Care Coordination Measures: 2016-2017

DRAFT REPORT FOR VOTING

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NATIONAL QUALITY FORUM

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Contents

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Executive Summary

Care coordination is a multidimensional concept and critical aspect of healthcare that spans the continuum of care ensuring quality care and better patient outcomes. It encompasses effective communication between patient, caregiver and provider, and facilitates linkages between the community and healthcare system. Coordination of care ensures that accountable structures and processes are in place for communication and integration of a comprehensive plan of care across providers and settings in alignment with patient and family preferences and goals.

Considered a fundamental component to the success of the healthcare system and patient outcomes, care coordination is essential to reducing preventable hospitalizations, an integral component to controlling health-care costs. Preventable hospital admissions accounted for nearly $31 billion.[1]

Currently, NQF's portfolio of care coordination measures includes measures for hospitalizations, emergency department (ED) use, timely transfer of information, medication reconciliation, advance care planning, and e-prescribing. Some of these measures date back to 2007, several are currently in use in accountability and quality improvement programs.

Recognizing the importance of care coordination measurement, the National Quality Forum (NQF) launched their first care coordination project in 2006. Through subsequent work, NQF endorsed a definition and framework for care coordination. In 2010, five measurement domains were established and, beginning in July 2011, NQF launched a multi-phased Care Coordination project focused on healthcare 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 to advance the field of care coordination measurement. Critical to this work was a commissioned paper examining electronic capabilities to support care coordination measurement as well as the findings of an environmental scan that informed the pathway forward and the goals for future measures.

During the next two phases, the Care Coordination Committee identified significant gaps in the portfolio of measures - primarily the lack of cross-cutting components of care coordination within measures and aligned their work with the related NQF project – Prioritizing Measure Gaps: Care Coordination. The Committee also updated the definition of care coordination as "…the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for healthcare and community services are met over time."

In addition to the phases described previously, during which the Committee reviewed measures, NQF's Measure Applications Partnership (MAP) identified an initial Care Coordination Family of Measures related to the National Quality Strategy (NQS) priorities and high-impact conditions. This Family of

Measures include: addressing avoidable admissions and readmissions, system infrastructure support, care transitions, communication, care planning, and patient surveys related to care coordination.

For the current phase of work, the Standing Committee evaluated two newly submitted measures and five measures undergoing maintenance review against NQF's standard evaluation criteria. Of these measures, the Standing Committee recommended one for endorsement, but did not recommend the remaining six measures for endorsement. The Standing Committee recommended one measure:

- 0326: Advance Care Plan

The Committee did not recommend the following measures:

- 0646: Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- 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 (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care
- 3170: Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit
- 3171: Percentage of Asthma ED visits followed by Evidence of Care Connection

Brief summaries of the measures currently under review are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

Care coordination is a multidimensional concept and critical aspect of healthcare that spans the continuum of care ensuring quality care and patient outcomes. It encompasses effective communication between patient, caregiver and provider, and facilitates linkages between the community and healthcare system. Coordination of care ensures that accountable structures and processes are in place for communication and integration of a comprehensive plan of care across providers and settings in alignment with patient and family preferences and goals.

Care that is poorly coordinated may lead to negative, unintended consequences including medication errors, and preventable hospital admissions causing poor outcomes.[2,3] The Agency for Healthcare Research and Quality (AHRQ) 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.[4] The cost of treating patients harmed by these events is estimated at $5 billion annually.[5] For example, individuals with chronic conditions whose care relies on effective coordination through a complex healthcare system, managed by multiple providers in multiple settings, often find it difficult to navigate the system of care. This can contribute to poor outcomes such as reducing preventable hospitalizations, an integral aspect to controlling health-care costs that accounted for nearly $31 billion.[6,7] Coordination of care is a critical process for the improvement of patient outcomes and the success of healthcare systems.

