NATIONAL QUALITY FORUM

Memo

TO: NQF Members

FR: NQF Staff

RE: Voting Draft Report: *NQF-Endorsed Measures for Care Coordination*

DA: June 23, 2014

Background

Care Coordination is increasingly recognized as fundamental to the success of healthcare systems and improved patient outcomes. Poorly coordinated care regularly leads to unnecessary suffering for patients, as well as avoidable readmissions and emergency department visits, increased medical errors, and higher costs. The Institute of Medicine (IOM) estimates that a potential opportunity of $240 billion in savings would result from care coordination initiatives such as patient education and the development of new provider payment models.[1]

NQF has undertaken several projects to provide guidance and measurement of care coordination, including a 2006 project that yielded an endorsed definition and framework for care coordination, a 2010 project through which 25 Preferred Practices and ten performance measures were endorsed, and a project completed in 2012 through which twelve performance measures were endorsed.

Most recently, the newly-convened Care Coordination Standing Committee which includes 24 members evaluated 12 measures: 1 new measure and 11 measures undergoing maintenance review against NQF's standard measure evaluation criteria for recommendation for endorsement. Eleven of the twelve measures were recommended for endorsement by the Committee.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from February 6, 2014 to February 20, 2014 for all of the measures under review; however no pre-evaluation comments were received.

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[1] IOM, *Roundtable on Value & Science-Driven health Care: The Healthcare Imperative: Lowering Costs and Improving Outcomes:* Workshop Serious Summary, Washington, DC: National Academies Press, 2010.

Post-evaluation comments

The Draft Report went out for Public and Member comment from April 29, 2014 to May 28, 2014. During this commenting period, NQF received 75 comments from 6 member organizations:

Consumers – 0	Professional – 0
Purchasers – 0	Health Plans – 2
Providers – 0	QMRI – 1
Supplier and Industry – 1	Public & Community Health - 2

A complete table of comments submitted pre- and post-evaluation, along with the responses to each comment and the actions taken by the Standing Committee, is posted to the project page on the NQF website, along with the measure submission forms.

The Committee reviewed all comments received and considered the pre-meeting comments prior to making endorsement recommendations. The Committee also responded to all post-evaluation comments. Revisions to the draft report and the accompanying measure specifications are identified as red-lined changes. (Note: Typographical errors and grammatical changes have not been red-lined, to assist in reading.)

Comments and their Disposition

Themes were identified in the post-evaluation comments regarding use of the evidence exception, feasibility of the measures, construction of several recommended measures as composites, and gaps in the portfolio. Several of the comments provided recommendations and/or expressed concerns regarding the specifications of the measures evaluated for endorsement. Additionally, several comments received were supportive of the Committee's decisions.

While there were several comments that were not supportive of the Committee's recommendations, most expressed their position on the measures without offering additional information that would promote further discussion of the measure.

Major themes were identified in the post-evaluation comments as follows:

1. Exercise of the exception to evidence for the ED patient transfer measures 0291-0297
2. Concern regarding the feasibility of the measures recommended for endorsement
3. Future recommendations regarding combining measures 0291-0297, and 0495-0497 as composites, and
4. Gaps in the Care Coordination portfolio.

Theme 1 – Evidence Base

Commenters expressed concern regarding the Committee's decision to exercise the exception to the evidence criterion for the seven ED patient transfer measures #0291-0297,

Committee response: The Committee recognizes that the state of the evidence within these measures is not ideal and notes that the literature presented does not provide a direct linkage to patient outcome; however, these measures display potential benefits to improve care coordination by addressing a foundational and critical aspect of patient safety. Additionally, the measures address an important gap in communication, which was weighed heavily by the Committee. Taking the above points into consideration, the Committee voted to move the measures forward by exercising the exception to the evidence criterion.

Theme 2 – Feasibility of Recommended Measures

Commenters expressed concern regarding the administrative burden associated with the need to collect data via data abstraction and from paper medical records for the recommended measure (#2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient).

Developer response: As for the burden of data collection, we consider this analogous to the effort required for the National Surgical Quality Improvement Program (NSQIP), which has been adopted by almost all U.S. hospitals and requires medical record review, often performed by trained nurses. The effort required for the proposed measures would be much less than that required for NSQIP (1-2 hours per day total) and would be fairly distributed to all hospitals.

Committee response: The Committee discussed the feasibility concerns raised for measure #2456, but emphasized that the concerns needed to be balanced by the need for more meaningful metrics which will begin to reflect the actual processes of care coordination.

Commenters were concerned about the ability of a patient or a caregiver to accurately communicate the necessary information needed for measures #2456.

Developer response, #2456: We acknowledge that patient/caregiver disclosure and recall of new and existing medications is an important data source in assembling an accurate medication history. However, because there may be limitations in the accuracy of this information (and indeed, in the accuracy of information from any source), our methods never rely on this information exclusively. As part of our methodology for completing a "gold standard" medication history with which to measure discrepancies, we require at least two independent sources of information, at least one of which must come from an entity other than a patient or caregiver. These include (but are not limited to) outpatient electronic medical record (EMR) medication lists, pharmacy prescription refill information, discharge medication lists, and non-electronic sources of information from primary care physicians and other outpatient offices and nursing facilities. These sources must be compared with each other and reviewed with patients, caregivers, and providers. We can never guarantee that the "gold standard" list is perfect, but it is as accurate as humanly possible. This methodology is highly reliable and has been performed in thousands of patients.

This measure will drive hospitals to implement interventions to improve their medication reconciliation processes. These processes include gathering medication information from several sources, not just patients and caregivers, knowing when to stop gathering additional data, consolidating data from discrepant sources into one coherent list (i.e., compiling a "best possible medication history"), and using the final list

to order medications at admission and discharge. Our measure accurately describes errors and omissions in any and all of these processes. Even hospitals with patient populations that have challenges to the comprehensive disclosure and recall of medications can score well in this measure if these steps are followed.

This new measure directly detects error rates in medication orders, enabling hospitals to better understand where their errors are occurring and the types of errors that exist. This will enable them to implement targeted interventions that reduce error rates. The result will be true improvements in medication safety during transitions in care.

Committee response: The Committee was in agreement that collecting accurate information from the patient/caregiver may pose a challenge but stated that utilizing medical trained professionals (i.e. pharmacists) to provide patient education may help to alleviate these inaccuracies overtime. Committee members also noted that the inaccuracy of patient recall may be overstated, citing a recent study indicating that nearly two-thirds of patients accurately recall newly prescribed medications, and that if appropriate patient education is provided this concern should not deter providers.

Theme 3 – Future Recommendations

Composite measures. Several commenters recommended that measures #0291-0297 be constructed as a composite.

Committee response: **T**he Committee discussed the issue of combining these measures into a composite measure at length during deliberations at the in-person meeting, noting that these seven measures (#0291, 0292, 0293, 0294, 0295, 0296, and 0297) regarding the transfer of patients from rural emergency departments to other facilities are intended to be reported together to communicate a comprehensive set of patient information as part of such transfers The Committee strongly recommended that in future, the developer construct these measures as a composite.

Commenters recommended measures #0495, 0496 and 0497 be constructed as a composite or otherwise captured in fewer measures.

Developer response: While we understand the concerns of the committee about the potential for unintended consequences of performance measures that evaluate the number of minutes a patient may reside in an emergency department prior to disposition, we do not think it is feasible to create a "composite" measure of the three ED throughput measures (NQF #s: 0495, 0496, and 0497). When these measures were first developed, the Emergency Department Technical Expert Panel (largely made up of representatives of the American College of Emergency Physicians as well as hospital representatives) discussed potential unintended consequences extensively. Here are the reasons we believe it is not feasible to create a composite measure:

NQF #0495 and NQF #0496 (median times from arrival to departure for patients seen in the ED and admitted to the hospital – 0495 and discharged from the ED – 0496) are measures from two separate reporting programs for hospitals. NQF 0495 is a part of the Hospital Inpatient Quality Reporting (HIQR) program and cases are sampled from hospital administrative claims for inpatients. NQF 0496 is a part of the Hospital Outpatient Quality Reporting (HOQR) program and cases are sampled based on E/M codes for ambulatory ED visits. These two programs (HIQR and HOQR) are separate programs specified in different federal laws and with different rule making processes.

Most acute care hospitals participate in the HIQR program but many do not currently participate in the HOQR program. Because participation is voluntary and because the sampling methodology for these two measures is so different, a composite measure is not feasible.

All three of these measures are reported as median times. The technical expert panel made the explicit decision to use median times to reduce the impact of outlier cases where a longer stay in the ED may reduce the need for hospitalization.

When the technical expert panel originally developed the measures, we considered setting some arbitrary time frame for ED throughput (the one discussed the most was a 4 hour window of time) and reporting these measures as proportions – e.g., the proportion of patients seen in the ED who were subsequently admitted and the time from arrival to ED departure was 4 hours or less. However, we felt that the risk of unintended consequences for a measure based on a proportion of patients whose departure was within an arbitrary time frame was much greater than using median times which addressed outlier cases. Median time measures allow a clinician to hold on to a patient longer when necessary whereas an arbitrary time frame may have pushed ED physicians to make rapid decisions to admit or discharge without appropriate evaluation or stabilization.

We are not aware of any methodology for creating composites for median times.

NQF #0497 (admit decision time to ED departure) is a component time of NQF #0495. It is not independent of 0495. NQF #0497 is the ED "boarding time" measure which was strongly supported by the ED Technical expert panel and the Emergency Department Benchmarking Alliance.

With respect to patients with psychiatric diagnoses, they are included in the measure information that is provided back to the hospital for quality improvement purposes, but are not included in the median times that are publicly reported. This decision was made to include them in a feedback measure to hospitals (we felt it was important to provide information to the hospital on throughput times for their entire ED population) but because of the variability in the availability of resources for follow-up or inpatient care for patients with psychiatric diagnoses, we did not include them in the public reported median times.

Committee response: Although the Committee acknowledged that these measures should remain as stand-alone measurers; it was recommended that the developer look to harmonize these measures with respect to ED median wait time in the future.

Portfolio gaps. Commenters noted gaps in the Care Coordination portfolio in the areas of bi-directional communication, patient reported outcomes and health IT.

Several commenters stressed the importance of bi-directional communication in assessing the quality of care coordination provided, specifically with respect to measures #0291-0297.

Committee response: In reviewing measures 0291-0297 the Committee noted that although communication has occurred, it does not mean that care coordination has occurred. However, the Committee agreed that the measures are important to address a gap area in terms of the transfer of ED patients from rural facilities to other facilities. The Committee stressed the need for measures that are bi-directional in nature and that address other aspects of care related to communication.

Another commenter expressed noted the scarcity of measures that address patient and family engagement. The commenter also recommended that measures of patient reported outcomes be included in the portfolio.

Committee response: The Committee discussed at length gaps in the Care Coordination portfolio of measures and the critical need for measures to be brought forward that assess bi-directional communication across settings, positive health outcomes, and patient and family engagement. During its discussions the Committee identified numerous areas where additional measure development is needed, and where persistent gaps across settings have been identified by NQF staff and the Measures Application Partnership (MAP), specifically:

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

The Committee agreed with the need for patient reported outcomes and acknowledged that these are being evaluated by NQF through the Person and Family Centered Care portfolio.

While these priorities have been emphasized in previous phases of this project, only one new measure (an outcome measure) was submitted during this phase of the project. The Committee and NQF strongly encourage the development and submission of measures addressing these identified gaps.

A commenter noted that with the withdrawal of several measures in the area of Health IT in addition to measure #0487: "EHR with EDI prescribing used in encounters were a prescribing event occurred" not being recommended for endorsement, leaves a significant gap in the portfolio in this important area.

Committee response: The Committee agreed that there is a critical need for the next generation of health IT focused measures that will reflect processes of true care coordination. Measure development in this area is strongly encouraged as this topic area evolves.

One commenter noted that medication-related problems are a major cause for serious adverse events and preventable hospitalizations and readmissions, and recommended that the Comprehensive Medication Management (CMM) process be recognized as a key component of care coordination. CMM is "a continuous systematic process used by providers to ensure patients' medications are coordinated, appropriate, understood by the patient and move patients toward clinical goals."

