed**

**Description:** Percentage of patients for whom a designated PTA medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Inpatient/Hospital; **Data Source:** Paper Medical Records

Medication reconciliation should occur at multiple transition points throughout an inpatient stay; however, this measure focuses on medication reconciliation on admission because information collected at this transition point is critical to inform treatment decisions during the inpatient stay and at discharge. Studies in both the psychiatric and nonpsychiatric settings have found that medication discrepancies are present in more than half of medical records for inpatient stays.<sup>7</sup> A composite version of the measure was reviewed by the Behavioral Health Standing Committee in 2017, but it was not recommended for endorsement. The developer updated the measure, based on the feedback received from the Committee, which included reducing the complexity of the measure by changing the measure scoring to pass/fail; harmonizing the measure to align with similar NQF-endorsed measures; and producing empirical evidence to support the outcome. The Committee expressed concerns around the low reliability score for the “external source” data element as well as the burden associated with the amount of time estimated to compute the measure (six minutes). The developer indicated that the concept of using external sources as part of a medication reconciliation process is based on evidence and guidelines. The developer also explained that the measure specifications are aimed at facilities using electronic health records and paper medical records, and if the measure were to be implemented, education would be included. Although this new measure is not currently publicly reported, the developer anticipates that implementing this measure will lead to improved standardization, fewer adverse events because of decreased discrepancies, improved standardization of documentation of medication reconciliation and minimized adverse drug events, thereby improving patient outcomes. The Committee recommended this measure for endorsement.

### 3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool) (Massachusetts General Hospital): Endorsed

**Description:** Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit; **Measure Type:** Process; **Level of Analysis:** Clinician: Group/Practice; Population: Regional and State; **Setting of Care:** Outpatient Services; **Data Source:** Claims; Electronic Health Records; Paper Medical Records

Studies show that children with psychosocial problems who receive psychosocial screening as a part of pediatric well child visits are more likely to receive outpatient mental health services. The Pediatric Symptom Checklist Tool (PSC-Tool) has wide adoption for routine psychosocial screening in pediatrics. An outcome version of the measure was reviewed and endorsed by the Committee in 2011, but lost endorsement in 2015 when the measure was re-specified and submitted as both a process and an outcome measure. At the time, the Committee recommended that the measure be simplified and be brought back for endorsement evaluation. The newly submitted process measure assesses the percentage of children who have a PSC-Tool administered during a pediatric well child visit and reflects feedback made by the Behavioral Health Committee in 2015. The developer provided evidence of studies that demonstrate the feasibility and acceptability of the PSC-Tool as a clinical and research measure with diverse populations and on a statewide scale. Some Committee members expressed concern for lack of evidence on screening and improved outcomes, and went as far to suggest that unintended consequences of being “tagged” as a result of psychosocial screening. Ultimately, the Committee agreed that while there was not a wealth of evidence, there were a series of randomized controlled trials linking screening with the PSC-Tool to improve outcomes for children who are found to be at risk. There is wide variation in performance rates of mental health screening as well as variation in performance rates for well child visits, which suggest a need for this measure. The measure is currently used in public reporting programs, and is included in several quality improvement and professional certification recognition programs. During the post-comment web meeting, the Committee discussed concerns raised by commenters regarding the capture of the numerator CPT code 96110 to identify use of the PSC screening tool in the measure as specified in the administrative claims version. The Committee questioned the reliability of the measure because the CPT code specified in the measure is not specific to the PSC-Tool. Ultimately, the Committee voted 17 to 2 to endorse the measure and strongly recommended that the developer remove the administrative claims version of the measure and move forward with only the chart abstraction version. The developer agreed to this change and resubmitted the measure specifications to reflect the removal of administrative claims. The Committee recommended endorsement of the measure as amended.

## References

- 1 National Institute of Mental Health. Mental Illness. <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>. Last accessed February 2018.
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- 5 Correll C, Detraux J, De Lepeleire, Jan, et al. Effects of antipsychotics, antidepressants and mood stabilizers on risk for physical diseases in people with schizophrenia, depression and bipolar disorder. *World Psychiatry*. 2015;14(2). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4471960/>. Last accessed February 2018.
- 6 Neufeld K, Yue J, Robinson T, et al. Antipsychotic Medication for Prevention and Treatment of Delirium in Hospitalized Adults: A Systematic Review and Meta-Analysis. *J Am Geriatr Soc*. 2016;64(4):705-714. <https://www.ncbi.nlm.nih.gov/pubmed/27004732>. Last accessed February 2018.
- 7 Brownlie K, Schneider C, Culliford R, et al. Medication reconciliation by a pharmacy technician in a mental health assessment unit. *Int J Clin Pharm*. 2014;36(2):303-309.

## Appendix A: Details of Measure Evaluation

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

### Endorsed Measures

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#### 3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

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

**Description:** Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy) within 7 or 14 days after discharge. This measure is reported across all detoxification settings.

**Numerator Statement:** Discharges in the denominator who have an inpatient, intensive outpatient, partial hospitalization, outpatient visit, residential, or drug prescription or procedure within 7 or 14 days after discharge from a detoxification episode.

**Denominator Statement:** Adult Medicaid beneficiary discharges from detoxification from January 1 to December 15 of the measurement year.

**Exclusions:** Not applicable. The measure does not have denominator exclusions.

**Adjustment/Stratification:** No risk adjustment or risk stratification

**Level of Analysis:** Population:Regional and State

**Setting of Care:** Inpatient/Hospital, Outpatient Services

**Type of Measure:** Process

**Data Source:** Claims

**Measure Steward:** Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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#### STANDING COMMITTEE MEETING [01/24/2018]

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

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **M-16; L-1; I-0**; 1b. Performance Gap: **H-12; M-5; L-0; I-0**

Rationale:

- The developer provided evidence that supported that continuity of care should occur within a short time after discharge from detoxification. The developer found 11 studies showing association of continuity with a range of better outcomes such as reduction in readmission, less criminal justice involvement, lower mortality, and improved employment.
- The Committee noted that there is strong evidence linking to improved outcomes for individuals who receive detoxification services with follow up care. Additionally, the Committee agreed that this measure is important given the current opioid epidemic coupled with high rates of overdose post-detox.

- The Committee requested clarification from the developer regarding the types and timing of pharmacotherapy as it relates to the measure. The developer confirmed that all FDA-approved pharmacotherapies for substance use disorder (SUD) are included in the measure.
- The Committee questioned how the use of monthly treatment and extended release pharmacotherapy, such as naltrexone, might be included in the seven and 14-day timeframes given that the prescription is for 30-days. The developer stated that in their testing they looked at all prescriptions, regardless of the number of days. However, for prescriptions that are given in 30-day dosages, they still require seven or 14 day follow-up given both SAMHSA and ASAM guidelines.
- The Committee requested more information on the developer's decision to choose 7- and 14-day follow-up periods. The developer confirmed that the follow-up periods are consistent with SAMHSA and other relevant guidelines. In addition, based on feedback from numerous stakeholders and state agencies, it was suggested that 7 days might not be feasible for some organizations, so the developer balanced 7 days as clinically appropriate with 14 days as a feasible benchmark for state Medicaid.
- The Committee questioned why telehealth was not included in the measure and the developer confirmed that telehealth had not been an option when the measure was being tested, but agreed that it could be included in future versions of the measure.
- There were concerns from the Committee that same day follow-up visits for newly discharged individuals is not included in the measure. The developer agreed that same day visits are important, but stated that there are limitations in the Medicaid claims data used to calculate the measure making it difficult, if not impossible, to identify same day visits. The Committee hopes to see the inclusion of same day visits in a future iteration of this measure.

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

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2c. For composite measures: Empirical Analysis Supporting Composite)

2a. Reliability: **H-2; M-14; L-1; I-0** 2b. Validity: **H-1; M-16; L-0; I-0**

### Rationale:

- The Committee asked for clarification on whether or not primary care is included and the developer confirmed that it is.
- The Committee questioned whether the denominator includes individuals who may have received Naloxone (Narcan) in the emergency department (ED) as a detox event and the developer responded that it is not included unless the patient had some sort of additional follow-up within the 7 to 14 days following discharge. The Committee had concerns that same day pharmacotherapy prescriptions did not meet the continuity of care criteria.
- The Committee questioned whether both primary and secondary diagnoses are included in the measure. The developer noted that they are allowing both primary and secondary diagnoses to count for follow-up visits because they recognize that a person may have a co-occurring diagnosis, therefore it is important to count any documented visit of a substance use diagnosis.
- The developer stated that the high signal-to-noise reliability testing results indicate the measure can discern performance between states with high precision.
- The developer noted that the convergent validity results indicate lower odds (8.3% for those with continuity at 14 days) of readmission to detox or overdose treatment among those episodes with continuity of care.

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

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

#### Rationale:

- The Committee agreed that there was enough data in the analysis to show the feasibility of the measure.
- The Committee raised concern that state Medicaid systems where mental health and substance use are “carved out”, that some treatments (i.e., detox, overdose treatment, and substance use disorder counseling admissions) may not appear in the Medicaid claims data and therefore could impede the feasibility of the measure.
- The Committee noted that the data could easily be extracted from Medicaid claims data across all states and can be consistently implemented.

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### 4. Use and Usability

*4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)*

4a. Use: **Pass-17; Not Pass-0**; 4b. Usability: **H-10; M-7; L-0; I-0**

#### Rationale:

- The Committee agreed that the intent of this measure is to foster improved continuity of care and that the measure has the potential to improve care for this population.
- While this is a new measure and not currently in use, the Committee anticipates it will be used by states to monitor and improve quality of care provided for Medicaid beneficiaries with alcohol and/or drug related use disorders.

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### 5. Related and Competing Measures

- This measure is related to NQF #0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) and NQF #2605: Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence. The developer stated that both of these measures have been harmonized to the extent possible, thus, the Committee did not discuss harmonization.

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### 6. Standing Committee Recommendation for Endorsement: Y-17; N-0

### 7. Public and Member Comment

- Five comments were received on this measure during the post-evaluation commenting period. Two comments were in support of the Committee’s decision to recommend the measure and another commenter encouraged the developer to incorporate telehealth into the next iteration of the measure. Another commenter suggested that modifications be made to the measure to ensure alignment, harmonization, and consistent terminology among similar measures. For example, use the term “medically supervised withdrawal” rather than “detox,” use the DSM-5 terminology “alcohol use disorder” rather than “alcohol dependence,” and include methadone and naltrexone in pharmacotherapy for opioid use disorder. Finally, one



commenter noted concern regarding the performance measurement of emergency physicians, who are completely dependent on community resources, whether it be office-based providers or opioid treatment programs, and that it can sometimes be challenging to connect patients to such services, as they do not always exist.

- Developer response: We agree that telehealth can increase access to treatment. We will take this suggestion into consideration during the next annual update opportunity.

We appreciate the feedback, and will take the suggestion to revise “detox” to “medically supervised withdrawal” into consideration during the next annual update opportunity. The measure was tested in data that included ICD-9 codes and therefore we used “alcohol dependence” instead of the more current “alcohol use disorder.” We will take this suggestion into consideration during the next annual update opportunity.

The measure currently includes methadone and naltrexone in pharmacotherapy for opioid use disorder. These codes are in the value set that accompanied the NQF materials we submitted for endorsement.

We agree there are many factors associated with receipt of follow-up care. The evidence suggests that patients who receive follow-up care after detoxification are less likely to experience a relapse in substance use or readmissions for another detoxification. The evidence also suggests that receipt of follow-up care for individuals who are newly prescribed antipsychotic medications is associated with better medication adherence, reduced medication side effects, and improved quality of life. We believe these measures present a valuable opportunity for the healthcare system to improve the quality of care delivered to individuals with substance use disorders and individuals newly prescribed antipsychotic medications.

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#### **8. Consensus Standards Approval Committee (CSAC) Review (May 8, 2018): Y-17; N-0**

CSAC Decision: Approved for endorsement

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#### **9. Appeals**

No appeals were received.

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### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

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

**Description:** Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.

**Numerator Statement:** Antipsychotic prescriptions from the denominator prescribed to a beneficiary who completed a follow-up visit with a provider with prescribing authority within four weeks of prescription of an antipsychotic medication.



**Denominator Statement:** New antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older.

**Exclusions:** • Medicaid beneficiaries with an acute inpatient admission during the four-week follow-up period after prescription of an antipsychotic medication

- Patients who expired within four weeks of new prescription date.

**Adjustment/Stratification:** No risk adjustment or risk stratification

**Level of Analysis:** Population: Regional and State

**Setting of Care:** Outpatient Services

**Type of Measure:** Process

**Data Source:** Claims

**Measure Steward:** Centers for Medicare and Medicaid Services (CMS)

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## **STANDING COMMITTEE MEETING [01/24/2018]**

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

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-2; M-15; L-0; I-0**; 1b. Performance Gap: **H-12; M-5; L-0; I-0**

#### Rationale:

- The developer presented four clinical guidelines in support of follow-up for individuals with new antipsychotic prescriptions. The Committee agreed that any type of health monitoring and follow-up is important for this target population.
- The Committee discussed the importance of including telemedicine as a follow-up method for the measure to improve access. The current specifications include telephone follow-up, and the developer intends to include telemedicine codes in future specifications.
- There was some concern from the Committee that Medicaid claims do not identify the content of the follow-up visit and that a follow-up encounter may not be specific to antipsychotic use. Incentivizing follow-up care does not guarantee or promote quality care; however, the Committee agreed that follow-up is an important support of adherence and monitoring.

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

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2c. For composite measures: Empirical Analysis Supporting Composite))

2a. Reliability: **H-3; M-14; L-0; I-0** 2b. Validity: **H-17; M-0; L-0; I-0**

#### Rationale:

- The Committee asked for clarification on whether the follow-up was with the prescribing provider. The developer confirmed that follow-up is not limited to the prescribing provider; the measure supports integrated team based care.
- The Committee questioned how follow-up might be linked to the prescribing episode. The developer responded that follow-up was not linked to the prescribing event and inclusion in the measure does not require a psychiatric diagnosis code. This allows the measure to best capture all types of follow-up care.

- While the Committee agreed that the exclusions were clear, there was some concern about the inclusion of Compazine and its use outside of psychotic disorders.
- The measure testing had high signal-to-noise reliability across the states indicating the measure can distinguish between state-level performances with respect to healthcare quality.
- There was a high level of agreement among the expert panel members on systematic assessment of face validity: 8 out of 11 agreed that the state-level performance scores can distinguish good from poor quality of care.

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### **3. Feasibility: H-13; M-4; L-0; I-0**

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

#### Rationale:

- The Committee agreed that there was enough data in the analysis to show the feasibility of the measure.
- All required data elements are available electronically.

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### **4. Use and Usability**

*4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)*

4a. Use: **Pass-17; Not Pass-0** 4b. Usability: **H-12; M-5; L-0; I-0**

#### Rationale:

- The Committee agreed that the intent of this measure is to foster improved continuity of care and that it has the potential to improve care for this population.
- The Committee agreed that while this is a new measure and not currently in use, they anticipate it will be used by states to monitor and improve quality of care provided for Medicaid beneficiaries with serious mental illness.

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### **5. Related and Competing Measures**

- This measure is related to NQF #0108: Follow-Up care for Children Prescribed ADHD Medication (ADD). The measures focus on different populations and different medications, but have been harmonized to the extent possible with same follow-up period and look-back period to establish a “new prescription”.

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### **6. Standing Committee Recommendation for Endorsement: N/A**

### **7. Public and Member Comment**

- Six comments were received on this measure during the post-evaluation commenting period. One commenter encouraged the developer to incorporate telehealth into the next iteration of the measure. Another commenter had concerns with the availability of prescribers and the variation between states and encouraged the developer to specify whether there should be risk-adjustment based upon provider density data or an exclusion related to the lack of provider availability. Finally, one commenter suggested expanding the measurement period to

30 days or 35 days (from 28) to account for use of long-acting injectable antipsychotics. There were further concerns that limiting the follow-up period may cause errors in the measurement and may have unintended consequences.

- Developer response: The measure specifications currently include two codes for “phone visits.” These codes are in the value set that accompanied the NQF materials we submitted for endorsement. At the next annual update opportunity, we will reevaluate the list of telehealth codes and consider incorporating additional telehealth codes in the measure’s specifications.

We agree that limited psychiatric prescribers can pose a barrier to follow-up care. This measure is intended to support a team-based, integrated approach to care, and as such allows the follow-up visit to occur with any type of prescribing provider; the prescriber is not limited to a psychiatrist or other mental health specialists.

We agree it is important to identify a follow-up time period that accurately measures performance and minimizes unintended consequences. This follow-up period aligns with recommendations from clinical guidelines, which range from 2 to 4 weeks following the initial prescription. The focus of this follow-up is to monitor side effects and assess the medication’s effectiveness. Our clinical advisory workgroup panel recommended a four week follow-up time period.

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## 8. Consensus Standards Approval Committee (CSAC) Review (May 8, 2018): Y-17; N-0

CSAC Decision: Approved for endorsement

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## 9. Appeals

No appeals were received.

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## 3317 Medication Reconciliation on Admission

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

**Description:** Percentage of patients for whom a designated PTA medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.

**Numerator Statement:** Number of patients for whom a designated Prior to Admission (PTA) medication list was generated by referencing one or more external sources of medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization when the admission date is Day 0.

**Denominator Statement:** All patients admitted to an inpatient facility from home or a non-acute setting.

**Exclusions:** The measure applies two exclusion criteria to ensure that it is feasible to complete the medication reconciliation process on admission to the IPF:

1. Patients transferred from an acute care setting
2. Patient admissions with a length of stay less than or equal to 2 days

**Adjustment/Stratification:** No risk adjustment or risk stratification

**Level of Analysis:** Facility

**Setting of Care:** Inpatient/Hospital

**Type of Measure:** Process

**Data Source:** Paper Medical Records

**Measure Steward:** Centers for Medicare & Medicaid Services

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## **STANDING COMMITTEE MEETING [02/06/2018]**

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

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-2; M-19; L-0; I-0**; 1b. Performance Gap: **H-9; M-12; L-0; I-0**;

#### Rationale:

- To support the measure, the developer provided two systematic reviews of the evidence for hospital-based medication reconciliation.
- The performance gap assessed data from nine Inpatient Psychiatric Facilities (IPF) with 100 patient admissions - each produced average measure scores equaling 50%.
- Fifteen of the 16 studies included by the developer required an external source be included in the medication reconciliation process – these also align with The Joint Commission’s National Patient Safety Goal (NPSG.03.06.01) on medication safety that are relevant to the admission process. The developer noted the rationale behind maintaining external sources as a part of the intervention was to align the measure with evidence.
- The developer deliberately allowed for a wide range of “external sources” to promote ease of use in collecting the data element by including sources such as caregiver and/or patient proxy interviews, medication containers, and electronic prescribing network systems (e.g., Allscripts and Surescripts).

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

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2c. For composite measures: Empirical Analysis Supporting Composite))

2a. Reliability: **H-0; M-14; L-7; I-0** 2b. Validity: **H-0; M-20; L-0; I-0**

#### Rationale:

- Inter-rater reliability testing results indicated overall agreement of 87%; however, one of the data elements “external source” had a low Kappa score of .18.
- Committee members stated concern for the low score and the burden associated with the amount of time (six-minutes) estimated to complete all of the components of the measure.
- The developer indicated that the concept of using external sources is a part of the measure and the practice is based on evidence and guidelines from other medication reconciliation programs.
- The developer noted that an anticipated result of implementing the measure would encourage Inpatient Psychiatric Facilities to standardize the “external source” data element. In addition, supporting education will be provided to facilities to assist in improving documentation practices, including a *Prior to Admission* form intended to reduce the time of an average chart

abstraction by providing a list of all external sources that could potentially be used in the medication reconciliation process.

- The developer provided a systematic assessment of face validity. The assessment of face validity indicated that the measure is viewed as valid by 100% of voting TEP members.

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### **3. Feasibility: H-1; M-14; L-7; I-0**

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

#### Rationale:

- The Committee agreed the measure is feasible for implementation. The Committee noted concern that the measure is specified to use manually chart-abstracted data from medical records, additional costs and burden. The developer responded that the measure is specified as such because only 36% of sites attested to using an EHR system.

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### **4. Use and Usability**

*4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)*

4a. Use: **Pass-20; Not Pass-0** 4b. Usability: **H-2; M-19; L-0; I-0**

#### Rationale:

- This measure is currently not in use. The planned use is to include the measure in the CMS Inpatient Psychiatric Facility Quality Reporting Program.

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### **5. Related and Competing Measures**

- This measure relates to:
  - 0097 Medication Reconciliation Post-Discharge
  - 0293 Medication Information
  - 0553 Care for Older Adults (COA) – Medication Review
  - 0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care of Any Other Site of Care)
  - 2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
- This measure has been harmonized to the extent possible with related measures by aligning timeframe specifications and data elements.
- There are no competing measures noted.

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### **6. Standing Committee Recommendation for Endorsement: Y-19; N-2**

### **7. Public and Member Comment**

- Four comments were received on this measure during the post-evaluation commenting period. One commenter supported the measure's intent to improve patient safety through a comprehensive medication reconciliation process, but was concerned that while this measure contains elements that are essential to generating a comprehensive medication list prior to

admission, the process is still subject to human error. A second commenter had two concerns with the measure's specifications, including that "external source" reliability should not be assumed and that the measure imparts significant burden due to the six minutes it takes to compute the measure score. Two commenters also suggested that the measure be specified as an eMeasure.

- Developer response: Thank you for your comments. The Medication Reconciliation on Admission measure does not attempt to assess the accuracy of the medication information collected. The intent of this measure is to set a minimum standard by assessing whether an attempt has been made to collect Prior to Admission (PTA) medications so that these can be reconciled in a timely manner and in a dedicated location in the medical record. While the measure requires a minimum of one external source of PTA medication information, such as an electronic prescribing network, providers are encouraged to consult as many sources as needed to compile the most accurate list of PTA medications.

The Medication Reconciliation on Admission measure does not attempt to assess the accuracy of the medication information collected. The intent of this measure is to set a minimum standard by assessing whether an attempt has been made to collect. Prior to Admission (PTA) medications so that these can be reconciled in a timely manner and in a dedicated location in the medical record. While the measure requires a minimum of one external source of PTA medication information, such as an electronic prescribing network, providers are encouraged to consult as many sources as needed to compile the most accurate list of PTA medications.

We anticipate that if this measure were to be implemented, the data elements could be captured in structured fields and the average abstraction time per record to collect the eight data elements is likely to decrease. Re-specification of the measure to allow for electronic capture may be considered in the future to promote interoperability as more facilities adopt EHR systems.

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## 8. Consensus Standards Approval Committee (CSAC) Review (May 8, 2018): Y-17; N-0

CSAC Decision: Approved for endorsement

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## 9. Appeals

No appeals were received.

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## 3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)

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

**Description:** Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

**Numerator Statement:** Number of patients with documentation that the PSC tool was administered as part of the well child visit.

**Denominator Statement:** Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

**Exclusions:** No exclusions.

**Adjustment/Stratification:** No risk adjustment or risk stratification

**Level of Analysis:** Clinician: Group/Practice, Population: Regional and State

**Setting of Care:** Outpatient Services

**Type of Measure:** Process

**Data Source:** Claims, Electronic Health Records, Paper Medical Records

**Measure Steward:** Massachusetts General Hospital

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## **STANDING COMMITTEE MEETING [02/06/2018]**

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

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-18; L-1; I-0**; 1b. Performance Gap: **H-13; M-6; L-0; I-0**

#### Rationale:

- The developer cited evidence from more than 180 studies over the past 30 years demonstrating the feasibility and acceptability of the PSC tool as a clinical and research assessment focused on diverse populations on a statewide scale. The developer also provided strong evidence that children who have a positive risk score on the PSC are more likely to be referred to and/or receive mental health services.
- Performance data provided by the developer show variability in statewide rates of mental health screening with formal tools for children by age. Statewide data broken down for children ages 3-17 years were higher (71.2%) than all children .5 to 20 years of age (62.8%).
- The Committee agreed this measure is a valuable screening tool because it spans a broad age range, multiple languages and broad range of problems.
- Committee members noted concern regarding the strength of the evidence for screening linked to improved outcomes. The developer cited a series of randomized controlled trials by Kolko et al suggesting screening with the PSC leads to better outcomes, specifically higher rates of follow-up for mental health conditions and lower symptom scores on average.
- Committee members supported the intent of the measure recognizing that less than 25% of children with mental health disorders receive treatment. The Committee noted that not screening could unintentionally lead to more harm.

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

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2c. For composite measures: Empirical Analysis Supporting Composite))

2a. Reliability: **M-20; L-0; I-0**; 2b. Validity: **M-20; L-0; I-0**

#### Rationale:

- Data element validity testing was conducted with a Kappa score of .84; this indicates a very high level of reliability and validity. Inter-rater reliability was also assessed yielding 94% agreement.

- The Committee noted concern regarding the lack of specified timeframes in the numerator and/or denominator. The developer responded that the lack of a timeframe was intentional to allow for flexibility in reporting the measure and to better align the encounter with an outcome.
- During the post-comment web meeting, the Committee discussed concerns that were raised by commenters regarding the capture of the numerator CPT code 96110 to identify use of the PSC screening tool in the measure as specified in the administrative claims version. The Committee agreed that since the CPT code that is specified within the measure is not specific to the PSC-tool, there is a lack of reliability in the measure. Ultimately, the Committee voted 17-2 to endorse the measure and strongly recommended that the developer remove the administrative claims version of the measure and move forward with only the chart abstraction version. The developer agreed to this change and resubmitted the measure specifications to reflect the removal of administrative claims.

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### **3. Feasibility: H-12; M-8; L-0; I-0**

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

#### Rationale:

- The Committee agreed the measure is feasible for implementation. The measure is specified for several data sources, including claims, electronic health records, and paper medical records. All data elements are in defined fields and available in a combination of electronic sources.

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### **4. Use and Usability**

*4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)*

4a. Use: **Pass-20; Not Pass-0** 4b. Usability: **H-12; M-9; L-0; I-0**

#### Rationale:

- According to the developer, this measure is publically reported in the Behavioral Health Screening Cumulative Quarterly Report. It is also used for professional certification and recognition programs and quality improvement with benchmarking.
- The Committee discussed the potential for “labeling” as an unintended consequence of the measure. The developer noted that Massachusetts Medicaid requires screening, and with over 10 years’ experience and over a million screenings with the PSC instrument, they have not seen a case of “labeling” or other related unintended consequences. The Committee ultimately determined that not screening would result in more harm.

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### **5. Related and Competing Measures**

- This measure is related to 0712 Depression Utilization of the PHQ-9 Tool and has been harmonized to the extent possible.
- There are no competing measures noted.

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### **6. Standing Committee Recommendation for Endorsement: Y-20; N-1**



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## 7. Public and Member Comment

- Six comments on this measure were received during the post-evaluation commenting period. Five of the commenters shared general support for the measure. One comment noted adoption of the PSC tool in primary care practices in North Carolina where the state tracks rates using claims data, and another commenter noted that the measure fills a behavioral health quality measurement gap. Another commenter recommended the measure be linked to a specific disease associated rating scale and referral to treatment. Two commenters expressed concern with the capture of the numerator CPT code 96110 to identify use of the PSC screening tool in the measure as specified in the administrative claims version. Finally, two comments were received related to the evaluation of measure 3332 and the lack of clarity on the voting process during the measure evaluation meetings for the scientific acceptability criterion. Specifically, the commenters questioned why the data element validity testing satisfied the reliability requirement given the fact that the developer provided inter-rater reliability results in addition to data element validity.
  - Developer response: Although we appreciate the comment by the American Psychiatric Association Foundation and its general support for the PSC screening tool, we do not agree that adding a diagnosis specific screening tool as a second step to follow a positive screen on the PSC can be justified at this time. Since the proposal for NQF endorsement for “Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)” is based heavily on the American Academy of Pediatrics recommendation for a single, general, first stage mental health screen as a part of all well child visits (and the EPSDT requirement for the same) we believe that adding a second stage to the required first stage of general screening would go beyond current guidelines and as well as the available evidence for positive outcomes based on such a step. If the PSC is endorsed by NQF as a single stage screen, it may be possible in the future to request additional endorsements for follow up assessments (as is now done with the PHQ-9) or second stage screens.

We appreciate the chance to respond to the comment by the Federation of American Hospitals (FAH). Comment 6870 states that although FAH supports the overall intent of measure 3332, the FAH comment: 1) questions whether the measure truly meets the Scientific Acceptability criteria [as specified]; and 2) expresses confusion about the process used to evaluate the measure. Since the process used to evaluate the measure pertains to NQF Measure Evaluation Criteria, we will defer to NQF to respond to this issue. With regard to the first part of the comment, the FAH reviewer notes that the measure is specified to be collected via administrative claims alone or using manual abstraction of paper or electronic health records. We think it is essential to keep in mind the word ‘or’ and the clause that follows it. The measure is specified to be collected via administrative claims alone or using manual abstraction of paper or electronic health records. It is up to the user to assess which mechanism of collection will produce results that are reliable and valid. We also agree that the validity of CPT code 96110 as evidence that a PSC was given would need to be established before using it (the CPT code) as evidence that a PSC had been given. If in any given system, a correspondence between 96110 and/or any other billing code and the PSC can be established (as it was in these clinics in Massachusetts), then using administrative data to code the presence of the psychosocial screen is a valid way to assess the presence of this quality indicator, as documented in our testing form. Should the Behavioral Health Standing Committee

concur, we are happy to add such a clarification to our measure information form.

We appreciate the chance to reply to the comment by the American Medical Association. We believe that this comment expresses essentially the same concerns as those noted by the Federation of American Hospitals and that we have addressed the first point in our response to the FAH comments and that NQF staff will address the second issue about reliability and validity testing.

- NQF response: Thank you for your comment. You are correct that if the developer provides inter-rater reliability testing results and data element validity testing results for the measure, the Committee must vote on both reliability and validity. The committee did vote on both reliability and validity for this measure. However, in the draft report released for public comment, NQF staff incorrectly reported voting results for validity only.

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#### **8. Consensus Standards Approval Committee (CSAC) Review (May 8, 2018): Y-17; N-0**

**CSAC Decision: Approved for endorsement**

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#### **9. Appeals**

No appeals were received.

## Measures Not Endorsed

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### 3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

#### [Submission](#)

**Description:** Proportion of inpatient hospitalizations for patients 65 years of age and older who receive an order for antipsychotic medication therapy.

**Numerator Statement:** Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter.

**Denominator Statement:** Denominator: Non-psychiatric inpatient hospitalizations for patients who are 65 and older.

**Exclusions:** Denominator Exclusions: Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette's syndrome, bipolar disorder, Huntington's disease during the encounter.

**Adjustment/Stratification:** No risk adjustment or risk stratification

**Level of Analysis:** Facility

**Setting of Care:** Inpatient/Hospital

**Type of Measure:** Process

**Data Source:** Electronic Health Records

**Measure Steward:** Centers for Medicare & Medicaid Services

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#### STANDING COMMITTEE MEETING [01/19/2018]

**1. Importance to Measure and Report:** Did not meet the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-7; L-11; I-2**; 1b. Performance Gap: **N/A**

#### Rationale:

- Some Committee members were concerned that the evidence provided was not directly linked to inappropriate inpatient encounter use.
- Additional research provided by the developer indicated antipsychotic exposure rates of non-psychiatric hospital admissions in 6 - 9% of visits.
- The Committee questioned what a reasonable benchmark for this performance gap might be and agreed that the measure as specified lacked clear benchmark threshold rates to indicate quality of care and support accountability.
- The Committee was concerned by depression and pharmacotherapy related inclusions and exclusions, highlighting multiple prior to admission scenarios that the measure might not adapt for including polypharmacy antipsychotics and the use of antipsychotics for treatment of depression.
- There was an additional concern that the definition of “danger to self or others” was too vague and that there may be an unintended consequence of increased restraint use as a result of the measure.
- The Committee encouraged the developer to adjust the measure based on their feedback and bring it back for evaluation in a future endorsement review cycle.