A variety of tools and approaches, when leveraged, can improve care coordination. Electronic health records (EHRs) can reduce unnecessary and costly duplication of patient services, while the number of serious medication events could also reduce costs through patient education and the reconciliation of medication lists.[8,9] The Institute of Medicine (IOM) indicates 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.[10] Care coordination is also positively associated with patient and family-reported receipt of family centered care, resulting in greater satisfaction with services, lower financial burden and fewer emergency department visits, among others.[11]

Recognizing the importance of care coordination measurement, the National Quality Forum (NQF) launched their first care coordination project in 2006. Through subsequent work, NQF endorsed a definition and framework for care coordination.[12] NQF initially defined care coordination as a: “function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time.” In 2010, NQF endorsed 10 performance measures and 25 Preferred Practices. These measures or consensus standards provide the foundation required to assess impact and progress towards patient outcomes. Beginning in July 2011, NQF launched a multi-phased Care Coordination project focused on healthcare 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 to advance the field of care coordination measurement. A commissioned paper examining electronic capabilities to support care coordination measurement as well as an environmental scan informed the pathway forward and the goals for future measures. During the next two phases, the Committee continued to endorse measures – 12 measures in Phase 2 and five measures in Phase 3.

Work also continued on identification of gaps in the portfolio, primarily the lack of cross-cutting components of care coordination within measures. During Phase 3, Care Coordination Committee, in concert with the NQF Measure Prioritization Committee, produced a report prioritizing measure gaps in care coordination. Recommendations from this work can found in the final report entitled *Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Care Coordination.* This report also includes an updated definition of care coordination as "…the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for healthcare and community services are met over time."

In addition to the phases described previously, during which the committee reviewed measures, NQF's Measure Applications Partnership (MAP) identified an initial Care Coordination Family of Measures related to the National Quality Strategy (NQS) priorities and high-impact conditions. This Family of Measures includes; addressing avoidable admissions and readmissions, system infrastructure support, care transitions, communication, care planning, and patient surveys related to care coordination.

For the current phase of Care Coordination work, the measures submitted focused on plan of care, medication reconciliation, timely transitions, and connections to clinical care management. Key measure topics emerged during this phase include:

Plan of Care

Care plans, specifically advance care plans aim to ensure that care near the end of life aligns with the patient's wishes.[13] Advance care planning is associated with improved health outcomes for older adults; including reducing admissions, and lengths of stay.[14,15,16,17] Advance directives are widely recommended as a strategy to improve compliance with patient wishes at the end of life, and thereby ensure appropriate use of healthcare resources at the end of life. However, the majority of older adults do not have advance care planning conversations with their clinicians.[18,19] A recent systematic review found only a few studies concerning advanced care planning in palliative care.[20] Although the results were promising, more high-quality studies are needed.

Medication Reconciliation

Medication reconciliation refers to the process of avoiding inadvertent inconsistencies during transitions in care by reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the medication regimen in the new care setting. 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, which highlights this as a significant care coordination issue.[21]

Timely Transitions

Poorly managed and untimely transitions can diminish health and increase healthcare 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 for 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 transitions is essential to not only improving patient and family experiences but also helping to minimize readmission rates.[22]

Connections to Clinical Care Management

Management and coordination of connections can enhance outcomes and lower costs. These connections include visits to a primary care practitioner and clinical management of medications. Literature reviews indicate that asthma is a prevalent chronic condition in children. ED visits for asthma care are a common, costly, and potentially preventable health service that may serve as a marker for both insufficiency of primary care and insufficiency of clinical management of asthma by the partnership of the family and the healthcare team. A study by Pearson et al. found that approximately 629,000 ED visits for pediatric asthma for Medicaid/CHIP enrollees cost $272 million in 2010. The average cost per visit was $433.[23]

Trends and Performance

The 2015 National Healthcare Quality and Disparities Report identified several trends and disparities related to measures of care coordination.[24] AHRQ found that, based on the 37 measures used to assess the NQS priority of care coordination through 2013, fewer than half of the measures showed improvement. On a positive note, AHRQ also reported that, although disparities were more common among measures of care coordination than the other priority areas, about 45% of disparities related to care coordination were getting smaller.