Committee response: The Committee agreed with the commenter and believes CMM to be a systematic approach to addressing gaps in the area of medication management

within the care coordination portfolio. The development and submission of measures in this area is strongly encouraged.

Measure Specific Comments

Measure 0291: Administrative Communication

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

Developer response: This measure looks for documentation that the communication occurred. This should not be a 'judgment call', either the communication is documented or it is not. This step of communication, prior to transfer is Emergency Medical Treatment and Active Labor Act (EMTALA) based to ensure that the services needed are available.

This measure has been tested in 16 states in more than 250 Critical Access Hospitals. Some data is available at http://www.flexmonitoring.org/publications/ds8/ at the Flex Monitoring Team website Rural Hospital Emergency Department Quality Measures: Aggregate Data Report (Data Summary Report #8)

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

Measure 0292: Vital Signs

Although in support of this measure, there was consensus that more vital signs need to be communicated when patients are transferred between facilities. Suggestions from commenters included EKG findings, if applicable, such as rhythm, ST changes, heart block, bundle branch blocks etc. Additionally, not only should pulsoximetry readings be noted but also any periods of desaturation, severity and length. Also if there were any large shifts in vitals, this should be identified as well (e.g. change in GCS from 12 to 3T or equivalent or HR shift from 60 to 125 bpm)

Developer response: The EKG suggestion is a good one. We will forward with the next review. Changes in VS should be noted in MD and nurse notes.

Committee response: The Committee encourages the gradual inclusion of these more specific vital signs in future measures.

Measure 0293: Medication Information

Commenters were in support of this measure, viewing this as a critical aspect of communication in care coordination. Although in support, there was emphasis to include further details of the medications administered (during transfer or at ED arrival), including time, method and patient response.

Developer response: The method, time, dose, etc. should be in the MAR. The responses to medications should be in the MD and Nurses notes.

Committee response: The Committee agrees with the developer's response.

Measure 0295: Physician Information

Although comments supported this measure, there were concerns that assessing compliance with the provision of physician information is important, which would minimize the burden of data collection for any new measures introduced into the healthcare system, thus questioning its feasibility.

Committee response: The Committee discussed the feasibility of this measure and agreed that the data abstraction did not appear to present an undue burden. It is expected that the adoption and use of electronic health records will help to reduce burden over time.

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

One commenter stated concerns surrounding the populations assessed within this measure, particularly patient diagnosis such as mental health and the potential treatment delays.

Developer response: We appreciate your support of these measures. These measures do provide the ability to drill down by mental health diagnosis, as the non-reporting strata contain cases with a mental health diagnosis (Table 7.01 in Appendix A of the Specifications Manual). For the inpatient setting, facilities are provided with an overall rate, a reporting rate, and a rate for cases with a psychiatric diagnosis. The reporting rate excludes cases with a psychiatric diagnosis. For the outpatient setting, there is an overall rate, a reporting rate, a rate for cases with a psychiatric diagnosis, and a rate for cases that are transferred. The reporting rate excludes the cases that are transferred and those with a psychiatric diagnosis. Facilities are able to determine treatment delays for other diagnoses by calculating throughout time according to diagnoses.

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

Measure 2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

One commenter questioned the specifications within this measure stating that the population should be exclusively high-risk patients, categorized by number of medications, and severity of illness or co-morbidities.

Developer response: Medication reconciliation is a process of identifying the most accurate list of all medications a patient is taking and should be taking —including name, dosage, frequency, route, purpose and duration — and using this list to provide correct medications for patients anywhere within the healthcare system. We advocate for facilitating this process for all patients to enhance patient safety and to reduce the incidence of adverse events. While we acknowledge the importance of caring for all patients, we realize that throughout hospitalization, high-risk patients often receive low-intensity efforts despite complex medication reconciliation needs. We consider this as a

potential failure mode in medication reconciliation. Therefore, one of the most important interventions to implement is a risk-stratification process with the provision to offer the intensive bundle to high-risk patients. The Intensive bundle has the same core elements of the standard bundle but addresses higher-risk patients who likely require additional dedicated time and expertise to manage the patient interview, reconciliation at discharge, and education for the patient. The MARQUIS toolkit includes a risk stratification tool with guidelines for operationalizing use of the tool by various providers and detailed descriptions of an intensive bundle that could be provided to high-risk patients.

If the concern is that certain hospitals will be unfairly penalized for caring for a high-risk patient population, we do have plans in place to adjust for number of medications and patient age during the 4-year roll-out period of this measure if warranted and approved by NQF and stakeholders. But we want to reiterate that medication reconciliation needs to be done correctly in all patients and that focusing solely on high-risk patients could lead to ignoring the process for many patients who would benefit from relatively simple interventions. Quality improvement efforts should improve the medication reconciliation process for all patients while recognizing the need to focus additional efforts on high-risk patients. Our measure as designed can accommodate both those realities.

Proposed Committee response: The Committee agrees with the developer's response.

Measure 2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Although supportive of this measure, there were comments that addressed the dependency on the quality of communication, particularly the patient and/or caregivers' comprehensive disclosure and recall aspect as it relates to existing and/or new medications, which may have implications for this measure.

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

Secondly, the developer strongly fosters the concept of patient-owned medication lists. If all patients admitted to the hospital came with a completely accurate and up-to-date medication list in their possession, then many of the hazards of poorly-done medication reconciliation would be avoided. The toolkit describes an intervention component which facilitates patient ownership of the list and provides a template to assist patients with

this process. If implemented, then over time patient and caregiver recall of medications would indeed become increasingly accurate.

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

NQF Member Voting

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

Please note that voting concludes on July 7, 2014 at 6:00 pm ET – no exceptions.

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

DRAFT REPORT FOR VOTING

June 23, 2014

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NATIONAL QUALITY FORUM

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

DRAFT REPORT

Executive Summary

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

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

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

In Phase 3 of this project, the Standing Committee evaluated 12 measures: ~~1~~ one new measure and 11 measures undergoing maintenance review against NQF's standard evaluation criteria. Eleven of the

measures were recommended for endorsement by the Committee, and one was not recommended (#0487: EHR with EDI prescribing used in encounters where a prescribing event occurred). The 11 measures that were recommended by the Standing Committee are:

- 0291: Administrative Communication
- 0292: Vital Signs
- 0293: Medication Information
- 0294: Patient Information
- 0295: Physician Information
- 0296: Nursing Information
- 0297: Procedures and Tests
- 0495: Median Time from ED Arrival to ED Departure for Admitted ED Patients
- 0496: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- 0497: Admit Decision Time to ED Departure Time for Admitted Patients
- 2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

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

Introduction

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

Because poorly coordinated care regularly leads to unnecessary suffering for patients, as well as avoidable readmissions and emergency department visits, increased medical errors, and higher costs, coordination of care is increasingly recognized as critical for improvement of patient outcomes and the success of healthcare systems. For example, individuals with chronic conditions and multiple co-morbidities—and their families and caregivers—often find it difficult to navigate our complex and fragmented healthcare system. As this ever-growing group transitions from one care setting to another, poor outcomes resulting from incomplete or inaccurate transfer of information, poor communication, and a lack of follow-up care become more likely. Yet the sharing of information across settings and between providers through electronic health records (EHRs) could reduce the unnecessary and costly duplication of patient services,[1] while the number of serious medication events could be reduced through patient education and the reconciliation of medication lists.[2] The Agency for Healthcare Research and Quality estimates that adverse medication events cause more than 770,000 injuries and

deaths each year, more than half of which affect those over age 65.[3] The cost of treating patients who are harmed by these events is estimated to be as high as $5 billion annually.[4] Furthermore, the Institute of Medicine has found that care coordination initiatives such as patient education and the development of new provider payment models could result in an estimated $240 billion in savings.[5]

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

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

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

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

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

Meanwhile, the HIT team at NQF initiated a project to assess the readiness of electronic data and health IT systems to support quality measurement of care planning during transitions of care, as well as provide recommendations for advancing such infrastructure. The expert panel convened for this project completed a review of industry initiatives related to the plan of care use in care coordination, workflow and data components related to the plan of care, and identification of the characteristics of the plan of care. This work informed an environmental scan to develop a baseline understanding of the use of HIT to support transitions of care and quality measurement. NQF worked with Brigham and Women's Hospital to conduct the environmental scan, and the results demonstrate the opportunity to improve data capture and exchange to support patient-centered, longitudinal plans of care. The TEP made recommendations to advance the capture of essential care plan data elements at the point of care, promote the adoption of interoperability standards, and enhance the use of care plan data in decision support. These recommendations could greatly advance quality improvement and measurement activities of care coordination. In 2012, NQF's Measure Applications Partnership (MAP) identified an initial group of measure families, sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the National Quality Strategy (NQS) priorities and high-impact conditions. MAP's Families of Measures report released October 1, 2012 includes a Care Coordination Measure Family with 62 available measures and a number of measure gap areas. The family includes measures addressing avoidable admissions and readmissions, system infrastructure support, care transitions, communication, care planning, and patient surveys related to care coordination. The MAP's Recommendations for Measures released January 28, 2014 included previously identified priority gap areas for care coordination in the areas of communication, system and infrastructure support and avoidable admissions and readmissions.

Building on previous work, in 2013 HHS engaged NQF to pursue a Care Coordination gaps prioritization project.[1] The prioritization work is concurrent with this project and is focused on assessing the status of measure gaps more broadly, and is intended to further advance the aims and priorities of the National Quality Strategy by identifying priorities for performance measurement; scanning for potential measures and measure concepts to address these priorities; and developing multi-stakeholder recommendations for future measure development and endorsement. This work is discussed in greater detail in the section of this report entitled "Improving NQF's Care Coordination Portfolio."

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

Emergency Department Transfers

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

Medication Reconciliation

Medication reconciliation refers to the process of avoiding inadvertent inconsistencies across transitions in care by reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new setting of care.
Such unintended inconsistencies—the omission of needed medications, unnecessarily duplicate existing therapies or incorrect dosages in medication regimens— may occur at any point of transition in care. Studies have shown that unintended medication discrepancies occur for nearly one-third of patients at admission, a similar proportion at the time of transfer from one site of care within a hospital, and in 14 percent of patients at hospital discharge thus showing a significant issue within care coordination.[10]

Timely Transitions

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

National Quality Strategy

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

Impact of Measurement

Care coordination is a vital aspect of health and healthcare services. When care is poorly coordinated—with inaccurate transmission of information, inadequate communication, and inappropriate follow-up care—patients who see multiple physicians and care providers can face medication errors, hospital readmissions, and avoidable emergency department visits. The effects of poorly coordinated care are particularly evident for people with chronic conditions, such as diabetes and hypertension, and those at high risk for multiple illnesses who often are expected to navigate a complex healthcare system. These standards will provide the structure, process, and outcome measures required to assess progress toward care coordination goals and to evaluate access, continuity, communication, and tracking of patients across providers and settings. Given the high-risk nature of transitions in care, this work will

build on ongoing efforts among the medical and surgical specialty societies to establish principles for effective patient hand-offs among clinicians and providers. As this ever-growing group attempts to navigate our complex healthcare system and transition from one care setting to another, they often are unprepared or unable to manage their care. Incomplete or inaccurate transfer of information, poor communication, and a lack of appropriate follow-up care can lead to confusion and poor outcomes, including medication errors and often preventable hospital readmissions and ED visits.[7]

Care Coordination Measure Evaluation: Refining the Evaluation Process

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

Standing Steering Committee

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

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

The Care Coordination Standing Committee currently includes 24 members (see Appendix D). Each member has been randomly appointed to serve an initial two- or three- year term, after which he/she may serve a subsequent 3-year term if desired.

NQF Portfolio of performance measures for Care Coordination

Currently, NQF's portfolio of care coordination measures includes measures for emergency department transfers, plan of care, e-prescribing, timely transitions, medication management, transition records, and medical home~~]~~. This portfolio contains 20 measures: 8 process measures, 3 outcome and resource use measures, 8 structural measures, and 1 composite measure (see table below). Eleven of these measures were~~will be~~ evaluated by the Care Coordination Committee in this phase.