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## **2. Scientific Acceptability of Measure Properties: N/A**

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2c. For composite measures: Empirical Analysis Supporting Composite))

2a. Reliability: **N/A** 2b. Validity: **N/A**

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## **3. Feasibility: N/A**

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

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## **4. Use and Usability**

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **N/A** 4b. Usability: **N/A**

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## **5. Related and Competing Measures**

- This measure is related to NQF #2111: Antipsychotic Use in Persons with Dementia and NQF #2933: Potentially Harmful Drug-Disease Interactions in the Elderly. The developer stated that both of these measures have been harmonized to the extent possible, thus, the Committee did not discuss harmonization.
- 

## **6. Standing Committee Recommendation for Endorsement: N/A**

## **7. Public and Member Comment**

- Three comments were received on this measure during the post-evaluation commenting period and all agreed with the Committee's decision not to recommend this measure for endorsement. One commenter also suggested that patients with schizoaffective disorder and patients with documented psychotic symptoms (e.g., delusions and hallucinations) also be excluded from the denominator.
    - Developer response: Thank you for the feedback. We look forward to exploring potential exclusions, including patients with psychotic symptoms or schizoaffective disorder, during further measure development and testing.
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## **8. Consensus Standards Approval Committee (CSAC) Review (May 8, 2018): Y-16; N-1**

CSAC Decision: Measure not approved for endorsement

## Appendix B: Behavioral Health and Substance Use Portfolio—Use in Federal Programs

NQF #	Title	Federal Programs: Finalized as of February 8, 2018
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Merit-based Incentive Payment System (MIPS) Qualified Health Plan (QHP) Quality Rating System (QRS)
0027	Medical Assistance With Smoking and Tobacco Use Cessation	Medicaid Qualified Health Plan (QHP) Quality Rating System (QRS)
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Merit-based Incentive Payment System (MIPS) Medicare Shared Savings Program (MSSP)
0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (eMeasure)	Merit-based Incentive Payment System (MIPS) Medicare Shared Savings Program (MSSP)
0104	Adult Major Depressive Disorder: Suicide Risk Assessment	Merit-based Incentive Payment System (MIPS)
0105	Antidepressant Medication Management (AMM)	Merit-based Incentive Payment System (MIPS) Quality Rating System (QRS) Qualified Health Plan (QHP) Medicaid
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Merit-based Incentive Payment System (MIPS) Qualified Health Plan (QHP) Quality Rating System (QRS) Medicaid
0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Medicare Shared Savings Program (MSSP) Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals Merit-based Incentive Payment System (MIPS) Medicaid
0418e	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eMeasure)	Medicare Shared Savings Program (MSSP) Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals Merit-based Incentive Payment System (MIPS) Medicaid Physician Compare, Physician Feedback/Quality and Resource Use Reports (QRUR) Physician Value-Based Payment Modifier (VBM)

NQF #	Title	Federal Programs: Finalized as of February 8, 2018
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Merit-based Incentive Payment System (MIPS) Hospital Compare Inpatient Psychiatric Facility Quality Reporting Medicare Physician Quality Reporting System Qualified Health Plan (QHP) Quality Rating System (QRS) Physician Feedback/Quality Resource Use Report Physician Value-Based Payment Modifier
0640	HBIPS-2 Hours of physical restraint use	Hospital Compare Inpatient Psychiatric Facility Quality Reporting
0641	HBIPS-3 Hours of seclusion use	Hospital Compare Inpatient Psychiatric Hospital Quality Reporting
0710	Depression Remission at Twelve Months	Merit-based Incentive Payment System (MIPS) Medicare Shared Savings Program (MSSP) Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals
0711	Depression Remission at Six Months	Medicare Physician Quality Reporting System Merit-Based Incentive Payment System (MIPS) Program Physician Feedback/Quality Resource Use Report Physician Value-Based Payment Modifier
0712	Depression Utilization of the PHQ-9 Tool	Merit-based Incentive Payment System (MIPS)
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Merit-based Incentive Payment System (MIPS)
1651	TOB-1 Tobacco Use Screening	Hospital Compare Inpatient Psychiatric Facility Quality Reporting
1654	TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	Hospital Compare Inpatient Psychiatric Hospital Facility Reporting
1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	Hospital Compare Inpatient Psychiatric Hospital Facility Reporting
1661	SUB-1 Alcohol Use Screening	Hospital Compare Inpatient Psychiatric Facility Quality Reporting

NQF #	Title	Federal Programs: Finalized as of February 8, 2018
1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	Hospital Compare Inpatient Psychiatric Facility Quality Reporting
1664	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Inpatient Psychiatric Facility Quality Reporting
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Merit-based Incentive Payment System (MIPS) Medicare Physician Quality Reporting System (PQRS) Physician Feedback/Quality and Resource Use Reports (QRUR) Physician Value-Based Payment Modifier (VBM)
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Medicaid
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Medicare Physician Quality Reporting System (PQRS) Physician Feedback/Quality and Resource Use Reports (QRUR) Physician Value-Based Payment Modifier (VBM) Merit-based Incentive Payment System (MIPS)
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Medicaid
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicaid
2801	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Medicaid

## Appendix C: Behavioral Health and Substance Use Standing Committee and NQF Staff

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## Appendix D: Measure Specifications

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### 3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

#### STEWARD

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

#### DESCRIPTION

Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy) within 7 or 14 days after discharge. This measure is reported across all detoxification settings.

#### TYPE

Process

#### DATA SOURCE

Claims Medicaid Analytic eXtract (MAX) 2013 and 2014 eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided. The inpatient file only contains inpatient hospital, sterilization, abortion and religious non-medical health care institution claims.

No data collection instrument provided Attachment Cont\_Care\_After\_Detox\_Value\_Sets.xlsx

#### LEVEL

Population : Regional and State

#### SETTING

Inpatient/Hospital, Outpatient Services

#### NUMERATOR STATEMENT

Discharges in the denominator who have an inpatient, intensive outpatient, partial hospitalization, outpatient visit, residential, or drug prescription or procedure within 7 or 14 days after discharge from a detoxification episode.

#### NUMERATOR DETAILS

Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.

The numerator includes individuals with any of the following within 14 days after discharge from detoxification:

- Pharmacotherapy on day of discharge through day 7 or 14.
- Outpatient, intensive outpatient, partial hospitalization, or residential

treatment procedure with a diagnosis of SUD on the day after discharge through day 7 or 14.

-Outpatient, intensive outpatient, partial hospitalization, or residential treatment with standalone SUD procedure on the day after discharge through day 7 or 14.

-Inpatient admission with an SUD diagnosis or procedure code on day after discharge through day 7 or 14.

-Long-term care institutional claims with an SUD diagnosis on day after discharge through day 7 or 14.

Continuity is reset to zero if an overdose diagnosis code appears on the same outpatient or inpatient claim.

SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes.

Pharmacotherapy includes naltrexone (short or long acting), acamprosate, or disulfiram for alcohol dependence treatment and buprenorphine for opioid dependence treatment, as well HCPCS codes to identify procedures related to injecting drugs (e.g., long-acting injectable naltrexone).

A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. States may need to adapt the list of codes to include state-specific codes.

#### DENOMINATOR STATEMENT

Adult Medicaid beneficiary discharges from detoxification from January 1 to December 15 of the measurement year.

#### DENOMINATOR DETAILS

Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.

Target population meets the following conditions:

- Medicaid beneficiaries aged 18 years and older and less than 65 years with at least one detox discharge during the year January 1-December 15.
- Enrolled in Medicaid during the month of detoxification discharge and the following month.

The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying detox episode.

Detoxification is identified using a combination of HCPCS codes, UB Revenue Codes and ICD-9/ICD-10 procedure codes. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. As with the numerator specifications, this document lists standardized specification for this measure. States will likely need to modify the specifications to include their state-specific codes.

#### EXCLUSIONS

Not applicable. The measure does not have denominator exclusions.

#### EXCLUSION DETAILS

Not applicable.

## RISK ADJUSTMENT

No risk adjustment or risk stratification

## STRATIFICATION

Location of detox is used as a stratification variable in analyses. If an inpatient hospital claim had an ICD-9/ICD-10 detoxification procedure code or a UB revenue code indicating detoxification, hospital inpatient treatment is assigned as the location of detox. In addition, hospital inpatient treatment is also assigned if a non-inpatient claim contains a HCPCS code indicating hospital inpatient detox. The remaining detox location assignments are very straightforward. Whenever possible, use of the HCPCS codes to determine location is most desired as it reflects the more precise detoxification location. The other stayover treatment location is designed to capture detox location from non-inpatient claims that do not contain a HCPCS code. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

## TYPE SCORE

Rate/proportion better quality = higher score

## ALGORITHM

The following steps are used to identify the denominator, numerator, and calculation of the measure rate:

Step 1: Identify denominator

Step 1A: Eligible population: Identify enrolled Medicaid beneficiaries ages 18-64 years who have any detoxification (withdrawal management) in inpatient hospital, residential addiction treatment program, or ambulatory detoxification (withdrawal management) discharge from January 1 to December 15 of the measurement year and are enrolled the month of detoxification and the following month. Age is calculated as of January 1 of the measurement year.

Step 1B: Overall: Among the Medicaid beneficiaries in Step 1A, identify all detoxification discharges using all inpatient, outpatient and ambulatory claims files or tables that contain HCPCS or ICD-9/ICD-10 procedure codes and UB revenue codes. If more than one detoxification in a year, treat each detoxification as a separate observation, e.g., an inpatient hospital detoxification in January and an ambulatory detoxification in July, counts as two observations.

Step 1B.1: Multiple detox claims that are within 1-2 days are combined into a single detox episode. Accordingly, sort the inpatient, outpatient and ambulatory detox discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine close-proximity episodes while retaining all clinical fields from each episode.

Step 1C: Detox location assignment: hospital inpatient, inpatient residential addiction, outpatient residential outpatient addiction, other stayover treatment and ambulatory detoxification. Use HCPCS detox procedure codes to assign detox location whenever possible; revenue center detox will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table. They will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 detox location when episodes are combined, assign the location using the first claim's location. If there is a TIE between a detox episode being identified via revenue center codes and a more specific category using HCPCS on the SAME claim, the HCPCS location prevails.

## Step 2: Identify numerator

Step 2A: Overall: From the denominator in Step 1B, identify those discharges from detoxification in any setting with a qualifying continuity service within 7 or 14 days after discharge.

Step 2A.1: Identify SUD continuity services: Continuity services are assigned using clinical claims billing information (e.g., diagnosis, procedure, revenue codes). The measure includes all claims files or data tables that contain clinical fields (e.g., inpatient hospital, outpatient, other ambulatory and long-term care). SUD diagnoses can be in any position – primary or secondary – for continuity services. Since multiple claims files or tables could each contain a continuity claim, the specification calls for creating continuity variables separately within each file type or table, sorting the files or tables by beneficiary ID and service dates, then putting them together in order to assign the set of variables that are “First” to occur relative to the detox episode discharge date. Continuity services have to occur the day after discharge through day 7 or 14.

Step 2A.2: Identify pharmacotherapy which may occur in multiple files or tables. For example, one claims file or data source may contain injectables, another claims file or table data source may contain oral medications. Consequently, pharmacotherapy variables are created separately in each source, the data sources are then sorted by beneficiary ID and service dates, then multiple pharmacotherapy data sources are put together so they will be in chronological order to assign “First” variables. Pharmacotherapy services could be provided on the same day as the discharge from detox through day 7 or 14.

Step 2A.3: Co-occurring events: Continuity service flags and pharmacotherapy flags are reset to zero if an overdose diagnosis code appears on the SAME claim as the continuity service. Further, outpatient continuity is also reset to zero if an emergency department visit occurs on the same day. If an inpatient continuity claim has an emergency department visit, it is allowed to remain a continuity service.

## Step 3: Calculate rate

Step 3A: Calculate the overall 7- or 14-day continuity rates by dividing the number of discharges with a qualifying continuity service (Step 2A) by the denominator (Step 1B).

Step 3B: Calculate the rates separately for each detox location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C).

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### 3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication

#### STEWARD

Centers for Medicare and Medicaid Services (CMS)

#### DESCRIPTION

Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.

#### TYPE

Process

#### DATA SOURCE

Claims Medicaid and Medicare administrative claims or encounter data and pharmacy claims. Data sources include:

- State Medicaid Management Information System (MMIS), MSIS, or T-MSIS or Medicaid Analytic eXtract (MAX) file: MAX PS, MAX RX, MAX IP, MAX OT
- Additional Data Sources for dual-eligible beneficiaries: Medicare Parts A, B, and D data

No data collection instrument provided Attachment  
Follow\_Up\_New\_Presc\_Antipsych\_Codes.xlsx

#### LEVEL

Population : Regional and State

#### SETTING

Outpatient Services

#### NUMERATOR STATEMENT

Antipsychotic prescriptions from the denominator prescribed to a beneficiary who completed a follow-up visit with a provider with prescribing authority within four weeks of prescription of an antipsychotic medication.

#### NUMERATOR DETAILS

The proposed numerator uses a four-week follow-up period based on clinical guidelines for appropriate follow-up after prescription of new antipsychotic medications. The optimal follow-up period was determined through testing and consultation with the Clinical Advisory Work group. The day after the prescription is counted as day 1 of the follow-up period. The date of the follow-up visit with a provider is determined by using the service date on the medical claim.

See attached Excel file for CPT and HCPCS codes that qualify for the numerator.

## DENOMINATOR STATEMENT

New antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older.

## DENOMINATOR DETAILS

Target population meets the following conditions:

1. Medicaid beneficiary age 18 years and older (including dual-eligible and Medicaid-only enrollees)
2. Newly prescribed an antipsychotic medication
3. Enrolled in Medicaid during the four months prior to and the four weeks following a new prescription of an antipsychotic medication

Beneficiaries with “newly filled prescription” are those who have had no antipsychotic medications dispensed for either new or refill prescriptions during a period of 120 days (four months) prior to the prescription fill date.

The measure focuses on new prescriptions of antipsychotic medications.

We used National Drug Codes to identify the following antipsychotic medications for this measure:

- aripiprazole (Abilify)
- asenapine maleate (Saphris)
- chlorpromazine hydrochloride
- clozapine (Clozaril, FazaClo, Versacloz)
- Compazine
- droperidol (Inapsine)
- fluoxetine hydrochloride-olanzapine (Symbyax)
- fluoxetine-olanzapine
- fluphenazine
- haloperidol (Haldol)
- iloperidone (Fanapt)
- loxapine succinate (Loxitane)
- lurasidone hydrochloride (Latuda)
- molindone hydrochloride (Moban)
- olanzapine (Zyprexa)
- paliperidone (Invega)
- Permitil
- perphenazine
- pimozide (Orap)
- prochlorperazine maleate
- quetiapine fumarate (Seroquel)
- risperidone (Risperdal)
- thioridazine hydrochloride
- thiothixene (Navane)
- trifluoperazine hydrochloride



- trilafox
- ziprasidone (Geodon)

See attached Excel file for NDCs that qualify for the denominator.

#### EXCLUSIONS

- Medicaid beneficiaries with an acute inpatient admission during the four-week follow-up period after prescription of an antipsychotic medication
- Patients who expired within four weeks of new prescription date.

#### EXCLUSION DETAILS

Acute inpatient admission during the four-week follow-up period: Beneficiaries with an inpatient admission during the four week follow-up period are excluded from the measure.

Death: Patients with a date of death during the four-week follow-up period are excluded from the measure.

#### RISK ADJUSTMENT

No risk adjustment or risk stratification

#### STRATIFICATION

Not applicable; this measure is not stratified.

#### TYPE SCORE

Rate/proportion better quality = lower score

#### ALGORITHM

To calculate the denominator:

Eligible Population:

1. Identify Medicaid beneficiaries (both dual-eligible and Medicaid-only enrollees) age 18 years and older.
2. From this group, identify those who were newly prescribed one or more antipsychotic medications.

Exclusions:

From the population identified in step 2

3. Remove any beneficiaries who were not continuously enrolled for at least four months before or four weeks following the new prescription.
4. Remove any beneficiaries who had an acute inpatient admission during the four weeks following the new prescription.
5. Remove any beneficiaries who died during the four weeks following the new prescription.

Numerator

From the beneficiaries within the denominator (after denominator exclusions have been applied)

6. Identify the number of beneficiaries who had a qualifying outpatient encounter within four weeks of the prescription date of the antipsychotic medication.

To calculate the measure score:

7. Divide the total number of beneficiaries in the numerator by the total number of beneficiaries in the denominator, after denominator exclusions have been applied.
8. Multiply this number by 100 to determine the performance rate.

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Disclaimers: 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 without warranty.

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### 3317 Medication Reconciliation on Admission

#### STEWARD

Centers for Medicare & Medicaid Services

#### DESCRIPTION

Percentage of patients for whom a designated PTA medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.

#### TYPE

Process

#### DATA SOURCE

Paper Medical Records The data dictionary and measure information form that provide instructions for abstracting the data for the measure are included with this application as an attachment. A structured chart abstraction tool with operational data definitions was developed in Microsoft Access for field testing. Prior to implementation, the measure developer will provide a finalized abstraction tool.

Available in attached appendix at A.1 No data dictionary

#### LEVEL

Facility

#### SETTING

Inpatient/Hospital

## NUMERATOR STATEMENT

Number of patients for whom a designated Prior to Admission (PTA) medication list was generated by referencing one or more external sources of medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization when the admission date is Day 0.

## NUMERATOR DETAILS

The numerator is operationalized into three key criteria of the medication reconciliation process that must be met:

1. Medications taken by the patient prior to admission are documented on a designated PTA medication list.
2. The PTA medication list is generated using at least one external source to identify the medications taken by the patient prior to admission.
3. All medications listed on the PTA medication list have a reconciliation action to continue, discontinue, or modify by the end of Day 2 of the hospitalization, or if there are no medications on the PTA medication list, the prescriber has signed the document by the end of Day 2 of the hospitalization to indicate his/her review of the PTA medication list.

The first criterion requires that the medical record contain a designated PTA Medication List to document medications that the patient is taking prior to admission. Documenting PTA medications in a designated location eliminates the potential for duplicative or inconsistent documentation of medication histories, avoids the potential for omitted medications, and provides a master source of PTA medication for easy reference by providers. PTA medications may include prescriptions, over-the-counter medications, herbals, vitamin/mineral/dietary (nutritional) supplements, and/or medical marijuana. This criterion aligns with one of the five elements of The Joint Commission's National Patient Safety Goal (NPSG.03.06.01) on medication reconciliation (The Joint Commission, 2016).

The second criterion requires that facilities consult at least one source external to the facility's records to increase comprehensive capture of all active medications on the PTA medication list. Incomplete or inaccurate PTA medication lists may result in inadequate medication reconciliation actions by the prescriber, which may lead to medication errors and ADEs. Given the absence of a single, accurate source of information on PTA medications (gold standard), the measure establishes a minimum standard for compiling PTA medication information rather than being prescriptive regarding which sources should be referenced. This requirement also aligns with other existing NQF-endorsed measures that focus on medication reconciliation. The measure allows for a wide-range of external sources to account for situations where the routinely consulted source fails to generate the information needed. For example, the patient may not be able or willing to provide information on PTA medications or a retail pharmacy may be closed or not willing to disclose PTA medications without obtaining prior patient consent. Therefore, to meet the External Source requirement, the facility can reference one or more of the following sources to compile the PTA medication list:

- Interview of the patient or patient proxy such as a caregiver
- Medication container brought in by patient or patient proxy
- Medication list brought by patient or patient proxy
- Patient support network, such as a group home
- Nursing home

- Outpatient prescriber or emergency department
- Retail pharmacy
- Prescription Drug Monitoring Program (PDMP)
- Electronic prescribing network system (e.g., Allscripts®, Surescripts®) or aggregate pharmacy billing records (such as, claims data using state/federal healthcare plans)

The third and final criterion requires that a licensed prescriber reconciles each medication on the PTA Medication List by the end of Day 2 of the hospitalization and documents whether the medication should be continued, discontinued, or modified. The date of admission is considered Day 0 and subsequent days are considered Day 1 and Day 2 for this measure. If there are no medications on the PTA medication list, the prescriber must sign the document by the end of Day 2 of the hospitalization to indicate his or her review of the PTA medication list for consideration in future treatment decisions. For example, information that indicates the patient is not taking any medications may be important to communicate to the treatment team because there may be a need to initiate treatment of indications that are discovered during admission. Signing the PTA medication list by the end of Day 2 of the hospitalization for patient admissions with no PTA medications also helps to improve communication between members of the care team and other providers during care transitions. To simplify chart abstraction and prevent abstractors from having to distinguish between medications, herbal supplements, and other remedies a patient might take, all entries on the PTA medication list must be reconciled to meet the requirements of the third criterion.

For additional details on each of the data elements included in the measure construct, refer to Appendix A.1, which includes the Data Dictionary and Data Collection Tool.

#### Citations

\*The Joint Commission. (2016). National patient safety goals effective January 1, 2017: Hospital Accreditation Program. Retrieved from [https://www.jointcommission.org/assets/1/6/NPSG\\_Chapter\\_HAP\\_Jan2017.pdf](https://www.jointcommission.org/assets/1/6/NPSG_Chapter_HAP_Jan2017.pdf)

#### DENOMINATOR STATEMENT

All patients admitted to an inpatient facility from home or a non-acute setting.

#### DENOMINATOR DETAILS

All adult and pediatric patients admitted to an IPF are eligible to be sampled, regardless of insurance types.

#### EXCLUSIONS

The measure applies two exclusion criteria to ensure that it is feasible to complete the medication reconciliation process on admission to the IPF:

1. Patients transferred from an acute care setting
2. Patient admissions with a length of stay less than or equal to 2 days

#### EXCLUSION DETAILS

Transfer from an Acute Care Setting:

The first exclusion criterion applies to patient admissions that result from a transfer from an acute care setting, such as another inpatient facility or inpatient unit. This exclusion is applied because medication reconciliation with outpatient medications may have been done at the

transferring facility and different medication reconciliation processes are required at the receiving IPF for those admissions to focus on the regimen that was used in the transferring facility. Patient admissions from long-term care facilities and emergency departments are not considered transfers and are included in the denominator for the measure.

#### Length of Stay Less than or Equal to 2 Days:

The second exclusion criterion applies to patient admissions with lengths of stay shorter than the time needed to adequately complete the medication reconciliation process. The timeframe from admission needed to complete the medication reconciliation process was discussed with the TEP, which recommended a requirement to complete reconciliation by the end of Day 2 if the day of admission is Day 0. They cited instances where patients are admitted on weekends and outpatient providers are not available to ascertain PTA medications or where patients are not stable enough to provide information immediately upon admission. The measure developer also evaluated this timeframe empirically using the field testing data to determine when most facilities could complete the medication reconciliation process. Table 2b2.2 in the NQF Measure Testing Form contains all records with complete medication reconciliation for all medications on the PTA medication list and shows the percentage of those records that had completed the medication reconciliation in one day increments of time from admission. This analysis confirmed the appropriateness of the 2-day timeframe for completing the medication reconciliation process.

#### RISK ADJUSTMENT

No risk adjustment or risk stratification

#### STRATIFICATION

Not applicable because this measure is not stratified.

#### TYPE SCORE

Rate/proportion better quality = higher score

#### ALGORITHM

To calculate the performance score:

1. Start processing. Run cases that are included in the Initial Patient Population as follows:
  - a. Find the patients that the performance measure is designed to address (all adult and pediatric patients admitted to the inpatient facility from home or a non-acute setting with a length of stay greater than two days).
2. Check Length of Stay (calculated as the Discharge Date minus the Admission Date).
  - a. If the Length of Stay is greater 2 days, continue processing and proceed to Transfer From an Acute Care Setting.
  - b. If the Length of Stay is less than or equal to 2 days, the record will proceed to Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
3. Check Transfer From an Acute Care Setting.
  - a. If the Transfer From an Acute Care Setting is equal to 1 (Yes), the case was admitted from a transfer from an acute care setting and the record will proceed to Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

- b. If the Transfer From an Acute Care Setting is equal to 2 (No), the case was admitted from an admission source other than an acute case setting. Continue processing and proceed to Designated PTA Medication List.
- 4. Check Designated PTA Medication List.
  - a. If the Designated PTA Medication List is equal to 1 (Yes), continue processing and proceed to External Source.
  - b. If the Designated PTA Medication List is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.
- 5. Check External Source.
  - a. If External Source is equal to 1 (Yes), continue processing and proceed to Reconciliation Action.
  - b. If External Source is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.
- 6. Check Reconciliation Action.
  - a. If Reconciliation Action is equal to 1 (Yes) or 3 (N/A), continue processing and proceed to Reconciliation Action by End of Day 2.
  - b. If Reconciliation Action is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.
- 7. Check Reconciliation Action by the end of Day 2 when the Admission date is Day 0.
  - a. If Reconciliation Action by End of Day 2 is equal to 1 (Yes), the record will proceed to Measure Category Assignment of E and will be in the Numerator Population. Stop processing.
  - b. If Reconciliation Action by End of Day 2 is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.

#### COPYRIGHT / DISCLAIMER

Not applicable; the measure is in the public domain.

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### 3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)

#### STEWARDS

Massachusetts General Hospital

#### DESCRIPTION

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

#### TYPE

Process

#### DATA SOURCE

Claims, Electronic Health Records, Paper Medical Records In administrative data:

If patient age  $\geq 3.0$  & age  $\leq 17.99$ ; claim for well child visit (99382 or 99383 or 99385 or 99392 or 99393 or 99394), assess presence of CPT 96110 code for screening.

In medical record (paper or electronic):

If patient age  $\Rightarrow$  3.0 & age  $\leq$  17.99; claim for well child visit (99382 or 99383 or 99385 or 99392 or 99393 or 99394), assess progress note, templated note, flowsheet, scanned in PSC, for evidence that screen was administered.

No data collection instrument provided No data dictionary

#### LEVEL

Clinician : Group/Practice, Population : Regional and State

#### SETTING

Outpatient Services

#### NUMERATOR STATEMENT

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

#### NUMERATOR DETAILS

Depending on the system, patients passing this quality measure are identified either through a review of administrative claims or the medical record. In claims data, the presence of a CPT code for screening (96110 in Massachusetts and many other states) on the same day as the WCV is required. In a chart review, the presence of a PSC score or PDF scan of it in the progress note, or score shown in the visit template or flowsheet documents the completion of the screen on the same day of the WCV. To receive credit, progress notes must indicate the name of the specific measure and actual score (eg, PSC given, score = not at risk).

#### DENOMINATOR STATEMENT

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

#### DENOMINATOR DETAILS

Cases are identified from administrative data for site. Number of unique patients ages 3.00 to 17.99 seen for a well-child visit (CPT 99381-99394) in a defined evaluation period, often a year.

#### EXCLUSIONS

No exclusions.

#### EXCLUSION DETAILS

N/A

#### RISK ADJUSTMENT

No risk adjustment or risk stratification

#### STRATIFICATION

N/A

#### TYPE SCORE

Rate/proportion better quality = higher score

#### ALGORITHM

Step 1. Count number of children aged 3-17 seen for a well child visit in state, region, clinic or other group during defined period (often, one year) using administrative data (CPT 99381-99394). N=total population. This is the denominator.

Step 2. Assess whether PSC was administered as a part of WCV, for the eligible population, using patient claims data or chart for indicator status. Pass if documentation that screen was given on the day of the WCV is present.

Step 3. Compute numerator = count of patients with completed PSC.

Step 4. Calculate clinic or other entity rate as numerator/denominator. No risk adjustment.