Refining the NQF Measure Evaluation Process

To streamline and improve the periodic evaluation of currently endorsed measures, NQF has updated its process for the evaluation of measures for maintenance of endorsement. This change took effect beginning October 1, 2015. NQF's endorsement criteria have not changed, and all measures continue to be evaluated using the same criteria. However, under the new approach, there is a shift in emphasis for evaluation of currently endorsed measures:

- **Evidence:** If the developer attests that the evidence for a measure has not changed since its previous endorsement evaluation, there is a decreased emphasis on evidence, meaning that a committee may accept the prior evaluation of this criterion without further discussion or need for a vote. This applies only to measures that previously passed the evidence criterion without an exception. If a measure was granted an evidence exception, the evidence for that measure must be revisited.
- **Opportunity for Improvement (Gap):** For re-evaluation of endorsed measures, there is increased emphasis on current performance and opportunity for improvement. Endorsed measures that are "topped out" with little opportunity for further improvement are eligible for Inactive Endorsement with Reserve Status.
- **Reliability**
    - Specifications: There is no change in the evaluation of the current specifications.

    - Testing: If the developer has not presented additional testing information, a committee may accept the prior evaluation of the testing results without further discussion or need for a vote.
- **Validity:** There is less emphasis on this criterion if the developer has not presented additional testing information, and a committee may accept the prior evaluation of this subcriterion without further discussion and vote. However, a committee still considers whether the specifications are consistent with the evidence. Also, for outcome measures, a committee discusses questions required for the SDS Trial even if no change in testing is presented.
- **Feasibility:** The emphasis on this criterion is the same for both new and previously endorsed measures, as feasibility issues might have arisen for endorsed measures that have been implemented.
- **Usability and Use:** For re-evaluation of endorsed measures, there is increased emphasis on the use of the measure, especially use for accountability purposes. There also is an increased emphasis on improvement in results over time and on unexpected findings, both positive and negative.

The New Endorsement and Appeals Process

In August 2016, NQF's Board of Directors approved changes to its ratification and appeals process. Following public comment and voting by the NQF membership, the Consensus Standards Approval Committee (CSAC) will make the final measure endorsement decision, without ratification by another body. Additionally, the Board requested NQF to establish a five-member Appeals Board that will be responsible for adjudicating all submitted appeals regarding measure endorsement decisions. These changes apply to NQF measure endorsement projects with in-person meetings scheduled after August 2016.

The newly, constituted Appeals Board, composed of NQF Board members and former CSAC and/or committee members, will adjudicate appeals to measure endorsement decisions without a review by the CSAC. The decision of the Appeals Board is final.

All submitted appeals will be published on the NQF website. Staff will compile the appeals for review by the Appeals Board, which will evaluate the concern(s) raised and determine if the appeal should warrant overturning the endorsement decision. Decisions on an appeal of endorsement will be publicly available on NQF's website.

Throughout the process, project staff will serve as liaisons between the CSAC, the Appeals Board, the committee, developers/stewards, and the appellant(s) to ensure the communication, cooperation, and appropriate coordination to complete the project efficiently.

NQF Portfolio of Performance Measures for Care Coordination Conditions

The Care Coordination Standing Committee (see Appendix D) oversees NQF's portfolio of Care Coordination measures that includes measures for emergency department transfers, plan of care, e-prescribing, timely transitions, medication management, and transition records (see Appendix B). This

portfolio contains 14 measures: eleven process measures and three outcome measures (see table below). The Care Coordination Standing Committee evaluated five of these existing measures.