NQF Care Coordination Portfolio of Measures

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

The remaining 9 measures are currently endorsed and not due for endorsement maintenance until August 2015, at which time they may ~~then~~ be reviewed for re-endorsement. Endorsement of measures by NQF is valued not only because the evaluation process itself is both rigorous and transparent, but also because evaluations are conducted by multi-stakeholder committees comprised of clinicians and other experts from hospitals and other healthcare providers, employers, health plans, public agencies, community coalitions, and patients—many of whom use measures on a daily basis to ensure better care. Moreover, NQF-endorsed measures undergo routine "maintenance" (i.e., re-evaluation) to ensure that they are still the best-available measures and reflect the current science. Importantly, legislative mandate requires that preference be given to NQF-endorsed measures for use in federal public reporting and performance-based payment programs. NQF measures also are used by a variety of stakeholders in the private sector, including hospitals, health plans, and communities.

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

Use of measures in the portfolio

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

Improving NQF's Care Coordination Portfolio

Addressing Measure Gaps

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

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

To ensure alignment between the gaps project and the current measure evaluation project detailed in this report, NQF staff presented the gap project's measure domains and framework to the evaluation Committee. The framework consists of three key measurement areas and a number of domains and sub-domains beneath each area. The overarching measurement areas are:

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

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

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

The Gaps Committee met in-person on April 3-4, 2014 and heard from co-chairs Don Casey and Gerri Lamb, who summarized the measure evaluation Committee's discussion. The draft Gaps report will be published online on June 23, 2014 and will be available for public comment at that time.

Committee input on gaps in the portfolio

During their discussions the Committee identified numerous areas where additional measure development is needed, and persistent gaps across settings have been identified by the MAP[14] and by NQF staff (as part of a recent analysis[11] of the full NQF portfolio), specifically:

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

Measures in the "pipeline"

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

Care Coordination Measure Evaluation

In Phase 3 of the Care Coordination Measure Evaluation Review, the Care Coordination Standing Committee evaluated ~~1~~one new measure~~s~~ and 11 measures undergoing maintenance review against NQF's standard evaluation criteria.

The full Committee discussed these measures during their March 18-19, 2014 two-day webinar meeting and in a follow-up call on April 1, 2014. To facilitate the evaluation, the Committee and candidate standards were divided into two workgroups for preliminary evaluation of the measures against the NQF criteria prior to consideration by the entire Standing Committee.

Care Coordination Phase 3 Measure Review Summary

	Maintenance	New	Total
Measures under consideration	11	1	12
Measures withdrawn from consideration	5	0	5
Measures recommended	10	1	11

	Maintenance	New	Total
Measures not recommended	1	0	1
Reasons for not recommending	Importance		

Comments Received prior to Committee evaluation

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

Comments Received after Committee evaluation

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

Overarching Issues

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

Insufficient Evidence Base

The Committee noted that NQF criteria have become more rigorous following the 2010 Task Force recommendations regarding evaluating evidence. In their review of a set of process measures related to patient transfers from emergency departments, the Committee concluded the evidence presented did not sufficiently support the claim that the measured processes improve health outcomes. The Committee discussed the set of measures at length, noting that the evidence presented to support the measures was insufficient. The Committee acknowledged that the state of the evidence in this area is not ideal however, and noted that although the literature presented does not provide a direct link to patient outcomes, these measures display potential benefits to improve care coordination as they address a foundational and critical aspect of patient safety. ~~.~~ The Committee noted the measures fill an important ~~that the measures address a~~ gap area regarding measures of emergency department

transfers that are focused on transfers from rural hospitals to other facilities, and that the measures support the communication aspect of Care Coordination by ensuring that adequate communication occurs between transferring facilities (especially patients in rural hospitals who can be at higher risk) and accepting facilities. As a result, the Committee ultimately exercised an exception to the evidence criterion, agreeing that it is beneficial to hold providers accountable for performance in the absence of empirical evidence, and that the benefits of the measure outweigh potential harms.

Recommended Composite

The Committee noted that a set of seven measures regarding the transfer of patients from rural emergency departments to other facilities is intended to be reported together to communicate a comprehensive set of patient information as part of such transfers. The Committee strongly recommended that in future, the developer construct these measures as a composite. Committee members were amenable to the idea of the set of measures being reported as a composite for the purposes of endorsement, while the developer would retain the capacity for each measure to be reported separately by current users of the measures.

The Committee discussed whether all seven measures should always be included with a transferred patient, and also suggested the measures might be reported differently with different data elements, depending on the next setting to which the patient is being transferred. While the Committee discussed the possibilities of how a composite might be constructed, e.g., as an all-or-none, or weighted average composite, the Committee agreed this is a consideration and decision for the developer, with the understanding the resulting composite performance measure should be based on sound measurement science, produce a reliable signal, and be a valid reflection of quality. The Committee also agreed with the concept that users should be able to "unpack" the composite and see individual scores on the components of the composite for their own improvement purposes.

Unidirectional measurement

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

Summary of Phase 3 Measure Evaluation

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

Eleven previously NQF-endorsed measures and one newly submitted measure were reviewed. Eleven of the twelve measures were recommended for endorsement.

0291: Administrative Communication (University of Minnesota Rural Health Research Center): Recommended

Description: *Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative information was communicated to the receiving facility within prior to departure****; Measure Type:*** *Process;* ***Level of Analysis:*** *Facility;* ***Setting of Care:*** *Hospital/Acute Care Facility;* ***Data Source:*** *Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry*

This measure has been NQF-endorsed since 2007 and while not currently in use, is anticipated to be used in public reporting, payment, regulatory and accreditation, and quality improvement programs at the facility level. The Committee noted that the evidence presented to support the measure focus is insufficient, but agreed to exercise the exception to the evidence criterion, noting the measure addresses a gap area; it is beneficial to hold providers accountable for performance of the measure in the absence of empirical evidence, and that the benefits of the measure outweigh potential harms. The Committee agreed this measure will have a high impact due to the fact that transfer of comprehensive information is critical, particularly for rural hospitals. The Committee noted there is an opportunity for improvement as communication problems are a major contributing factor to adverse events in hospitals, accounting for 65 percent of sentinel events tracked by the Joint Commission, and that deficits exist in the transfer of patient information between hospitals and primary care physicians in the community, and between hospitals and long term facilities. The Committee agreed the measure addresses a high priority aspect of healthcare, and recommended the measure.

0292: Vital Signs (University of Minnesota Rural Health Research Center): Recommended

Description: *Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that the entire vital signs record was communicated to the receiving FACILITY within 60 minutes of departure****; Measure Type:*** *Process;* ***Level of Analysis:*** *Facility;* ***Setting of Care:*** *Hospital/Acute Care Facility;* ***Data Source:*** *Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy*

Similar to 0291, this measure has been NQF-endorsed since 2007 and while not currently in use, is anticipated to be used in public reporting, payment, regulatory and accreditation, and quality improvement programs at the facility level. The Committee noted that the evidence presented to support the measure focus is insufficient, but agreed to exercise the exception to the evidence criterion, noting the measure addresses a gap area; it is beneficial to hold providers accountable for performance of the measure in the absence of empirical evidence, and that the benefits of the measure outweigh

potential harms. The Committee recommended the measure, agreeing there is an opportunity for improvement, and that this measure will have a high impact due to the fact that transfer of vital signs is critical, especially for rural hospitals. However, the Committee expressed the need for measures like this to go further than just assessing vital signs of pulse, respiratory rate, blood pressure, oxygen saturation, and temperature.

0293: Medication Information (University of Minnesota Rural Health Research Center): Recommended

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

Similar to 0291 and 0292, this measure has been NQF-endorsed since 2007 and while not currently in use, is anticipated to be used in public reporting, payment, regulatory and accreditation, and quality improvement programs at the facility level. The Committee noted that the evidence presented to support the measure focus is insufficient, but agreed to exercise the exception to the evidence criterion, noting the measure addresses a gap area; it is beneficial to hold providers accountable for performance of the measure in the absence of empirical evidence, and that the benefits of the measure outweigh potential harms. The Committee recommended the measure, agreeing there is an opportunity for improvement and noting the importance of receiving a comprehensive medication list with a full history, making this a high impact measure in terms of improving the coordination of care.

0294: Patient Information (University of Minnesota Rural Health Research Center): Recommended

Description: *Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that patient information was communicated to the receiving FACILITY within 60 minutes of departure****; Measure Type:*** *Process;* ***Level of Analysis:*** *Facility;* ***Setting of Care:*** *Hospital/Acute Care Facility;* ***Data Source:*** *Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy*

Similar to 0291, 0292 and 0293, this measure has been NQF-endorsed since 2007 and while not currently in use, is anticipated to be used in public reporting, payment, regulatory and accreditation, and quality improvement programs at the facility level. The Committee noted that the evidence presented to support the measure focus is insufficient, but agreed to exercise the exception to the evidence criterion, noting the measure addresses a gap area; it is beneficial to hold providers accountable for performance of the measure in the absence of empirical evidence, and that the benefits of the measure outweigh potential harms. In reviewing the validity testing presented, the Committee noted it was done by systematic assessment of face validity at the measure performance score and review of an expert panel. The Committee pointed out that the expert panel was relatively small and lacked consumer

representation. As a result, the Committee agreed the measure passed the scientific acceptability criterion by a slim margin, indicating that true consensus was not reached on the validity of the measure. The Committee also discussed the potential administrative burden of the measure, noting that the use of multiple data sources (EHR, lab and paper) is needed to implement this measure. The Committee ultimately recommended the measure, stating that there is an opportunity for improvement for this measure and it addresses a high priority area.

0295: Physician Information (University of Minnesota Rural Health Research Center): Recommended

Description: *Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that physician information was communicated to the receiving FACILITY within 60 minutes of departure****; Measure Type:*** *Process;* ***Level of Analysis:*** *Facility;* ***Setting of Care:*** *Hospital/Acute Care Facility;* ***Data Source:*** *Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy*

Similar to 0291, 0292, 0293 and 294, this measure has been NQF-endorsed since 2007 and while not currently in use, is anticipated to be used in public reporting, payment, regulatory and accreditation, and quality improvement programs at the facility level. The Committee noted that the evidence presented to support the measure focus is insufficient, but agreed to exercise the exception to the evidence criterion, noting the measure addresses a gap area; it is beneficial to hold providers accountable for performance of the measure in the absence of empirical evidence, and that the benefits of the measure outweigh potential harms. The Committee recommended the measure, stating that there is an opportunity for improvement for this measure and it addresses a high priority area.

0296: Nursing Information (University of Minnesota Rural Health Research Center): Recommended

Description: *Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that nursing information was communicated to the receiving FACILITY within 60 minutes of departure****; Measure Type:*** *Process;* ***Level of Analysis:*** *Facility;* ***Setting of Care:*** *Hospital/Acute Care Facility;* ***Data Source:*** *Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy*

Similar to 0291, 0292 , 0293, 0294 and 0295, this measure has been NQF-endorsed since 2007 and while not currently in use, is anticipated to be used in public reporting, payment, regulatory and accreditation, and quality improvement programs at the facility level. The Committee noted that the evidence presented to support the measure focus is insufficient, but agreed to exercise the exception to the evidence criterion, noting the measure addresses a gap area; it is beneficial to hold providers accountable for performance of the measure in the absence of empirical evidence, and that the benefits of the measure outweigh potential harms. The Committee stated that there is an opportunity for improvement for this measure and it addresses a high priority area. The Committee discussed the

feasibility of the measure at length, but determined that the data abstraction does not appear to place undue burden on the facility, although it may be somewhat difficult to collect without designated discrete data fields. The Committee recommended the measure.

0297: Procedures and Tests (University of Minnesota Rural Health Research Center): Recommended

Description: *Performance Measure Name: Procedures and Tests*

*Description: Patients who are transferred from an ED to another healthcare facility have communicated with the receiving facility within 60 minutes of discharge a list of tests done and results sent.**; Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility; **Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy*

Similar to 0291, 0292 , 0293, 0294, 0295 and 0296, this measure has been NQF-endorsed since 2007 and while not currently in use, is anticipated to be used in public reporting, payment, regulatory and accreditation, and quality improvement programs at the facility level. The Committee noted that the evidence presented to support the measure focus is insufficient, but agreed to exercise the exception to the evidence criterion, noting the measure addresses a gap area; it is beneficial to hold providers accountable for performance of the measure in the absence of empirical evidence, and that the benefits of the measure outweigh potential harms. In reviewing the reliability testing for the measure, the Committee expressed concerns that the inter-rater reliability testing results are relatively low and raised questions about the level of training and experience that would be needed to report the measure. In reviewing the performance gap for the measure, the Committee agreed it is sufficient by a slim margin, indicating that true consensus was not reached. The Committee agreed the measure addresses a high priority area and recommended the measure.