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## Appendix E1: Related Measures (tabular format)

### Comparison of NQF #3312, NQF #0004, and NQF #2605

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
Steward	Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services	National Committee for Quality Assurance	National Committee for Quality Assurance
Description	Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy) within 7 or 14 days after discharge. This measure is reported across all detoxification settings.	<p>The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following.</p> <ul style="list-style-type: none"> <li>- Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.</li> <li>- Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.</li> </ul>	<p>The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.</p> <p>Four rates are reported:</p> <ul style="list-style-type: none"> <li>- The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge.</li> <li>- The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge.</li> <li>- The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge.</li> <li>- The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.</li> </ul>
Type	Process	Process	Process

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
Data Source	<p>Claims Medicaid Analytic eXtract (MAX) 2013 and 2014 eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided. The inpatient file only contains inpatient hospital, sterilization, abortion and religious non-medical health care institution claims.</p> <p>No data collection instrument provided Attachment Cont_Care_After_Detox_Value_Sets.xlsx</p>	<p>Claims, Electronic Health 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).</p> <p>URL Attachment 0004_IET_Value_Sets-635860535088567062.xlsx</p>	<p>Claims Both the numerator and the denominator for this measure are based on administrative claims data.</p> <p>No data collection instrument provided Attachment 2605_Follow_Up_After_ED_Discharge_for_Mental_Health_Conditions_Value_Sets-636220757625866651.xlsx</p>
Level	Population : Regional and State	Health Plan, Integrated Delivery System	Health Plan, Population : Regional and State
Setting	Inpatient/Hospital, Outpatient Services	Emergency Department and Services, Inpatient/Hospital, Outpatient Services	Inpatient/Hospital, Outpatient Services
Numerator Statement	<p>Discharges in the denominator who have an inpatient, intensive outpatient, partial hospitalization, outpatient visit, residential, or drug prescription or procedure within 7 or 14 days after discharge from a detoxification episode.</p>	<p>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 the index episode start date. ---</p> <p>Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive</p>	<p>The numerator for each denominator population consists of two rates:</p> <p>Mental Health</p> <ul style="list-style-type: none"> <li>- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge</li> <li>- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with</li> </ul>

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
		outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).	<p>a primary diagnosis of mental health within 30 days after emergency department discharge</p> <p>Alcohol or Other Drug Dependence</p> <ul style="list-style-type: none"> <li>- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge</li> <li>- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after emergency department discharge</li> </ul>
Numerator Details	<p>Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.</p> <p>The numerator includes individuals with any of the following within 14 days after discharge from detoxification:</p> <ul style="list-style-type: none"> <li>-Pharmacotherapy on day of discharge through day 7 or 14.</li> <li>-Outpatient, intensive outpatient, partial hospitalization, or residential treatment procedure with a diagnosis of SUD on the day after discharge through day 7 or 14.</li> <li>-Outpatient, intensive outpatient, partial hospitalization, or residential treatment with standalone SUD</li> </ul>	<p>Index Episode Start Date: The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the first 10 and ½ months of the measurement year (e.g., January 1 to November 15) with a diagnosis of AOD.</p> <ul style="list-style-type: none"> <li>- For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit (not resulting in an inpatient stay), the Index Episode Start Date is the date of service.</li> <li>- For an inpatient (acute or nonacute) event, the Index Episode Start Date is the date of discharge.</li> <li>- For an ED visit that results in an inpatient event, the Index Episode Start Date is the date of the inpatient discharge.</li> <li>- For direct transfers, the Index Episode Start Date is the discharge date from the second admission</li> </ul> <p>INITIATION OF AOD TREATMENT</p>	<p>Mental Health</p> <p>Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge</p> <ul style="list-style-type: none"> <li>- A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> <li>- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> <li>- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> <li>- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).</li> <li>- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> </ul>

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
	<p>procedure on the day after discharge through day 7 or 14.</p> <p>-Inpatient admission with an SUD diagnosis or procedure code on day after discharge through day 7 or 14.</p> <p>-Long-term care institutional claims with an SUD diagnosis on day after discharge through day 7 or 14.</p> <p>Continuity is reset to zero if an overdose diagnosis code appears on the same outpatient or inpatient claim.</p> <p>SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes.</p> <p>Pharmacotherapy includes naltrexone (short or long acting), acamprosate, or disulfiram for alcohol dependence treatment and buprenorphine for opioid dependence treatment, as well HCPCS codes to identify procedures related to injecting drugs (e.g., long-acting injectable naltrexone).</p> <p>A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. States may need to adapt the list of codes to include state-specific codes.</p>	<p>If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the patient is compliant</p> <p>If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the patient must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, with an AOD diagnosis, on the Index Episode Start Date or in the 13 days after the Index Episode Start Date (14 total days). If the Index Episode Start Date and the initiation visit occur on the same day, they must be with different providers in order to count. Any of the following code combinations meet criteria:</p> <ul style="list-style-type: none"> <li>- An acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute and nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay.</li> <li>- IET Stand Alone Visits Value Set WITH AOD Dependence Value Set</li> <li>- IET Visits Group 1 Value Set WITH IET POS Group 1 Value Set AND AOD Dependence Value Set</li> <li>- IET Visits Group 2 Value Set WITH IET POS Group 2 Value Set AND AOD Dependence Value Set.</li> </ul> <p>(See corresponding Excel document for appropriate value sets)</p> <p>Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment</p>	<ul style="list-style-type: none"> <li>- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> <li>- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> </ul> <p>Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge</p> <ul style="list-style-type: none"> <li>- A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> <li>- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> <li>- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> <li>- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).</li> <li>- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> <li>- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> <li>- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the</li> </ul>

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
		<p>- See corresponding Excel document for the Detoxification Value Set.</p> <p>---</p> <p><b>ENGAGEMENT OF AOD TREATMENT</b></p> <p>Identify all patients who meet the following criteria:</p> <p>1) Numerator compliant for the Initiation of AOD Treatment numerator and</p> <p>2) Two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis, beginning on the day after the initiation encounter through 29 days after the initiation event (29 total days). Multiple engagement visits may occur on the same day, but they must be with different providers in order to count. Any of the following code combinations meet criteria:</p> <ul style="list-style-type: none"> <li>– An acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute or nonacute inpatient admissions: First Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set), Then Identify the admission date for the stay.</li> <li>– IET Stand Alone Visits Value Set with AOD Dependence Value Set.</li> <li>– IET Visits Group 1 Value Set with IET POS Group 1 Value Set and AOD Dependence Value Set.</li> <li>– IET Visits Group 2 Value Set with IET POS Group 2 Value Set and AOD Dependence Value Set.</li> </ul> <p>For patients who initiated treatment via an inpatient admission, the 29-day period for the two engagement visits begins the day after discharge.</p>	<p>emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</p> <ul style="list-style-type: none"> <li>- Transitional care management services (TCM 14 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).</li> <li>- Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.</li> </ul> <p><b>Alcohol or Other Drug Dependence</b></p> <p>Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge. Any of the following code combinations meet criteria:</p> <ul style="list-style-type: none"> <li>- IET Stand Alone Visits Value Set with a primary diagnosis of AOD (AOD Dependence Value Set).</li> <li>- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).</li> <li>- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).</li> </ul> <p>Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis alcohol or other drug dependence within 30 days after emergency department discharge. Any of the following code combinations meet criteria:</p>

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
		Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying engagement of AOD treatment. The time frame for engagement, which includes the initiation event, is 30 total days.	<ul style="list-style-type: none"> <li>- IET Stand Alone Visits Value Set with AOD Dependence Value Set</li> <li>- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).</li> <li>- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).</li> </ul>
Denominator Statement	Adult Medicaid beneficiary discharges from detoxification from January 1 to December 15 of the measurement year.	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).	Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.
Denominator Details	<p>Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.</p> <p>Target population meets the following conditions:</p> <ul style="list-style-type: none"> <li>• Medicaid beneficiaries aged 18 years and older and less than 65 years with at least one detox discharge during the year January 1-December 15.</li> <li>• Enrolled in Medicaid during the month of detoxification discharge and the following month.</li> </ul>	<p>Identify the Index Episode. Identify all patients in the specified age range who during the first 10 and ½ months of the measurement year (e.g., January 1 to November 15) had one of the following:</p> <ul style="list-style-type: none"> <li>• An outpatient visit, intensive outpatient encounter or partial hospitalization with a diagnosis of AOD. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> <li>– IET Stand Alone Visits Value Set WITH AOD Dependence Value Set.</li> <li>– IET Visits Group 1 Value Set WITH IET POS Group 1 Value Set AND AOD Dependence Value Set.</li> <li>– IET Visits Group 2 Value Set WITH IET POS Group 2 Value Set AND AOD Dependence Value Set.</li> </ul> </li> </ul>	<p>Age: 18 years and older as of the date of discharge</p> <p>Benefit: Medical and Behavioral Health</p> <p>Continuous Enrollment: Date of emergency department visit through 30 days after discharge</p> <p>Diagnosis criteria: Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health (see Mental Health Diagnosis Value Set) or alcohol or other drug dependence (see AOD Dependence Value Set) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not individuals. If a person has more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Use only facility claims to identify</p>

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
	<p>The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying detox episode.</p> <p>Detoxification is identified using a combination of HCPCS codes, UB Revenue Codes and ICD-9/ICD-10 procedure codes. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. As with the numerator specifications, this document lists standardized specification for this measure. States will likely need to modify the specifications to include their state-specific codes.</p>	<p>(See corresponding Excel document for the appropriate value sets)</p> <ul style="list-style-type: none"> <li>• A detoxification visit (See corresponding Excel document for the Detoxification Value Set)</li> <li>• An ED visit with a diagnosis of AOD (See corresponding Excel document for the ED Value Set and the AOD Dependence Value Set).</li> <li>• An acute or nonacute inpatient discharge with either a diagnosis of AOD (AOD Dependence Value Set) or an AOD procedure code (AOD Procedures Value Set). To identify acute and nonacute inpatient discharges: First, identify all acute and nonacute inpatient stays (Inpatient Stay Value Set), Second, identify the discharge date for the stay.</li> </ul> <p>For patients with more than one episode of AOD, use the first episode.</p> <p>For patients whose first episode was an ED visit that resulted in an inpatient event, use the inpatient discharge.</p> <p>Select the Index Episode Start Date.</p>	<p>denominator events (including admissions or direct transfers). Do not use professional claims.</p>
Exclusions	<p>Not applicable. The measure does not have denominator exclusions.</p>	<p>Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. (See corresponding Excel document for the AOD Dependence Value Set)</p> <p>Exclude from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) patients whose initiation of treatment event is an inpatient stay with a</p>	<p>The following are exclusions from the denominator:</p> <ul style="list-style-type: none"> <li>-If the discharge is followed by readmission or direct transfer to an emergency department for a principal diagnosis of mental health or alcohol or other drug dependence within the 30-day follow-up period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.</li> <li>-Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 30-day</li> </ul>



	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
		discharge date after December 1 of the measurement year.	follow-up period, regardless of primary diagnosis for the admission. These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Exclusion Details	Not applicable.	<p>Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. (See corresponding Excel document for the AOD Dependence Value Set)</p> <ul style="list-style-type: none"> <li>- For an inpatient Index Episode Start Date, use the admission date to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.</li> <li>- For an ED visit that results in an inpatient event, use the ED date of service to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.</li> <li>- For direct transfers, use the first admission to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.</li> </ul>	See Section S.10 for exclusion details
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification 123834   140881   135810 123834   140881   135810	No risk adjustment or risk stratification 123834   140881   135810 123834   140881   135810



	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
Stratification	Location of detox is used as a stratification variable in analyses. If an inpatient hospital claim had an ICD-9/ICD-10 detoxification procedure code or a UB revenue code indicating detoxification, hospital inpatient treatment is assigned as the location of detox. In addition, hospital inpatient treatment is also assigned if a non-inpatient claim contains a HCPCS code indicating hospital inpatient detox. The remaining detox location assignments are very straightforward. Whenever possible, use of the HCPCS codes to determine location is most desired as it reflects the more precise detoxification location. The other stayover treatment location is designed to capture detox location from non-inpatient claims that do not contain a HCPCS code. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.	The total population is stratified by age: 13-17 and 18+ years of age. Report two age stratifications and a total rate. The total is the sum of the age stratifications.	Not applicable.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	The following step are used to identify the denominator, numerator, and calculation of the measure rate: Step 1: Identify denominator Step 1A: Eligible population: Identify enrolled Medicaid beneficiaries ages 18-64 years who have any detoxification (withdrawal management) in inpatient	Step 1. Determine the eligible population. The eligible population is all patients who satisfy all specified denominator criteria (S9-S11). Step 2. Search administrative systems to identify numerator events for all patients in the eligible population (S6).	Mental Health Step 1: Determine the eligible population. Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health. Step 1B: Exclude patients who meet the exclusion criteria as specified in the “Denominator Exclusion Details” section.

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
	<p>hospital, residential addiction treatment program, or ambulatory detoxification (withdrawal management) discharge from January 1 to December 15 of the measurement year and are enrolled the month of detoxification and the following month. Age is calculated as of January 1 of the measurement year.</p> <p>Step 1B: Overall: Among the Medicaid beneficiaries in Step 1A, identify all detoxification discharges using all inpatient, outpatient and ambulatory claims files or tables that contain HCPCS or ICD-9/ICD-10 procedure codes and UB revenue codes. If more than one detoxification in a year, treat each detoxification as a separate observation, e.g., an inpatient hospital detoxification in January and an ambulatory detoxification in July, counts as two observations.</p> <p>Step 1B.1: Multiple detox claims that are within 1-2 days are combined into a single detox episode. Accordingly, sort the inpatient, outpatient and ambulatory detox discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine close-proximity episodes while retaining all clinical fields from each episode.</p>	<p>Step 3. Calculate the rate of numerator events in the eligible population. 123834   140881   135810</p>	<p>Step 2: Identify the numerator.</p> <p>Step 2A: Identify those who had a qualifying follow-up visit within 7 days.</p> <p>Step 2B: Identify those who had a qualifying follow-up visit within 30 days.</p> <p>Step 3: Calculate the rates.</p> <p>Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B).</p> <p>Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B).</p> <p>Alcohol or Other Drug Dependence</p> <p>Step 1: Determine the eligible population.</p> <p>Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug dependence.</p> <p>Step 1B: Exclude patients who meet the exclusion criteria as specified in the “Denominator Exclusion Details” section.</p> <p>Step 2: Identify the numerator.</p> <p>Step 2A: Identify those who had a qualifying follow-up visit within 7 days.</p> <p>Step 2B: Identify those who had a qualifying follow-up visit within 30 days.</p> <p>Step 3: Calculate the rates.</p> <p>Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B).</p> <p>Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days</p>

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
	<p>Step 1C: Detox location assignment: hospital inpatient, inpatient residential addiction, outpatient residential addiction, other stayover treatment and ambulatory detoxification. Use HCPCS detox procedure codes to assign detox location whenever possible; revenue center detox will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table. They will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 detox location when episodes are combined, assign the location using the first claim's location. If there is a TIE between a detox episode being identified via revenue center codes and a more specific category using HCPCS on the SAME claim, the HCPCS location prevails.</p> <p>Step 2: Identify numerator</p> <p>Step 2A: Overall: From the denominator in Step 1B, identify those discharges from detoxification in any setting with a qualifying continuity service within 7 or 14 days after discharge.</p> <p>Step 2A.1: Identify SUD continuity services: Continuity services are assigned using clinical claims billing information (e.g., diagnosis, procedure, revenue codes). The measure includes</p>		<p>(Step 2B) by the denominator (after exclusions) (Step 1B). 123834   140881   135810</p>

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
	<p>all claims files or data tables that contain clinical fields (e.g., inpatient hospital, outpatient, other ambulatory and long-term care). SUD diagnoses can be in any position – primary or secondary – for continuity services. Since multiple claims files or tables could each contain a continuity claim, the specification calls for creating continuity variables separately within each file type or table, sorting the files or tables by beneficiary ID and service dates, then putting them together in order to assign the set of variables that are “First” to occur relative to the detox episode discharge date. Continuity services have to occur the day after discharge through day 7 or 14.</p> <p>Step 2A.2: Identify pharmacotherapy which may occur in multiple files or tables. For example, one claims file or data source may contain injectables, another claims file or table data source may contain oral medications. Consequently, pharmacotherapy variables are created separately in each source, the data sources are then sorted by beneficiary ID and service dates, then multiple pharmacotherapy data sources are put together so they will be in chronological order to assign “First” variables. Pharmacotherapy services could be provided on the same day as</p>		

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
	<p>the discharge from detox through day 7 or 14.</p> <p>Step 2A.3: Co-occurring events: Continuity service flags and pharmacotherapy flags are reset to zero if an overdose diagnosis code appears on the SAME claim as the continuity service. Further, outpatient continuity is also reset to zero if an emergency department visit occurs on the same day. If an inpatient continuity claim has an emergency department visit, it is allowed to remain a continuity service.</p> <p>Step 3: Calculate rate</p> <p>Step 3A: Calculate the overall 7- or 14-day continuity rates by dividing the number of discharges with a qualifying continuity service (Step 2A) by the denominator (Step 1B).</p> <p>Step 3B: Calculate the rates separately for each detox location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C).</p>		
Submission items	<p>5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)</p> <p>2605 : Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence</p>	<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: N/A</p>	<p>5.1 Identified measures: 0576 : Follow-Up After Hospitalization for Mental Illness (FUH)</p> <p>1937 : Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)</p> <p>3312 : Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs</p> <p>5a.1 Are specs completely harmonized? Yes</p>

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
	<p>5a.1 Are specs completely harmonized? No</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: Follow-up time period: NQF 2605 examines follow-up care 7 days and 30 days after discharge. Our proposed measure (#3312) examines follow-up care 7 days and 14 days after discharge. The 14 day follow-up time period aligns with NQF 0004 and the non-NQF endorsed Continuity of Care After Detoxification measure developed by the Washington Circle, and reflects the input of some public commenters that adults should receive some type of care within two weeks of discharge from detoxification. Diagnoses: NQF 2605 requires a primary diagnosis of alcohol and other drug dependence (AOD) for the follow-up service. Our proposed measure (#3312) requires a primary or secondary diagnosis of AOD. We allow a primary or secondary AOD diagnosis to address potential inaccuracies in how AOD diagnoses are coded. For example, some providers may be concerned about the stigma associated with an AOD diagnosis and therefore code it as a secondary diagnosis. Also, for adults with co-occurring mental health and AOD disorders, the assignment of primary and secondary diagnoses can be challenging and sometimes arbitrary.</p>		<p>5a.2 If not completely harmonized, identify difference, rationale, impact: Portions of the specifications for this measure have been adapted from the existing health plan measures (Follow-up After Hospitalization for Mental Illness NQF #0576 and Follow-up After Hospitalization for Schizophrenia NQF#1937). The proposed measure is harmonized with the two existing NQF-endorsed measures. The following highlights the differences between the measures: -Population focus (denominator): The proposed measure targets patients discharged from the emergency department (not inpatient) and also focuses on patients with alcohol or other drug dependence disorders.- Numerator: The proposed measure captures follow-up with a primary mental health or alcohol or other drug dependence diagnosis (regardless of the type of provider).</p> <p>5b.1 If competing, why superior or rationale for additive value: Not applicable.</p>

	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
	<p>The differences in follow-up time period, location and diagnoses between NQF 2605 and our proposed measure (3312) do not impact the measure's interpretability in which a higher rate is indicative of better quality. Both measures rely on administrative data. The differences in measure specifications between 2605 and 3312 are minor and expected to have minimal impact on data collection burden.</p> <p>5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no other NQF-endorsed measures that conceptually address the same measure focus and same target population.</p>		

## Comparison of NQF #3313 and NQF #0108

	3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
Steward	Centers for Medicare and Medicaid Services (CMS)	National Committee for Quality Assurance
Description	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.	Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.
Type	Process	Process
Data Source	Claims Medicaid and Medicare administrative claims or encounter data and pharmacy claims. Data sources include: <ul style="list-style-type: none"> <li>State Medicaid Management Information System (MMIS), MSIS, or T-MSIS or Medicaid Analytic eXtract (MAX) file: MAX PS, MAX RX, MAX IP, MAX OT</li> <li>Additional Data Sources for dual-eligible beneficiaries: Medicare Parts A, B, and D data</li> </ul> No data collection instrument provided Attachment Follow_Up_New_Presc_Antipsych_Codes.xlsx	Claims (Only), Pharmacy This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system. No data collection instrument provided Attachment 0108_ADD_Value_Sets.xlsx
Level	Population : Regional and State	Health Plan, Integrated Delivery System
Setting	Outpatient Services	Clinician Office/Clinic
Numerator Statement	Antipsychotic prescriptions from the denominator prescribed to a beneficiary who completed a follow-up visit with a provider with prescribing authority within four weeks of prescription of an antipsychotic medication.	Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.
Numerator Details	The proposed numerator uses a four-week follow-up period based on clinical guidelines for appropriate follow-up after prescription of new antipsychotic medications. The optimal follow-up period was determined through testing and consultation with the Clinical Advisory	RATE 1. INITIATION PHASE NUMERATOR An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the earliest prescription dispensing date for a new ADHD medication. Any of the following



	3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
	<p>Work group. The day after the prescription is counted as day 1 of the follow-up period. The date of the follow-up visit with a provider is determined by using the service date on the medical claim.</p> <p>See attached Excel file for CPT and HCPCS codes that qualify for the numerator.</p>	<p>code combinations billed by a practitioner with prescribing authority meet criteria:</p> <p>ADD Stand Alone Visits Value Set.</p> <p>ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.</p> <p>ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.</p> <p>Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit.</p> <p><b>RATE 2. CONTINUATION AND MAINTENANCE PHASE NUMERATOR</b></p> <p>Children who are numerator compliant for Rate 1. Initiation Phase, AND have documentation of at least two follow-up visits with any practitioner from 31–300 days (9 months) after the earliest prescription dispensing date for a new ADHD medication.</p> <p>One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:</p> <p>ADD Stand Alone Visits Value Set.</p> <p>ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.</p> <p>ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.</p> <p>Telephone Visits Value Set.</p>
Denominator Statement	New antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older.	Children 6-12 years of age newly prescribed ADHD medication.
Denominator Details	<p>Target population meets the following conditions:</p> <ol style="list-style-type: none"> <li>1. Medicaid beneficiary age 18 years and older (including dual-eligible and Medicaid-only enrollees)</li> <li>2. Newly prescribed an antipsychotic medication</li> <li>3. Enrolled in Medicaid during the four months prior to and the four weeks following a new prescription of an antipsychotic medication</li> </ol> <p>Beneficiaries with “newly filled prescription” are those who have had no antipsychotic medications dispensed for either new or refill prescriptions during a period of 120 days (four months) prior to the prescription fill date.</p>	<p><b>RATE 1. INITIATION PHASE DENOMINATOR</b></p> <p>Children age 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year. who were dispensed a new ADHD medication during the 12-month Intake Period (Table ADD-A). Patients must have all of the following:(1) A 120-day (4-month) negative medication history on or before the Index Prescription Date. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.</p> <p>(2) Continuous enrollment for 120 days prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.</p>

	3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
	<p>The measure focuses on new prescriptions of antipsychotic medications.</p> <p>We used National Drug Codes to identify the following antipsychotic medications for this measure:</p> <ul style="list-style-type: none"> <li>• aripiprazole (Abilify)</li> <li>• asenapine maleate (Saphris)</li> <li>• chlorpromazine hydrochloride</li> <li>• clozapine (Clozaril, FazaClo, Versacloz)</li> <li>• Compazine</li> <li>• droperidol (Inapsine)</li> <li>• fluoxetine hydrochloride-olanzapine (Symbyax)</li> <li>• fluoxetine-olanzapine</li> <li>• fluphenazine</li> <li>• haloperidol (Haldol)</li> <li>• iloperidone (Fanapt)</li> <li>• loxapine succinate (Loxitane)</li> <li>• lurasidone hydrochloride (Latuda)</li> <li>• molindone hydrochloride (Moban)</li> <li>• olanzapine (Zyprexa)</li> <li>• paliperidone (Invega)</li> <li>• Permitil</li> <li>• perphenazine</li> <li>• pimozide (Orap)</li> <li>• prochlorperazine maleate</li> <li>• quetiapine fumarate (Seroquel)</li> <li>• risperidone (Risperdal)</li> <li>• thioridazine hydrochloride</li> <li>• thiothixene (Navane)</li> <li>• trifluoperazine hydrochloride</li> <li>• trilafon</li> <li>• ziprasidone (Geodon)</li> </ul>	<p>(3) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:</p> <p>A principal mental health diagnosis (Mental Health Diagnosis Value Set).</p> <p>A principal diagnosis of chemical dependency (Chemical Dependency Value Set)</p> <p>Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.</p> <p>Table ADD-A: ADHD Medications</p> <p>CNS stimulants: Amphetamine-dextroamphetamine, dexamethylphenidate, dextroamphetamine, lisdexamfetamine, methamphetamine, methylphenidate</p> <p>Alpha-2 receptor agonists: Clonidine, guanfacine</p> <p>Miscellaneous: Atomoxetine</p> <p>---</p> <p><b>RATE 2. CONTINUATION AND MAINTENANCE PHASE DENOMINATOR</b></p> <p>Children who meet the eligible population criteria for Rate 1. Initiation Phase who have been continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date. Patients must have all of the following:</p> <p>(1) The patient must have filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&amp;M Phase [9 months].)</p> <p>Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.</p> <p>Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).</p> <p>(2) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index</p>

	3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
	See attached Excel file for NDCs that qualify for the denominator.	Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set). A principal diagnosis of chemical dependency (Chemical Dependency Value Set).
Exclusions	<ul style="list-style-type: none"> <li>Medicaid beneficiaries with an acute inpatient admission during the four-week follow-up period after prescription of an antipsychotic medication</li> <li>Patients who expired within four weeks of new prescription date.</li> </ul>	<p>Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date</p> <p>Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.</p> <p>Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.</p>
Exclusion Details	<p>Acute inpatient admission during the four-week follow-up period: Beneficiaries with an inpatient admission during the four week follow-up period are excluded from the measure.</p> <p>Death: Patients with a date of death during the four-week follow-up period are excluded from the measure.</p>	<p>Exclude from the denominator for both rates, children who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date</p> <p>Exclude from the denominator for both rates, children with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year</p> <p>Exclude from the denominator for both rates patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).</p>
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	Not applicable; this measure is not stratified.	N/A
Type Score	Rate/proportion better quality = lower score	Rate/proportion better quality = higher score

	3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
Algorithm	<p>To calculate the denominator:</p> <p>Eligible Population:</p> <ol style="list-style-type: none"> <li>1. Identify Medicaid beneficiaries (both dual-eligible and Medicaid-only enrollees) age 18 years and older.</li> <li>2. From this group, identify those who were newly prescribed one or more antipsychotic medications.</li> </ol> <p>Exclusions:</p> <p>From the population identified in step 2</p> <ol style="list-style-type: none"> <li>3. Remove any beneficiaries who were not continuously enrolled for at least four months before or four weeks following the new prescription.</li> <li>4. Remove any beneficiaries who had an acute inpatient admission during the four weeks following the new prescription.</li> <li>5. Remove any beneficiaries who died during the four weeks following the new prescription.</li> </ol> <p>Numerator</p> <p>From the beneficiaries within the denominator (after denominator exclusions have been applied)</p> <ol style="list-style-type: none"> <li>6. Identify the number of beneficiaries who had a qualifying outpatient encounter within four weeks of the prescription date of the antipsychotic medication.</li> </ol> <p>To calculate the measure score:</p> <ol style="list-style-type: none"> <li>7. Divide the total number of beneficiaries in the numerator by the total number of beneficiaries in the denominator, after denominator exclusions have been applied.</li> <li>8. Multiply this number by 100 to determine the performance rate.</li> </ol>	<p>INITIATION PHASE: ELIGIBLE POPULATION</p> <p>Step 1: Identify all children in the specified age range (Children 6-12 years of age: 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year) who were dispensed an ADHD medication (Table ADD-A) during the 12-month Intake Period.</p> <p>Step 2: Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.</p> <p>Step 3: Calculate continuous enrollment. Patients must be continuously enrolled for 120 days (4 months) prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.</p> <p>Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter (Acute Inpatient Value Set) in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set) AND/OR A principal diagnosis of chemical dependency (Chemical Dependency Value Set).</p> <p>Step 5: Determine the number of patients in the eligible population with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:</p> <p>ADD Stand Alone Visits Value Set.</p> <p>ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.</p> <p>ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.</p> <p>Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit.</p> <p>Step 6: Calculate a rate (number of children receiving a follow-up visit with a prescriber within 30 days of the Index Prescription Start Date).</p> <p>---</p> <p>CONTINUATION AND MAINTENANCE PHASE: ELIGIBLE POPULATION</p> <p>Step 1: Identify all patients who meet the eligible population criteria for Rate 1—Initiation Phase.</p>

	3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
		<p>Step 2: Calculate continuous enrollment. Patients must be continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date.</p> <p>Step 3: Calculate the continuous medication treatment. Using the patients in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&amp;M Phase [9 months].) Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).</p> <p>Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:</p> <ul style="list-style-type: none"> <li>A principal mental health diagnosis (Mental Health Diagnosis Value Set).</li> <li>A principal diagnosis of chemical dependency (Chemical Dependency Value Set).</li> </ul> <p>Step 5: Identify all patients in the eligible population who meet the following criteria:</p> <ul style="list-style-type: none"> <li>(1) Numerator compliant for Rate 1—Initiation Phase, and</li> <li>(2) At least two follow-up visits from 31–300 days (9 months) after the Index Prescription Start Date with any practitioner.</li> </ul> <p>One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:</p> <ul style="list-style-type: none"> <li>ADD Stand Alone Visits Value Set.</li> <li>ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.</li> <li>ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.</li> <li>Telephone Visits Value Set.</li> </ul> <p>Step 6: Calculate a rate (number of children receiving two follow-up visits with any practitioner from 31-300 days after the Index Prescription Start Date).</p>

	3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
		<p><b>ADDITIONAL EXCLUSION:</b> Exclude from the denominator for both rates, patients with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year</p> <p><b>NOTE</b> (1) Patients who have multiple overlapping prescriptions should count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug). (2) Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the Index Prescription Start Date).</p>
Submission items	<p>5.1 Identified measures: 0108 : Follow-Up Care for Children Prescribed ADHD Medication (ADD)</p> <p>5a.1 Are specs completely harmonized? Yes</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: This measure differs from NQF 0108 in that it focuses on adults rather children, and on antipsychotic medications rather than ADHD medications. The measures are completely harmonized to the extent possible, with the same follow-up period and look-back period to establish a “new prescription.”</p> <p>5b.1 If competing, why superior or rationale for additive value: Not applicable.</p>	<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: N/A</p>

## Comparison of NQF #3315e, NQF #2111, and NQF #2993

	3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting	2111 Antipsychotic Use in Persons with Dementia	2993 Potentially Harmful Drug-Disease Interactions in the Elderly
Steward	Centers for Medicare & Medicaid Services	Pharmacy Quality Alliance	National Committee for Quality Assurance
Description	Proportion of inpatient hospitalizations for patients 65 years of age and older who receive an order for antipsychotic medication therapy.	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.	<p>The percentage of patients 65 years of age and older who have evidence of an underlying disease, condition or health concern and who are dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Four rates are reported for this measure:</p> <ul style="list-style-type: none"> <li>-Rate 1: The percentage of those with a history of falls that received a potentially harmful medication</li> <li>-Rate 2: The percentage of those with dementia that received a potentially harmful medication</li> <li>-Rate 3: The percentage of those with chronic kidney disease that received a potentially harmful medication</li> <li>-Rate 4: Total rate</li> </ul> <p>A lower rate represents better performance for all rates.</p>
Type	Process	Process	Process
Data Source	Electronic Health Records Hospitals collect EHR data using certified electronic health record technology (CEHRT). The human readable format and XML are contained in the eCQM specifications attached in question S.2a. No additional tools are used for data collection for eMeasures.	Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information. No data collection instrument provided Attachment 1_ICD_Codes_AUPD_Jul2017.xlsx	Claims, Electronic Health Data, Electronic Health Records This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred

	No data collection instrument provided Attachment AP_ValueSets.xlsx		Provider Organizations via NCQA's online data submission system. No data collection instrument provided Attachment DDE_Value_Sets-635979522717911582.xlsx
Level	Facility	Health Plan, Other	Health Plan, Integrated Delivery System
Setting	Inpatient/Hospital	Other, Pharmacy The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy, etc.	Outpatient Services
Numerator Statement	Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter.	The number of patients in the denominator who had at least one prescription and > 30 days supply for any antipsychotic medication during the measurement period and do not have a diagnosis of schizophrenia, bipolar disorder, Huntington's disease or Tourette's Syndrome.	Numerator 1: Patients with a history of falls who received at least one potentially harmful medication from Table DDE-A or Table DDE-B Numerator 2: Patients with a diagnosis of dementia who received at least one potentially harmful medication from Table DDE-D Numerator 3: Patients with chronic kidney disease who received at least one potentially harmful medication from Table DDE-E Numerator 4: The sum of the three numerators
Numerator Details	The time period for data collection is the measurement year (12-month period). Numerator: Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter. Antipsychotic orders are represented with the QDM datatype and value set of Medication, Order: Antipsychotic Medications (OID: 2.16.840.1.113883.3.464.1003.196.12.1255).	The number of patients in the denominator who had at least one prescription and > 30 days supply for any antipsychotic medication during the measurement period (See Table Dementia C) and do not have a diagnosis for schizophrenia, bipolar disorder, Huntington's disease or Tourette's Syndrome (See Table Dementia D) Table Dementia C: Antipsychotic Medications Aripiprazole Asenapine	Rate 1 numerator: Dispensed an ambulatory prescription for an anticonvulsant, nonbenzodiazepine hypnotic, or SSRI (Table DDE-A), antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Table DDE-B) on or between the index episode start data and December 31 of the measurement year. Rate 2 numerator: Dispensed an ambulatory prescription for an antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic



	<p>Numerator exclusions: Inpatient hospitalizations for patients with documented indication that they are threatening harm to self or others</p> <p>Threat to self or others is represented with the QDM datatype and value set of Symptom: Threat to themselves or others (OID: 2.16.840.1.113883.3.464.1003.195.12.1020).</p> <p>To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at <a href="https://vsac.nlm.nih.gov/">https://vsac.nlm.nih.gov/</a>. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.</p>	<p>Cariprazine Chlorpromazine Clozapine Fluphenazine Haloperidol Iloperidone Loxapine Lurasidone Olanzapine Paliperidone Perphenazine Pimozide Quetiapine Risperidone Thioridazine Thiothixene Trifluoperazine Ziprasidone</p> <p>Note: The active ingredients are limited to oral, sublingual, injectable and intramuscular formulations only. Includes combination products.</p> <p>Table Dementia D: Disease Codes for Specific Disorders for Exclusion</p> <p>ICD-9</p> <p>Schizophrenia: 295.0x to 295.9x</p> <p>Bipolar/Manic Disorder: 296.0x 296.1x 296.4x to 296.9x</p> <p>Huntington's disease 333.4</p>	<p>antidepressant (Table DDE-B), or H2 receptor antagonist or anticholinergic agent (Table DDE-D) on or between the IESD and December 31 of the measurement year.</p> <p>Rate 3 numerator: Dispensed an ambulatory prescription for an NSAID or Cox-2 selective NSAID (Table DDE-E) on or between the IESD and December 31 of the measurement year.</p> <p>Rate 4 numerator: The sum of numerators 1, 2 and 3.</p> <p>Note: Do not include denied claims.</p> <p>...</p> <p>Table DDE-A: Potentially Harmful Drugs – Rate 1</p> <p>Anticonvulsants:</p> <p>Carbamazepine, Clobazam, Divalproex sodium, Ethosuximide, Ethotoin, Ezogabine, Felbamate, Fosphenytoin, Gabapentin, Lacosamide, Lamotrigine, Levetiracetam, Mephobarbital, Methsuximide, Oxcarbazepine, Phenobarbital, Phenytoin, Pregabalin, Primidone, Rufinamide, Tiagabine HCL, Topiramate, Valproate sodium, Valproic acid, Vigabatrin, Zonisamide</p> <p>SSRIs:</p> <p>Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Setraline</p> <p>---</p> <p>Table DDE-B: Potentially Harmful Drugs – Rate 1 (History of Falls) and Rate 2 (Dementia)</p> <p>Antipsychotics:</p> <p>Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Chlorpromazine, Clozapine, Fluphenazine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Perphenazine, Pimozide, Quetiapine, Risperidone, Thioridazine, Thiothixene, Trifluoperazine, Ziprasidone</p>
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			<p>Anticholinergic agents, skeletal muscle relaxants Cyclobenzaprine, Orphenadrine Anticholinergic agents, SSRIs: Paroxetine Anticholinergic agents, antiarrhythmic: Disopyramide ---</p> <p>Table DDE-E: Cox-2 Selective NSAIDs and Nonasprin NSAIDs Cox-2 Selective NSAIDs: Celecoxib Nonaspirin NSAIDs: Diclofenac potassium, Diclofenac sodium, Etodolac, Fenoprofen, Flurbiprofen, Ibuprofen, Indomethacin, Ketoprofen, Ketorolac, Meclofenamate, Mefenamic acid, Meloxicam, Nabumetone, Naproxen, Naproxen sodium, Oxaprozin, Piroxicam, Sulindac, Tolmetin</p>
Denominator Statement	Denominator: Non-psychiatric inpatient hospitalizations for patients who are 65 and older.	All patients 65 years of age and older continuously enrolled during the measurement period with a diagnosis of dementia and/or two or more prescription claims within the measurement year for a cholinesterase inhibitor or an NMDA receptor antagonist within the measurement year where the sum of days supply is >60.	All patients ages 65 years of age and older with a history of falls, dementia or chronic kidney disease in the measurement year or the year prior to the measurement year.
Denominator Details	The time period for data collection is the measurement year (12-month period). Denominator: Non-psychiatric inpatient hospitalizations for patients who are 65 and older.	All patients 66 years of age and older as of the last day of the measurement year who were continuously enrolled (i.e., had not disenrolled or died) during the measurement year with both pharmacy and medical benefits and had a diagnosis of dementia (Table Dementia A)	All patients ages 67 years and older as of December 31 of the measurement year with a history of falls, dementia or chronic kidney disease. Each of the four rates in the measure has a different denominator:

	<p>Inpatient hospitalizations are represented with the QDM datatype and value set of Encounter, Performed: Encounter Inpatient (OID: 2.16.840.1.113883.3.666.5.3001).</p> <p>To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at <a href="https://vsac.nlm.nih.gov/">https://vsac.nlm.nih.gov/</a>. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.</p>	<p>and/or two or more prescription claims for a cholinesterase inhibitor or an NMDA receptor antagonist (Dementia Table B) within the measurement year where the sum of days supply is &gt;60.</p> <p>For a beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).</p> <p>Table Dementia B: Cholinesterase Inhibitors and NMDA Receptor Antagonists</p> <p>donepezil rivastigmine galantamine memantine</p> <p>Note: The active ingredients are limited to oral and transdermal formulations only.</p> <p>Dementia Table A: Codes to Identify Dementia</p> <p>ICD-9</p> <p>046.11 046.19 290.0 290.1x 290.2x 290.3 290.4x 291.1 291.2 292.82 294.10 294.11 294.20 331.0</p>	<p>Rate 1 denominator: Patients with an accidental fall or hip fracture (Note: hip fractures are used as a proxy for identifying accidental falls). Individuals with either of the following on or between January 1 of the year prior to the measurement year and December 1 of the measurement year meet criteria:</p> <ul style="list-style-type: none"> <li>-An accidental fall (Falls Value Set).</li> <li>-An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set), with a hip fracture (Hip Fractures Value Set).</li> <li>-An acute or nonacute inpatient discharge with a hip fracture (Hip Fractures Value Set). To identify acute and nonacute inpatient discharges: 1) Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2) Identify the discharge date for the stay.</li> </ul> <p>Rate 2 denominator: Patients with a diagnosis of dementia (Dementia Value Set) or a dispensed dementia medication (Table DDE-C) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.</p> <p>Rate 3 denominator: Patients with chronic kidney disease as identified by a diagnosis of ESRD (ESRD Value Set), stage 4 chronic kidney disease (CKD Stage 4 Value Set) or kidney transplant (Kidney Transplant Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.</p> <p>Rate 4 denominator: The sum of the denominators for rates 1, 2 and 3</p> <p>-----</p> <p>Note: Patients with more than one disease or condition may appear in the measure multiple</p>
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		331.11 331.19 331.2 331.82 ICD-10 F01.51 F02.80 F03.90 G30.9 G31.83 A81.00 A81.01 A81.09 F01.50 F02.81 F03.91 F10.27 F10.96 F10.97 F13.27 F13.97 F18.97 F19.17 F19.27 F19.97 G30.0 G30.1 G30.8 G31.01 G31.09 G31.1	times (i.e., in each indicator for which they qualify). See S.2.b for all Value Sets Table DDE-C: Prescriptions to Identify Members with Dementia Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigmine Miscellaneous central nervous system agents: Memantine
Exclusions	Denominator Exclusions: Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette's syndrome, bipolar disorder, Huntington's disease during the encounter.	N/A	The following are exclusions for the condition-specific rates and total rate: For those who meet denominator criteria for the history of falls rate (Rate 1): exclude those with a diagnosis of psychosis, schizophrenia, bipolar disorder or seizure disorder. For those who meet denominator criteria for those with dementia rate (Rate 2): exclude those with a diagnosis of psychosis, schizophrenia or bipolar disorder.
Exclusion Details	Denominator Exclusions: Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette's syndrome, bipolar disorder, Huntington's disease during the encounter.	N/A	For those who meet denominator criteria for the history of falls rate (Rate 1): Exclude patients with a diagnosis of psychosis (Psychosis Value Set), schizophrenia (Schizophrenia Value Set), bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) or seizure disorder (Seizure Disorders Value Set) on or between

	<p>Theses exclusions are represented with the QDM datatype of Diagnosis.</p> <ul style="list-style-type: none"> <li>- Schizophrenia (OID: 2.16.840.1.113883.3.464.1003.105.12.1104)</li> <li>- Tourette's Syndrome (OID: 2.16.840.1.113883.3.464.1003.105.12.1030)</li> <li>- Bipolar Disorder (OID: 2.16.840.1.113883.3.67.1.101.1.128)</li> <li>- Huntington's Disease (OID: 2.16.840.1.113883.3.464.1003.105.12.1032)</li> </ul> <p>To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at <a href="https://vsac.nlm.nih.gov/">https://vsac.nlm.nih.gov/</a>. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.</p>		<p>January 1 of the year prior to the measurement year and December 1 of the measurement year. For those who meet denominator criteria for those with dementia rate (Rate 2): Exclude patients with a diagnosis of psychosis (Psychosis Value Set), schizophrenia (Schizophrenia Value Set) or bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.</p> <p>See S.2.b for all Value Sets</p>
Risk Adjustment	Stratification by risk category/subgroup	<p>No risk adjustment or risk stratification</p> <p>114349   135329</p> <p>114349   135329</p>	<p>No risk adjustment or risk stratification</p> <p>123834</p> <p>123834</p>
Stratification	<p>Results include a total score and the following strata:</p> <ul style="list-style-type: none"> <li>- Stratum 1 - Patients who were admitted or transferred to the ICU during the inpatient encounter</li> <li>- Stratum 2 - Patients who were not admitted or transferred to the ICU during the inpatient encounter</li> </ul> <p>These strata are identified using the QDM datatype of Encounter, Performed.</p> <p>ICU Admission or Transfer (OID: 2.16.840.1.113883.17.4077.3.2040)</p> <p>To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at <a href="https://vsac.nlm.nih.gov/">https://vsac.nlm.nih.gov/</a>. A list of value sets for</p>	N/A	No risk adjustment or risk stratification

	the measure is attached in the Excel workbook provided for question S.2b.		
Type Score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score
Algorithm	Please see the attached HQMF specifications for the complete measure logic. Additionally, a flow diagram of the denominator and numerator logic is attached to the NQF submission form as a supplemental document in response to question A.1, 'AP_LogicFlow_for S.14 response.pdf'.	<p>Step One: Calculate the denominator by identifying the number of all eligible patients with either:</p> <ol style="list-style-type: none"> <li>1) A diagnosis of dementia (Table Dementia A) and/or</li> <li>2) Individuals with two or more prescription claims (within the measurement year) for a cholinesterase inhibitor or an NMDA receptor antagonist (Table Dementia B) where the sum of days supply is &gt;60</li> </ol> <p>Step Two: Calculate the numerator by identifying the number of persons in the denominator who have greater than 30 days supply for any antipsychotic medication during the measurement period (Table Dementia C) and do not have a diagnosis for schizophrenia, bipolar disorder, Huntington's Disease or Tourette's Syndrome (Table Dementia D).</p> <p>Step Three: Divide the numerator (step two) by the denominator (step one) and multiply times 100 to calculate the rate as a percentage. 114349 135329</p>	<p>Step 1. Determine the eligible population: All patients 67 years of age and older as of the end (i.e., December 31) of the measurement year.</p> <p>Step 2: Identify the denominators for each of the four rates:</p> <p>Rate 1: Those in the eligible population with a history of falls (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Exclude patients with a diagnosis of psychosis, schizophrenia, bipolar disorder, or seizure disorder (see S.11 for details). Identify the index episode start date.</p> <p>Rate 2: Those in the eligible population with a dementia (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Exclude patients with a diagnosis of psychosis, schizophrenia or bipolar disorder (see S.11 for details). Identify the index episode start date.</p> <p>Rate 3: Those in the eligible population with end stage renal disease (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the index episode start date.</p> <p>Rate 4: The sum of denominators for Rates 1, 2 and 3.</p> <p>Step 3: Identify the numerators: Individuals in each of the denominators who have received at least one potentially harmful medication on or after the index episode start date (see definitions</p>

			<p>of potentially harmful medications for each numerator in section 5.6).</p> <p>Step 4: Calculate the rates:</p> <p>Rate 1 – Numerator 1 divided by denominator 1.</p> <p>Rate 2 – Numerator 2 divided by denominator 2.</p> <p>Rate 3 – Numerator 3 divided by denominator 3.</p> <p>Rate 4 – The sum of the three numerators divided by the sum of the three denominators.</p> <p>Note: for this measure a lower rate indicates better performance for all four rates.</p> <p>Index Episode Start Date. The earliest diagnosis, procedure or prescription between January 1 of the year prior to the measurement year and December 1 of the measurement year.</p> <p>For an outpatient claim/encounter, the IESD is the date of service.</p> <p>For an inpatient claim/encounter, the IESD is the discharge date.</p> <p>For dispensed prescriptions, the IESD is the dispense date. 123834</p>
Submission items	<p>5.1 Identified measures: 2111 : Antipsychotic Use in Persons with Dementia</p> <p>2993 : Potentially Harmful Drug-Disease Interactions in the Elderly</p> <p>5a.1 Are specs completely harmonized? Yes</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: These measures are harmonized to the extent possible. While all measures assess the potentially inappropriate use of antipsychotic medications, this is the only measure that assesses use of antipsychotic medications in the inpatient hospital setting. CMS N011.01 and CMS N031.02 are intended for use in the nursing home setting. Measures NQF 2111 and NQF 2993 assess health plan</p>	<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value:</p>	<p>5.1 Identified measures: 0022 : Use of High-Risk Medications in the Elderly (DAE)</p> <p>5a.1 Are specs completely harmonized? No</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: This measure and NQF 0022 have a similar focus (measuring potentially inappropriate medication use in the elderly) and reporting level (health plan), however they have different target populations. This measure targets patients with a specific condition or disease that can experience adverse effects when combined with certain medications that are recommended to be avoided for that condition. NQF 0022 targets a larger population of all older adults and assesses use of high-risk</p>



	<p>performance. This measure’s eligible population includes all patients in an inpatient hospital setting who are age 65 and older, which aligns with the age for measures NQF 2111 and NQF 2993. NQF 2111 and NQF 2993 only assess older adults with dementia, whereas this measure includes all older adults. The denominator exclusions are similar across measures. The exclusions in this measure—schizophrenia, Tourette’s syndrome, Huntington’s disease, and bipolar disorder—are similar to exclusions in related measures. CMS N011.01, CMS N031.02, and NQF 2111 exclude patients with schizophrenia, Tourette’s syndrome, or Huntington’s disease. NQF 2111 also excludes patients with bipolar disorder. NQF 2993 excludes patients with psychosis, schizophrenia, or bipolar disorder. This measure also excludes from the numerator people in the inpatient setting who are identified as a threat to themselves or others. No other measure excludes these patients, although this exclusion is appropriate for the hospital setting. The specific antipsychotic medications included in each measure are the same, with only three exceptions; NQF 2111 does not include brexpiprazole, cariprazine, and molindone whereas NQF 2993 and the measure under development include these medications.</p> <p>5b.1 If competing, why superior or rationale for additive value: Not applicable</p>		<p>medications that have been recommended to be avoided in all older adults.</p> <p>5b.1 If competing, why superior or rationale for additive value: N/A</p>
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## Comparison of NQF #3317, NQF #0097, NQF #0293, NQF #0553, NQF #0646, and NQF#2988

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
Steward	Centers for Medicare & Medicaid Services	National Committee for Quality Assurance	University of Minnesota Rural Health Research Center	National Committee for Quality Assurance	PCPI	Kidney Care Quality Alliance (KCQA)
Description	Percentage of patients for whom a designated PTA medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.	The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that medication information was communicated to the receiving FACILITY within 60 minutes of departure	Percentage of adults 66 years and older who had a medication review during the measurement year; a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Percentage of patient-months for which medication reconciliation* was performed and documented by an eligible professional.** * "Medication reconciliation" is defined as the process of creating the most accurate list of all home medications that the patient is taking, including name, indication, dosage, frequency, and route, by comparing the most recent medication list in the dialysis medical record to one or more external list(s) of

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
						<p>medications obtained from a patient or caregiver (including patient-/caregiver-provided “brown bag” information), pharmacotherapy information network (e.g., Surescripts), hospital, or other provider.</p> <p>** For the purposes of medication reconciliation, “eligible professional” is defined as: physician, RN, ARNP, PA, pharmacist, or pharmacy technician.</p>
Type	Process	Process	Process	Process	Process	Process
Data Source	Paper Medical Records The data dictionary and measure information form that provide instructions for	Claims (Only), Electronic Health Record (Only), Paper Records Health Plan Level:	Claims (Only), Electronic Health Record (Only), Imaging-Diagnostic, Laboratory, Management Data,	Claims, Electronic Health Records, Paper Medical Records NCQA collects HEDIS data directly from Health	EHRs Hybrid, Paper Records See attached data collection tool.	Electronic Health Records, Other Dialysis facility medical record; intended for use by CMS

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>abstracting the data for the measure are included with this application as an attachment. A structured chart abstraction tool with operational data definitions was developed in Microsoft Access for field testing. Prior to implementation, the measure developer will provide a finalized abstraction tool.</p> <p>Available in attached appendix at A.1 No data dictionary</p>	<p>- This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan patients. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Maintenance Organizations via NCQA's online data submission system.</p> <p>Physician Level:</p> <p>- This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the PQRS program,</p>	<p>Other, Paper Records, Pharmacy Other Attachment EDTC_3_NQF_0293.doc x</p>	<p>Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). URL Attachment 0553_COA_Medication_Review_Value_Sets.xlsx</p>	<p>Available in attached appendix at A.1 No data dictionary</p>	<p>in its CROWNWeb ESRD Clinical Data Repository. No data collection instrument provided No data dictionary</p>

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
		this measure is coded using CPT and CPT Category II codes specific to quality measurement. No data collection instrument provided No data dictionary				
Level	Facility	Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System	Facility	Health Plan, Integrated Delivery System	Facility, Integrated Delivery System	Facility
Setting	Inpatient/Hospital	Clinician Office/Clinic	Hospital	Inpatient/Hospital, Outpatient Services, Post-Acute Care	Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF	Post-Acute Care

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
Numerator Statement	Number of patients for whom a designated Prior to Admission (PTA) medication list was generated by referencing one or more external sources of medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization when the admission date is Day 0.	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.		At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.	Discharges in which the patient or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications TO BE TAKEN by Patient - Continued* Medications prescribed before inpatient stay that patient should continue to take after discharge, AND - Changed* Medications prescribed before inpatient stay with a change in dosage or directions after discharge that differs from what the patient was taking prior to the inpatient stay, AND - New*	Number of patient-months for which medication reconciliation was performed and documented by an eligible professional during the reporting period. The medication reconciliation MUST: • Include the name or other unique identifier of the eligible professional; AND • Include the date of the reconciliation; AND • Address ALL known home medications (prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<p>Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge</p> <p>* Prescribed dosage, instructions, and intended duration must be included for each continued, changed and new medication listed</p> <p>Medications NOT TO BE TAKEN by Patient</p> <p>- Discontinued</p> <p>Medications taken by patient before the inpatient stay that should be discontinued or held after discharge,</p> <p>AND</p> <p>- Allergies and Adverse Reactions</p> <p>Medications administered during the</p>	<p>AND</p> <ul style="list-style-type: none"> <li>• Address for EACH home medication: Medication name(1), indication(2), dosage(2), frequency(2), route of administration(2), start and end date (if applicable)(2), discontinuation date (if applicable)(2), reason medication was stopped or discontinued (if applicable)(2), and identification of individual who authorized stoppage or discontinuation of medication (if applicable)(2);</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>• List any allergies, intolerances, or adverse drug events experienced by the patient.</li> </ul> <p>1. For patients in a clinical trial, it is</p>

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued	acknowledged that it may be unknown as to whether the patient is receiving the therapeutic agent or a placebo. 2. “Unknown” is an acceptable response for this field.
Numerator Details	<p>The numerator is operationalized into three key criteria of the medication reconciliation process that must be met:</p> <ol style="list-style-type: none"> <li>1. Medications taken by the patient prior to admission are documented on a designated PTA medication list.</li> <li>2. The PTA medication list is generated using at least one external source to identify the medications taken by</li> </ol>	<p>This measure is specified for medical record or administrative data collection.</p> <p>Medical Record Numerator Details:</p> <ul style="list-style-type: none"> <li>- Documentation in the outpatient medical record must include evidence of medication reconciliation between the inpatient medication list and the medication list in the outpatient medical record, and the date on</li> </ul>	See attachment S.2b	<p>ADMINISTRATIVE</p> <p>Any of the following meet criteria:</p> <ul style="list-style-type: none"> <li>- Both of the following on the same date of service during the measurement year: At least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist AND The presence of a medication list in the medical record</li> </ul>	<p>Time Period for Data Collection: At each discharge during measurement period</p> <p>Numerator Instructions:</p> <ul style="list-style-type: none"> <li>• For the purposes of this measure, “medications” includes prescription, over-the-counter, and herbal products. Generic and proprietary names should be provided for each medication, when available.</li> <li>• Given the complexity of the medication</li> </ul>	<p>NUMERATOR STEP 1.</p> <p>For each patient meeting the denominator criteria in the given calculation month, identify all patients with each of the following three numerator criteria (a, b, and c) documented in the facility medical record to define the numerator for that month:</p> <p>A. Facility attestation that during the calculation month:</p>



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	<p>the patient prior to admission.</p> <p>3. All medications listed on the PTA medication list have a reconciliation action to continue, discontinue, or modify by the end of Day 2 of the hospitalization, or if there are no medications on the PTA medication list, the prescriber has signed the document by the end of Day 2 of the hospitalization to indicate his/her review of the PTA medication list.</p> <p>The first criterion requires that the medical record contain a designated PTA Medication List to document medications that the patient is taking prior to admission.</p> <p>Documenting PTA</p>	<p>which it was performed. Any of the following evidence meets criteria: (1) Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in meds since discharge, same meds at discharge, discontinue all discharge meds), (2) Documentation of the patient's current medications with a notation that the discharge medications were reviewed, (3) Documentation that the provider "reconciled the current and discharge meds," (4) Documentation of a current medication list, a discharge medication list and notation that the appropriate</p>		<p>(Medication List Value Set).</p> <ul style="list-style-type: none"> <li>- Transitional care management services (TCM 7 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 22 of the year after the measurement year.</li> <li>- Transitional care management services (TCM 14 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 15 of the year after the measurement year.</li> </ul> <p>(See corresponding Excel document for the</p>	<p>reconciliation process and variability across inpatient facilities in documentation of that process, this measure does not require that the medication list be organized under the "taken/NOT taken" headings OR the specified sub-categories, provided that the status of each medication (continued, changed, new, or discontinued) is specified within the list AND any allergic reactions are identified. For Administrative: Numerator Elements to be identified through medical record abstraction: see Sample Data Collection Tool attached in Appendix A.1.</p>	<p>1. The patient's most recent medication list in the dialysis medical record was reconciled to one or more external list(s) of medications obtained from the patient/caregiver (including patient-/caregiver-provided "brown-bag" information), pharmacotherapy information network (e.g., Surescripts®), hospital, or other provider AND that ALL known medications (prescriptions, OTCs, herbals, vitamin/mineral/dietary [nutritional] supplements, and medical marijuana) were reconciled; AND</p> <p>2. ALL of the following items were addressed</p>

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>medications in a designated location eliminates the potential for duplicative or inconsistent documentation of medication histories, avoids the potential for omitted medications, and provides a master source of PTA medication for easy reference by providers. PTA medications may include prescriptions, over-the-counter medications, herbals, vitamin/mineral/dietary (nutritional) supplements, and/or medical marijuana. This criterion aligns with one of the five elements of The Joint Commission’s National Patient Safety Goal (NPSG.03.06.01) on medication</p>	<p>practitioner type reviewed both lists on the same date of service, (5) Notation that no medications were prescribed or ordered upon discharge</p> <p>Administrative: Medication Reconciliation CPT Codes: - 99495: Transitional care management services with the following required elements: (1) communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, (2) medical decision making of at least moderate complexity during the service period and (3) face-to-face visit, within</p>		<p>value sets referenced above)</p> <p>Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.</p> <p>Medication management must be furnished no later than the date of the face-to-face visit.</p> <p>---</p> <p>MEDICAL RECORD Documentation must come from the same medical record and must include one of the following:</p> <ul style="list-style-type: none"> <li>• A medication list in the medical record, AND evidence of a</li> </ul>	<p>This measure may also be implemented in EHRs:</p> <p>This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for medication reconciliation and the information required for this measure is based on individualized patient information unique to one episode of care (i.e., inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p>	<p>for EACH identified medication:</p> <ul style="list-style-type: none"> <li>a) Medication name;</li> <li>b) Indication (or “unknown”);</li> <li>c) Dosage (or “unknown”);</li> <li>d) Frequency (or “unknown”);</li> <li>e) Route of administration (or “unknown”);</li> <li>f) Start date (or “unknown”);</li> <li>g) End date, if applicable (or “unknown”);</li> <li>h) Discontinuation date, if applicable (or “unknown”);</li> <li>i) Reason medication was stopped or discontinued, if applicable (or “unknown”); and</li> </ul>

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	<p>reconciliation (The Joint Commission, 2016). The second criterion requires that facilities consult at least one source external to the facility's records to increase comprehensive capture of all active medications on the PTA medication list. Incomplete or inaccurate PTA medication lists may result in inadequate medication reconciliation actions by the prescriber, which may lead to medication errors and ADEs. Given the absence of a single, accurate source of information on PTA medications (gold standard), the measure establishes a minimum standard for compiling PTA medication</p>	<p>14 calendar days of discharge.</p> <ul style="list-style-type: none"> <li>- 99496: Transitional care management services with the following required elements: (1) communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, (2) medical decision making of high complexity during the service period and (3) face-to-face visit, within 7 calendar days of discharge.</li> <li>- 1111F: Discharge med/current med merge</li> </ul>		<p>medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed</p> <ul style="list-style-type: none"> <li>• Notation that the patient is not taking any medication and the date when it was noted</li> </ul> <p>A review of side effects for a single medication at the time of prescription alone is not sufficient.</p> <p>An outpatient visit is not required to meet criteria.</p> <p>Prescribing practitioner is defined as a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the</p>	<p>Producing the Reconciled Medication List:</p> <p>Facilities that have implemented an EHR system should utilize their system to develop a standardized template for the Reconciled Medication List. A standardized template will ensure that all required data elements specified in the measure are included whenever a Reconciled Medication List is generated from the EHR. Each facility has the autonomy to customize the format of the Reconciled Medication List, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution.</p>	<p>j) Identification of individual who authorized stoppage or discontinuation of medication, if applicable (or "unknown"); AND</p> <p>3. Allergies, intolerances, and adverse drug events were addressed and documented.</p> <p>B. Date of the medication reconciliation.</p> <p>C. Identity of eligible professional performing the medication reconciliation.</p> <p>NUMERATOR STEP 2.</p> <p>Repeat "Numerator Step 1" for each month of the one-year reporting period to define the final</p>

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>information rather than being prescriptive regarding which sources should be referenced. This requirement also aligns with other existing NQF-endorsed measures that focus on medication reconciliation. The measure allows for a wide-range of external sources to account for situations where the routinely consulted source fails to generate the information needed. For example, the patient may not be able or willing to provide information on PTA medications or a retail pharmacy may be closed or not willing to disclose PTA medications without obtaining prior patient consent. Therefore, to</p>			<p>authority to prescribe medications.</p>	<p>Systematic External Reporting that the Reconciled Medication List was provided to patient:</p> <p>In order to report, at the facility level, which of the discharged patients have received a Reconciled Medication List, a discrete data field and code indicating the patient received a reconciled medication list at discharge may be needed in the EHR. Each facility should determine the most effective way to identify whether or not the patient received the reconciled medication list.</p> <p>Transmitting the Reconciled Medication List:</p>	<p>numerator (patient-months).</p>

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	<p>meet the External Source requirement, the facility can reference one or more of the following sources to compile the PTA medication list:</p> <ul style="list-style-type: none"> <li>• Interview of the patient or patient proxy such as a caregiver</li> <li>• Medication container brought in by patient or patient proxy</li> <li>• Medication list brought by patient or patient proxy</li> <li>• Patient support network, such as a group home</li> <li>• Nursing home</li> <li>• Outpatient prescriber or emergency department</li> <li>• Retail pharmacy</li> <li>• Prescription Drug Monitoring Program (PDMP)</li> </ul>				<p>This performance measure does not require that the Reconciled Medication List be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model (<a href="https://ecqi.healthit.gov">https://ecqi.healthit.gov</a>)</p>	

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	<ul style="list-style-type: none"> <li>Electronic prescribing network system (e.g., Allscripts®, Surescripts®) or aggregate pharmacy billing records (such as, claims data using state/federal healthcare plans)</li> </ul> <p>The third and final criterion requires that a licensed prescriber reconciles each medication on the PTA Medication List by the end of Day 2 of the hospitalization and documents whether the medication should be continued, discontinued, or modified. The date of admission is considered Day 0 and subsequent days are considered Day 1 and Day 2 for this measure. If there are no medications on the PTA medication list, the</p>				<p>v/qdm). RxNorm has been named as the recommended vocabulary for medications and can be used to identify the medications to which the allergies exist. Allergies (non-substance) and Adverse Reactions to medications should be expressed using SNOMED-CT. The use of recognized interoperability standards for the transmission of the Reconciled Medication List information will ensure that the information can be</p>	

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	<p>prescriber must sign the document by the end of Day 2 of the hospitalization to indicate his or her review of the PTA medication list for consideration in future treatment decisions. For example, information that indicates the patient is not taking any medications may be important to communicate to the treatment team because there may be a need to initiate treatment of indications that are discovered during admission. Signing the PTA medication list by the end of Day 2 of the hospitalization for patient admissions with no PTA medications also helps to improve</p>				received into the destination EHR.	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>communication between members of the care team and other providers during care transitions. To simplify chart abstraction and prevent abstractors from having to distinguish between medications, herbal supplements, and other remedies a patient might take, all entries on the PTA medication list must be reconciled to meet the requirements of the third criterion.</p> <p>For additional details on each of the data elements included in the measure construct, refer to Appendix A.1, which includes the Data Dictionary and Data Collection Tool.</p> <p>Citations</p>					



	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	*The Joint Commission. (2016). National patient safety goals effective January 1, 2017: Hospital Accreditation Program. Retrieved from <a href="https://www.jointcommission.org/assets/1/6/NPSG_Chapter_HAP_Jan2017.pdf">https://www.jointcommission.org/assets/1/6/NPSG_Chapter_HAP_Jan2017.pdf</a>					
Denominator or Statement	All patients admitted to an inpatient facility from home or a non-acute setting.	All discharges from an in-patient setting for patients who are 18 years and older.	All emergency department patients who are transferred to another healthcare facility	All patients 66 and older as of the end (e.g., December 31) of the measurement year.	All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care	Total number of patient-months for all patients permanently assigned to a dialysis facility during the reporting period.
Denominator or Details	All adult and pediatric patients admitted to an IPF are eligible to be	The denominator for this measure is identified by administrative codes,	The population of the EDTC measure set is defined by identifying patients admitted the	Use administrative data to identify all patients 66 years and older as of	Time Period for Data Collection: At each discharge during measurement period	DENOMINATOR STEP 1. Identify all in-center and home hemodialysis and peritoneal dialysis

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	sampled, regardless of insurance types.	which are specific to the level of reporting. The denominator for both levels of reporting is based on episodes, not patients. If patients have more than one discharge, include all discharges between January 1 and December 1 of the measurement year. This measure is stratified by age group so three denominator groups are identified for each level of reporting: Patients age 18-64, Patients age 65+ and all patients. Health Plan Level: Administrative: - An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.	emergency department and transferred from the emergency department to other healthcare facilities: DC codes: 3 Hospice –healthcare facility 4a Acute Care Facility-General Inpatient Care 4b Acute Care Facility-Critical Access Hospital 4c Acute Care Facility-Cancer Hospital or Children’s Hospital 4d Acute Care Facility – Department of Defense or Veteran’s Administration 5 Other health care facility	the end of the measurement year.	Note: Facilities are responsible for determining the appropriate use of codes. For Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill): <ul style="list-style-type: none"> <li>0111 (Hospital Inpatient (Including Medicare Part A), Admit through Discharge Claim)</li> <li>0114 (Hospital Inpatient (Including Medicare Part A), Interim - Last Claim)</li> <li>0121 (Hospital Inpatient (Medicare Part B only), Admit through Discharge Claim)</li> <li>0124 (Hospital Inpatient (Medicare Part</li> </ul>	patients permanently assigned to the dialysis facility in the given calculation month. DENOMINATOR STEP 2. For all patients included in the denominator in the given calculation month in “Denominator Step 1”, identify and remove all in-center hemodialysis patients who received < 7 dialysis treatments in the calculation month. DENOMINATOR STEP 3. Repeat “Denominator Step 1” and “Denominator Step 2” for each month of the one-year reporting period.