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

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

This measure has been NQF-endorsed since 2008, and is included in the CMS Hospital Inpatient Quality Reporting program and the Joint Commission accreditation program. The measure is intended to address reducing the time patients remain in the emergency department (ED), which can improve access to treatment and increase quality of care. The Committee agreed sufficient evidence is presented to support the measure. Reviewing performance on the measure since prior endorsement however,

Committee members expressed concern that the 5 quarters of trend data provided over years 2012 and 2013 showed little to no improvement on the measure. The developer explained that this trend may continue as crowding in the ED continues to be a problem and may increase due to other factors (such as the expansion of state Medicaid programs as part of the Affordable Care Act). The Committee recommended the measure, agreeing the opportunity for improvement persists and that if performance is stagnating or declining, the measure is an important tool in assessing ED crowding and potentially monitoring the impacts of ACA implementation on ED crowding.

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

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

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

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

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

This measure has been NQF-endorsed since 2008, and is included in the CMS Hospital Inpatient Quality Reporting program and the Joint Commission accreditation program. The measure is intended to address reducing the time patients remain in the emergency department (ED), which can improve

access to treatment and increase quality of care. The Committee agreed that this measure speaks more directly to care coordination than 0495 and 0496 as it focuses on the time from the decision to admit, to actual patient discharge from the ED. The measure emphasizes the logistical aspects of care that occur after initial evaluation. The Committee noted that although the literature cited in support of the measure does not appear to specifically address the narrow window of "decision to departure", the Committee agreed that the evidence supports the importance of timely care and the poor outcomes associated with delays in care. The Committee recommended the measure, agreeing a gap in performance persists and that the measure addresses a high priority area.

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

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

This measure was newly submitted to NQF and, while not currently in use, is anticipated to be implemented within 5-years for use in accountability applications (a specific program was not identified). The Committee agreed the evidence presented to support the measure was sufficient; A systematic review was presented including 26 studies consistently demonstrating that medication reconciliation interventions result in a reduction in medication discrepancies, potential adverse drug events, adverse drug events, and a reduction in health care utilization, however the studies were of fair quality, as graded by the United States Preventive Services Task Force (USPSTF). While the Committee agreed there is an opportunity for improvement, and the measure will have a high impact as a proxy outcome or short-term outcome of good care coordination around medication, Committee members noted there is not a strong connection between the measure and long-term error reduction and overall better patient outcomes. However, the Committee agreed that this measure more closely approximates aspirational measures of care coordination as it incorporates a check and balance component that goes beyond ~~a "unidirectional" approach.~~ simply checking that a procedure was done. The Committee recommended that further study be done to determine the long-term benefits of medication reconciliation interventions and the results be presented in future. Committee members also raised concerns about the feasibility of the measure, and the potential need for a study pharmacist to implement to measure, but ultimately agreed to recommend the measure.

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

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

Ambulatory Care : Clinician Office/Clinic; ***Data Source:*** *Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy*

This measure has been NQF-endorsed since 2008 and is in use in the Primary Care Information Project, which is part of New York City Department of Health & Mental Hygiene. Reviewing the evidence presented to support the measure, Committee members expressed doubt that measuring the number of electronic prescriptions will lead to meaningful conclusions about or improvements in quality of care. The developer presented studies displaying a high prevalence of medication errors, however the Committee pointed out that they do not show a clear link between the measure of the number of electronic prescriptions and health outcomes. As a result, the Committee agreed the evidence presented is insufficient to support the measure and that there is low confidence that the measure addresses a significant health problem. The Committee also agreed that while there do not appear to be potential harms associated with this measure, the potential benefits of this measure in improving the quality of care or patient outcomes are not clear, and the Committee did not recommend the measure.

Measures withdrawn by the developer and were not considered.

The following measures were withdrawn during the measure evaluation period

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

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Appendix A: Details of Measure Evaluation

Measures Recommended

Measures not recommended

Measures withdrawn from consideration

Measures Recommended

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

0291 Administrative Communication

Submission | Specifications

Description: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative information was communicated to the receiving facility within prior to departure

Numerator Statement: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative information was communicated to the receiving facility prior to departure

- Nurse communication with receiving hospitals
- Practitioner communication with receiving practitioner or transfer coordinator

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

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

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

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

Measure Steward: University of Minnesota Rural Health Research Center

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

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

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

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

Rationale:

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

Minnesota are not stratified by race, gender or ethnicity. One Committee member articulated a desire to see disparities information. The developer explained that the measures are already disparity-sensitive as rural hospitals have a higher percentage of low-income and a higher percentage of elderly patients.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **H-0**; **M-12**; **L-7**; **I-4** 2b. Validity: **H-0**; **M-16**; **L-4**; **I-2**
<u>Rationale</u>:

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

3. Feasibility: H-10; M-10; L-2; I-0
(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)
<u>Rationale</u>:

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

4. Use and Usability: H-7; M-12; L-0; I-3
*(*4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)
<u>Rationale</u>:

- A member of the Committee questioned how the measure has been used since prior endorsement. The

0291 Administrative Communication
developer explained that as of January 2012, the state of Minnesota requires the submission of this data from all of its critical access hospitals. However, the developer does not have access to data due to privacy regulations. • The Committee suggested that in future, the focus of this suite of measures could be expanded to include patients transferred to additional settings, such as home health.
5. Related and Competing Measures • The measure is related to other measures in the suite: 0292, 0293, 0294, 0295, 0296, and 0297.
Standing Committee Recommendation for Endorsement: Y-16; N-6 • The Steering Committee recommended this measure for endorsement acknowledging that while communication may have occurred, it does not necessarily mean care coordination has occurred. However, the committee stated that these are small steps towards care coordination, since there are not many measures that encompass every aspect of care coordination.
6. Public and Member Comment: Comments received: • Several comments were posed recommending a bi-directional approach as it is difficult to confirm receipt of communication from a transferring facility prior to a patient's departure. The data element description is not clear and seems implied. Additionally, many of the methods of communication (i.e. facsimile or eDelivery) are viewed as problematic and do not warrant proof that the intended recipient has the appropriate information. Developer response: • This measure looks for documentation that the communication occurred. This should not be a "judgment call," either the communication is documented or it is not. This step of communication, prior to transfer is EMTALA based to ensure that the services needed are available. Committee response: EMTALA is evolving and determining how it is being used is relative. The Committee continues to emphasize that bi-directional communication that closes the loop is critical in ensuring that care is coordinated.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

0292 Vital Signs
Submission | Specifications
Description: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that the entire vital signs record was communicated to the receiving FACILITY within 60 minutes of departure **Numerator Statement**: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that the entire vital signs record was communicated to the receiving facility within 60 minutes of departure • Pulse • Respiratory rate • Blood pressure • Oxygen saturation • Temperature

0292 Vital Signs

- Glasgow score (where appropriate)

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

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

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

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

Measure Steward: University of Minnesota Rural Health Research Center

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

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

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

1a. Evidence: **H-0**; **M-0**; **L-1; IE-19; I-3** 1b. Performance Gap: **H-0**; **M-13**; **L-5**; **I-4** 1c. High Priority: **H-6**; **M-11**; **L-4**; **I-1**

Rationale:

- Similar to 0291, the Committee agreed the evidence presented to support the measure is insufficient, however, elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.

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

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

2a. Reliability: **H-0**; **M-15**; **L-4**; **I-3** 2b. Validity: **H-0**; **M-13**; **L-7**; **I-2**

Rationale:

- The Committee discussed that the difference between this measure and 0291 was the content of the data being transferred with the patient.
- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.

3. Feasibility: H-12; M-9; L-1; I-0

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

Rationale:

- The Committee discussed that data the measure would be easy to collect, and agreed feasibility for the measure is high. However, the Committee discussed that this is is measure assessing transfers of data, instead of quality of care.

0292 Vital Signs
4. Use and Usability: H-4; M-12; L-3; I-2 *(*4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences) Rationale: • The Committee agreed the measure will enhance quality and is being used in a variety of other projects. The developer explained that additional data is beginning to come in for this measure.
5. Related and Competing Measures • The measure is related to other measures in the suite: 0291, 0293, 0294, 0295, 0296, and 0297.
Standing Committee Recommendation for Endorsement: Y-16; N-5 • Standing Committee members noted that just because communication has occurred, it does not mean that care coordination has occurred. However, they did acknowledge there is no one measure that includes every aspect of care coordination.
6. Public and Member Comment: Comments received: • Although in support of this measure, there was consensus that more vital signs need to be communicated. Suggestions from commenters included EKG findings, if applicable such as rhythm, ST changes, heart block, bundle branch blocks etc. Additionally, not only should pulsoximetry readings be noted but also any periods of desaturation, severity and length. Also if there were any large shifts in vitals, this should be identified as well (e.g. change in GCS from 12 to 3T or equivalent or HR shift from 60 to 125 bpm). Developer response: • The EKG suggestion is a good one. We will forward with the next review. The developer was in agreement that changes in vital signs should be noted in MD and nurse notes. Committee response: • The Committee agreed that although condition-specific vital signs are beneficial, more generally-based vital signs are crucial. The Committee encourages the gradual inclusion of these more specific vital signs in future measures.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

0293 Medication Information
Submission | Specifications
Description: 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 **Numerator Statement**: 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 • Documentation regarding medication history • Allergies • Medications given (MAR) **Denominator Statement**: All emergency department patients who are transferred to another healthcare facility **Exclusions**: All emergency department patients not discharged to another healthcare facility.

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

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

Measure Steward: University of Minnesota Rural Health Research Center

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

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

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

1a. Evidence: **H-0**; **M-0**; **L-1; IE-14; I-8** 1b. Performance Gap: **H-0**; **M-14**; **L-5**; **I-4** 1c. High Priority: **H-2**; **M-17**; **L-1**; **I-2**

<u>Rationale</u>:

- Similar to 0291 and 0292, the Committee agreed the evidence presented to support the measure is insufficient, however, the Committee elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.
- Committee members discussed the importance of receiving a comprehensive medication list with a full history, and agreed the measure will have a high impact in terms of improving the coordination of care.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-0**; **M-14**; **L-3**; **I-5** 2b. Validity: **H-0**; **M-12**; **L-8**; **I-2**

<u>Rationale</u>:

- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.
- Committee members discussed that while this measure is specified for rural hospitals, it can be used for any facility even though it was originally developed to assess rural hospitals. The developer acknowledged that the measure can be used at other hospitals, but it would not apply to larger, tertiary university hospitals.

3. Feasibility: H-10; M-11; L-0; I-1

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

<u>Rationale</u>:

- Committee members agreed this measure is highly feasible since data is capture during routine aspects of care coordination.

4. Use and Usability: H-1; M-16; L-4; I-0

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

<u>Rationale</u>:

- A member of the Committee questioned how the measure has been used since its prior endorsement. The developer explained that as of January 2012, the state of Minnesota requires the submission of this data from all of its critical access hospitals, though the developer itself has not been given access to the

data due to privacy regulations. Additionally, the QIO in Minnesota, Stratus Health, is now on contract to lead 8 more states in the requirement of submission of data on these measures.

5. Related and Competing Measures

- The measure is related to other measures in the suite: 0291, 0292, 0294, 0295, 0296, and 0297.

Standing Committee Recommendation for Endorsement: Y-14; N-8

6. Public and Member Comment:

Comments received:

- Commenters were in support of this measure viewing this as a critical aspect of communication in care coordination. Although in support, there was emphasis to include further details of the medications administered (during transfer or at ED arrival), including time, method, and patient response.

Developer response:

- The method, time, dose, etc. should be in the MAR. The responses to medications should be in the MD and nurses notes.