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
		<p>- Stratify the denominator by age group based on age as of December 31 of the measurement year: Patients 18-64 years of age; Patients 65 years of age and older; All Patients 18 years of age and older.</p> <p>Physician Level:</p> <p>- Patients who were discharged from an acute or nonacute inpatient facility on or between January 1 and December 1 of the measurement year and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care. Codes to identify visit with on-</p>			<p>B only), Interim - Last Claim)</p> <ul style="list-style-type: none"> <li>• 0181 (Hospital - Swing Beds, Admit through Discharge Claim)</li> <li>• 0184 (Hospital - Swing Beds, Interim - Last Claim)</li> <li>• 0211 (Skilled Nursing-Inpatient (Including Medicare Part A), Admit through Discharge Claim)</li> <li>• 0214 (Skilled Nursing-Inpatient (Including Medicare Part A), Interim - Last Claim)</li> <li>• 0221 (Skilled Nursing-Inpatient (Medicare Part B only), Admit through Discharge Claim)</li> <li>• 0224 (Skilled Nursing- Inpatient (Medicare Part B only), Interim - Last Claim)</li> </ul>	

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		<p>going care provider are below.</p> <p>- Stratify the denominator by age group based on age on the date of encounter: Patients 18-64 years of age; Patients 65 years of age and older; All Patients 18 years of age and older.</p> <p>CPT encounter codes for visit with Ongoing Care Provider:</p> <p>90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348,</p>			<ul style="list-style-type: none"> <li>• 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)</li> <li>• 0284 (Skilled Nursing-Swing Beds, Interim - Last Claim)</li> </ul> <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> <li>• 01 (Discharged to home or self care (routine discharge))</li> <li>• 02 (Discharged/transferred to a short term general hospital for inpatient care)</li> <li>• 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)</li> <li>• 04 (Discharged/transferred</li> </ul>	

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		99349, 99350, 99495, 99496, G0402, G0438, G0439			<p>to a facility that provides custodial or supportive care)</p> <ul style="list-style-type: none"> <li>• 05 (Discharged/transferred to a designated cancer center or children’s hospital)</li> <li>• 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care)</li> <li>• 21 (Discharged/transferred to court/law enforcement)</li> <li>• 43 (Discharged/transferred to a federal health care facility)</li> <li>• 50 (Hospice – home)</li> </ul>	

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					<ul style="list-style-type: none"> <li>• 51 (Hospice - medical facility (certified) providing hospice level of care)</li> <li>• 61 (Discharged/transferred to hospital-based Medicare approved swing bed)</li> <li>• 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)</li> <li>• 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))</li> <li>• 64 (Discharged/transferred to a nursing facility certified under Medicaid but not</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<p>certified under Medicare)</p> <ul style="list-style-type: none"> <li>• 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)</li> <li>• 66 (Discharged/transferred to a Critical Access Hospital (CAH))</li> <li>• 69 (Discharged/transferred to a designated disaster alternative care site)</li> <li>• 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)</li> <li>• 81 (Discharged to home or self care with a planned acute care hospital inpatient readmission)</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<ul style="list-style-type: none"> <li>• 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)</li> <li>• 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission)</li> <li>• 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)</li> <li>• 85 (Discharged/transferred to a designated cancer center or children's</li> </ul>	



	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<p>hospital with a planned acute care hospital inpatient readmission)</p> <ul style="list-style-type: none"> <li>• 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)</li> <li>• 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)</li> <li>• 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission)</li> <li>• 89 (Discharged/transferred to a hospital-based</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<p>Medicare approved swing bed with a planned acute care hospital inpatient readmission)</p> <ul style="list-style-type: none"> <li>• 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission)</li> <li>• 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission)</li> <li>• 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<p>Medicare with a planned acute care hospital inpatient readmission)</p> <ul style="list-style-type: none"> <li>• 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission)</li> <li>• 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission)</li> <li>• 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<p>hospital inpatient readmission) OR UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> <li>• 0131 (Hospital Outpatient, Admit through Discharge Claim)</li> <li>• 0134 (Hospital Outpatient, Interim - Last Claim)</li> </ul> <p>AND UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> <li>• 0762 (Hospital Observation)</li> <li>• 0490 (Ambulatory Surgery)</li> <li>• 0499 (Other Ambulatory Surgery)</li> </ul> <p>AND Discharge Status (Form Locator 17)</p>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<ul style="list-style-type: none"> <li>• 01 (Discharged to home or self care (routine discharge))</li> <li>• 02 (Discharged/transferred to a short term general hospital for inpatient care)</li> <li>• 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)</li> <li>• 04 (Discharged/transferred to a facility that provides custodial or supportive care)</li> <li>• 05 (Discharged/transferred to a designated cancer center or children's hospital)</li> <li>• 06 (Discharged/transferred</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<p>to home under care of an organized home health service organization in anticipation of covered skilled care)</p> <ul style="list-style-type: none"> <li>• 21 (Discharged/transferred to court/law enforcement)</li> <li>• 43 (Discharged/transferred to a federal health care facility)</li> <li>• 50 (Hospice – home)</li> <li>• 51 (Hospice - medical facility (certified) providing hospice level of care)</li> <li>• 61 (Discharged/transferred to hospital-based Medicare approved swing bed)</li> <li>• 62 (Discharged/transferred</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<p>to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)</p> <ul style="list-style-type: none"> <li>• 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))</li> <li>• 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)</li> <li>• 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)</li> <li>• 66 (Discharged/transferred to a Critical Access Hospital (CAH))</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<ul style="list-style-type: none"> <li>• 69 (Discharged/transferred to a designated disaster alternative care site)</li> <li>• 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)</li> <li>• 81 (Discharged to home or self-care with a planned acute care hospital inpatient readmission)</li> <li>• 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)</li> <li>• 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification)</li> </ul>	



	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<p>with a planned acute care hospital inpatient readmission)</p> <ul style="list-style-type: none"> <li>• 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)</li> <li>• 85 (Discharged/transferred to a designated cancer center or children’s hospital with a planned acute care hospital inpatient readmission)</li> <li>• 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<ul style="list-style-type: none"> <li>• 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)</li> <li>• 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission)</li> <li>• 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission)</li> <li>• 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					part units of a hospital with a planned acute care hospital inpatient readmission) <ul style="list-style-type: none"> <li>• 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission)</li> <li>• 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission)</li> <li>• 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					<p>care hospital inpatient readmission)</p> <ul style="list-style-type: none"> <li>• 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission)</li> <li>• 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission)</li> </ul> <p>This measure may also be implemented in EHRs:</p> <p>Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer</p>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
					(ADT) system, or from another electronic system where this information is stored.	
Exclusions	<p>The measure applies two exclusion criteria to ensure that it is feasible to complete the medication reconciliation process on admission to the IPF:</p> <ol style="list-style-type: none"> <li>1. Patients transferred from an acute care setting</li> <li>2. Patient admissions with a length of stay less than or equal to 2 days</li> </ol>	<p>The following exclusions are applicable to the Health Plan Level measure.</p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count only the readmission discharge</li> </ul>	All emergency department patients not discharged to another healthcare facility.	N/A	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p>	In-center patients who receive < 7 hemodialysis treatments in the facility during the reporting month.

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
		or the discharge from the facility to which the patient was transferred.				
Exclusion Details	Transfer from an Acute Care Setting: The first exclusion criterion applies to patient admissions that result from a transfer from an acute care setting, such as another inpatient facility or inpatient unit. This exclusion is applied because medication reconciliation with outpatient medications may have been done at the transferring facility and different medication reconciliation processes are required at the receiving IPF for those admissions to focus on the regimen that was	N/A	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine	N/A	Time Period for Data Collection: At each discharge during measurement period According to the PCPI methodology, exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (i.e., the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not	As detailed in “Denominator Step 2” above, transient patients, defined as in-center patients who receive < 7 hemodialysis treatments in the facility during the reporting month, are excluded from the measure.

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>used in the transferring facility. Patient admissions from long-term care facilities and emergency departments are not considered transfers and are included in the denominator for the measure.</p> <p>Length of Stay Less than or Equal to 2 Days:</p> <p>The second exclusion criterion applies to patient admissions with lengths of stay shorter than the time needed to adequately complete the medication reconciliation process. The timeframe from admission needed to complete the medication reconciliation process was discussed with the TEP, which recommended a</p>				<p>enter the decision. For measure Reconciled Medication List Received by Discharged Patients, exclusions include patients who died and patients who left against medical advice or discontinued care. Exclusions, including applicable value sets, are included in the measure specifications.</p> <p>Additional details by data source are as follows:</p> <p>For Administrative Data: UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> <li>• 07 (Left against medical advice or discontinued care)</li> <li>• 20 (Expired)</li> <li>• 40 (Expired at home)</li> <li>• 41 (Expired in a medical facility (e.g.</li> </ul>	

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>requirement to complete reconciliation by the end of Day 2 if the day of admission is Day 0. They cited instances where patients are admitted on weekends and outpatient providers are not available to ascertain PTA medications or where patients are not stable enough to provide information immediately upon admission. The measure developer also evaluated this timeframe empirically using the field testing data to determine when most facilities could complete the medication reconciliation process. Table 2b2.2 in the NQF Measure Testing Form</p>				<p>hospital, SNF, ICF, or free standing hospice))</p> <ul style="list-style-type: none"> <li>• 42 (Expired - place unknown)</li> </ul> <p>This measure may also be implemented in EHRs:</p> <p>Discharges meeting denominator exclusions criteria should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p>	



	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	contains all records with complete medication reconciliation for all medications on the PTA medication list and shows the percentage of those records that had completed the medication reconciliation in one day increments of time from admission. This analysis confirmed the appropriateness of the 2-day timeframe for completing the medication reconciliation process.					
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification 123834   140881 123834   140881	No risk adjustment or risk stratification	No risk adjustment or risk stratification 110032   123834   140881 110032   123834   140881	No risk adjustment or risk stratification 140560 140560	No risk adjustment or risk stratification 111070 111070

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
Stratification	Not applicable because this measure is not stratified.	N/A		N/A	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.	Not applicable.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score		Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	To calculate the performance score: 1. Start processing. Run cases that are included in the Initial Patient Population as follows:	Step 1: Determine the eligible population. The eligible population is all the patients aged 18 years and older. Step 2: Determine number of patients	The measure is calculated using an all-or-none approach. Other analysis may be useful for improvement or reporting. Data	Step 1. Determine the eligible population: All patients 66 years and older as of the end (e.g., December 31) of the measurement year	To calculate performance rates: 1. Find the patients who meet the initial population (i.e., the general group of patients that a set of	Scores are calculated using the following algorithm. For each calculation month in the one-year reporting period:

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>a. Find the patients that the performance measure is designed to address (all adult and pediatric patients admitted to the inpatient facility from home or a non-acute setting with a length of stay greater than two days).</p> <p>2. Check Length of Stay (calculated as the Discharge Date minus the Admission Date).</p> <p>a. If the Length of Stay is greater 2 days, continue processing and proceed to Transfer From an Acute Care Setting.</p> <p>b. If the Length of Stay is less than or equal to 2 days, the record will proceed to Measure Category Assignment of B and will not be in the</p>	<p>meeting the denominator criteria as specified in section S.9 above. The denominator includes all patients discharged from an inpatient facility. Patients may be counted more than once in the denominator if they had more than one discharge during the measurement year. Stratify the patients by age groups.</p> <p>Step 3: Determine the number of patients who meet the numerator criteria as specified in section S.6 above. The numerator includes all patients who had a reconciliation of the discharge medications with the current medication list in the</p>	<p>elements are identified for the measure. If the data element is not appropriate for the patient, items scored as NA (not applicable) are counted in the measure as a positive, or ‘yes,’ response and the patient will meet the measure criteria. The patient will either need to meet the criteria for all of the data elements (or have an NA) to pass the measure.</p>	<p>Step 2: Identify the denominator: The denominator is the eligible population</p> <p>Step 3: Identify the numerator: Individuals in the denominator who have documentation of at least one medication review conducted by a prescribing practitioner or clinical pharmacist and have a medication list in their medical record.</p> <p>Step 4: Calculate the rate:</p> <p>Numerator/Denominator 110032   123834   140881</p>	<p>performance measures is designed to address).</p> <p>2. From the patients within the initial population criteria, find the patients who qualify for the denominator. (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.</p> <p>3. Find the patients who qualify for denominator exclusions and subtract from the denominator.</p> <p>4. From the patients within the denominator, find the patients who meet the numerator criteria (i.e., the group of patients in the denominator for whom</p>	<p>1. IDENTIFY THE “RAW DENOMINATOR POPULATION”</p> <p>Identify all in-center and home hemodialysis and peritoneal dialysis patients permanently assigned to the dialysis facility during the given calculation month.</p> <p>2. REMOVE PATIENTS MEETING MEASURE EXCLUSION CRITERIA TO DEFINE THE “FINAL DENOMINATOR POPULATION” FOR THE CALCULATION MONTH</p> <p>For all patients included in the denominator during the given calculation month in Step 1 above, identify and remove all in-center patients who received &lt; 7 hemodialysis treatments during the given calculation month.</p>

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	<p>Measure Population. Stop processing.</p> <p>3. Check Transfer From an Acute Care Setting.</p> <p>a. If the Transfer From an Acute Care Setting is equal to 1 (Yes), the case was admitted from a transfer from an acute care setting and the record will proceed to Measure Category Assignment of B and will not be in the Measure Population. Stop processing.</p> <p>b. If the Transfer From an Acute Care Setting is equal to 2 (No), the case was admitted from an admission source other than an acute case setting. Continue processing and proceed to Designated PTA Medication List.</p>	<p>outpatient medical record documented.</p> <p>Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2 for each age strata. 123834  140881</p>			<p>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</p> <p>If the patient does not meet the numerator, this case represents a quality failure. 140560</p>	<p>3. IDENTIFY THE “NUMERATOR POPULATION” FOR THE CALCULATION MONTH</p> <p>For each patient remaining in the denominator during the given calculation month after Step 2, identify all patients with each of the following three numerator criteria (a, b, and c) documented in the facility medical record to define the numerator for that month:</p> <p>A. Facility attestation that during the calculation month:</p> <p>1. The patient’s most recent medication list in the dialysis medical record was reconciled to one or more external list(s) of medications obtained from the</p>

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	<p>4. Check Designated PTA Medication List.</p> <p>a. If the Designated PTA Medication List is equal to 1 (Yes), continue processing and proceed to External Source.</p> <p>b. If the Designated PTA Medication List is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.</p> <p>5. Check External Source.</p> <p>a. If External Source is equal to 1 (Yes), continue processing and proceed to Reconciliation Action.</p> <p>b. If External Source is equal to 2 (No), the record will proceed to Measure Category Assignment of D and</p>					<p>patient/caregiver (including patient-/caregiver-provided “brown-bag” information), pharmacotherapy information network (e.g., Surescripts®), hospital, or other provider AND that ALL known medications (prescriptions, OTCs, herbals, vitamin/mineral/dietary [nutritional] supplements, and medical marijuana) were reconciled; AND</p> <p>2. ALL of the following items were addressed for EACH identified medication:</p> <p>a) Medication name;</p> <p>b) Indication (or “unknown”);</p>

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	<p>will be in the Measure Population. Stop processing.</p> <p>6. Check Reconciliation Action.</p> <p>a. If Reconciliation Action is equal to 1 (Yes) or 3 (N/A), continue processing and proceed to Reconciliation Action by End of Day 2.</p> <p>b. If Reconciliation Action is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.</p> <p>7. Check Reconciliation Action by the end of Day 2 when the Admission date is Day 0.</p> <p>a. If Reconciliation Action by End of Day 2 is equal to 1 (Yes), the record will proceed to</p>					<p>c) Dosage (or “unknown”);</p> <p>d) Frequency (or “unknown”);</p> <p>e) Route of administration (or “unknown”);</p> <p>f) Start date (or “unknown”);</p> <p>g) End date, if applicable (or “unknown”);</p> <p>h) Discontinuation date, if applicable (or “unknown”);</p> <p>i) Reason medication was stopped or discontinued, if applicable (or “unknown”); and</p> <p>j) Identification of individual who authorized stoppage or discontinuation of medication, if applicable (or “unknown”);</p> <p>AND</p>

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>Measure Category Assignment of E and will be in the Numerator Population. Stop processing.</p> <p>b. If Reconciliation Action by End of Day 2 is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.</p>					<p>3. Allergies, intolerances, and adverse drug events were addressed and documented.</p> <p>B. Date of medication reconciliation.</p> <p>C. Identity of eligible professional performing medication reconciliation.</p> <p>4. CALCULATE THE PERFORMANCE SCORE FOR THE CALCULATION MONTH</p> <p>Calculate the facility's performance score for the given calculation month as follows:</p> <p>Month's Performance Score = Month's Final Numerator Population ÷ Month's Final Denominator Population</p>

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
						<p>5. CALCULATE THE ANNUAL PERFORMANCE SCORE</p> <p>Calculate the facility's annual performance score as follows:</p> <p>Facility's Annual Performance Score = (Facility's Month 1 Score + Month 2 Score +..... + Month 12 Score) ÷ 12</p> <p>111070</p>
Submission items	<p>5.1 Identified measures:</p> <p>0293 : Medication Information</p> <p>0097 : Medication Reconciliation Post-Discharge</p> <p>0646 : Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self</p>	<p>5.1 Identified measures:</p> <p>0419 : Documentation of Current Medications in the Medical Record</p> <p>0646 : Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>	<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value:</p>	<p>5.1 Identified measures:</p> <p>0097 : Medication Reconciliation Post-Discharge</p> <p>0646 : Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>	<p>5.1 Identified measures:</p> <p>0293 : Medication Information</p> <p>0097 : Medication Reconciliation Post-Discharge</p> <p>0419 : Documentation of Current Medications in the Medical Record</p> <p>0553 : Care for Older Adults (COA) – Medication Review</p>	<p>5.1 Identified measures:</p> <p>0097 : Medication Reconciliation Post-Discharge</p> <p>0554 : Medication Reconciliation Post-Discharge (MRP)</p> <p>2456 : Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient</p>



	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>Care or Any Other Site of Care)</p> <p>0553 : Care for Older Adults (COA) – Medication Review</p> <p>2988 : Medication Reconciliation for Patients Receiving Care at Dialysis Facilities</p> <p>5a.1 Are specs completely harmonized? Yes</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: The Measure Developer evaluated existing measures in the NQF portfolio to determine whether the Medication Reconciliation on Admission measure would compete with existing measures. Among the five NQF-endorsed measures that</p>	<p>0553 : Care for Older Adults (COA) – Medication Review</p> <p>2456 : Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient</p> <p>5a.1 Are specs completely harmonized? No</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: See 5b.1 for more details.</p> <p>5b.1 If competing, why superior or rationale for additive value: This measure assesses medication reconciliation between a discharge medication list and an outpatient medication list conducted post hospital</p>		<p>0554 : Medication Reconciliation Post-Discharge (MRP)</p> <p>5a.1 Are specs completely harmonized? No</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: See answer 5b.1 for more details.</p>	<p>5a.1 Are specs completely harmonized? No</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: Overall, our measure differs from existing medication reconciliation measures in that it focuses on whether or not a reconciled medication list was provided to discharged patients rather than just on whether or not reconciliation was performed. We feel that our measure better reflects the patient-focused aspect of medication reconciliation. In addition, our measure is intended for implementation at the facility-level, whereas</p>	<p>5a.1 Are specs completely harmonized? No</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: Medication Reconciliation for Patients Receiving Care at Dialysis Facilities is harmonized with existing NQF-endorsed medication reconciliation measures in that all similarly specify that the medication reconciliation must address ALL prescriptions, over-the-counters,herbals,vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency, and route. The KCQA</p>

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>evaluate the medication reconciliation process, three (NQF #0097, #0553, #2988) are specified for the outpatient setting and the two (NQF #0293 and #0646) that are specified for the inpatient setting focus on communication of information at discharge. Therefore, the Medication Reconciliation on Admission measure is the only measure that evaluates medication reconciliation on admission to an inpatient facility. To align definitions with other measures that establish a designated timeframe by which a given process must be completed from admission, the Measure</p>	<p>discharge by an ongoing care provider and documented in the outpatient record. The denominator for this measure is all patients 18+ discharged from an inpatient facility to the community.</p> <p>Related Measures:</p> <p>Measure 0553 is conducted at health plan level. This measure assesses annual outpatient medication review by a prescribing practitioner or clinical pharmacist among all patients aged 66+. A hospital discharge is not required to meet denominator criteria therefore the measure has a different target population than measure 0097 and is not a competing measure.</p>			<p>0097 and 0553 are intended for use at the health plan and integrated delivery system-level, while 0419 is intended for EP-level reporting. In addition, 0553 focuses on elderly patients, whereas our measure includes all adult patients. Given the differences in focus and measurement-level, we feel that our measure is complementary to other measures related to medication reconciliation and management by focusing on the patient receipt of a reconciled medication list.</p> <p>5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no</p>	<p>measure, however, is unique among the currently endorsed medication reconciliation measures in that the level of analysis is the dialysis facility. The KCQA measure also moves beyond a single "check/box", specifying multiple components that must be met to be counted as a "success." It requires the following additional information on each medication, where applicable and known: indication, start and end date, discontinuation date, reason the medication was stopped or discontinued, and identification of the individual who authorized stoppage or discontinuation of the</p>

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	Developer harmonized the Medication Reconciliation on Admission measure timeframes with the timeframe specifications of SUB-1 Alcohol Use Screening (NQF 1661) and TOB-1 Tobacco Use Screening (NQF 1651), developed by The Joint Commission. Both measures define the length of stay in calendar days. Standardizing definitions for calculating length of stay using the admission and discharge dates without factoring-in the admission and discharge times will not only help reduce confusion across measures but also help to improve the reliability of the	Measure 0646 is conducted at the facility level. This measure assesses whether the patient received a reconciled medication list at the time of discharge. The denominator for this measure is all patients, regardless of age, discharged from the hospital. This measure is only focused on the reconciliation of medications that were prescribed during the inpatient stay and looks to see if the patient themselves receive this reconciled list at discharge. This measure does not address whether a reconciled medication list is documented in the outpatient medical record. Therefore the			existing NQF-endorsed measures that address both the same target population and measure focus.	medication. Additionally, given the increasing frequency with which medical marijuana is prescribed, the KCQA measure specifies that this pharmacotherapeutic agent must be addressed during the reconciliation. KCQA believes these additional foci are necessary to ensure the medication reconciliation process is as comprehensive as possible to better identify and effectively address potential sources of adverse drug-related events and not function merely as a single “check-box” measure. Testing demonstrated these data elements are effectively captured and

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>measure scores by eliminating the need to capture times, which were found to be unreliable during field testing. To develop the three data elements associated with the medication reconciliation process, the Measure Developer compared the conceptual descriptions and definitions of five NQF-endorsed measures (NQF 0553, NQF 2988, NQF 0293, NQF 0646, and NQF 0097) that evaluate the medication reconciliation process. Four of the five measures explicitly require a designated medication list. For this measure, the Measure Developer operationalized that</p>	<p>measure focus is different from measure 0097, which focuses on whether or not a patients' discharge medications were reconciled with their current medications in the outpatient setting. Measure 2456 is conducted at the hospital/acute facility level. This measure assesses the quality of the medication reconciliation process in the hospital by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. This process is completed by a trained pharmacist who at the time of admission, compares the admission</p>				<p>recorded in facility's electronic medical record systems during the routine medication reconciliation process. 5b.1 If competing, why superior or rationale for additive value: Not applicable; this medication management measure is unique in its specific focus on the ESRD population.</p>

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>requirement with the Designated PTA Medication List data element. Of the three measures that required collection of medications, two had requirements for the types of sources that should be referenced to compile the list. For the Medication Reconciliation on Admission measure, the Measure Developer set to establish a minimum standard and aligned with the approach to require “one or more external sources.” While several measures required the type of information to be collected on each medication, the Measure Developer decided not to include those data elements in</p>	<p>orders to the preadmission medication list to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This measure does not address whether a reconciled medication list is documented in the outpatient medical record after discharge. Therefore the measure focus is different from measure 0097. Measure 0419 is conducted at the provider level. This measure looks at the percentage of visits for all patients 18+ for which the eligible professional attests to documenting a list of</p>				

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>this measure given the high performance and low variation for those data elements in testing. Each of the measures defines the process of reconciling the medications on the list differently. The Measure Developer incorporated aspects of each definition that are most applicable to the IPF setting. For example, the Measure Developer aligned with measures that require that the reconciliation be completed by a prescriber and that there be documentation of whether each medication be continued, modified, or discontinued. Finally, the Measure Developer considered different approaches to scoring</p>	<p>current medications using all immediate resources available on the date of the encounter. The list must include all known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements AND must contain the medications' name, dosage, frequency and route of administration. This measure only looks for documentation of current medications and is not focused on reconciling medications after a discharge. The measure has a different target population and measure focus and is</p>				

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>the measure. Four of the five NQF-endorsed measures require that all aspects of the medication reconciliation process be completed for a patient to pass the measure. The fifth measure evaluates the number of patient months for which the medication reconciliations were completed, however, this is only applicable in the outpatient setting. Therefore, the Measure Developer aligned the scoring approach to produce measure scores that represent the percentage of patient admissions that meet all the medication reconciliation criteria.</p> <p>5b.1 If competing, why superior or rationale for</p>	therefore not competing.				

	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	<p>additive value: This measure complements other existing measures because it focuses on the completion of the medication reconciliation process by the end of Day 2 of the hospitalization to the facility, which is not addressed by any existing measure. Medication reconciliation on admission is important to inform accurate medication reconciliation at discharge, which is evaluated by two of the existing measures. Medication reconciliation on admission also ensures that efforts to reconcile medications in the outpatient setting are continued at the</p>					



	3317 Medication Reconciliation on Admission	0097 Medication Reconciliation Post-Discharge	0293 Medication Information	0553 Care for Older Adults (COA) – Medication Review	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
	transition to the inpatient setting.					

## Comparison of NQF #3332 and NQF #0712

	3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)	0712 Depression Utilization of the PHQ-9 Tool
Steward	Massachusetts General Hospital	MN Community Measurement
Description	Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia who have a completed PHQ-9 or PHQ-9M tool during the measurement period.
Type	Process	Process
Data Source	<p>Claims, Electronic Health Records, Paper Medical Records In administrative data:</p> <p>If patient age =&gt; 3.0 &amp; age =&lt; 17.99; claim for well child visit (99382 or 99383 or 99385 or 99392 or 99393 or 99394), assess presence of CPT 96110 code for screening.</p> <p>In medical record (paper or electronic):</p> <p>If patient age =&gt; 3.0 &amp; age =&lt; 17.99; claim for well child visit (99382 or 99383 or 99385 or 99392 or 99393 or 99394), assess progress note, templated note, flowsheet, scanned in PSC, for evidence that screen was administered.</p> <p>No data collection instrument provided No data dictionary</p>	<p>Electronic Health Record (Only), Paper Records PROM</p> <p>The PHQ-9 depression assessment tool is a patient reported outcome tool that is in the public domain and can be obtained for free use on the Patient Health Questionnaire (PHQ) Screeners website at <a href="http://www.phqscreeners.com">www.phqscreeners.com</a>. Modes of administration include traditional paper, mail, electronic and telephonic. The tool is available on the website with 79 language translations available.</p> <p>The PHQ-9 tool is validated for use as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response). [Löwe B, Unutzer J, Callahan CM, Perkins AJ, Kroenke K. Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. Med Care 2004;42:1194-1201 and Kroenke K, Spitzer RL, Williams JBW, Löwe B. The Patient Health Questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. Gen Hosp Psychiatry 2010]</p> <p>The PHQ-9M is a modified version of the PHQ-9 tool for adolescents. Please refer to discussion in S.16.</p> <p>Available at measure-specific web page URL identified in S.1 Attachment MNCM_Depression_Care_VS_Specs_Definitions_w_Redesign_11-9-2017-636162830143430795.xlsx</p>
Level	Clinician : Group/Practice, Population : Regional and State	Facility, Clinician : Group/Practice
Setting	Outpatient Services	Clinician Office/Clinic, Behavioral Health : Outpatient
Numerator Statement	Number of patients with documentation that the PSC tool was administered as part of the well child visit.	Adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) included in the denominator who have at least one PHQ-9 or PHQ-9M tool administered and completed during a four month measurement period.
Numerator Details	Depending on the system, patients passing this quality measure are identified either through a	The total number of unique adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) in the denominator who had a least one PHQ-9 or

	3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)	0712 Depression Utilization of the PHQ-9 Tool
	review of administrative claims or the medical record. In claims data, the presence of a CPT code for screening (96110 in Massachusetts and many other states) on the same day as the WCV is required. In a chart review, the presence of a PSC score or PDF scan of it in the progress note, or score shown in the visit template or flowsheet documents the completion of the screen on the same day of the WCV. To receive credit, progress notes must indicate the name of the specific measure and actual score (eg, PSC given, score = not at risk).	<p>PHQ-9M tool administered and completed during a four month measurement period in which a visit or contact with the patient has occurred.</p> <p>Partially completed tools (e.g. answering 6 of the 9 questions) do not count as a completed tool. A valid PHQ-9 or PHQ-9M requires the completion of all nine questions for accurate scoring.</p> <p>The numerator rate is calculated as follows:</p> <p># pts with major depression or dysthymia with one or more completed PHQ-9 or PHQ-9M tools/ # pts with major depression or dysthymia with a visit or contact during the measurement period</p> <p>Rates are stratified by adolescents (12 to 17 years of age) and adults (18 years of age or older).</p> <p>Time period for data collection: four month measurement periods (In the MN program 2/01 to 5/31, 6/01 to 9/30 and 10/01 to 1/31) with dates of service occurring within the four month period.</p>
Denominator Statement	Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.	Adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia.
Denominator Details	Cases are identified from administrative data for site. Number of unique patients ages 3.00 to 17.99 seen for a well-child visit (CPT 99381-99394) in a defined evaluation period, often a year.	<p>The target population, patients age 12 and older with the diagnosis of major depression or dysthymia, regardless of severity level of the PHQ-9 or PHQ-9M.</p> <p>The number of unique patients who had a least one visit or contact with a provider during the measurement period with a diagnosis of major depression or dysthymia (Major Depression or Dysthymia Value Set). Contact is defined as visit, telephone call, e-visit or other contact that is associated with a PHQ-9 tool being completed by the patient.</p>
Exclusions	No exclusions.	Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis of bipolar or personality disorder, schizophrenia or psychotic disorder, or pervasive developmental disorder are excluded.
Exclusion Details	N/A	<p>Required exclusions:</p> <ul style="list-style-type: none"> <li>•Patient had an active diagnosis of bipolar disorder (Bipolar Disorder Value Set)</li> <li>•Patient had an active diagnosis of schizophrenia or psychotic disorder (Schizophrenia or Psychotic Disorder Value Set)</li> </ul> <p>Allowable exclusions:</p>

	3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)	0712 Depression Utilization of the PHQ-9 Tool
		<ul style="list-style-type: none"> <li>•Patient was a permanent nursing home resident any time during the measurement period</li> <li>•Patient was in hospice or receiving palliative care any time during the measurement period</li> <li>•Patient died prior to the end of the measurement period</li> <li>•Patient had an active diagnosis of personality disorder (Personality Disorder Value Set) [These are the same exclusions as the related outcome measures]</li> </ul> <p>Please see field specifications in the attached data dictionary.</p>
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	N/A	This measure is stratified by age range and results are reported separately by age: Adolescents (12-17 years of age) and Adults (18 years of age and older).
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	<p>Step 1. Count number of children aged 3-17 seen for a well child visit in state, region, clinic or other group during defined period (often, one year) using administrative data (CPT 99381-99394). N=total population. This is the denominator.</p> <p>Step 2. Assess whether PSC was administered as a part of WCV, for the eligible population, using patient claims data or chart for indicator status. Pass if documentation that screen was given on the day of the WCV is present.</p> <p>Step 3. Compute numerator = count of patients with completed PSC.</p> <p>Step 4. Calculate clinic or other entity rate as numerator/denominator. No risk adjustment.</p>	<p>This measure is calculated by submitting a count of patients for the denominator and a count of patients in the numerator to a HIPAA secure data portal as part of the process in uploading a detailed patient file to calculate the six and twelve month remission outcome rates.</p> <p>The numerator rate is calculated as follows:</p> <p># pts with major depression or dysthymia with one or more completed PHQ-9 or PHQ-9M tools/ # pts with major depression or dysthymia with a visit or contact during the measurement period</p> <p>Query processes that medical groups follow to obtain counts:</p> <p>During the four month measurement period (e.g. dates of service 6/1/2016 to 9/30/2016) how many patients had an office visit or other contact and diagnosis codes for major depression or dysthymia? (Major Depression or Dysthymia Value Set). (denominator)</p> <p>Of these patients, how many had a PHQ-9 tool completed? (numerator)</p> <p>The counting process is validated during the denominator certification process (where groups document all steps in identifying the depression population). Groups are asked to describe the process they use for obtaining the counts. Denominator documents are</p>

	3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)	0712 Depression Utilization of the PHQ-9 Tool
		reviewed (certified) by MNMCM staff prior to data collection and submission. This is to insure that all groups are identifying their population correctly.
Submission items	<p>5.1 Identified measures: 0712 : Depression Utilization of the PHQ-9 Tool</p> <p>5a.1 Are specs completely harmonized? Yes</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: The age range for the PHQ-9 (NQH 712) has recently been expanded to include youth 12 to 17 years of age with a diagnosis of depression. The currently submitted measure, the PSC, screens for a broader band of problems (other emotional problems like anxiety as well as other types of problems like attention and behavior) and a larger age range (3-17) than the PHQ-9. Along with the PHQ-9, the PSC is actually one of the specific tools mentioned by the US Preventive Services Task Force as a screen for depression in youth (Forman-Hoffman et al., 2016). Although studies have shown that the PSC identifies about 80% of the youth with depression who are found with the PHQ-9, only about half of the youth with serious psychosocial problems on the PSC are identified with the PHQ-9 (Richardson et al., 2010). The PSC is a representative of a broader class of screening tools (brief broadband psychosocial screens) that are required for use in conjunction with pediatric well child visits in the Massachusetts EPSDT program. Other similar broadband tools are the Strengths and Difficulties Questionnaires and the Child Behavior Checklist. The Massachusetts EPSDT CBHI program provides a short (now 13) list of approved tools (both broad and narrow band) and allows the pediatrician to use</p>	<p>5.1 Identified measures: 0711 : Depression Remission at Six Months</p> <p>0710 : Depression Remission at Twelve Months</p> <p>1884 : Depression Response at Six Months- Progress Towards Remission</p> <p>1885 : Depression Response at Twelve Months- Progress Towards Remission</p> <p>5a.1 Are specs completely harmonized? Yes</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: There are related, complimentary measures for depression remission, response that are PAIRED with this process measure. MN Community Measurement is the measure steward for these related measures and they are completely harmonized. The remission measures are considered the “gold standard” of depression outcomes and measure the same population of patients at two different points in time, six and twelve months after index contact with diagnosis and elevated PHQ-9. The response measures, also at six and twelve months are considered as progress towards the desired goal of remission with a reduction in PHQ-9 score of greater than 50% representing a reduction in the severity of symptoms.</p>

	3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)	0712 Depression Utilization of the PHQ-9 Tool
	<p>the one deemed most appropriate for each case. In a review of nearly 6000 medical charts, Savageau and her associates found that about 40% of all screens were PSC's compared to only about 1% that were PHQ-9's (Savageau et al., 2016; Savageau et al., 2017, May) suggesting that the PSC is at least in the past ten years more widely used by pediatricians in Massachusetts.</p> <p>The reference list is included in the attached appendix.</p>	

## Appendix E2: Related Measures (narrative format)

### Comparison of NQF #3312, NQF #0004, and NQF #2605

3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

#### *Steward*

##### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

##### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

National Committee for Quality Assurance

##### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

National Committee for Quality Assurance

#### *Description*

##### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy) within 7 or 14 days after discharge. This measure is reported across all detoxification settings.

##### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following.

- Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

##### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.

Four rates are reported:

- The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge.
- The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge.
- The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge.
- The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.

#### *Type*

### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Process

### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

Process

### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

Process

#### *Data Source*

### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Claims Medicaid Analytic eXtract (MAX) 2013 and 2014 eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided. The inpatient file only contains inpatient hospital, sterilization, abortion and religious non-medical health care institution claims.

No data collection instrument provided Attachment

Cont\_Care\_After\_Detox\_Value\_Sets.xlsx

### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

Claims, Electronic Health 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 Attachment 0004\_IET\_Value\_Sets-635860535088567062.xlsx

### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

Claims Both the numerator and the denominator for this measure are based on administrative claims data.

No data collection instrument provided Attachment

2605\_Follow\_Up\_After\_ED\_Discharge\_for\_Mental\_Health\_Conditions\_Value\_Sets-636220757625866651.xlsx



### *Level*

#### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Population : Regional and State

#### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

Health Plan, Integrated Delivery System

#### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

Health Plan, Population : Regional and State

### *Setting*

#### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Inpatient/Hospital, Outpatient Services

#### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

#### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

Inpatient/Hospital, Outpatient Services

### *Numerator Statement*

#### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Discharges in the denominator who have an inpatient, intensive outpatient, partial hospitalization, outpatient visit, residential, or drug prescription or procedure within 7 or 14 days after discharge from a detoxification episode.

#### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

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 the index episode start date.

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Engagement of AOD Treatment:

Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).

#### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

The numerator for each denominator population consists of two rates:

Mental Health

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge

- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge

#### Alcohol or Other Drug Dependence

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge

- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after emergency department discharge

### *Numerator Details*

#### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.

The numerator includes individuals with any of the following within 14 days after discharge from detoxification:

- Pharmacotherapy on day of discharge through day 7 or 14.

- Outpatient, intensive outpatient, partial hospitalization, or residential treatment procedure with a diagnosis of SUD on the day after discharge through day 7 or 14.

- Outpatient, intensive outpatient, partial hospitalization, or residential treatment with standalone SUD procedure on the day after discharge through day 7 or 14.

- Inpatient admission with an SUD diagnosis or procedure code on day after discharge through day 7 or 14.

- Long-term care institutional claims with an SUD diagnosis on day after discharge through day 7 or 14.

Continuity is reset to zero if an overdose diagnosis code appears on the same outpatient or inpatient claim.

SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes.

Pharmacotherapy includes naltrexone (short or long acting), acamprosate, or disulfiram for alcohol dependence treatment and buprenorphine for opioid dependence treatment, as well HCPCS codes to identify procedures related to injecting drugs (e.g., long-acting injectable naltrexone).

A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. States may need to adapt the list of codes to include state-specific codes.

#### 0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Index Episode Start Date: The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the first 10 and ½ months of the measurement year (e.g., January 1 to November 15) with a diagnosis of AOD.

- For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit (not resulting in an inpatient stay), the Index Episode Start Date is the date of service.
- For an inpatient (acute or nonacute) event, the Index Episode Start Date is the date of discharge.
- For an ED visit that results in an inpatient event, the Index Episode Start Date is the date of the inpatient discharge.
- For direct transfers, the Index Episode Start Date is the discharge date from the second admission

##### INITIATION OF AOD TREATMENT

If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the patient is compliant

If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the patient must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, with an AOD diagnosis, on the Index Episode Start Date or in the 13 days after the Index Episode Start Date (14 total days). If the Index Episode Start Date and the initiation visit occur on the same day, they must be with different providers in order to count. Any of the following code combinations meet criteria:

- An acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute and nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay.
- IET Stand Alone Visits Value Set WITH AOD Dependence Value Set
- IET Visits Group 1 Value Set WITH IET POS Group 1 Value Set AND AOD Dependence Value Set
- IET Visits Group 2 Value Set WITH IET POS Group 2 Value Set AND AOD Dependence Value Set.

(See corresponding Excel document for appropriate value sets)

Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment

- See corresponding Excel document for the Detoxification Value Set.

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##### ENGAGEMENT OF AOD TREATMENT

Identify all patients who meet the following criteria:

- 1) Numerator compliant for the Initiation of AOD Treatment numerator and
- 2) Two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis, beginning on the day after the initiation encounter through 29 days after the initiation event (29 total days). Multiple engagement

visits may occur on the same day, but they must be with different providers in order to count. Any of the following code combinations meet criteria:

- An acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute or nonacute inpatient admissions: First Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set), Then Identify the admission date for the stay.
- IET Stand Alone Visits Value Set with AOD Dependence Value Set.
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and AOD Dependence Value Set.
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and AOD Dependence Value Set.

For patients who initiated treatment via an inpatient admission, the 29-day period for the two engagement visits begins the day after discharge.

Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying engagement of AOD treatment.

The time frame for engagement, which includes the initiation event, is 30 total days.

#### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

##### **Mental Health**

Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge

- A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge

- A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).

- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 14 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.

#### Alcohol or Other Drug Dependence

Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge. Any of the following code combinations meet criteria:

- IET Stand Alone Visits Value Set with a primary diagnosis of AOD (AOD Dependence Value Set).
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis alcohol or other drug dependence within 30 days after emergency department discharge. Any of the following code combinations meet criteria:

- IET Stand Alone Visits Value Set with AOD Dependence Value Set
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).

#### *Denominator Statement*

### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Adult Medicaid beneficiary discharges from detoxification from January 1 to December 15 of the measurement year.

#### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).

#### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.

#### *Denominator Details*

#### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.

Target population meets the following conditions:

- Medicaid beneficiaries aged 18 years and older and less than 65 years with at least one detox discharge during the year January 1-December 15.
- Enrolled in Medicaid during the month of detoxification discharge and the following month.

The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying detox episode.

Detoxification is identified using a combination of HCPCS codes, UB Revenue Codes and ICD-9/ICD-10 procedure codes. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. As with the numerator specifications, this document lists standardized specification for this measure. States will likely need to modify the specifications to include their state-specific codes.

#### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

Identify the Index Episode. Identify all patients in the specified age range who during the first 10 and ½ months of the measurement year (e.g., January 1 to November 15) had one of the following:

- An outpatient visit, intensive outpatient encounter or partial hospitalization with a diagnosis of AOD. Any of the following code combinations meet criteria:
  - IET Stand Alone Visits Value Set WITH AOD Dependence Value Set.
  - IET Visits Group 1 Value Set WITH IET POS Group 1 Value Set AND AOD Dependence Value Set.
  - IET Visits Group 2 Value Set WITH IET POS Group 2 Value Set AND AOD Dependence Value Set.

(See corresponding Excel document for the appropriate value sets)

- A detoxification visit (See corresponding Excel document for the Detoxification Value Set)
- An ED visit with a diagnosis of AOD (See corresponding Excel document for the ED Value Set and the AOD Dependence Value Set).

- An acute or nonacute inpatient discharge with either a diagnosis of AOD (AOD Dependence Value Set) or an AOD procedure code (AOD Procedures Value Set). To identify acute and nonacute inpatient discharges: First, identify all acute and nonacute inpatient stays (Inpatient Stay Value Set), Second, identify the discharge date for the stay.

For patients with more than one episode of AOD, use the first episode.

For patients whose first episode was an ED visit that resulted in an inpatient event, use the inpatient discharge.

Select the Index Episode Start Date.

### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

Age: 18 years and older as of the date of discharge

Benefit: Medical and Behavioral Health

Continuous Enrollment: Date of emergency department visit through 30 days after discharge

Diagnosis criteria: Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health (see Mental Health Diagnosis Value Set) or alcohol or other drug dependence (see AOD Dependence Value Set) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not individuals. If a person has more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Use only facility claims to identify denominator events (including admissions or direct transfers). Do not use professional claims.

#### *Exclusions*

### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Not applicable. The measure does not have denominator exclusions.

### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. (See corresponding Excel document for the AOD Dependence Value Set)

Exclude from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) patients whose initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.

### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

The following are exclusions from the denominator:

-If the discharge is followed by readmission or direct transfer to an emergency department for a principal diagnosis of mental health or alcohol or other drug dependence within the 30-day follow-up period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.

-Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 30-day follow-up period, regardless of primary diagnosis for the admission.

These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

### *Exclusion Details*

#### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Not applicable.

#### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. (See corresponding Excel document for the AOD Dependence Value Set)

- For an inpatient Index Episode Start Date, use the admission date to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

- For an ED visit that results in an inpatient event, use the ED date of service to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

- For direct transfers, use the first admission to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

#### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

See Section S.10 for exclusion details

### *Risk Adjustment*

#### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

No risk adjustment or risk stratification

#### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

No risk adjustment or risk stratification

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123834 | 140881 | 135810

#### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

No risk adjustment or risk stratification

123834 | 140881 | 135810

123834 | 140881 | 135810



## *Stratification*

### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Location of detox is used as a stratification variable in analyses. If an inpatient hospital claim had an ICD-9/ICD-10 detoxification procedure code or a UB revenue code indicating detoxification, hospital inpatient treatment is assigned as the location of detox. In addition, hospital inpatient treatment is also assigned if a non-inpatient claim contains a HCPCS code indicating hospital inpatient detox. The remaining detox location assignments are very straightforward. Whenever possible, use of the HCPCS codes to determine location is most desired as it reflects the more precise detoxification location. The other stayover treatment location is designed to capture detox location from non-inpatient claims that do not contain a HCPCS code. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

The total population is stratified by age: 13-17 and 18+ years of age.

Report two age stratifications and a total rate.

The total is the sum of the age stratifications.

### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

Not applicable.

## *Type Score*

### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

Rate/proportion better quality = higher score

### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

Rate/proportion better quality = higher score

### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

Rate/proportion better quality = higher score

## *Algorithm*

### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

The following steps are used to identify the denominator, numerator, and calculation of the measure rate:

Step 1: Identify denominator

Step 1A: Eligible population: Identify enrolled Medicaid beneficiaries ages 18-64 years who have any detoxification (withdrawal management) in inpatient hospital, residential addiction treatment program, or ambulatory detoxification (withdrawal management) discharge from January 1 to December 15 of the measurement year and are enrolled the month of detoxification and the following month. Age is calculated as of January 1 of the measurement year.

Step 1B: Overall: Among the Medicaid beneficiaries in Step 1A, identify all detoxification discharges using all inpatient, outpatient and ambulatory claims files or tables that contain HCPCS or ICD-9/ICD-10 procedure codes and UB revenue codes. If more than one detoxification in a year, treat each detoxification as a separate observation, e.g., an inpatient hospital detoxification in January and an ambulatory detoxification in July, counts as two observations.

Step 1B.1: Multiple detox claims that are within 1-2 days are combined into a single detox episode. Accordingly, sort the inpatient, outpatient and ambulatory detox discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine close-proximity episodes while retaining all clinical fields from each episode.

Step 1C: Detox location assignment: hospital inpatient, inpatient residential addiction, outpatient residential outpatient addiction, other stayover treatment and ambulatory detoxification. Use HCPCS detox procedure codes to assign detox location whenever possible; revenue center detox will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table. They will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 detox location when episodes are combined, assign the location using the first claim's location. If there is a TIE between a detox episode being identified via revenue center codes and a more specific category using HCPCS on the SAME claim, the HCPCS location prevails.

Step 2: Identify numerator

Step 2A: Overall: From the denominator in Step 1B, identify those discharges from detoxification in any setting with a qualifying continuity service within 7 or 14 days after discharge.

Step 2A.1: Identify SUD continuity services: Continuity services are assigned using clinical claims billing information (e.g., diagnosis, procedure, revenue codes). The measure includes all claims files or data tables that contain clinical fields (e.g., inpatient hospital, outpatient, other ambulatory and long-term care). SUD diagnoses can be in any position – primary or secondary – for continuity services. Since multiple claims files or tables could each contain a continuity claim, the specification calls for creating continuity variables separately within each file type or table, sorting the files or tables by beneficiary ID and service dates, then putting them together in order to assign the set of variables that are “First” to occur relative to the detox episode discharge date. Continuity services have to occur the day after discharge through day 7 or 14.

Step 2A.2: Identify pharmacotherapy which may occur in multiple files or tables. For example, one claims file or data source may contain injectables, another claims file or table data source may contain oral medications. Consequently, pharmacotherapy variables are created separately in each source, the data sources are then sorted by beneficiary ID and service dates, then multiple pharmacotherapy data sources are put together so they will be in chronological order to assign “First” variables. Pharmacotherapy services could be provided on the same day as the discharge from detox through day 7 or 14.

Step 2A.3: Co-occurring events: Continuity service flags and pharmacotherapy flags are reset to zero if an overdose diagnosis code appears on the SAME claim as the continuity service. Further, outpatient continuity is also reset to zero if an emergency department

visit occurs on the same day. If an inpatient continuity claim has an emergency department visit, it is allowed to remain a continuity service.

Step 3: Calculate rate

Step 3A: Calculate the overall 7- or 14-day continuity rates by dividing the number of discharges with a qualifying continuity service (Step 2A) by the denominator (Step 1B).

Step 3B: Calculate the rates separately for each detox location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C).

#### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

Step 1. Determine the eligible population. The eligible population is all patients who satisfy all specified denominator criteria (S9-S11).

Step 2. Search administrative systems to identify numerator events for all patients in the eligible population (S6).

Step 3. Calculate the rate of numerator events in the eligible population. 123834 | 140881 | 135810

#### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

Mental Health

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health.

Step 1B: Exclude patients who meet the exclusion criteria as specified in the “Denominator Exclusion Details” section.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B).

Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B).

Alcohol or Other Drug Dependence

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug dependence.

Step 1B: Exclude patients who meet the exclusion criteria as specified in the “Denominator Exclusion Details” section.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B).

Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B).

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### *Submission items*

#### **3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs**

5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

2605 : Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Follow-up time period: NQF 2605 examines follow-up care 7 days and 30 days after discharge. Our proposed measure (#3312) examines follow-up care 7 days and 14 days after discharge. The 14 day follow-up time period aligns with NQF 0004 and the non-NQF endorsed Continuity of Care After Detoxification measure developed by the Washington Circle, and reflects the input of some public commenters that adults should receive some type of care within two weeks of discharge from detoxification. Diagnoses: NQF 2605 requires a primary diagnosis of alcohol and other drug dependence (AOD) for the follow-up service. Our proposed measure (#3312) requires a primary or secondary diagnosis of AOD. We allow a primary or secondary AOD diagnosis to address potential inaccuracies in how AOD diagnoses are coded. For example, some providers may be concerned about the stigma associated with an AOD diagnosis and therefore code it as a secondary diagnosis. Also, for adults with co-occurring mental health and AOD disorders, the assignment of primary and secondary diagnoses can be challenging and sometimes arbitrary. The differences in follow-up time period, location and diagnoses between NQF 2605 and our proposed measure (3312) do not impact the measure's interpretability in which a higher rate is indicative of better quality. Both measures rely on administrative data. The differences in measure specifications between 2605 and 3312 are minor and expected to have minimal impact on data collection burden.

5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no other NQF-endorsed measures that conceptually address the same measure focus and same target population.

#### **0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

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: N/A

#### **2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence**

5.1 Identified measures: 0576 : Follow-Up After Hospitalization for Mental Illness (FUH)

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

3312 : Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Portions of the specifications for this measure have been adapted from the existing health plan measures (Follow-up After Hospitalization for Mental Illness NQF #0576 and Follow-up After Hospitalization for Schizophrenia NQF#1937). The proposed measure is harmonized with the two existing NQF-endorsed measures. The following highlights the differences between the measures: -Population focus (denominator): The proposed measure targets patients discharged from the emergency department (not inpatient) and also focuses on patients with alcohol or other drug dependence disorders.-Numerator: The proposed measure captures follow-up with a primary mental health or alcohol or other drug dependence diagnosis (regardless of the type of provider).

5b.1 If competing, why superior or rationale for additive value: Not applicable.

## Comparison of NQF #3313 and NQF #0108

3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication

0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)

### Steward

#### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

Centers for Medicare and Medicaid Services (CMS)

#### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

National Committee for Quality Assurance

### Description

#### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.

#### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.

An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

### Type

#### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

Process

#### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

Process

### Data Source

#### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

Claims Medicaid and Medicare administrative claims or encounter data and pharmacy claims. Data sources include:

- State Medicaid Management Information System (MMIS), MSIS, or T-MSIS or Medicaid Analytic eXtract (MAX) file: MAX PS, MAX RX, MAX IP, MAX OT
- Additional Data Sources for dual-eligible beneficiaries: Medicare Parts A, B, and D data

No data collection instrument provided Attachment

Follow\_Up\_New\_Presc\_Antipsych\_Codes.xlsx

### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

Claims (Only), Pharmacy This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 0108\_ADD\_Value\_Sets.xlsx

#### *Level*

### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

Population : Regional and State

### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

Health Plan, Integrated Delivery System

#### *Setting*

### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

Outpatient Services

### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

Clinician Office/Clinic

#### *Numerator Statement*

### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

Antipsychotic prescriptions from the denominator prescribed to a beneficiary who completed a follow-up visit with a provider with prescribing authority within four weeks of prescription of an antipsychotic medication.

### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.

#### *Numerator Details*

### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

The proposed numerator uses a four-week follow-up period based on clinical guidelines for appropriate follow-up after prescription of new antipsychotic medications. The optimal follow-up period was determined through testing and consultation with the Clinical Advisory Work group. The day after the prescription is counted as day 1 of the follow-up period. The date of the follow-up visit with a provider is determined by using the service date on the medical claim.

See attached Excel file for CPT and HCPCS codes that qualify for the numerator.

### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

#### **RATE 1. INITIATION PHASE NUMERATOR**

An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the earliest prescription dispensing date for a new ADHD medication. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

ADD Stand Alone Visits Value Set.

ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.

ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.

Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit.

#### **RATE 2. CONTINUATION AND MAINTENANCE PHASE NUMERATOR**

Children who are numerator compliant for Rate 1. Initiation Phase, AND have documentation of at least two follow-up visits with any practitioner from 31–300 days (9 months) after the earliest prescription dispensing date for a new ADHD medication.

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:

ADD Stand Alone Visits Value Set.

ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.

ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.

Telephone Visits Value Set.

### *Denominator Statement*

#### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

New antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older.

### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

Children 6-12 years of age newly prescribed ADHD medication.

### *Denominator Details*

#### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

Target population meets the following conditions:

1. Medicaid beneficiary age 18 years and older (including dual-eligible and Medicaid-only enrollees)
2. Newly prescribed an antipsychotic medication
3. Enrolled in Medicaid during the four months prior to and the four weeks following a new prescription of an antipsychotic medication

Beneficiaries with “newly filled prescription” are those who have had no antipsychotic medications dispensed for either new or refill prescriptions during a period of 120 days (four months) prior to the prescription fill date.

The measure focuses on new prescriptions of antipsychotic medications.



We used National Drug Codes to identify the following antipsychotic medications for this measure:

- aripiprazole (Abilify)
- asenapine maleate (Saphris)
- chlorpromazine hydrochloride
- clozapine (Clozaril, FazaClo, Versacloz)
- Compazine
- droperidol (Inapsine)
- fluoxetine hydrochloride-olanzapine (Symbyax)
- fluoxetine-olanzapine
- fluphenazine
- haloperidol (Haldol)
- iloperidone (Fanapt)
- loxapine succinate (Loxitane)
- lurasidone hydrochloride (Latuda)
- molindone hydrochloride (Moban)
- olanzapine (Zyprexa)
- paliperidone (Invega)
- Permitil
- perphenazine
- pimozide (Orap)
- prochlorperazine maleate
- quetiapine fumarate (Seroquel)
- risperidone (Risperdal)
- thioridazine hydrochloride
- thiothixene (Navane)
- trifluoperazine hydrochloride
- trilafon
- ziprasidone (Geodon)

See attached Excel file for NDCs that qualify for the denominator.

#### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

##### **RATE 1. INITIATION PHASE DENOMINATOR**

Children age 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year. who were dispensed a new ADHD medication during the 12-month Intake Period (Table ADD-A). Patients must have all of the following:(1) A 120-day (4-month) negative medication history on or before the Index Prescription Date. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

(2) Continuous enrollment for 120 days prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.

(3) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set)

Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

Table ADD-A: ADHD Medications

CNS stimulants: Amphetamine-dextroamphetamine, dexamethylphenidate, dextroamphetamine, lisdexamfetamine, methamphetamine, methylphenidate

Alpha-2 receptor agonists: Clonidine, guanfacine

Miscellaneous: Atomoxetine

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#### RATE 2. CONTINUATION AND MAINTENANCE PHASE DENOMINATOR

Children who meet the eligible population criteria for Rate 1. Initiation Phase who have been continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date. Patients must have all of the following:

(1) The patient must have filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].)

Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

(2) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

#### *Exclusions*

##### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

- Medicaid beneficiaries with an acute inpatient admission during the four-week follow-up period after prescription of an antipsychotic medication
- Patients who expired within four weeks of new prescription date.

#### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date

Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.

Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.

#### *Exclusion Details*

#### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

Acute inpatient admission during the four-week follow-up period: Beneficiaries with an inpatient admission during the four week follow-up period are excluded from the measure.

Death: Patients with a date of death during the four-week follow-up period are excluded from the measure.

#### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

Exclude from the denominator for both rates, children who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date

Exclude from the denominator for both rates, children with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year

Exclude from the denominator for both rates patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

#### *Risk Adjustment*

#### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

No risk adjustment or risk stratification

#### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

No risk adjustment or risk stratification

#### *Stratification*

#### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

Not applicable; this measure is not stratified.

#### 0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)

N/A

#### Type Score

#### 3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication

Rate/proportion better quality = lower score

#### 0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Rate/proportion better quality = higher score

#### Algorithm

#### 3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication

To calculate the denominator:

Eligible Population:

1. Identify Medicaid beneficiaries (both dual-eligible and Medicaid-only enrollees) age 18 years and older.
2. From this group, identify those who were newly prescribed one or more antipsychotic medications.

Exclusions:

From the population identified in step 2

3. Remove any beneficiaries who were not continuously enrolled for at least four months before or four weeks following the new prescription.
4. Remove any beneficiaries who had an acute inpatient admission during the four weeks following the new prescription.
5. Remove any beneficiaries who died during the four weeks following the new prescription.

Numerator

From the beneficiaries within the denominator (after denominator exclusions have been applied)

6. Identify the number of beneficiaries who had a qualifying outpatient encounter within four weeks of the prescription date of the antipsychotic medication.

To calculate the measure score:

7. Divide the total number of beneficiaries in the numerator by the total number of beneficiaries in the denominator, after denominator exclusions have been applied.
8. Multiply this number by 100 to determine the performance rate.

#### 0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)

INITIATION PHASE: ELIGIBLE POPULATION

Step 1: Identify all children in the specified age range (Children 6-12 years of age: 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year) who were dispensed an ADHD medication (Table ADD-A) during the 12-month Intake Period.

Step 2: Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3: Calculate continuous enrollment. Patients must be continuously enrolled for 120 days (4 months) prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.

Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter (Acute Inpatient Value Set) in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set) AND/OR A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Step 5: Determine the number of patients in the eligible population with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

ADD Stand Alone Visits Value Set.

ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.

ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.

Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit.

Step 6: Calculate a rate (number of children receiving a follow-up visit with a prescriber within 30 days of the Index Prescription Start Date).

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#### CONTINUATION AND MAINTENANCE PHASE: ELIGIBLE POPULATION

Step 1: Identify all patients who meet the eligible population criteria for Rate 1—Initiation Phase.

Step 2: Calculate continuous enrollment. Patients must be continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date.

Step 3: Calculate the continuous medication treatment. Using the patients in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].) Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Step 5: Identify all patients in the eligible population who meet the following criteria:

(1) Numerator compliant for Rate 1—Initiation Phase, and

(2) At least two follow-up visits from 31–300 days (9 months) after the Index Prescription Start Date with any practitioner.

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:

ADD Stand Alone Visits Value Set.

ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.

ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.

Telephone Visits Value Set.

Step 6: Calculate a rate (number of children receiving two follow-up visits with any practitioner from 31–300 days after the Index Prescription Start Date).

ADDITIONAL EXCLUSION:

Exclude from the denominator for both rates, patients with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year

NOTE

(1) Patients who have multiple overlapping prescriptions should count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).

(2) Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the Index Prescription Start Date).

### *Submission items*

#### **3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**

5.1 Identified measures: 0108 : Follow-Up Care for Children Prescribed ADHD Medication (ADD)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: This measure differs from NQF 0108 in that it focuses on adults rather children, and on antipsychotic medications rather than ADHD medications. The measures are completely harmonized to the extent possible, with the same follow-up period and look-back period to establish a “new prescription.”

5b.1 If competing, why superior or rationale for additive value: Not applicable.

#### **0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)**

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: N/A

## Comparison of NQF #3315e, NQF #2111, and NQF #2993

3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

2111 Antipsychotic Use in Persons with Dementia

2993 Potentially Harmful Drug-Disease Interactions in the Elderly

### *Steward*

#### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Centers for Medicare & Medicaid Services

#### **2111 Antipsychotic Use in Persons with Dementia**

Pharmacy Quality Alliance

#### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

National Committee for Quality Assurance

### *Description*

#### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Proportion of inpatient hospitalizations for patients 65 years of age and older who receive an order for antipsychotic medication therapy.

#### **2111 Antipsychotic Use in Persons with Dementia**

The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.

#### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

The percentage of patients 65 years of age and older who have evidence of an underlying disease, condition or health concern and who are dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Four rates are reported for this measure:

- Rate 1: The percentage of those with a history of falls that received a potentially harmful medication

- Rate 2: The percentage of those with dementia that received a potentially harmful medication

- Rate 3: The percentage of those with chronic kidney disease that received a potentially harmful medication

- Rate 4: Total rate

A lower rate represents better performance for all rates.

### *Type*

#### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Process

#### **2111 Antipsychotic Use in Persons with Dementia**

Process

#### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

Process



## *Data Source*

### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Electronic Health Records Hospitals collect EHR data using certified electronic health record technology (CEHRT). The human readable format and XML are contained in the eCQM specifications attached in question S.2a. No additional tools are used for data collection for eMeasures.

No data collection instrument provided Attachment AP\_ValueSets.xlsx

### **2111 Antipsychotic Use in Persons with Dementia**

Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.

No data collection instrument provided Attachment 1\_ICD\_Codes\_AUPD\_Jul2017.xlsx

### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

Claims, Electronic Health Data, Electronic Health Records This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment DDE\_Value\_Sets-635979522717911582.xlsx

## *Level*

### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Facility

### **2111 Antipsychotic Use in Persons with Dementia**

Health Plan, Other

### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

Health Plan, Integrated Delivery System

## *Setting*

### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Inpatient/Hospital

### **2111 Antipsychotic Use in Persons with Dementia**

Other, Pharmacy The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy, etc.

### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

Outpatient Services

## *Numerator Statement*

### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter.

### **2111 Antipsychotic Use in Persons with Dementia**

The number of patients in the denominator who had at least one prescription and > 30 days supply for any antipsychotic medication during the measurement period and do not have a diagnosis of schizophrenia, bipolar disorder, Huntington's disease or Tourette's Syndrome.

### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

Numerator 1: Patients with a history of falls who received at least one potentially harmful medication from Table DDE-A or Table DDE-B

Numerator 2: Patients with a diagnosis of dementia who received at least one potentially harmful medication from Table DDE-D

Numerator 3: Patients with chronic kidney disease who received at least one potentially harmful medication from Table DDE-E

Numerator 4: The sum of the three numerators

#### *Numerator Details*

### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

The time period for data collection is the measurement year (12-month period).

Numerator: Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter.

Antipsychotic orders are represented with the QDM datatype and value set of Medication, Order: Antipsychotic Medications (OID: 2.16.840.1.113883.3.464.1003.196.12.1255).

Numerator exclusions: Inpatient hospitalizations for patients with documented indication that they are threatening harm to self or others

Threat to self or others is represented with the QDM datatype and value set of Symptom: Threat to themselves or others (OID: 2.16.840.1.113883.3.464.1003.195.12.1020).

To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at <https://vsac.nlm.nih.gov/>. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

### **2111 Antipsychotic Use in Persons with Dementia**

The number of patients in the denominator who had at least one prescription and > 30 days supply for any antipsychotic medication during the measurement period (See Table Dementia C) and do not have a diagnosis for schizophrenia, bipolar disorder, Huntington's disease or Tourette's Syndrome (See Table Dementia D)

Table Dementia C: Antipsychotic Medications

Aripiprazole

Asenapine

Cariprazine

Chlorpromazine

Clozapine

Fluphenazine

Haloperidol

Iloperidone

Loxapine  
Lurasidone  
Olanzapine  
Paliperidone  
Perphenazine  
Pimozide  
Quetiapine  
Risperidone  
Thioridazine  
Thiothixene  
Trifluoperazine  
Ziprasidone

Note: The active ingredients are limited to oral, sublingual, injectable and intramuscular formulations only. Includes combination products.