Committee response:

- The Committee agrees with the developer's response.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

0294 Patient Information

Submission | Specifications

Description: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that patient information was communicated to the receiving FACILITY within 60 minutes of departure

Numerator Statement: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that patient information was communicated to the receiving FACILITY within 60 minutes of departure

- Patient name
- Address
- Date of birth
- Gender
- Significant other contact information
- Health insurance information

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

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

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

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

Measure Steward: University of Minnesota Rural Health Research Center

0294 Patient Information

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

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

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

1a. Evidence: **H-0**; **M-2**; **L-0**; **I-5; IE-14**; 1b. Performance Gap: **H-0**; **M-14**; **L-7**; **I-1;** 1c. Impact: **H-0**; **M-18**; **L-4**; **I-1**

Rationale:

- Similar to 0291, 0292 and 0293, the Committee agreed the evidence presented to support the measure is insufficient, however, the Committee elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.

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

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

2a. Reliability: **H-0**; **M-16**; **L-4**; **I-3** 2b. Validity: **H-0**; **M-13**; **L-7**; **I-3**

Rationale:

- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.

  Committee members expressed concerns that the 60 minutes time frame may lead to variation, due to differences is distance traveled, but concluded reliability testing for the measures was sufficient.

3. Feasibility: H-8; M-13; L-1; I-0

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

Rationale:

- The Committee discussed the potential administrative burden of the measure, due to the multiple data sources (EHR, lab and paper) required to report the measures. The developer explained that the records being transferred are relatively short and there have been no complaints about the burden in the implementation of this measure.
- The Committee accepted this explanation and agreed the measure is feasible.

4. Use and Usability: H-1; M-16; L-4; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- The measure is not currently publicly reported or used in other accountability applications.

5. Related and Competing Measures

- The measure is related to other measures in the suite: 0291, 0292, 0293, 0295, 0296, 0297.

Standing Committee Recommendation for Endorsement: **Y-15**; **N-7**

6. Public and Member Comment:

Comments received:

- Commenters generally expressed support for the measure and the Committee's recommendation for endorsement.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

0294 Patient Information
9. Appeals

0295 Physician Information
Submission | Specifications
Description: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that physician information was communicated to the receiving FACILITY within 60 minutes of departure **Numerator Statement**: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that physician information was communicated to the receiving FACILITY within 60 minutes of departure • Physician or practitioner history and physical • Physician or practitioner orders and plan **Denominator Statement**: All emergency department patients who are transferred to another healthcare facility **Exclusions**: All emergency department patients not transferred to another healthcare facility **Adjustment/Stratification**: **Level of Analysis:** Facility **Setting of Care:** Hospital/Acute Care Facility **Type of Measure**: Process **Data Source**: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy **Measure Steward**: University of Minnesota Rural Health Research Center
STANDING COMMITTEE MEETING [03/18/2014-03/19/2014] **1. Importance to Measure and Report: The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: **H-0**; **M-5**; **L-0**; **I-6; IE-11**; 1b. Performance Gap: **H-0**; **M-16**; **L-2**; **I-4;** 1c. Impact: **H-4**; **M-13**; **L-4**; **I-1** Rationale: • Similar to 0291, 0292, 293 and 0294, the Committee agreed the evidence presented to support the measure is insufficient, however, the Committee elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: **H-0**; **M-15**; **L-5**; **I-2** 2b. Validity: **H-0**; **M-12**; **L-7**; **I-3** Rationale: • For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria. • Committee members expressed concerns that a lack of resources in rural hospitals compared to urban hospitals may lead to variation on this measure, but concluded the measure is reliable. A Committee member also noted that the expert panel used for the testing was relatively small and lacked consumer

0295 Physician Information
representation. The Committee agreed the measure is valid, but only by a slim margin, indicating true consensus was not reached.
3. Feasibility: H-4; M-13; L-3; 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 this measure is feasible and data abstraction does not appear to place undue burden on the facility, although it may be somewhat difficult to collect without discrete data fields being used.
4. Use and Usability: H-1; M-17; L-3; I-0 *(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)* Rationale: • The measure is not currently publicly reported or used in other accountability applications.
5. Related and Competing Measures • The measure is related to other measures in the suite: 0291,0292, 0293, 0294, 0296, 0297.
Standing Committee Recommendation for Endorsement: **Y-15**; **N-6**
6. Public and Member Comment: Comments received: • Although comments supported this measure, there were concerns that although assessing compliance with the provision of this type of information is important, this should minimize the burden of data collection for any new measures introduced into the healthcare system, thus questioning its feasibility. Committee response: • The Committee discussed the feasibility of this measure and agrees that the data abstraction does not appear to present an undue burden. It is expected that the adoption and use of electronic health records will help to reduce burden over time.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

0296 Nursing Information
Submission | Specifications
Description: Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that nursing information was communicated to the receiving FACILITY within 60 minutes of departure **Numerator Statement**: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that nursing information was communicated to the receiving facility within 60 minutes of departure • Assessments/intervention/response • Impairments

0296 Nursing Information

- Catheters
- Immobilizations
- Respiratory support
- Oral limitations

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

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

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

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

Measure Steward: University of Minnesota Rural Health Research Center

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

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

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

1a. Evidence: **H-0**; **M-2**; **L-0**; **I-5; IE-14**; 1b. Performance Gap: **H-0**; **M-14**; **L-4**; **I-2;** 1c. Impact: **H-5**; **M-13**; **L-1**; **I-2**

Rationale:

- Similar to 0291, 0292, 293 , 0294 and 0295, the Committee agreed the evidence presented to support the measure is insufficient, however, the Committee elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.

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

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

2a. Reliability: **H-0**; **M-15**; **L-3**; **I-3** 2b. Validity: **H-0**; **M-14**; **L-2**; **I-5**

Rationale:

- For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.

3. Feasibility: H-3; M-15; L-0; I-1

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

Rationale:

- The Committee determined this measure was feasible and data abstraction does not appear to place an undue burden on the facility, although data collection may be somewhat difficult without designated discrete data fields.

4. Use and Usability: H-2; M-13; L-2; I-3

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

Rationale:

0296 Nursing Information
• The measure is not currently publicly reported or used in other accountability applications.
5. Related and Competing Measures • The measure is related to other measures in the suite: 0291, 0292, 0293, 0294, 0295, 0297.
Standing Committee Recommendation for Endorsement: **Y-15**; **N-5**
6. Public and Member Comment: Comments received: • Commenters generally expressed support for the measure and the Committee's recommendation for endorsement.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

0297 Procedures and Tests
Submission | Specifications
Description: Performance Measure Name: Procedures and Tests Description: Patients who are transferred from an ED to another healthcare facility have communicated with the receiving facility within 60 minutes of discharge a list of tests done and results sent. **Numerator Statement**: Percentage of patients transferred to another Healthcare Facility whose medical record documentation indicated that procedure and test information was communicated to the receiving FACILITY within 60 minutes of departure • Tests & procedures done • Tests & procedure results sent **Denominator Statement**: All emergency department patients who are transferred to another Healthcare Facility **Exclusions**: ED admissions not transferred to another Healthcare facility. **Adjustment/Stratification**: **Level of Analysis:** Facility **Setting of Care:** Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility **Type of Measure**: Process **Data Source**: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy **Measure Steward**: University of Minnesota Rural Health Research Center
STANDING COMMITTEE MEETING [03/18/2014-03/19/2014] **1. Importance to Measure and Report: The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: **H-0**; **M-1**; **L-0**; **I-3; IE-15** 1b. Performance Gap: **H-0**; **M-12**; **L-5**; **I-2** 1c. Impact: **H-7**; **M-10**; **L-0**; **I-2** Rationale: • Similar to 0291, 0292, 293 , 0294 and 0295, the Committee agreed the evidence presented to support the

0297 Procedures and Tests
measure is insufficient, however, the Committee elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.
2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u> (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: **H-0**; **M-12**; **L-3**; **I-3** 2b. Validity: **H-0**; **M-13**; **L-1**; **I-4** <u>Rationale</u>: • For all the measures, the Committee agreed that reliability and validity testing were sufficient to meet the criteria.
3. Feasibility: H-5; M-12; L-0; I-1 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* <u>Rationale</u>: • The Committee determined this measure was feasible and data abstraction does not appear to place undue burden on the facility, although may be somewhat difficult to collect without discrete data fields being used.
4. Use and Usability: H-2; M-13; L-2; I-1 *(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)* <u>Rationale</u>: • The measure is not currently publicly reported or used in other accountability applications.
5. Related and Competing Measures • The measure is related to other measures in the suite: 0291,0292, 0293, 0294, 0295, 0296.
Standing Committee Recommendation for Endorsement: **Y-14**; **N-5**
6. Public and Member Comment: <u>Comments received:</u> • <u>Commenters generally expressed support for the measure and the Committee's recommendation for endorsement.</u>
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients
Submission | Specifications
Description: This measure assesses the median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department **Numerator Statement:** Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for

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

patients admitted to the facility from the emergency department.

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

Exclusions: Patients who are not an ED Patient

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Outcome

Data Source: Electronic Clinical Data, Electronic Health Record

Measure Steward: Centers for Medicare and Medicaid Services

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

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

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

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

<u>Rationale</u>:

- Committee members expressed concerns regarding the strength of the evidence presented linking Emergency Department (ED) stays and patient outcomes.
    - The developer explained that most EDs are experiencing overcrowding and that this can lead to ambulance refusals, prolonged waiting times and delays in care for patients. Reducing the time spent in the Emergency Department for admitted patients may also mean that patients receive the specific care that they need that cannot or should not be provided in the ED sooner.
    - According to studies cited by the developer, there is an overall link of ED stays with the outcomes of care. In particular, studies cited a link between longer ED stays and poor patient outcomes for specific conditions.
- Some Committee members noted that although this evidence significant, it could tend to reflect research interests. However, the Committee ultimately agreed the evidence presented is sufficient to support the measure.
- Committee members noted the trend data provided did not show improvement in performance on this measure since previous endorsement. According to the data provided, there was a difference of roughly 70 to 80 minutes in median time from ED arrival to ED departure for admitted patients, when comparing the top 10 percent with the national median. Additionally, there is no evidence of disparities in ED crowding.
    - The developer noted that the evidence clearly shows wide variation in ED wait times with room for improvement. While the data provided does not show improvement over time, that data was collected over a relatively short time window (15 months). It was suggested that examining trends over a longer period of time would show more variability in ED length of stay, although not necessarily improvement.
- Committee members agreed that this measure may help motivate improvements and potentially avoid long-term declines in performance. It addresses a high priority area and could also be an important tool for evaluating changes associated with implementation of the Affordable Care Act (ACA). As more and

more patients are admitted through the ED, timeliness of care within the ED will take on greater importance in determining overall timeliness of care for admitted patients.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **N/A** 2b. Validity: **H-3**; **M-11**; **L-5**; **I-0**
<u>Rationale</u>:

- Committee members agreed that the specifications provided were clear and precise, making the measure adequate for consistent implementation.
- The Committee discussed that reliability testing was not needed because validity testing had been done at the critical data element level with good results, indicating the validity of the measure.
    - The developer explained that there were two data elements, "decision to admit time" and "ED departure time" with slightly lower agreement rates (63.29 and 76.79% respectively), due to the nature of testing time related elements, which are more prone to mismatch. The ICC statistics for these elements were very high when those time values were grouped in intervals rather than as single discreet points.
- Some Committee members conveyed uncertainity about the low kappa statistic for the data element "observation services" but noted there was a high agreement rate.
    - The developer explained that the definition of the element had been recently updated to ease abstraction from medical charts. However the impact of that change has been investigated empirically.
    - Committee members noted that the strong kappa statistics for the arrival and departure time elements suggests that this is not a substantial concern, but only if the time stamps used as the gold standard comparison were a reflection of real care processes and not just an artifact of administrative processes.
- Committee members noted that the measure is not risk adjusted to account for severity of illness, and that more acute patients may require specialized care, which may not be readily available for ED admitted patients. However, the Committee ultimately agreed the validity of the measure is demonstrated.

3. Feasibility: H-12; M-7; L-0; I-0
(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)
<u>Rationale</u>:

- Committee members agreed the measure is feasible.