Table Dementia D: Disease Codes for Specific Disorders for Exclusion

ICD-9

Schizophrenia:

295.0x to 295.9x

Bipolar/Manic Disorder:

296.0x

296.1x

296.4x to 296.9x

Huntington's disease

333.4

Tourette's Syndrome

307.23

ICD-10

Schizophrenia/schizophreniform

F20.0 F20.1 F20.2 F20.3

F20.5 F20.81

F20.89 F20.9 F25.9

Mania

F30.10 F30.11 F30.12 F30.13 F30.2

F30.3 F30.4 F30.8 F30.9

Bipolar

F31.0 F31.10 F31.11 F31.12 F31.13 F31.2

F31.30 F31.31 F31.32 F31.4 F31.5 F31.60 F31.61

F31.62 F31.63 F31.64 F31.70 F31.71

F31.72 F31.73 F31.74 F31.75

F31.76 F31.77 F31.78 F31.81 F31.89 F31.9

Tourettes

F95.2

Huntington's Disease

G10

Psychotic disorder

F06.0 F06.2 F06.33

Other psychotic disorders

F21 F23 F24 F28 F29 F53

Schizoaffective

F25.0 F25.1 F25.8

MDD with psychotic features

F32.3 F33.3

### 2993 Potentially Harmful Drug-Disease Interactions in the Elderly

Rate 1 numerator: Dispensed an ambulatory prescription for an anticonvulsant, nonbenzodiazepine hypnotic, or SSRI (Table DDE-A), antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Table DDE-B) on or between the index episode start data and December 31 of the measurement year.

Rate 2 numerator: Dispensed an ambulatory prescription for an antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Table DDE-B), or H2 receptor antagonist or anticholinergic agent (Table DDE-D) on or between the IESD and December 31 of the measurement year.

Rate 3 numerator: Dispensed an ambulatory prescription for an NSAID or Cox-2 selective NSAID (Table DDE-E) on or between the IESD and December 31 of the measurement year.

Rate 4 numerator: The sum of numerators 1, 2 and 3.

Note: Do not include denied claims.

...

Table DDE-A: Potentially Harmful Drugs – Rate 1

Anticonvulsants:

Carbamazepine, Clobazam, Divalproex sodium, Ethosuximide, Ethotoin, Ezogabine, Felbamate, Fosphenytoin, Gabapentin, Lacosamide, Lamotrigine, Levetiracetam, Mephobarbital, Methsuximide, Oxcarbazepine, Phenobarbital, Phenytoin, Pregabalin, Primidone, Rufinamide, Tiagabine HCL, Topiramate, Valproate sodium, Valproic acid, Vigabatrin, Zonisamide

SSRIs:

Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Setraline

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Table DDE-B: Potentially Harmful Drugs – Rate 1 (History of Falls) and Rate 2 (Dementia)

Antipsychotics:

Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Chlorpromazine, Clozapine, Fluphenazine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine,

Paliperidone, Perphenazine, Pimozide, Quetiapine, Risperidone, Thioridazine, Thiothixene, Trifluoperazine, Ziprasidone

Benzodiazepine hypnotics:

Alprazolam, Chlordiazepoxide products, Clonazepam, Clorazepate-Dipotassium, Diazepam, Estazolam, Flurazepam HCL, Lorazepam, Midazolam HCL, Oxazepam, Quazepam, Temazepam, Triazolam

Nonbenzodiazepine hypnotics:

Eszopiclone, Zaleplon, Zolpidem

Tricyclic antidepressants:

Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6 mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine

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Table DDE-D: Potentially Harmful Drugs – Rate 2 (Dementia)

H2 receptor antagonists:

Cimetidine, Famotidine, Nizatidine, Ranitidine

Anticholinergic agents, antiemetics:

Prochlorperazine, Promethazine

Anticholinergic agents, antihistamines:

Carbinoxamine, Chlorpheniramine, Hydroxyzine products, Brompheniramine, Clemastine, Cyproheptadine, Promethazine, Triprolidine, Dimenhydrinate, Diphenhydramine, Meclizine, Dexbrompheniramine, Dexchlorpheniramine, Doxylamine

Anticholinergic Agents, antimuscarinics (oral)

Atropine, Homatropine, Belladonna alkaloids, Dicyclomine, Hyoscyamine, Propantheline, Scopolamine, Clidinium-chlordiazepoxide

Anticholinergic agents, antimuscarinics (oral)

Darifenacin, Fesoterodine, Solifenacin, Trospium, Flavoxate, Oxybutynin, Tolterodine

Anticholinergic agents, anti-Parkinson agents

Benzotropine, Trihexyphenidyl

Anticholinergic agents, skeletal muscle relaxants

Cyclobenzaprine, Orphenadrine

Anticholinergic agents, SSRIs:

Paroxetine

Anticholinergic agents, antiarrhythmic:

Disopyramide

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Table DDE-E: Cox-2 Selective NSAIDs and Nonasprin NSAIDs

Cox-2 Selective NSAIDs:

Celecoxib

Nonaspirin NSAIDs:

Diclofenac potassium, Diclofenac sodium, Etodolac, Fenoprofen, Flurbiprofen, Ibuprofen, Indomethacin, Ketoprofen, Ketorolac, Meclofenamate, Mefenamic acid, Meloxicam, Nabumetone, Naproxen, Naproxen sodium, Oxaprozin, Piroxicam, Sulindac, Tolmetin

### *Denominator Statement*

#### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Denominator: Non-psychiatric inpatient hospitalizations for patients who are 65 and older.

#### **2111 Antipsychotic Use in Persons with Dementia**

All patients 65 years of age and older continuously enrolled during the measurement period with a diagnosis of dementia and/or two or more prescription claims within the measurement year for a cholinesterase inhibitor or an NMDA receptor antagonist within the measurement year where the sum of days supply is >60.

#### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

All patients ages 65 years of age and older with a history of falls, dementia or chronic kidney disease in the measurement year or the year prior to the measurement year.

### *Denominator Details*

#### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

The time period for data collection is the measurement year (12-month period).

Denominator: Non-psychiatric inpatient hospitalizations for patients who are 65 and older.

Inpatient hospitalizations are represented with the QDM datatype and value set of Encounter, Performed: Encounter Inpatient (OID: 2.16.840.1.113883.3.666.5.3001).

To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at <https://vsac.nlm.nih.gov/>. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

#### **2111 Antipsychotic Use in Persons with Dementia**

All patients 66 years of age and older as of the last day of the measurement year who were continuously enrolled (i.e., had not disenrolled or died) during the measurement year with both pharmacy and medical benefits and had a diagnosis of dementia (Table Dementia A) and/or two or more prescription claims for a cholinesterase inhibitor or an NMDA receptor antagonist (Dementia Table B) within the measurement year where the sum of days supply is >60.

For a beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).

Table Dementia B: Cholinesterase Inhibitors and NMDA Receptor Antagonists

donepezil

rivastigmine

galantamine

memantine

Note: The active ingredients are limited to oral and transdermal formulations only.

Dementia Table A: Codes to Identify Dementia

ICD-9

046.11  
 046.19  
 290.0  
 290.1x  
 290.2x  
 290.3  
 290.4x  
 291.1  
 291.2  
 292.82  
 294.10  
 294.11  
 294.20  
 331.0  
 331.11  
 331.19  
 331.2  
 331.82  
 ICD-10  
 F01.51 F02.80 F03.90  
 G30.9  
 G31.83  
 A81.00 A81.01 A81.09  
 F01.50 F02.81 F03.91  
 F10.27 F10.96 F10.97  
 F13.27 F13.97  
 F18.97  
 F19.17 F19.27 F19.97  
 G30.0 G30.1 G30.8  
 G31.01 G31.09 G31.1

### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

All patients ages 67 years and older as of December 31 of the measurement year with a history of falls, dementia or chronic kidney disease. Each of the four rates in the measure has a different denominator:

Rate 1 denominator: Patients with an accidental fall or hip fracture (Note: hip fractures are used as a proxy for identifying accidental falls). Individuals with either of the following on or between January 1 of the year prior to the measurement year and December 1 of the measurement year meet criteria:

-An accidental fall (Falls Value Set).

-An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set), with a hip fracture (Hip Fractures Value Set).

-An acute or nonacute inpatient discharge with a hip fracture (Hip Fractures Value Set). To identify acute and nonacute inpatient discharges: 1) Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2) Identify the discharge date for the stay.

Rate 2 denominator: Patients with a diagnosis of dementia (Dementia Value Set) or a dispensed dementia medication (Table DDE-C) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Rate 3 denominator: Patients with chronic kidney disease as identified by a diagnosis of ESRD (ESRD Value Set), stage 4 chronic kidney disease (CKD Stage 4 Value Set) or kidney transplant (Kidney Transplant Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Rate 4 denominator: The sum of the denominators for rates 1, 2 and 3

-----

Note: Patients with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify).

See S.2.b for all Value Sets

Table DDE-C: Prescriptions to Identify Members with Dementia

Cholinesterase inhibitors:

Donepezil, Galantamine, Rivastigmine

Miscellaneous central nervous system agents:

Memantine

## *Exclusions*

### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Denominator Exclusions: Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette's syndrome, bipolar disorder, Huntington's disease during the encounter.

### **2111 Antipsychotic Use in Persons with Dementia**

N/A

### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

The following are exclusions for the condition-specific rates and total rate:

For those who meet denominator criteria for the history of falls rate (Rate 1): exclude those with a diagnosis of psychosis, schizophrenia, bipolar disorder or seizure disorder.

For those who meet denominator criteria for those with dementia rate (Rate 2): exclude those with a diagnosis of psychosis, schizophrenia or bipolar disorder.

## *Exclusion Details*

### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Denominator Exclusions: Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette's syndrome, bipolar disorder, Huntington's disease during the encounter.



These exclusions are represented with the QDM datatype of Diagnosis.

- Schizophrenia (OID: 2.16.840.1.113883.3.464.1003.105.12.1104)
- Tourette's Syndrome (OID: 2.16.840.1.113883.3.464.1003.105.12.1030)
- Bipolar Disorder (OID: 2.16.840.1.113883.3.67.1.101.1.128)
- Huntington's Disease (OID: 2.16.840.1.113883.3.464.1003.105.12.1032)

To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at <https://vsac.nlm.nih.gov/>. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

### **2111 Antipsychotic Use in Persons with Dementia**

N/A

### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

For those who meet denominator criteria for the history of falls rate (Rate 1): Exclude patients with a diagnosis of psychosis (Psychosis Value Set), schizophrenia (Schizophrenia Value Set), bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) or seizure disorder (Seizure Disorders Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

For those who meet denominator criteria for those with dementia rate (Rate 2): Exclude patients with a diagnosis of psychosis (Psychosis Value Set), schizophrenia (Schizophrenia Value Set) or bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

See S.2.b for all Value Sets

### *Risk Adjustment*

#### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Stratification by risk category/subgroup

#### **2111 Antipsychotic Use in Persons with Dementia**

No risk adjustment or risk stratification

114349| 135329

114349| 135329

#### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

No risk adjustment or risk stratification

123834

123834

### *Stratification*

#### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Results include a total score and the following strata:

- Stratum 1 - Patients who were admitted or transferred to the ICU during the inpatient encounter
- Stratum 2 - Patients who were not admitted or transferred to the ICU during the inpatient encounter

These strata are identified using the QDM datatype of Encounter, Performed.

ICU Admission or Transfer (OID: 2.16.840.1.113883.17.4077.3.2040)

To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at <https://vsac.nlm.nih.gov/>. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

#### **2111 Antipsychotic Use in Persons with Dementia**

N/A

#### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

No risk adjustment or risk stratification

#### *Type Score*

##### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Rate/proportion better quality = lower score

##### **2111 Antipsychotic Use in Persons with Dementia**

Rate/proportion better quality = lower score

##### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

Rate/proportion better quality = lower score

#### *Algorithm*

##### **3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

Please see the attached HQMF specifications for the complete measure logic. Additionally, a flow diagram of the denominator and numerator logic is attached to the NQF submission form as a supplemental document in response to question A.1, 'AP\_LogicFlow\_for S.14 response.pdf'.

##### **2111 Antipsychotic Use in Persons with Dementia**

Step One:

Calculate the denominator by identifying the number of all eligible patients with either:

- 1) A diagnosis of dementia (Table Dementia A) and/or
- 2) Individuals with two or more prescription claims (within the measurement year) for a cholinesterase inhibitor or an NMDA receptor antagonist (Table Dementia B) where the sum of days supply is >60

Step Two:

Calculate the numerator by identifying the number of persons in the denominator who have greater than 30 days supply for any antipsychotic medication during the measurement period (Table Dementia C) and do not have a diagnosis for schizophrenia, bipolar disorder, Huntington's Disease or Tourette's Syndrome (Table Dementia D).

Step Three:

Divide the numerator (step two) by the denominator (step one) and multiply times 100 to calculate the rate as a percentage. 114349 | 135329

## 2993 Potentially Harmful Drug-Disease Interactions in the Elderly

Step 1. Determine the eligible population: All patients 67 years of age and older as of the end (i.e., December 31) of the measurement year.

Step 2: Identify the denominators for each of the four rates:

Rate 1: Those in the eligible population with a history of falls (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Exclude patients with a diagnosis of psychosis, schizophrenia, bipolar disorder, or seizure disorder (see S.11 for details). Identify the index episode start date.

Rate 2: Those in the eligible population with a dementia (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Exclude patients with a diagnosis of psychosis, schizophrenia or bipolar disorder (see S.11 for details). Identify the index episode start date.

Rate 3: Those in the eligible population with end stage renal disease (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the index episode start date.

Rate 4: The sum of denominators for Rates 1, 2 and 3.

Step 3: Identify the numerators: Individuals in each of the denominators who have received at least one potentially harmful medication on or after the index episode start date (see definitions of potentially harmful medications for each numerator in section S.6).

Step 4: Calculate the rates:

Rate 1 – Numerator 1 divided by denominator 1.

Rate 2 – Numerator 2 divided by denominator 2.

Rate 3 – Numerator 3 divided by denominator 3.

Rate 4 – The sum of the three numerators divided by the sum of the three denominators.

Note: for this measure a lower rate indicates better performance for all four rates.

Index Episode Start Date. The earliest diagnosis, procedure or prescription between January 1 of the year prior to the measurement year and December 1 of the measurement year.

For an outpatient claim/encounter, the IESD is the date of service.

For an inpatient claim/encounter, the IESD is the discharge date.

For dispensed prescriptions, the IESD is the dispense date. 123834

### Submission items

#### 3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

5.1 Identified measures: 2111 : Antipsychotic Use in Persons with Dementia

2993 : Potentially Harmful Drug-Disease Interactions in the Elderly

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: These measures are harmonized to the extent possible. While all measures assess the potentially inappropriate use of antipsychotic medications, this is the only measure that assesses use of antipsychotic medications in the inpatient hospital setting. CMS N011.01 and CMS N031.02 are intended for use in the nursing home setting. Measures NQF 2111 and NQF 2993 assess health plan performance. This measure's eligible population includes all

patients in an inpatient hospital setting who are age 65 and older, which aligns with the age for measures NQF 2111 and NQF 2993. NQF 2111 and NQF 2993 only assess older adults with dementia, whereas this measure includes all older adults. The denominator exclusions are similar across measures. The exclusions in this measure—schizophrenia, Tourette’s syndrome, Huntington’s disease, and bipolar disorder—are similar to exclusions in related measures. CMS N011.01, CMS N031.02, and NQF 2111 exclude patients with schizophrenia, Tourette’s syndrome, or Huntington’s disease. NQF 2111 also excludes patients with bipolar disorder. NQF 2993 excludes patients with psychosis, schizophrenia, or bipolar disorder. This measure also excludes from the numerator people in the inpatient setting who are identified as a threat to themselves or others. No other measure excludes these patients, although this exclusion is appropriate for the hospital setting. The specific antipsychotic medications included in each measure are the same, with only three exceptions; NQF 2111 does not include brexpiprazole, cariprazine, and molindone whereas NQF 2993 and the measure under development include these medications.

5b.1 If competing, why superior or rationale for additive value: Not applicable

#### **2111 Antipsychotic Use in Persons with Dementia**

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:

#### **2993 Potentially Harmful Drug-Disease Interactions in the Elderly**

5.1 Identified measures: 0022 : Use of High-Risk Medications in the Elderly (DAE)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: This measure and NQF 0022 have a similar focus (measuring potentially inappropriate medication use in the elderly) and reporting level (health plan), however they have different target populations. This measure targets patients with a specific condition or disease that can experience adverse effects when combined with certain medications that are recommended to be avoided for that condition. NQF 0022 targets a larger population of all older adults and assesses use of high-risk medications that have been recommended to be avoided in all older adults.

5b.1 If competing, why superior or rationale for additive value: N/A

## Comparison of NQF #3317, NQF #0097, NQF #0293, NQF #0553, NQF #0646, and NQF#2988

3317 Medication Reconciliation on Admission

0097 Medication Reconciliation Post-Discharge

0293 Medication Information

0553 Care for Older Adults (COA) – Medication Review

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

2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities

### *Steward*

#### **3317 Medication Reconciliation on Admission**

Centers for Medicare & Medicaid Services

#### **0097 Medication Reconciliation Post-Discharge**

National Committee for Quality Assurance

#### **0293 Medication Information**

University of Minnesota Rural Health Research Center

#### **0553 Care for Older Adults (COA) – Medication Review**

National Committee for Quality Assurance

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

PCPI

#### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Kidney Care Quality Alliance (KCQA)

### *Description*

#### **3317 Medication Reconciliation on Admission**

Percentage of patients for whom a designated PTA medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.

#### **0097 Medication Reconciliation Post-Discharge**

The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.

#### **0293 Medication Information**

Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that medication information was communicated to the receiving FACILITY within 60 minutes of departure

#### **0553 Care for Older Adults (COA) – Medication Review**

Percentage of adults 66 years and older who had a medication review during the measurement year; a review of all a patient’s medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.

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

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

#### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Percentage of patient-months for which medication reconciliation\* was performed and documented by an eligible professional.\*\*

\* “Medication reconciliation” is defined as the process of creating the most accurate list of all home medications that the patient is taking, including name, indication, dosage, frequency, and route, by comparing the most recent medication list in the dialysis medical record to one or more external list(s) of medications obtained from a patient or caregiver (including patient-/caregiver-provided “brown bag” information), pharmacotherapy information network (e.g., Surescripts), hospital, or other provider.

\*\* For the purposes of medication reconciliation, “eligible professional” is defined as: physician, RN, ARNP, PA, pharmacist, or pharmacy technician.

### *Type*

#### **3317 Medication Reconciliation on Admission**

Process

#### **0097 Medication Reconciliation Post-Discharge**

Process

#### **0293 Medication Information**

Process

#### **0553 Care for Older Adults (COA) – Medication Review**

Process

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

Process

#### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Process

### *Data Source*

#### **3317 Medication Reconciliation on Admission**

Paper Medical Records The data dictionary and measure information form that provide instructions for abstracting the data for the measure are included with this application as

an attachment. A structured chart abstraction tool with operational data definitions was developed in Microsoft Access for field testing. Prior to implementation, the measure developer will provide a finalized abstraction tool.

Available in attached appendix at A.1 No data dictionary

#### **0097 Medication Reconciliation Post-Discharge**

Claims (Only), Electronic Health Record (Only), Paper Records Health Plan Level:

- This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan patients. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Maintenance Organizations via NCQA's online data submission system.

Physician Level:

- This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the PQRS program, this measure is coded using CPT and CPT Category II codes specific to quality measurement.

No data collection instrument provided No data dictionary

#### **0293 Medication Information**

Claims (Only), Electronic Health Record (Only), Imaging-Diagnostic, Laboratory, Management Data, Other, Paper Records, Pharmacy Other

Attachment EDTC\_3\_NQF\_0293.docx

#### **0553 Care for Older Adults (COA) – Medication Review**

Claims, Electronic Health Records, Paper Medical 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 Attachment 0553\_COA\_Medication\_Review\_Value\_Sets.xlsx

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

EHRs Hybrid, Paper Records See attached data collection tool.

Available in attached appendix at A.1 No data dictionary

#### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Electronic Health Records, Other Dialysis facility medical record; intended for use by CMS in its CROWNWeb ESRD Clinical Data Repository.

No data collection instrument provided No data dictionary

### *Level*

#### **3317 Medication Reconciliation on Admission**

Facility

#### **0097 Medication Reconciliation Post-Discharge**

Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System

#### **0293 Medication Information**

Facility

**0553 Care for Older Adults (COA) – Medication Review**

Health Plan, Integrated Delivery System

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

Facility, Integrated Delivery System

**2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Facility

*Setting*

**3317 Medication Reconciliation on Admission**

Inpatient/Hospital

**0097 Medication Reconciliation Post-Discharge**

Clinician Office/Clinic

**0293 Medication Information**

Hospital

**0553 Care for Older Adults (COA) – Medication Review**

Inpatient/Hospital, Outpatient Services, Post-Acute Care

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

Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF

**2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Post-Acute Care

*Numerator Statement*

**3317 Medication Reconciliation on Admission**

Number of patients for whom a designated Prior to Admission (PTA) medication list was generated by referencing one or more external sources of medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization when the admission date is Day 0.

**0097 Medication Reconciliation Post-Discharge**

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

**0293 Medication Information**

**0553 Care for Older Adults (COA) – Medication Review**

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



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

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

Medications TO BE TAKEN by Patient

- Continued\*

Medications prescribed before inpatient stay that patient should continue to take after discharge, AND

- Changed\*

Medications prescribed before inpatient stay with a change in dosage or directions after discharge that differs from what the patient was taking prior to the inpatient stay, AND

- New\*

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

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

Medications NOT TO BE TAKEN by Patient

- Discontinued

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

- Allergies and Adverse Reactions

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

#### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Number of patient-months for which medication reconciliation was performed and documented by an eligible professional during the reporting period.

The medication reconciliation MUST:

- Include the name or other unique identifier of the eligible professional;

AND

- Include the date of the reconciliation;

AND

- Address ALL known home medications (prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);

AND

- Address for EACH home medication: Medication name(1), indication(2), dosage(2), frequency(2), route of administration(2), start and end date (if applicable)(2), discontinuation date (if applicable)(2), reason medication was stopped or discontinued (if applicable)(2), and identification of individual who authorized stoppage or discontinuation of medication (if applicable)(2);

AND

- List any allergies, intolerances, or adverse drug events experienced by the patient.

1. For patients in a clinical trial, it is acknowledged that it may be unknown as to whether the patient is receiving the therapeutic agent or a placebo.
2. “Unknown” is an acceptable response for this field.

### *Numerator Details*

#### **3317 Medication Reconciliation on Admission**

The numerator is operationalized into three key criteria of the medication reconciliation process that must be met:

1. Medications taken by the patient prior to admission are documented on a designated PTA medication list.
2. The PTA medication list is generated using at least one external source to identify the medications taken by the patient prior to admission.
3. All medications listed on the PTA medication list have a reconciliation action to continue, discontinue, or modify by the end of Day 2 of the hospitalization, or if there are no medications on the PTA medication list, the prescriber has signed the document by the end of Day 2 of the hospitalization to indicate his/her review of the PTA medication list.

The first criterion requires that the medical record contain a designated PTA Medication List to document medications that the patient is taking prior to admission. Documenting PTA medications in a designated location eliminates the potential for duplicative or inconsistent documentation of medication histories, avoids the potential for omitted medications, and provides a master source of PTA medication for easy reference by providers. PTA medications may include prescriptions, over-the-counter medications, herbals, vitamin/mineral/dietary (nutritional) supplements, and/or medical marijuana. This criterion aligns with one of the five elements of The Joint Commission’s National Patient Safety Goal (NPSG.03.06.01) on medication reconciliation (The Joint Commission, 2016).

The second criterion requires that facilities consult at least one source external to the facility’s records to increase comprehensive capture of all active medications on the PTA medication list. Incomplete or inaccurate PTA medication lists may result in inadequate medication reconciliation actions by the prescriber, which may lead to medication errors and ADEs. Given the absence of a single, accurate source of information on PTA medications (gold standard), the measure establishes a minimum standard for compiling PTA medication information rather than being prescriptive regarding which sources should be referenced. This requirement also aligns with other existing NQF-endorsed measures that focus on medication reconciliation. The measure allows for a wide-range of external sources to account for situations where the routinely consulted source fails to generate the information needed. For example, the patient may not be able or willing to provide information on PTA medications or a retail pharmacy may be closed or not willing to disclose PTA medications without obtaining prior patient consent. Therefore, to meet the External Source requirement, the facility can reference one or more of the following sources to compile the PTA medication list:

- Interview of the patient or patient proxy such as a caregiver
- Medication container brought in by patient or patient proxy
- Medication list brought by patient or patient proxy
- Patient support network, such as a group home
- Nursing home

- Outpatient prescriber or emergency department
  - Retail pharmacy
  - Prescription Drug Monitoring Program (PDMP)
  - Electronic prescribing network system (e.g., Allscripts®, Surescripts®) or aggregate pharmacy billing records (such as, claims data using state/federal healthcare plans)
- The third and final criterion requires that a licensed prescriber reconciles each medication on the PTA Medication List by the end of Day 2 of the hospitalization and documents whether the medication should be continued, discontinued, or modified. The date of admission is considered Day 0 and subsequent days are considered Day 1 and Day 2 for this measure. If there are no medications on the PTA medication list, the prescriber must sign the document by the end of Day 2 of the hospitalization to indicate his or her review of the PTA medication list for consideration in future treatment decisions. For example, information that indicates the patient is not taking any medications may be important to communicate to the treatment team because there may be a need to initiate treatment of indications that are discovered during admission. Signing the PTA medication list by the end of Day 2 of the hospitalization for patient admissions with no PTA medications also helps to improve communication between members of the care team and other providers during care transitions. To simplify chart abstraction and prevent abstractors from having to distinguish between medications, herbal supplements, and other remedies a patient might take, all entries on the PTA medication list must be reconciled to meet the requirements of the third criterion.

For additional details on each of the data elements included in the measure construct, refer to Appendix A.1, which includes the Data Dictionary and Data Collection Tool.

#### Citations

\*The Joint Commission. (2016). National patient safety goals effective January 1, 2017: Hospital Accreditation Program. Retrieved from [https://www.jointcommission.org/assets/1/6/NPSG\\_Chapter\\_HAP\\_Jan2017.pdf](https://www.jointcommission.org/assets/1/6/NPSG_Chapter_HAP_Jan2017.pdf)

### 0097 Medication Reconciliation Post-Discharge

This measure is specified for medical record or administrative data collection.

#### Medical Record Numerator Details:

- Documentation in the outpatient medical record must include evidence of medication reconciliation between the inpatient medication list and the medication list in the outpatient medical record, and the date on which it was performed. Any of the following evidence meets criteria: (1) Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in meds since discharge, same meds at discharge, discontinue all discharge meds), (2) Documentation of the patient's current medications with a notation that the discharge medications were reviewed, (3) Documentation that the provider "reconciled the current and discharge meds," (4) Documentation of a current medication list, a discharge medication list and notation that the appropriate practitioner type reviewed both lists on the same date of service, (5) Notation that no medications were prescribed or ordered upon discharge

#### Administrative:

#### Medication Reconciliation CPT Codes:

- 99495: Transitional care management services with the following required elements: (1) communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, (2) medical decision making of at least moderate complexity during the service period and (3) face-to-face visit, within 14 calendar days of discharge.
- 99496: Transitional care management services with the following required elements: (1) communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, (2) medical decision making of high complexity during the service period and (3) face-to-face visit, within 7 calendar days of discharge.
- 1111F: Discharge med/current med merge

## **0293 Medication Information**

See attachment S.2b

## **0553 Care for Older Adults (COA) – Medication Review**

### **ADMINISTRATIVE**

Any of the following meet criteria:

- Both of the following on the same date of service during the measurement year: At least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist AND The presence of a medication list in the medical record (Medication List Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 22 of the year after the measurement year.
- Transitional care management services (TCM 14 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 15 of the year after the measurement year.

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

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

---

### **MEDICAL RECORD**

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

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

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

An outpatient visit is not required to meet criteria.

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

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

Time Period for Data Collection: At each discharge during measurement period

Numerator Instructions:

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

For Administrative:

Numerator Elements to be identified through medical record abstraction: see Sample Data Collection Tool attached in Appendix A.1.

This measure may also be implemented in EHRs:

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

Producing the Reconciled Medication List:

Facilities that have implemented an EHR system should utilize their system to develop a standardized template for the Reconciled Medication List. A standardized template will ensure that all required data elements specified in the measure are included whenever a Reconciled Medication List is generated from the EHR. Each facility has the autonomy to customize the format of the Reconciled Medication List, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution.

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

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

Transmitting the Reconciled Medication List:

This performance measure does not require that the Reconciled Medication List be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model (<https://ecqi.healthit.gov/qdm>). RxNorm has been named as the recommended vocabulary for medications and can be used to identify the medications to which the allergies exist. Allergies (non-substance) and Adverse Reactions

to medications should be expressed using SNOMED-CT. The use of recognized interoperability standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR.

### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

NUMERATOR STEP 1. For each patient meeting the denominator criteria in the given calculation month, identify all patients with each of the following three numerator criteria (a, b, and c) documented in the facility medical record to define the numerator for that month:

A. Facility attestation that during the calculation month:

1. The patient's most recent medication list in the dialysis medical record was reconciled to one or more external list(s) of medications obtained from the patient/caregiver (including patient-/caregiver-provided "brown-bag" information), pharmacotherapy information network (e.g., Surescripts®), hospital, or other provider AND that ALL known medications (prescriptions, OTCs, herbals, vitamin/mineral/dietary [nutritional] supplements, and medical marijuana) were reconciled;

AND

2. ALL of the following items were addressed for EACH identified medication:

- a) Medication name;
- b) Indication (or "unknown");
- c) Dosage (or "unknown");
- d) Frequency (or "unknown");
- e) Route of administration (or "unknown");
- f) Start date (or "unknown");
- g) End date, if applicable (or "unknown");
- h) Discontinuation date, if applicable (or "unknown");
- i) Reason medication was stopped or discontinued, if applicable (or "unknown"); and
- j) Identification of individual who authorized stoppage or discontinuation of medication, if applicable (or "unknown");

AND

3. Allergies, intolerances, and adverse drug events were addressed and documented.

B. Date of the medication reconciliation.

C. Identity of eligible professional performing the medication reconciliation.

NUMERATOR STEP 2. Repeat "Numerator Step 1" for each month of the one-year reporting period to define the final numerator (patient-months).

### *Denominator Statement*

#### **3317 Medication Reconciliation on Admission**

All patients admitted to an inpatient facility from home or a non-acute setting.

#### **0097 Medication Reconciliation Post-Discharge**

All discharges from an in-patient setting for patients who are 18 years and older.

**0293 Medication Information**

All emergency department patients who are transferred to another healthcare facility

**0553 Care for Older Adults (COA) – Medication Review**

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

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

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

**2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Total number of patient-months for all patients permanently assigned to a dialysis facility during the reporting period.

*Denominator Details***3317 Medication Reconciliation on Admission**

All adult and pediatric patients admitted to an IPF are eligible to be sampled, regardless of insurance types.

**0097 Medication Reconciliation Post-Discharge**

The denominator for this measure is identified by administrative codes, which are specific to the level of reporting. The denominator for both levels of reporting is based on episodes, not patients. If patients have more than one discharge, include all discharges between January 1 and December 1 of the measurement year. This measure is stratified by age group so three denominator groups are identified for each level of reporting: Patients age 18-64, Patients age 65+ and all patients.

Health Plan Level:

Administrative:

- An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.
- Stratify the denominator by age group based on age as of December 31 of the measurement year: Patients 18-64 years of age; Patients 65 years of age and older; All Patients 18 years of age and older.

Physician Level:

- Patients who were discharged from an acute or nonacute inpatient facility on or between January 1 and December 1 of the measurement year and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care. Codes to identify visit with on-going care provider are below.
- Stratify the denominator by age group based on age on the date of encounter: Patients 18-64 years of age; Patients 65 years of age and older; All Patients 18 years of age and older.

CPT encounter codes for visit with Ongoing Care Provider:

90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335,

99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0402, G0438, G0439

#### **0293 Medication Information**

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

DC codes:

3 Hospice –healthcare facility

4a Acute Care Facility- General Inpatient Care

4b Acute Care Facility- Critical Access Hospital

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

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

5 Other health care facility

#### **0553 Care for Older Adults (COA) – Medication Review**

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

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

Time Period for Data Collection: At each discharge during measurement period

Note: Facilities are responsible for determining the appropriate use of codes.