4. Use and Usability: H-7; M-8; L-4; I-0
(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)
<u>Rationale</u>:

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

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients
widespread use, supporting its usability (currently used by the Joint Commission Accreditation program). • Committee members agreed that this measure would be an important tool in monitoring impacts of changes in health care coverage and insurance policies. • Committee members suggested that it is unclear how the performance results can be used to further the goal of high-quality, efficient healthcare. The data provided displayed no improvement and the developer notes that this trend may continue due to other factors (such as the expansion of state Medicaid programs). However, there do not appear to be any unintended consequences associated with the measure.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-13**; **N-6**
6. Public and Member Comment: Comments received: • Recommendations were provided concerning the populations assessed within this measure, particularly patient diagnosis. In this instance, mental health as there is research that indicates treatment delays. Developer response: • We appreciate your support of these measures. These measures do provide the ability to drill down by mental health diagnosis, as the non-reporting strata contain cases with a mental health diagnosis (Table 7.01 in Appendix A of the Specifications Manual). For the inpatient setting, facilities are provided with an overall rate, a reporting rate, and a rate for cases with a psychiatric diagnosis. The reporting rate excludes cases with a psychiatric diagnosis. For the outpatient setting, there is an overall rate, a reporting rate, a rate for cases with a psychiatric diagnosis, and a rate for cases that are transferred. The reporting rate excludes the cases that are transferred and those with a psychiatric diagnosis. Facilities are able to determine treatment delays for other diagnoses by calculating throughout time according to diagnoses. Committee response: • For quality purposes, the Committee agrees there is value in being able to access more details relative to treatment delays, by drilling down to the facility level, so that institutes may use this information and make improvements.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients
Submission | Specifications
Description: This measure assesses the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department **Numerator Statement:** Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department. **Denominator Statement:** Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department. **Exclusions:** Patients who expired in the emergency department **Adjustment/Stratification**:

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

Level of Analysis: Facility
Setting of Care: Hospital/Acute Care Facility
Type of Measure: Outcome
Data Source: Administrative claims

Measure Steward: Centers for Medicare and Medicaid Services

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

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

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

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

Rationale:

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

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

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

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

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

Rationale:

- Committee members agreed that the specifications provided were clear and precise, making the measure adequate for consistent implementation.
- Reliability testing was not needed because validity testing had been done at the critical data element level with good results, indicating the validity of the measure.
- Some Committee members were concerned about the low kappa statistic for the data element "observation services" but noted there was a high agreement rate.
    - The developer explained that the definition of the element had been recently updated to ease abstraction from medical charts. However the impact of that change has been not been investigated empirically.
- Committee members noted that during the workgroup calls, there was some sensitivity around exclusions surrounding the denominator. It was unclear as to who was identified in the denominator as well as those who were not in the site populations.

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

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

Rationale:

- Committee members agreed the measure is feasible.

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

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

Rationale:

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

5. Related and Competing Measures

- No related or competing measures noted.

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

6. Public and Member Comment:

Comments received:

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

Developer response:

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

Committee response:

- The Committee agrees with the developer's response.

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

0497 Admit Decision Time to ED Departure Time for Admitted Patients
Submission | Specifications
Description: This measure assesses the median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status **Numerator Statement:** Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. **Denominator Statement:** Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. **Exclusions:** Any ED Patient from the facility's emergency department. **Adjustment/Stratification**: **Level of Analysis:** Individual, Group/Practice, Facility, Health Plan **Setting of Care:** Hospital/Acute Care Facility **Type of Measure**: Process **Data Source**: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Electronic Clinical Data : Pharmacy **Measure Steward**: Centers for Medicare and Medicaid Services
STANDING COMMITTEE MEETING [03/18-19/2014] **1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: **H-1**; **M-10**; **L-1**; **I-4; IE-1**; 1b. Performance Gap: **H-2**; **M-15**; **L-1**; **I-0;** 1c. Impact: **H-8**; **M-8**; **L-2**; **I-0** <u>Rationale</u>: • Committee members agreed that this measure speaks more directly to care coordination than 0495 and 0496, as it focuses on the time from decision to admit to actual patient discharge from the ED. The Committee noted the measure emphasizes the logistical aspects of care that occur after initial evaluation. Although Committee members noted the literature cited in support of the measure does not appear to specifically address this narrow window from decision to departure, the Committee agreed the evidence presented supports the importance of timely care and poor outcomes associated with delays in care. • Committee members noted the lack of significant improvement in performance on the measure since prior endorsement. o The developer explained that although there have not been significant improvements within the metrics; there are areas of coordination of services on the inpatient side that show improvement. The developer is however, working closely with the Emergency Department Benchmarking Alliance to standardize these metrics across all settings, and include electronic medical records. The developer stated they do also recognize this measure is somewhat

0497 Admit Decision Time to ED Departure Time for Admitted Patients

dependent on Emergency Department volume. CMS, as the steward, has made the decision at least for the public display of the data, to start stratifying this performance measure by total Emergency Department annual volume, which will eventually capture a better picture of how hospitals are moving performance over time.

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

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **N/A** 2b. Validity: **H-4**; **M-12**; **L-2**; **I-0**
<u>Rationale</u>:

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

3. Feasibility: H-10; M-7; L-1; I-0
(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)
<u>Rationale</u>:

- Committee members agreed the measure is feasible.

4. Use and Usability: H-7; M-11; L-0; I-0
(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)
<u>Rationale</u>:

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

5. Related and Competing Measures

- No related or competing measures noted.

0497 Admit Decision Time to ED Departure Time for Admitted Patients
Standing Committee Recommendation for Endorsement: **Y-15**; **N-3**
6. Public and Member Comment: Comments received: • Commenters recommended combining measures #0495, #0496, and #0497 to create a single composite to assess the efficiency and effectiveness of emergency room processes and medical decision-making. Developer response: • While we understand the concerns of the Committee about the potential for unintended consequences of performance measures, we do not think it is feasible to create a "composite" measure of the three ED throughput measures. This is due to the fact that #0495 and #0496 are measures from two separating reporting programs for hospitals and also because we are not aware of any methodology for creating composites for median times. Committee response: • The Committee agrees with the developer's response.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
Submission | Specifications
Description: This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adul **Numerator Statement**: For each sampled inpatient in the denominator, the total number of unintentional medication discrepancies in admission orders plus the total number of unintentional medication discrepancies in discharge orders. **Denominator Statement**: The patient denominator includes a random sample of all potential adults admitted to the hospital. Our recommendation is that 25 patients are sampled per month, or approximately 1 patient per weekday. So, for example, if among those 25 patients, 75 unin **Exclusions**: Patients that are discharged or expire before a gold standard medication list can be obtained. **Adjustment/Stratification**: **Level of Analysis:** Facility **Setting of Care:** Hospital/Acute Care Facility **Type of Measure**: Outcome **Data Source**: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy **Measure Steward**: Brigham and Women's Hospital
STANDING COMMITTEE MEETING [03/18/2014-03/19/2014] **1. Importance to Measure and Report: The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: **H-1**; **M-14**; **L-0**; **I-2; IE-0**; 1b. Performance Gap: **H-8**; **M-9**; **L-0**; **I-0;** 1c. Impact: **H-12**; **M-5**; **L-0**; **I-0** Rationale:

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

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

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

- The Committee determined that the measure specifications were reliable and valid, noting that all codes necessary to calculate the measure were present and the specifications were consistent with the evidence presented, however, suggested for future development the developer move past just listing medications and focus on appropriate usage.
- The Committee expressed concerns regarding the small sample size used in the testing and lack of risk adjustment done in the reliability testing. The developer explained they did take these factors into consideration but ultimately favored feasibility over reliability. Requiring extra data collection and adding to the regular work flow may cause too high of a burden on providers. The developer further explained that many training precautions were taken to assure that pharmacists at different hospitals were implementing the same process. The Committee accepted the developer's explanation and agreed that while the sample size was small, the reliability testing results are acceptable.
- Committee members agreed the measure is valid, noting validity testing was performed at the performance measure score with a systematic assessment of face validity indicated: literature is cited to support that the process of pharmacists taking pre-administration medication histories is a proxy for a

gold-standard medication history.

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

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

Rationale:

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

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

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

Rationale:

- This is a new measure and is not currently being publicly reported but a 5-year plan for use in accountability applications was presented by the developer, although a specific program was not identified. The Committee agreed with the developer that improvements in the number of patients measured and gap in care with use of the measured intervention after 18 months were seen and the presented data was statistically significant.

5. Related and Competing Measures

- No related or competing measures noted.

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

6. Public and Member Comment:

Comments received:

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

Developer response:

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

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

Committee response:

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

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

Measures Not Recommended

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

Submission | Specifications

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

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

Denominator Statement: All patient encounters where medication prescribing occurred

Exclusions: 1. controlled substance(s) requiring non-EDI prescription are printed, or

2. prescriptions are printed due to patient preference for non-EDI prescription and indicated in a structured and auditable format, or

3. no prescriptions are generated during the encounter, or

4. the receiving-end of EDI transmission is inoperable and unable to receive EDI transmission at the time of prescribing

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Structure

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

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

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

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

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

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

Rationale:

- While the Committee noted that electronic prescribing is becoming more common, potentially leading to fewer errors in dispensing than handwritten prescriptions, they agreed it is not clear that measuring the number of electronic prescriptions alone will lead to any meaningful conclusions about or improvements in quality of care. Although the developer cited several studies displaying a high prevalence of medication errors, the Committee pointed out that they do not show a clear link between the measure of the number of electronic prescription and health outcomes. Committee members encouraged the developer to provide more recent data and evidence to support measure focus given the rapid changes in the use of electronic health records in the United States.
- The Committee agreed the evidence presented was insufficient to support the measure and that there is low confidence that the measure addresses a significant health problem.
- The Committee also agreed that while there do not appear to be any potential harms associated with this measure, the potential benefits of this measure in improving the quality of care or patient outcomes are not clear, and did not recommend the measure.

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

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

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

Rationale:

- N/A

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

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

Rationale:

- N/A

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

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

Rationale:

- N/A

5. Related and Competing Measures

- No related or competing measures noted.

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

Rationale

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

6. Public and Member Comment:

Comments received:

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

Measures Withdrawn from consideration

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

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

Appendix B: NQF Care Coordination Portfolio and related measures

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

Communication

- 0291: Administrative Communication
- 0292: Vital Signs
- 0293: Medication Information
- 0294: Patient Information
- 0295: Physician Information
- 0296: Nursing Information
- 0297: Procedures and Tests
- *0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- *0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)
- *0649: Transition Record with Specified Elements Received by Discharged Patients (ED Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Information Systems

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

Transitions or Handoffs

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

Healthcare Home

- *0494: Medical Home System Survey (NCQA)

- *1909: Medical Home System Survey (MHSS)

Proactive Plan of Care and Follow-Up

- *0326: Advance Care Plan

Appendix C: Care Coordination Portfolio—Use In Federal Programs

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

NQF #	Title	Endorsement	Federal Programs: Current Finalized 2013-2014	Federal Programs: Under Consideration 2013-2014
0553	Care for Older Adults- Medication Review	Endorsed	Medicare Part C plan Rating	
0648	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Endorsed	Initial Core Set of health Care Quality Measures for Medicaid-Eligible Adults	

Appendix D: Project Standing Committee and NQF Staff

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Appendix E: Measure Specifications

	0291 Administrative Communication
Steward	University of Minnesota Rural Health Research Center
Description	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative information was communicated to the receiving facility within prior to departure
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative information was communicated to the receiving facility prior to departure • Nurse communication with receiving hospitals • Practitioner communication with receiving practitioner or transfer coordinator
Numerator Details	See attachment in S.2b
Denominator Statement	All emergency department patients who are transferred to another healthcare facility
Denominator Details	The population of the EDTC measure set is defined by identifying patients admitted the emergency department and transferred from the emergency department to other healthcare facilities: DC codes: 3 Hospice –healthcare facility 4a Acute Care Facility- General Inpatient Care 4b Acute Care Facility- Critical Access Hospital 4c Acute Care Facility- Cancer Hospital or Children's Hospital 4d Acute Care Facility – Department of Defense or Veteran's Administration 5 Other health care facility
Exclusions	All emergency department patients not discharged to another healthcare facility.
Exclusion details	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine

	0292 Vital Signs
Steward	University of Minnesota Rural Health Research Center
Description	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that the entire vital signs record was communicated to the receiving FACILITY within 60 minutes of departure
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that the entire vital signs record was communicated to the receiving facility within 60 minutes of departure • Pulse • Respiratory rate • Blood pressure • Oxygen saturation • Temperature • Glasgow score (where appropriate)
Numerator Details	See attachment in S.2b
Denominator Statement	All emergency department patients who are transferred to another healthcare facility
Denominator Details	The population of the EDTC measure set is defined by identifying patients admitted the emergency department and transferred from the emergency department to other healthcare facilities: DC codes: 3 Hospice –healthcare facility 4a Acute Care Facility- General Inpatient Care 4b Acute Care Facility- Critical Access Hospital 4c Acute Care Facility- Cancer Hospital or Children's Hospital 4d Acute Care Facility – Department of Defense or Veteran's Administration 5 Other health care facility
Exclusions	All emergency department patients not discharged to another healthcare facility.
Exclusion details	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine

	0293 Medication Information
Steward	University of Minnesota Rural Health Research Center
Description	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
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	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 • Documentation regarding medication history • Allergies • Medications given (MAR)
Numerator Details	See attachment S.2b
Denominator Statement	All emergency department patients who are transferred to another healthcare facility
Denominator Details	The population of the EDTC measure set is defined by identifying patients admitted the emergency department and transferred from the emergency department to other healthcare facilities: DC codes: 3 Hospice –healthcare facility 4a Acute Care Facility- General Inpatient Care 4b Acute Care Facility- Critical Access Hospital 4c Acute Care Facility- Cancer Hospital or Children's Hospital 4d Acute Care Facility – Department of Defense or Veteran's Administration 5 Other health care facility
Exclusions	All emergency department patients not discharged to another healthcare facility.
Exclusion details	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine

	0294 Patient Information
Steward	University of Minnesota Rural Health Research Center
Description	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that patient information was communicated to the receiving FACILITY within 60 minutes of departure
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that patient information was communicated to the receiving FACILITY within 60 minutes of departure • Patient name • Address • Date of birth • Gender • Significant other contact information • Health insurance information
Numerator Details	See attachment S.2b
Denominator Statement	All emergency department patients who are transferred to another healthcare facility
Denominator Details	The population of the EDTC measure set is defined by identifying patients admitted the emergency department and transferred from the emergency department to other healthcare facilities: DC codes: 3 Hospice –healthcare facility 4a Acute Care Facility- General Inpatient Care 4b Acute Care Facility- Critical Access Hospital 4c Acute Care Facility- Cancer Hospital or Children's Hospital 4d Acute Care Facility – Department of Defense or Veteran's Administration 5 Other health care facility
Exclusions	All emergency department patients not discharged to another healthcare facility
Exclusion details	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine

	0295 Physician Information
Steward	University of Minnesota Rural Health Research Center
Description	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that physician information was communicated to the receiving FACILITY within 60 minutes of departure
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that physician information was communicated to the receiving FACILITY within 60 minutes of departure • Physician or practitioner history and physical • Physician or practitioner orders and plan
Numerator Details	See attachment S.2b
Denominator Statement	All emergency department patients who are transferred to another healthcare facility
Denominator Details	The population of the EDTC measure set is defined by identifying patients admitted the emergency department and transferred from the emergency department to other healthcare facilities: DC codes: 3 Hospice –healthcare facility 4a Acute Care Facility- General Inpatient Care 4b Acute Care Facility- Critical Access Hospital 4c Acute Care Facility- Cancer Hospital or Children's Hospital 4d Acute Care Facility – Department of Defense or Veteran's Administration 5 Other health care facility
Exclusions	All emergency department patients not transferred to another healthcare facility
Exclusion details	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine

	0296 Nursing Information
Steward	University of Minnesota Rural Health Research Center
Description	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that nursing information was communicated to the receiving FACILITY within 60 minutes of departure
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that nursing information was communicated to the receiving facility within 60 minutes of departure • Assessments/intervention/response • Impairments • Catheters • Immobilizations • Respiratory support • Oral limitations
Numerator Details	See S.2b attachement
Denominator Statement	All emergency department patients who are transferred to another healthcare facility
Denominator Details	The population of the EDTC measure set is defined by identifying patients admitted the emergency department and transferred from the emergency department to other healthcare facilities: DC codes: 3 Hospice –healthcare facility 4a Acute Care Facility- General Inpatient Care 4b Acute Care Facility- Critical Access Hospital 4c Acute Care Facility- Cancer Hospital or Children's Hospital 4d Acute Care Facility – Department of Defense or Veteran's Administration 5 Other health care facility
Exclusions	All emergency department patients not discharged to another healthcare facility
Exclusion details	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine

	0297 Procedures and Tests
Steward	University of Minnesota Rural Health Research Center
Description	Performance Measure Name: Procedures and Tests Description: Patients who are transferred from an ED to another healthcare facility have communicated with the receiving facility within 60 minutes of discharge a list of tests done and results sent.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy
Level	Facility
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	Percentage of patients transferred to another Healthcare Facility whose medical record documentation indicated that procedure and test information was communicated to the receiving FACILITY within 60 minutes of departure • Tests & procedures done • Tests & procedure results sent
Numerator Details	See S.2b attachment
Denominator Statement	All emergency department patients who are transferred to another Healthcare Facility
Denominator Details	The population of the EDTC measure set is defined by identifying patients admitted to the emergency department and transfers from the emergency department to these facilities: 3 Hospice –healthcare facility 4a Acute Care Facility- General Inpatient Care 4b Acute Care Facility- Critical Access Hospital 4c Acute Care Facility- Cancer Hospital or Children's Hospital 4d Acute Care Facility – Department of Defense or Veteran's Administration 5 Other health care facility
Exclusions	ED admissions not transferred to another Healthcare facility.
Exclusion details	ED admissions with discharge codes of: Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients
Steward	Centers for Medicare and Medicaid Services
Description	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.
Numerator Details	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.
Denominator Statement	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.
Denominator Details	Any ED Patient from the facility's emergency department. Data Element Name: ED Patient Collected For: ED-1, ED-2 Definition: Patient received care in a dedicated emergency department of the facility. Suggested Data Collection Question: Was the patient an ED patient at the facility? Allowable Values: Y (Yes) There is documentation the patient was an ED patient. N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation. Notes for Abstraction: • For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department. • Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient). • Patients presenting to the ED who do not receive care or services in the ED abstract as a "No" (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor). • Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a "Yes". ED: • If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select "No". This applies even if the emergency department or observation unit is part of your hospital's system (e.g., your hospital's free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select "No", even if the transferred patient is seen in this facility's ED. • If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select "No". This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select "No", even if the transferred patient is seen in this facility's ED. Suggested Data Sources:

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients
	• Emergency department record • Face sheet • Registration form Inclusion Guidelines for Abstraction: None Exclusion Guidelines for Abstraction: • Urgent Care • Fast Track ED • Terms synonymous with Urgent Care
Exclusions	Patients who are not an ED Patient
Exclusion details	All non-ED patients are excluded from this measure. Data Element Name: ED Patient Collected For: ED-1, ED-2 Definition: Patient received care in a dedicated emergency department of the facility. Suggested Data Collection Question: Was the patient an

	0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients
Steward	Centers for Medicare and Medicaid Services
Description	Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department
Type	Outcome
Data Source	Administrative claims
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.
Numerator Details	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.
Denominator Statement	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.
Denominator Details	Any ED Patient from the facility's emergency department E/M Codes Emergency Department 99281 Emergency department visit, new or established patient 99282 Emergency department visit, new or established patient 99283 Emergency department visit, new or established patient 99284 Emergency department visit, new or established patient 99285 Emergency department visit, new or established patient 99291 Critical care, evaluation and management
Exclusions	Patients who expired in the emergency department
Exclusion details	Discharge Code Value 6: Expired

	0497 Admit Decision Time to ED Departure Time for Admitted Patients
Steward	Centers for Medicare and Medicaid Services
Description	Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry
Level	Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual
Setting	Hospital/Acute Care Facility
Numerator Statement	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. Included Populations: Any ED Patient from the facility's emergency department
Numerator Details	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. Included Populations: Any ED Patient from the facility's emergency department Excluded Populations: Pa
Denominator Statement	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. Included Populations: Any ED Patient from the facility's emergency department Excluded Populations: Pa
Denominator Details	Any ED Patient from the facility's emergency department. Data Element Name: ED Patient Collected For: ED-1, ED-2 Definition: Patient received care in a dedicated emergency department of the facility. Suggested Data Collection Question: Was the patient an ED patient at the facility? Allowable Values: Y (Yes) There is documentation the patient was an ED patient. N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation. Notes for Abstraction: • For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department. • Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient). • Patients presenting to the ED who do not receive care or services in the ED abstract as a "No" (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor). • Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a

	0497 Admit Decision Time to ED Departure Time for Admitted Patients
	"Yes". ED: • If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select "No". This applies even if the emergency department or observation unit is part of your hospital's system (e.g., your hospital's free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select "No", even if the transferred patient is seen in this facility's ED. • If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select "No". This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select "No", even if the transferred patient is seen in this facility's ED. Suggested Data Sources: • Emergency department record • Face sheet • Registration form Inclusion Guidelines for Abstraction: None Exclusion Guidelines for Abstraction: • Urgent Care • Fast Track ED • Terms synonymous with Urgent Care
Exclusions	Patients who are not an ED Patient
Exclusion details	All non-ED patients are excluded from this measure, with no other exclusions. Data Element Name: ED Patient Collected For: ED-1, ED-2 Definition: Patient received care in a dedicated emergency department of the facility. Suggested Data Collection Que

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
Steward	Brigham and Women's Hospital
Description	This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adul
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	For each sampled inpatient in the denominator, the total number of unintentional medication discrepancies in admission orders plus the total number of unintentional medication discrepancies in discharge orders.

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
Numerator Details	First, a “gold-standard” preadmission medication history is taken by a trained study pharmacist at each site, following a strict protocol and using all available sources of information, including subject and family/caregiver interviews, prescription pill
Denominator Statement	The patient denominator includes a random sample of all potential adults admitted to the hospital. Our recommendation is that 25 patients are sampled per month, or approximately 1 patient per weekday. So, for example, if among those 25 patients, 75 unin
Denominator Details	Patients are randomly selected each day from a list of admitted patients the day before. A target number of patients are selected(e.g. one patient per weekday) and these patients are interviewed by the pharmacist.
Exclusions	Patients that are discharged or expire before a gold standard medication list can be obtained.
Exclusion details	Please see exclusion listed above in S.10.

Appendix F: Related and Competing Measures

Comparison of NQF #0291, #0292, #0293, #0294, #0295, #0296 and #0297

	0291 Administrative Communication	0292 Vital Signs	0293 Medication Information	0294 Patient Information	0295 Physician Information	0296 Nursing Information	0297 Procedures and Tests
Steward	University of Minnesota Rural Health Research Center	University of Minnesota Rural Health Research Center	University of Minnesota Rural Health Research Center	University of Minnesota Rural Health Research Center	University of Minnesota Rural Health Research Center	University of Minnesota Rural Health Research Center	University of Minnesota Rural Health Research Center
Description	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative information was communicated to the receiving facility within prior to departure	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that the entire vital signs record was communicated to the receiving FACILITY within 60 minutes of departure	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 patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that patient information was communicated to the receiving FACILITY within 60 minutes of departure	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that physician information was communicated to the receiving FACILITY within 60 minutes of departure	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that nursing information was communicated to the receiving FACILITY within 60 minutes of departure	Performance Measure Name: Procedures and Tests Description: Patients who are transferred from an ED to another healthcare facility have communicated with the receiving facility within 60 minutes of discharge a list of tests done and results sent.
Type	Process	Process	Process	Process	Process	Process	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy	Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Electronic Clinical Data : Pharmacy
Level	Facility	Facility	Facility	Facility	Facility	Facility	Facility