For Administrative:

Identify patients discharged from inpatient facility using the following:

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

- 0111 (Hospital Inpatient (Including Medicare Part A), Admit through Discharge Claim)
- 0114 (Hospital Inpatient (Including Medicare Part A), Interim - Last Claim)
- 0121 (Hospital Inpatient (Medicare Part B only), Admit through Discharge Claim)
- 0124 (Hospital Inpatient (Medicare Part B only), Interim - Last Claim)
- 0181 (Hospital - Swing Beds, Admit through Discharge Claim)
- 0184 (Hospital - Swing Beds, Interim - Last Claim)
- 0211 (Skilled Nursing-Inpatient (Including Medicare Part A), Admit through Discharge Claim)
- 0214 (Skilled Nursing-Inpatient (Including Medicare Part A), Interim - Last Claim)
- 0221 (Skilled Nursing-Inpatient (Medicare Part B only), Admit through Discharge Claim)
- 0224 (Skilled Nursing- Inpatient (Medicare Part B only), Interim - Last Claim)
- 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)
- 0284 (Skilled Nursing-Swing Beds, Interim - Last Claim)

AND

Discharge Status (Form Locator 17)

- 01 (Discharged to home or self care (routine discharge))
- 02 (Discharged/transferred to a short term general hospital for inpatient care)



- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to a facility that provides custodial or supportive care)
- 05 (Discharged/transferred to a designated cancer center or children's hospital)
- 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care)
- 21 (Discharged/transferred to court/law enforcement)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 69 (Discharged/transferred to a designated disaster alternative care site)
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
- 81 (Discharged to home or self care with a planned acute care hospital inpatient readmission)
- 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)
- 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission)
- 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)
- 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission)
- 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)
- 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)
- 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission)
- 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission)

- 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission)
- 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission)
- 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission)
- 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission)
- 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission)
- 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission)

OR

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

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

AND

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

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

AND

Discharge Status (Form Locator 17)

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

- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 69 (Discharged/transferred to a designated disaster alternative care site)
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
- 81 (Discharged to home or self-care with a planned acute care hospital inpatient readmission)
- 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)
- 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission)
- 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)
- 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission)
- 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)
- 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)
- 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission)
- 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission)
- 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission)
- 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission)
- 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission)
- 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission)
- 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission)
- 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission)

This measure may also be implemented in EHRs:

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

### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

DENOMINATOR STEP 1. Identify all in-center and home hemodialysis and peritoneal dialysis patients permanently assigned to the dialysis facility in the given calculation month.

DENOMINATOR STEP 2. For all patients included in the denominator in the given calculation month in “Denominator Step 1”, identify and remove all in-center hemodialysis patients who received < 7 dialysis treatments in the calculation month.

DENOMINATOR STEP 3. Repeat “Denominator Step 1” and “Denominator Step 2” for each month of the one-year reporting period.

#### *Exclusions*

#### **3317 Medication Reconciliation on Admission**

The measure applies two exclusion criteria to ensure that it is feasible to complete the medication reconciliation process on admission to the IPF:

1. Patients transferred from an acute care setting
2. Patient admissions with a length of stay less than or equal to 2 days

#### **0097 Medication Reconciliation Post-Discharge**

The following exclusions are applicable to the Health Plan Level measure.

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

#### **0293 Medication Information**

All emergency department patients not discharged to another healthcare facility.

#### **0553 Care for Older Adults (COA) – Medication Review**

N/A

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

Patients who died

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

### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

In-center patients who receive < 7 hemodialysis treatments in the facility during the reporting month.

#### *Exclusion Details*

#### **3317 Medication Reconciliation on Admission**

Transfer from an Acute Care Setting:

The first exclusion criterion applies to patient admissions that result from a transfer from an acute care setting, such as another inpatient facility or inpatient unit. This exclusion is applied because medication reconciliation with outpatient medications may have been done at the transferring facility and different medication reconciliation processes are

required at the receiving IPF for those admissions to focus on the regimen that was used in the transferring facility. Patient admissions from long-term care facilities and emergency departments are not considered transfers and are included in the denominator for the measure.

Length of Stay Less than or Equal to 2 Days:

The second exclusion criterion applies to patient admissions with lengths of stay shorter than the time needed to adequately complete the medication reconciliation process. The timeframe from admission needed to complete the medication reconciliation process was discussed with the TEP, which recommended a requirement to complete reconciliation by the end of Day 2 if the day of admission is Day 0. They cited instances where patients are admitted on weekends and outpatient providers are not available to ascertain PTA medications or where patients are not stable enough to provide information immediately upon admission. The measure developer also evaluated this timeframe empirically using the field testing data to determine when most facilities could complete the medication reconciliation process. Table 2b2.2 in the NQF Measure Testing Form contains all records with complete medication reconciliation for all medications on the PTA medication list and shows the percentage of those records that had completed the medication reconciliation in one day increments of time from admission. This analysis confirmed the appropriateness of the 2-day timeframe for completing the medication reconciliation process.

#### **0097 Medication Reconciliation Post-Discharge**

N/A

#### **0293 Medication Information**

Exclusions:

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

#### **0553 Care for Older Adults (COA) – Medication Review**

N/A

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

Time Period for Data Collection: At each discharge during measurement period

According to the PCPI methodology, exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (i.e., the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure Reconciled Medication List Received by Discharged Patients, exclusions include patients who died and patients who left against medical advice or discontinued care. Exclusions, including applicable value sets, are included in the measure specifications.

Additional details by data source are as follows:

For Administrative Data:

UB-04 (Form Locator 17 - Discharge Status):

- 07 (Left against medical advice or discontinued care)
- 20 (Expired)
- 40 (Expired at home)
- 41 (Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice))
- 42 (Expired - place unknown)

This measure may also be implemented in EHRs:

Discharges meeting denominator exclusions criteria should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.

### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

As detailed in “Denominator Step 2” above, transient patients, defined as in-center patients who receive < 7 hemodialysis treatments in the facility during the reporting month, are excluded from the measure.

### *Risk Adjustment*

#### **3317 Medication Reconciliation on Admission**

No risk adjustment or risk stratification

#### **0097 Medication Reconciliation Post-Discharge**

No risk adjustment or risk stratification

123834 | 140881

123834 | 140881

#### **0293 Medication Information**

No risk adjustment or risk stratification

#### **0553 Care for Older Adults (COA) – Medication Review**

No risk adjustment or risk stratification

110032 | 123834 | 140881

110032 | 123834 | 140881

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

No risk adjustment or risk stratification

140560

140560

#### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

No risk adjustment or risk stratification

111070

111070

### *Stratification*

#### **3317 Medication Reconciliation on Admission**

Not applicable because this measure is not stratified.

#### **0097 Medication Reconciliation Post-Discharge**

N/A

#### **0293 Medication Information**

#### **0553 Care for Older Adults (COA) – Medication Review**

N/A

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

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

#### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Not applicable.

### *Type Score*

#### **3317 Medication Reconciliation on Admission**

Rate/proportion better quality = higher score

#### **0097 Medication Reconciliation Post-Discharge**

Rate/proportion better quality = higher score

#### **0293 Medication Information**

#### **0553 Care for Older Adults (COA) – Medication Review**

Rate/proportion better quality = higher score

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

Rate/proportion better quality = higher score

#### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Rate/proportion better quality = higher score

### *Algorithm*

#### **3317 Medication Reconciliation on Admission**

To calculate the performance score:

1. Start processing. Run cases that are included in the Initial Patient Population as follows:

- a. Find the patients that the performance measure is designed to address (all adult and pediatric patients admitted to the inpatient facility from home or a non-acute setting with a length of stay greater than two days).
2. Check Length of Stay (calculated as the Discharge Date minus the Admission Date).
  - a. If the Length of Stay is greater 2 days, continue processing and proceed to Transfer From an Acute Care Setting.
  - b. If the Length of Stay is less than or equal to 2 days, the record will proceed to Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
3. Check Transfer From an Acute Care Setting.
  - a. If the Transfer From an Acute Care Setting is equal to 1 (Yes), the case was admitted from a transfer from an acute care setting and the record will proceed to Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
  - b. If the Transfer From an Acute Care Setting is equal to 2 (No), the case was admitted from an admission source other than an acute case setting. Continue processing and proceed to Designated PTA Medication List.
4. Check Designated PTA Medication List.
  - a. If the Designated PTA Medication List is equal to 1 (Yes), continue processing and proceed to External Source.
  - b. If the Designated PTA Medication List is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.
5. Check External Source.
  - a. If External Source is equal to 1 (Yes), continue processing and proceed to Reconciliation Action.
  - b. If External Source is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.
6. Check Reconciliation Action.
  - a. If Reconciliation Action is equal to 1 (Yes) or 3 (N/A), continue processing and proceed to Reconciliation Action by End of Day 2.
  - b. If Reconciliation Action is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.
7. Check Reconciliation Action by the end of Day 2 when the Admission date is Day 0.
  - a. If Reconciliation Action by End of Day 2 is equal to 1 (Yes), the record will proceed to Measure Category Assignment of E and will be in the Numerator Population. Stop processing.
  - b. If Reconciliation Action by End of Day 2 is equal to 2 (No), the record will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.

#### **0097 Medication Reconciliation Post-Discharge**

Step 1: Determine the eligible population. The eligible population is all the patients aged 18 years and older.

Step 2: Determine number of patients meeting the denominator criteria as specified in section S.9 above. The denominator includes all patients discharged from an inpatient



facility. Patients may be counted more than once in the denominator if they had more than one discharge during the measurement year. Stratify the patients by age groups.

Step 3: Determine the number of patients who meet the numerator criteria as specified in section S.6 above. The numerator includes all patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.

Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2 for each age strata. 123834 | 140881

#### **0293 Medication Information**

The measure is calculated using an all-or-none approach. Other analysis may be useful for improvement or reporting. Data elements are identified for the measure. If the data element is not appropriate for the patient, items scored as NA (not applicable) are counted in the measure as a positive, or 'yes,' response and the patient will meet the measure criteria. The patient will either need to meet the criteria for all of the data elements (or have an NA) to pass the measure.

#### **0553 Care for Older Adults (COA) – Medication Review**

Step 1. Determine the eligible population: All patients 66 years and older as of the end (e.g., December 31) of the measurement year

Step 2: Identify the denominator: The denominator is the eligible population

Step 3: Identify the numerator: Individuals in the denominator who have documentation of at least one medication review conducted by a prescribing practitioner or clinical pharmacist and have a medication list in their medical record.

Step 4: Calculate the rate: Numerator/Denominator 110032 | 123834 | 140881

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

To calculate performance rates:

1. Find the patients who meet the initial population (i.e., the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator. (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. Find the patients who qualify for denominator exclusions and subtract from the denominator.
4. From the patients within the denominator, find the patients who meet the numerator criteria (i.e., 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

If the patient does not meet the numerator, this case represents a quality failure. 140560

#### **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

Scores are calculated using the following algorithm. For each calculation month in the one-year reporting period:

1. IDENTIFY THE "RAW DENOMINATOR POPULATION"

Identify all in-center and home hemodialysis and peritoneal dialysis patients permanently assigned to the dialysis facility during the given calculation month.

**2. REMOVE PATIENTS MEETING MEASURE EXCLUSION CRITERIA TO DEFINE THE “FINAL DENOMINATOR POPULATION” FOR THE CALCULATION MONTH**

For all patients included in the denominator during the given calculation month in Step 1 above, identify and remove all in-center patients who received < 7 hemodialysis treatments during the given calculation month.

**3. IDENTIFY THE “NUMERATOR POPULATION” FOR THE CALCULATION MONTH**

For each patient remaining in the denominator during the given calculation month after Step 2, identify all patients with each of the following three numerator criteria (a, b, and c) documented in the facility medical record to define the numerator for that month:

**A. Facility attestation that during the calculation month:**

1. The patient’s most recent medication list in the dialysis medical record was reconciled to one or more external list(s) of medications obtained from the patient/caregiver (including patient-/caregiver-provided “brown-bag” information), pharmacotherapy information network (e.g., Surescripts®), hospital, or other provider AND that ALL known medications (prescriptions, OTCs, herbals, vitamin/mineral/dietary [nutritional] supplements, and medical marijuana) were reconciled;

AND

**2. ALL of the following items were addressed for EACH identified medication:**

- a) Medication name;
- b) Indication (or “unknown”);
- c) Dosage (or “unknown”);
- d) Frequency (or “unknown”);
- e) Route of administration (or “unknown”);
- f) Start date (or “unknown”);
- g) End date, if applicable (or “unknown”);
- h) Discontinuation date, if applicable (or “unknown”);
- i) Reason medication was stopped or discontinued, if applicable (or “unknown”); and
- j) Identification of individual who authorized stoppage or discontinuation of medication, if applicable (or “unknown”);

AND

3. Allergies, intolerances, and adverse drug events were addressed and documented.

B. Date of medication reconciliation.

C. Identity of eligible professional performing medication reconciliation.

**4. CALCULATE THE PERFORMANCE SCORE FOR THE CALCULATION MONTH**

Calculate the facility’s performance score for the given calculation month as follows:

Month’s Performance Score = Month’s Final Numerator Population ÷ Month’s Final Denominator Population

**5. CALCULATE THE ANNUAL PERFORMANCE SCORE**

Calculate the facility’s annual performance score as follows:

Facility's Annual Performance Score = (Facility's Month 1 Score + Month 2 Score + ..... + Month 12 Score) ÷ 12 111070

### *Submission items*

#### **3317 Medication Reconciliation on Admission**

5.1 Identified measures: 0293 : Medication Information

0097 : Medication Reconciliation Post-Discharge

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

0553 : Care for Older Adults (COA) – Medication Review

2988 : Medication Reconciliation for Patients Receiving Care at Dialysis Facilities

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The Measure Developer evaluated existing measures in the NQF portfolio to determine whether the Medication Reconciliation on Admission measure would compete with existing measures. Among the five NQF-endorsed measures that evaluate the medication reconciliation process, three (NQF #0097, #0553, #2988) are specified for the outpatient setting and the two (NQF #0293 and #0646) that are specified for the inpatient setting focus on communication of information at discharge. Therefore, the Medication Reconciliation on Admission measure is the only measure that evaluates medication reconciliation on admission to an inpatient facility. To align definitions with other measures that establish a designated timeframe by which a given process must be completed from admission, the Measure Developer harmonized the Medication Reconciliation on Admission measure timeframes with the timeframe specifications of SUB-1 Alcohol Use Screening (NQF 1661) and TOB-1 Tobacco Use Screening (NQF 1651), developed by The Joint Commission. Both measures define the length of stay in calendar days. Standardizing definitions for calculating length of stay using the admission and discharge dates without factoring-in the admission and discharge times will not only help reduce confusion across measures but also help to improve the reliability of the measure scores by eliminating the need to capture times, which were found to be unreliable during field testing. To develop the three data elements associated with the medication reconciliation process, the Measure Developer compared the conceptual descriptions and definitions of five NQF-endorsed measures (NQF 0553, NQF 2988, NQF 0293, NQF 0646, and NQF 0097) that evaluate the medication reconciliation process. Four of the five measures explicitly require a designated medication list. For this measure, the Measure Developer operationalized that requirement with the Designated PTA Medication List data element. Of the three measures that required collection of medications, two had requirements for the types of sources that should be referenced to compile the list. For the Medication Reconciliation on Admission measure, the Measure Developer set to establish a minimum standard and aligned with the approach to require "one or more external sources." While several measures required the type of information to be collected on each medication, the Measure Developer decided not to include those data elements in this measure given the high performance and low variation for those data elements in testing. Each of the measures defines the process of reconciling the medications on the list differently. The Measure Developer incorporated aspects of each definition that are most applicable to the IPF setting. For example, the Measure Developer aligned with measures that require that the

reconciliation be completed by a prescriber and that there be documentation of whether each medication be continued, modified, or discontinued. Finally, the Measure Developer considered different approaches to scoring the measure. Four of the five NQF-endorsed measures require that all aspects of the medication reconciliation process be completed for a patient to pass the measure. The fifth measure evaluates the number of patient months for which the medication reconciliations were completed, however, this is only applicable in the outpatient setting. Therefore, the Measure Developer aligned the scoring approach to produce measure scores that represent the percentage of patient admissions that meet all the medication reconciliation criteria.

5b.1 If competing, why superior or rationale for additive value: This measure complements other existing measures because it focuses on the completion of the medication reconciliation process by the end of Day 2 of the hospitalization to the facility, which is not addressed by any existing measure. Medication reconciliation on admission is important to inform accurate medication reconciliation at discharge, which is evaluated by two of the existing measures. Medication reconciliation on admission also ensures that efforts to reconcile medications in the outpatient setting are continued at the transition to the inpatient setting.

#### **0097 Medication Reconciliation Post-Discharge**

5.1 Identified measures: 0419 : Documentation of Current Medications in the Medical Record

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

0553 : Care for Older Adults (COA) – Medication Review

2456 : Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: See 5b.1 for more details.

5b.1 If competing, why superior or rationale for additive value: This measure assesses medication reconciliation between a discharge medication list and an outpatient medication list conducted post hospital discharge by an ongoing care provider and documented in the outpatient record. The denominator for this measure is all patients 18+ discharged from an inpatient facility to the community.

Related Measures:

Measure 0553 is conducted at health plan level. This measure assesses annual outpatient medication review by a prescribing practitioner or clinical pharmacist among all patients aged 66+. A hospital discharge is not required to meet denominator criteria therefore the measure has a different target population than measure 0097 and is not a competing measure.

Measure 0646 is conducted at the facility level. This measure assesses whether the patient received a reconciled medication list at the time of discharge. The denominator for this measure is all patients, regardless of age, discharged from the hospital. This measure is only focused on the reconciliation of medications that were prescribed during the inpatient stay and looks to see if the patient themselves receive this reconciled list at discharge. This measure does not address whether a reconciled medication list is documented in the

outpatient medical record. Therefore the measure focus is different from measure 0097, which focuses on whether or not a patients' discharge medications were reconciled with their current medications in the outpatient setting.

Measure 2456 is conducted at the hospital/acute facility level. This measure assesses the quality of the medication reconciliation process in the hospital by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. This process is completed by a trained pharmacist who at the time of admission, compares the admission orders to the preadmission medication list to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This measure does not address whether a reconciled medication list is documented in the outpatient medical record after discharge. Therefore the measure focus is different from measure 0097.

Measure 0419 is conducted at the provider level. This measure looks at the percentage of visits for all patients 18+ for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. The list must include all known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements AND must contain the medications' name, dosage, frequency and route of administration. This measure only looks for documentation of current medications and is not focused on reconciling medications after a discharge. The measure has a different target population and measure focus and is therefore not competing.

#### **0293 Medication Information**

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:

#### **0553 Care for Older Adults (COA) – Medication Review**

5.1 Identified measures: 0097 : Medication Reconciliation Post-Discharge

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

0554 : Medication Reconciliation Post-Discharge (MRP)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: See answer 5b.1 for more details.

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

5.1 Identified measures: 0293 : Medication Information

0097 : Medication Reconciliation Post-Discharge

0419 : Documentation of Current Medications in the Medical Record

0553 : Care for Older Adults (COA) – Medication Review

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Overall, our measure differs from existing medication reconciliation measures in that it focuses on

whether or not a reconciled medication list was provided to discharged patients rather than just on whether or not reconciliation was performed. We feel that our measure better reflects the patient-focused aspect of medication reconciliation. In addition, our measure is intended for implementation at the facility-level, whereas 0097 and 0553 are intended for use at the health plan and integrated delivery system-level, while 0419 is intended for EP-level reporting. In addition, 0553 focuses on elderly patients, whereas our measure includes all adult patients. Given the differences in focus and measurement-level, we feel that our measure is complementary to other measures related to medication reconciliation and management by focusing on the patient receipt of a reconciled medication list.

5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no existing NQF-endorsed measures that address both the same target population and measure focus.

## **2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities**

5.1 Identified measures: 0097 : Medication Reconciliation Post-Discharge

0554 : Medication Reconciliation Post-Discharge (MRP)

2456 : Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Medication Reconciliation for Patients Receiving Care at Dialysis Facilities is harmonized with existing NQF-endorsed medication reconciliation measures in that all similarly specify that the medication reconciliation must address ALL prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency, and route. The KCQA measure, however, is unique among the currently endorsed medication reconciliation measures in that the level of analysis is the dialysis facility. The KCQA measure also moves beyond a single "check/box", specifying multiple components that must be met to be counted as a "success." It requires the following additional information on each medication, where applicable and known: indication, start and end date, discontinuation date, reason the medication was stopped or discontinued, and identification of the individual who authorized stoppage or discontinuation of the medication. Additionally, given the increasing frequency with which medical marijuana is prescribed, the KCQA measure specifies that this pharmacotherapeutic agent must be addressed during the reconciliation. KCQA believes these additional foci are necessary to ensure the medication reconciliation process is as comprehensive as possible to better identify and effectively address potential sources of adverse drug-related events and not function merely as a single "check-box" measure. Testing demonstrated these data elements are effectively captured and recorded in facility's electronic medical record systems during the routine medication reconciliation process.

5b.1 If competing, why superior or rationale for additive value: Not applicable; this medication management measure is unique in its specific focus on the ESRD population.

## Comparison of NQF #3332 and NQF #0712

3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)

0712 Depression Utilization of the PHQ-9 Tool

### *Steward*

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Massachusetts General Hospital

#### **0712 Depression Utilization of the PHQ-9 Tool**

MN Community Measurement

### *Description*

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

#### **0712 Depression Utilization of the PHQ-9 Tool**

The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia who have a completed PHQ-9 or PHQ-9M tool during the measurement period.

### *Type*

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Process

#### **0712 Depression Utilization of the PHQ-9 Tool**

Process

### *Data Source*

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Claims, Electronic Health Records, Paper Medical Records In administrative data:

If patient age => 3.0 & age =< 17.99; claim for well child visit (99382 or 99383 or 99385 or 99392 or 99393 or 99394), assess presence of CPT 96110 code for screening.

In medical record (paper or electronic):

If patient age => 3.0 & age =< 17.99; claim for well child visit (99382 or 99383 or 99385 or 99392 or 99393 or 99394), assess progress note, templated note, flowsheet, scanned in PSC, for evidence that screen was administered.

No data collection instrument provided No data dictionary

#### **0712 Depression Utilization of the PHQ-9 Tool**

Electronic Health Record (Only), Paper Records PROM

The PHQ-9 depression assessment tool is a patient reported outcome tool that is in the public domain and can be obtained for free use on the Patient Health Questionnaire (PHQ) Screeners website at [www.phqscreeners.com](http://www.phqscreeners.com). Modes of administration include traditional



paper, mail, electronic and telephonic. The tool is available on the website with 79 language translations available.

The PHQ-9 tool is validated for use as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response). [Löwe B, Unutzer J, Callahan CM, Perkins AJ, Kroenke K. Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. *Med Care* 2004;42:1194-1201 and Kroenke K, Spitzer RL, Williams JBW, Löwe B. The Patient Health Questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. *Gen Hosp Psychiatry* 2010]

The PHQ-9M is a modified version of the PHQ-9 tool for adolescents. Please refer to discussion in S.16.

Available at measure-specific web page URL identified in S.1 Attachment  
MNCM\_Depression\_Care\_VS\_Specs\_Definitions\_w\_Redesign\_11-9-2017-636162830143430795.xlsx

### *Level*

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Clinician : Group/Practice, Population : Regional and State

#### **0712 Depression Utilization of the PHQ-9 Tool**

Facility, Clinician : Group/Practice

### *Setting*

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Outpatient Services

#### **0712 Depression Utilization of the PHQ-9 Tool**

Clinician Office/Clinic, Behavioral Health : Outpatient

### *Numerator Statement*

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

#### **0712 Depression Utilization of the PHQ-9 Tool**

Adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) included in the denominator who have at least one PHQ-9 or PHQ-9M tool administered and completed during a four month measurement period.

### *Numerator Details*

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Depending on the system, patients passing this quality measure are identified either through a review of administrative claims or the medical record. In claims data, the presence of a CPT code for screening (96110 in Massachusetts and many other states) on the same day as the WCV is required. In a chart review, the presence of a PSC score or PDF scan of it in the progress note, or score shown in the visit template or flowsheet documents the completion of the screen on the same day of the WCV. To receive credit,



progress notes must indicate the name of the specific measure and actual score (eg, PSC given, score = not at risk).

#### **0712 Depression Utilization of the PHQ-9 Tool**

The total number of unique adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) in the denominator who had a least one PHQ-9 or PHQ-9M tool administered and completed during a four month measurement period in which a visit or contact with the patient has occurred.

Partially completed tools (e.g. answering 6 of the 9 questions) do not count as a completed tool. A valid PHQ-9 or PHQ-9M requires the completion of all nine questions for accurate scoring.

The numerator rate is calculated as follows:

# pts with major depression or dysthymia with one or more completed PHQ-9 or PHQ-9M tools/  
# pts with major depression or dysthymia with a visit or contact during the measurement period

Rates are stratified by adolescents (12 to 17 years of age) and adults (18 years of age or older).

Time period for data collection: four month measurement periods (In the MN program 2/01 to 5/31, 6/01 to 9/30 and 10/01 to 1/31) with dates of service occurring within the four month period.

#### *Denominator Statement*

##### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

##### **0712 Depression Utilization of the PHQ-9 Tool**

Adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia.

#### *Denominator Details*

##### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Cases are identified from administrative data for site. Number of unique patients ages 3.00 to 17.99 seen for a well-child visit (CPT 99381-99394) in a defined evaluation period, often a year.

##### **0712 Depression Utilization of the PHQ-9 Tool**

The target population, patients age 12 and older with the diagnosis of major depression or dysthymia, regardless of severity level of the PHQ-9 or PHQ-9M.

The number of unique patients who had a least one visit or contact with a provider during the measurement period with a diagnosis of major depression or dysthymia (Major Depression or Dysthymia Value Set). Contact is defined as visit, telephone call, e-visit or other contact that is associated with a PHQ-9 tool being completed by the patient.

## *Exclusions*

### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

No exclusions.

### **0712 Depression Utilization of the PHQ-9 Tool**

Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis of bipolar or personality disorder, schizophrenia or psychotic disorder, or pervasive developmental disorder are excluded.

## *Exclusion Details*

### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

N/A

### **0712 Depression Utilization of the PHQ-9 Tool**

Required exclusions:

- Patient had an active diagnosis of bipolar disorder (Bipolar Disorder Value Set)
- Patient had an active diagnosis of schizophrenia or psychotic disorder (Schizophrenia or Psychotic Disorder Value Set)

Allowable exclusions:

- Patient was a permanent nursing home resident any time during the measurement period
- Patient was in hospice or receiving palliative care any time during the measurement period
- Patient died prior to the end of the measurement period
- Patient had an active diagnosis of personality disorder (Personality Disorder Value Set)

[These are the same exclusions as the related outcome measures]

Please see field specifications in the attached data dictionary.

## *Risk Adjustment*

### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

No risk adjustment or risk stratification

### **0712 Depression Utilization of the PHQ-9 Tool**

No risk adjustment or risk stratification

## *Stratification*

### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

N/A

### **0712 Depression Utilization of the PHQ-9 Tool**

This measure is stratified by age range and results are reported separately by age: Adolescents (12-17 years of age) and Adults (18 years of age and older).

### Type Score

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Rate/proportion better quality = higher score

#### **0712 Depression Utilization of the PHQ-9 Tool**

Rate/proportion better quality = higher score

### Algorithm

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

Step 1. Count number of children aged 3-17 seen for a well child visit in state, region, clinic or other group during defined period (often, one year) using administrative data (CPT 99381-99394). N=total population. This is the denominator.

Step 2. Assess whether PSC was administered as a part of WCV, for the eligible population, using patient claims data or chart for indicator status. Pass if documentation that screen was given on the day of the WCV is present.

Step 3. Compute numerator = count of patients with completed PSC.

Step 4. Calculate clinic or other entity rate as numerator/denominator. No risk adjustment.

#### **0712 Depression Utilization of the PHQ-9 Tool**

This measure is calculated by submitting a count of patients for the denominator and a count of patients in the numerator to a HIPAA secure data portal as part of the process in uploading a detailed patient file to calculate the six and twelve month remission outcome rates.

The numerator rate is calculated as follows:

# pts with major depression or dysthymia with one or more completed PHQ-9 or PHQ-9M tools/

# pts with major depression or dysthymia with a visit or contact during the measurement period

Query processes that medical groups follow to obtain counts:

During the four month measurement period (e.g. dates of service 6/1/2016 to 9/30/2016) how many patients had an office visit or other contact and diagnosis codes for major depression or dysthymia? (Major Depression or Dysthymia Value Set). (denominator)

Of these patients, how many had a PHQ-9 tool completed? (numerator)

The counting process is validated during the denominator certification process (where groups document all steps in identifying the depression population). Groups are asked to describe the process they use for obtaining the counts. Denominator documents are reviewed (certified) by MNMCM staff prior to data collection and submission. This is to insure that all groups are identifying their population correctly.

### Submission items

#### **3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)**

5.1 Identified measures: 0712 : Depression Utilization of the PHQ-9 Tool

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: The age range for the PHQ-9 (NQF 712) has recently been expanded to include youth 12 to 17 years of age with a diagnosis of depression. The currently submitted measure, the PSC, screens for a broader band of problems (other emotional problems like anxiety as well as other types of problems like attention and behavior) and a larger age range (3-17) than the PHQ-9. Along with the PHQ-9, the PSC is actually one of the specific tools mentioned by the US Preventive Services Task Force as a screen for depression in youth (Forman-Hoffman et al., 2016). Although studies have shown that the PSC identifies about 80% of the youth with depression who are found with the PHQ-9, only about half of the youth with serious psychosocial problems on the PSC are identified with the PHQ-9 (Richardson et al., 2010). The PSC is a representative of a broader class of screening tools (brief broadband psychosocial screens) that are required for use in conjunction with pediatric well child visits in the Massachusetts EPSDT program. Other similar broadband tools are the Strengths and Difficulties Questionnaires and the Child Behavior Checklist. The Massachusetts EPSDT CBHI program provides a short (now 13) list of approved tools (both broad and narrow band) and allows the pediatrician to use the one deemed most appropriate for each case. In a review of nearly 6000 medical charts, Savageau and her associates found that about 40% of all screens were PSC's compared to only about 1% that were PHQ-9's (Savageau et al., 2016; Savageau et al., 2017, May) suggesting that the PSC is at least in the past ten years more widely used by pediatricians in Massachusetts. The reference list is included in the attached appendix.

#### **0712 Depression Utilization of the PHQ-9 Tool**

5.1 Identified measures: 0711 : Depression Remission at Six Months

0710 : Depression Remission at Twelve Months

1884 : Depression Response at Six Months- Progress Towards Remission

1885 : Depression Response at Twelve Months- Progress Towards Remission

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: There are related, complimentary measures for depression remission, response that are PAIRED with this process measure. MN Community Measurement is the measure steward for these related measures and they are completely harmonized. The remission measures are considered the "gold standard" of depression outcomes and measure the same population of patients at two different points in time, six and twelve months after index contact with diagnosis and elevated PHQ-9. The response measures, also at six and twelve months are considered as progress towards the desired goal of remission with a reduction in PHQ-9 score of greater than 50% representing a reduction in the severity of symptoms.

## Appendix F: Pre-Evaluation Comments

Comments received as of January 10, 2018.

Topic	Commenter	Comment
3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting (eCQM) (Mathematica Policy Research): Not Recommended	American Academy of Neurology	The American Academy of Neurology in general supports the measure, but notes the following potential concerns. Was an exclusion/exception considered for patients that pose harm to themselves or others? There is concern the population impacted will be small given published rates of between 9-6% for use of antipsychotic medications in inpatient settings. Defined outcomes are general and will be difficult to link to the measure as opposed to other factors that might effect post-hospital morbidity and mortality. Finally, reducing unnecessary continuation of antipsychotics following discharge would be a more tangible outcome.

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