	0291 Administrative Communication	0292 Vital Signs	0293 Medication Information	0294 Patient Information	0295 Physician Information	0296 Nursing Information	0297 Procedures and Tests
Setting	Hospital/Acute Care Facility	Hospital/Acute Care Facility	Hospital/Acute Care Facility	Hospital/Acute Care Facility	Hospital/Acute Care Facility	Hospital/Acute Care Facility	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative information was communicated to the receiving facility prior to departure •Nurse communication with receiving hospitals •Practitioner communication with receiving practitioner or transfer coordinator	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that the entire vital signs record was communicated to the receiving facility within 60 minutes of departure •Pulse •Respiratory rate •Blood pressure •Oxygen saturation •Temperature •Glasgow score (where appropriate)	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 •Documentation regarding medication history •Allergies •Medications given (MAR)	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that patient information was communicated to the receiving FACILITY within 60 minutes of departure •Patient name •Address •Date of birth • Gender • Significant other contact information • Health insurance information	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that physician information was communicated to the receiving FACILITY within 60 minutes of departure •Physician or practitioner history and physical •Physician or practitioner orders and plan	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that nursing information was communicated to the receiving facility within 60 minutes of departure •Assessments/intervention/response •Impairments •Catheters •Immobilizations •Respiratory support •Oral limitations	Percentage of patients transferred to another Healthcare Facility whose medical record documentation indicated that procedure and test information was communicated to the receiving FACILITY within 60 minutes of departure •Tests & procedures done •Tests & procedure results sent
Numerator Details	See attachment in S.2b	See attachment in S.2b	See attachment S.2b	See attachment S.2b	See attachment S.2b	See S.2b attachement	See S.2b attachment
Denominator Statement	All emergency department patients who are transferred to another healthcare facility	All emergency department patients who are transferred to another healthcare facility	All emergency department patients who are transferred to another healthcare facility	All emergency department patients who are transferred to another healthcare facility	All emergency department patients who are transferred to another healthcare facility	All emergency department patients who are transferred to another healthcare facility	All emergency department patients who are transferred to another Healthcare Facility

	0291 Administrative Communication	0292 Vital Signs	0293 Medication Information	0294 Patient Information	0295 Physician Information	0296 Nursing Information	0297 Procedures and Tests
Denominator Details	The population of the EDTC measure set is defined by identifying patients admitted the emergency department and transferred from the emergency department to other healthcare facilities: DC codes: 3 Hospice –healthcare facility 4a Acute Care Facility- General Inpatient Care 4b Acute Care Facility- Critical Access Hospital 4c Acute Care Facility- Cancer Hospital or Children's Hospital 4d Acute Care Facility – Department of Defense or Veteran's Administration 5 Other health care facility	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	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	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	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	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	The population of the EDTC measure set is defined by identifying patients admitted to the emergency department and transfers from the emergency department to these facilities: 3 Hospice –healthcare facility 4a Acute Care Facility- General Inpatient Care 4b Acute Care Facility- Critical Access Hospital 4c Acute Care Facility- Cancer Hospital or Children's Hospital 4d Acute Care Facility – Department of Defense or Veteran's Administration 5 Other health care facility
Exclusions	All emergency department patients not discharged to another healthcare facility.	All emergency department patients not discharged to another healthcare facility.	All emergency department patients not discharged to another healthcare facility.	All emergency department patients not discharged to another healthcare facility	All emergency department patients not transferred to another healthcare facility	All emergency department patients not discharged to another healthcare facility	ED admissions not transferred to another Healthcare facility.

	0291 Administrative Communication	0292 Vital Signs	0293 Medication Information	0294 Patient Information	0295 Physician Information	0296 Nursing Information	0297 Procedures and Tests
Exclusion Details	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine	Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine	ED admissions with discharge codes of: Exclusions: 1 Home 2 Hospice-home 6 Expired 7 AMA (left against medical advice) 8 Not documented/unable to determine

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

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

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

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

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	preadmission medication list is then compared with the medical team's documented preadmission medication list and with all admission and discharge medication orders. Any discrepancies between the gold-standard history and medication orders are identified and reasons for these changes sought from the medical record. Pharmacists may also need to communicate directly with the medical team to clarify reasons for discrepancies, as needed. Medication discrepancies that are not clearly intentional are then recorded, along with the reason for the discrepancy: 1. History error: the order is incorrect because the medical team's preadmission medication list is incorrect (e.g., the team did not know the patient was taking aspirin prior to admission, does not record it in the preadmission medication list, and therefore does not order it at admission) 2. Reconciliation error: the medical team's preadmission medication list is correct, but there is still an error in the orders. For example, the team knew the patient was taking aspirin prior to admission and documents it in the preadmission medication list. The team decides to hold the aspirin on admission for a clinical reason		Value Set --- MEDICAL RECORD Documentation in the medical record must include evidence of medication reconciliation, and the date on which it was performed. The following evidence meets criteria: • Notation that medications prescribed or ordered upon discharge were reconciled with the current medications (in outpatient record) by the appropriate practitioner type, or • A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type (the organization must be able to distinguish between the patient's discharge medications and the patient's current medications). or • Notation that no medications were prescribed or ordered upon discharge Only documentation in the outpatient chart meets the intent of the measure, but an in-person, outpatient visit is not required	services (TCM 7 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 22 of the year after the measurement year. Transitional care management services (TCM 14 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 15 of the year after the measurement year. (See corresponding Excel document for the value sets referenced above) Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit. Medication reconciliation and management must be furnished no later than the date of the face-to-face visit. --- MEDICAL RECORD Documentation must come from the same medical record and must include the following:	Current Medications not Documented, Patient not Eligible G8430: Eligible professional attests the patient is not eligible for medication documentation OR Current Medications with Name, Dosage, Frequency, Route not Documented, Reason not Given G8428: Current medications not documented by the eligible professional, reason not given. Definitions: Current Medications – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.	(continued, new, or discontinued) is specified within the list AND any allergic reactions are identified. For EHR: This measure does not lend itself to a "traditional specification" for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for medication reconciliation and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure. Producing the Reconciled Medication List Facilities that have implemented an EHR system should utilize their system to develop a standardized template for the Reconciled Medication List. A standardized template will ensure that all required data elements specified in the measure are included whenever a Reconciled Medication List is generated from the EHR. Each facility has the autonomy to customize the format of the Reconciled Medication List, based on clinical workflow, policies and procedures, and the patient

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	such as bleeding, but the team forgets to restart the aspirin at discharge. The admission discrepancy would be considered intentional (no error, not counted in the numerator), but the discharge discrepancy would be counted as a reconciliation error. The type of error should also be recorded: omission, discrepancy in dose, route, frequency, or formulation, or an additional medication. Lastly, the time of the error should be recorded: admission vs. discharge.			• 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.		population treated at the individual institution. Systematic External Reporting that the Reconciled Medication List was provided to patient In order to report, at the facility level, which of the discharged patients have received a Reconciled Medication List, a discrete data field and code indicating the patient received a reconciled medication list at discharge may be needed in the EHR. Each facility should determine the most effective way to identify whether or not the patient received the reconciled medication list. Transmitting the Reconciled Medication List This performance measure does not require that the Reconciled Medication List be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum. RxNorm has been named as the recommended vocabulary for medications and can be used to identify the medications to

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

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
		99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 AND CPT Category II code 1110F: Patient discharged from an inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) within the last 30 days.	If patients have more than one discharge, include all discharges during the first 11 months of the measurement year. If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count the only the readmission discharge or the discharge from the facility to which the patient was transferred. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first 11 months of the measurement year (e.g., December 1). --- MEDICAL RECORD Same as ADMINISTRATIVE. The denominator is based on the discharge date found in the administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.		Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0270, G0402, G0438, G0439	For Claims/Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) AND Discharge Status (Form Locator 17) • 01 (Discharged to home care or self care (routine discharge) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
						nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children's hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
						distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) OR UB-04 (Form Locator 04 - Type of Bill): • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) AND UB-04 (Form Locator 42 - Revenue Code): • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) AND Discharge Status (Form Locator 17) • 01 (Discharged to home care or self care (routine discharge) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
						designated cancer center or children's hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Exclusions	Patients that are discharged or expire before a gold standard medication list can be obtained.	N/A	N/A	N/A	ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION. A patient is not eligible or excluded (B) from the performance denominator (PD) if one or more of the following reason exists: • Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.	Patients who died Patients who left against medical advice (AMA) or discontinued care

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Exclusion Details	Please see exclusion listed above in S.10.	N/A	N/A	N/A	For the purposes of identifying performance exclusions, Denominator Exclusions (B) are defined by providers reporting the exclusion clinical quality action. For this measure, the clinical exclusion code is numerator HCPCS G8430. Current Medications not Documented, Patient not Eligible G8430: Eligible professional attests the patient is not eligible for medication documentation	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception.

Comparison of NQF #0495, #0496 and #0497

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients	0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients	0497 Admit Decision Time to ED Departure Time for Admitted Patients
Steward	Centers for Medicare & Medicaid	Centers for Medicare & Medicaid	Centers for Medicare & Medicaid
Description	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department	Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department	Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status
Type	Outcome	Process	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records
Level	Facility	Facility	Facility
Setting	Hospital/Acute Care Facility	Hospital/Acute Care Facility	Hospital/Acute Care Facility
Numerator Statement	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. Included Populations: Any ED Patient from the facility's emergency department
Numerator Details	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. Included Populations: Any ED Patient from the facility's emergency department Excluded Populations: Patients who are not an ED Patient Data Elements: • Decision to Admit Date • Decision to Admit Time • ED Departure Date • ED Departure Time • ED Patient • ICD-9-CM Principal Diagnosis Code

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients	0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients	0497 Admit Decision Time to ED Departure Time for Admitted Patients
Denominator Statement	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. Included Populations: Any ED Patient from the facility's emergency department Excluded Populations: Patients who are not an ED Patient Data Elements: • Decision to Admit Date • Decision to Admit Time • ED Departure Date • ED Departure Time • ED Patient • ICD-9-CM Principal Diagnosis Code
Denominator Details	Any ED Patient from the facility's emergency department. Data Element Name: ED Patient Collected For: ED-1, ED-2 Definition: Patient received care in a dedicated emergency department of the facility. Suggested Data Collection Question: Was the patient an ED patient at the facility? Allowable Values: Y (Yes) There is documentation the patient was an ED patient. N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation. Notes for Abstraction: • For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department. • Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and	Any ED Patient from the facility's emergency department E/M Codes Emergency Department 99281 Emergency department visit, new or established patient 99282 Emergency department visit, new or established patient 99283 Emergency department visit, new or established patient 99284 Emergency department visit, new or established patient 99285 Emergency department visit, new or established patient 99291 Critical care, evaluation and management	Any ED Patient from the facility's emergency department. Data Element Name: ED Patient Collected For: ED-1, ED-2 Definition: Patient received care in a dedicated emergency department of the facility. Suggested Data Collection Question: Was the patient an ED patient at the facility? Allowable Values: Y (Yes) There is documentation the patient was an ED patient. N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation. Notes for Abstraction: • For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department. • Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred

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

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients	0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients	0497 Admit Decision Time to ED Departure Time for Admitted Patients
	Collected For: ED-1, ED-2 Definition: Patient received care in a dedicated emergency department of the facility. Suggested Data Collection Question: Was the patient an ED patient at the facility? Allowable Values: Y (Yes) There is documentation the patient was an ED patient. N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation. Notes for Abstraction: • For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department. • Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient). • Patients presenting to the ED who do not receive care or services in the ED abstract as a "No" (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor). • Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a "Yes". ED: • If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select "No". This applies even if the emergency department or observation unit is part of your hospital's system (e.g., your hospital's free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select "No", even if the transferred patient is seen in this facility's ED. • If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select "No". This applies even if the two hospitals are close in proximity, part of the		Data Element Name: ED Patient Collected For: ED-1, ED-2 Definition: Patient received care in a dedicated emergency department of the facility. Suggested Data Collection Question: Was the patient an ED patient at the facility? Allowable Values: Y (Yes) There is documentation the patient was an ED patient. N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation. Notes for Abstraction: • For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department. • Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient). • Patients presenting to the ED who do not receive care or services in the ED abstract as a "No" (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor). • Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a "Yes". ED: • If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select "No". This applies even if the emergency department or observation unit is part of your hospital's system (e.g., your hospital's free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select "No", even if the transferred patient is seen in this facility's ED. • If the patient is transferred to your hospital from an outside

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients	0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients	0497 Admit Decision Time to ED Departure Time for Admitted Patients
	same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED. Suggested Data Sources: • Emergency department record • Face sheet • Registration form Inclusion Guidelines for Abstraction: None Exclusion Guidelines for Abstraction: • Urgent Care • Fast Track ED • Terms synonymous with Urgent Care		hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED. Suggested Data Sources: • Emergency department record • Face sheet • Registration form Inclusion Guidelines for Abstraction: None Exclusion Guidelines for Abstraction: • Urgent Care • Fast Track ED • Terms synonymous with Urgent Care

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