Table 1. NQF Care Coordination Portfolio of Measures

	Process	Outcome/Resource Use	Structural	Composite
Emergency Department Transfers	4	0	0	0
Plan of Care	1	0	0	0
E-prescribing	0	0	0	0
Timely Transitions	1	2	0	0
Medication Management	2	1	0	0
Transition Records	3	0	0	0
Medical Home	0	0	0	0
Total	11	3	0	0

Additional measures related to Care Coordination are in other projects. These include various diabetes assessment and screening measures (Health and Well-being/Behavioral Health project), eye care measures (EENT project), ACEI/ARB medication measures (Cardiovascular project), complications and outcomes measures (Health and Well-being/Surgery projects), and one cost and resource use measure (Resource Use project).

National Quality Strategy

NQF-endorsed measures for Care Coordination support the National Quality Strategy (NQS). 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 healthcare in the U.S. 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.*

Quality measures for Care Coordination care align with several of the NQS priorities, including:

- Making care safer
- Communication and Care Coordination

Safe care is fundamental to improving quality. More than half of patients have greater than one medication discrepancy at hospital admission placing patients at risk for adverse drug events. Accrediting bodies such as the Joint Commission recognize the importance of reconciliation of medications and include this as a 2017 National Patient Safety Goal. Coordination of care is an important healthcare priority, ensuring patient and family needs and preferences be met through the exchange of healthcare information across people, functions, and sites. Effective care coordination

maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes.

Use of Measures in the Portfolio

Endorsement of measures by NQF is valued due to the rigor and transparency of the process conducted by multi-stakeholder committees. Committee members include clinicians and experts from the full range of 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, federal law requires that preference be given to NQF-endorsed measures for use in selected 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.

Many measures are in use in at least one federal program. For example, two measures are currently in use in the Home Health Value Based Purchasing and another three are used in Hospital Compare as well as Hospital Inpatient/Outpatient Quality Reporting. Several of the care coordination measures have been included in the Care Coordination Family of Measures by the NQF-convened MAP. See Appendix C for details of federal program use for the measures in the portfolio.

Improving NQF's Care Coordination Portfolio

During their discussions at both the in-person meeting and at the post-meeting call, the Committee identified numerous areas where gaps remain. They discussed the current state of measurement, which includes "small pieces of a broad continuum of care"— such as the transfer of information and transitions including medication reconciliation. Several members spoke to the importance of measures that include specifics on the transfer of information at critical transitions. Other members discussed the importance of up to date evidence to support these and other care coordination measures vital to ensuring the delivery of high quality care coordination.

One member suggested that care providers should think about what information the next provider needs—to see themselves as a team of providers to improve healthcare. Additionally, the Committee suggested the creation of a plan of care that has the basic elements needed to ensure continuity of care, as well shifting the focus to prioritizing patient's lists of concerns and preferences. A care plan would be central to this focus and the work would address and identify these building blocks. Another member discussed the work that is underway at the American College of Physicians (ACP) with their High Value Care Coordination Toolkit in connecting primary care physicians with specialty groups. Another member suggested that care coordination could be a "test case" for moving the field forward on the incorporation of patient preferences and goals into a care plan for patients as they move through the health system. The Committee discussed the path forward could be to create the building blocks in a care plan - a short list of items that are common to most care plans and treatment plans – as well as an individual list of concerns. The Committee also suggested that utilizing the current work of the ACP as well as other groups could enhance this work.

Specific suggestions from the Committee on the types of measures needed in the Care Coordination portfolio include measures that:

- Reflect patient preferences as they move through the healthcare system;
- Incorporate the care plan as the core document including the basic elements for all providers across the continuum, inclusive of the patient's voice and goals;
- Encompass some of the practical and basic elements of transition such as medication reconciliation; and
- Are evidence-based for the specific measure focus.

Care Coordination Measure Evaluation

On February 22, 2017, the Care Coordination Standing Committee evaluated two new measures and five measures undergoing maintenance review against NQF's standard evaluation criteria. To facilitate the evaluation, the Committee performed a preliminary review of the measures against the evaluation sub-criteria. This pre-work prepared both the Committee and the developers for the review by the entire Standing Committee.

Table 2. Care Coordination Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	5	2	7
Measures recommended for endorsement	1	--	1
Measures not recommended for endorsement	4	2	6
Measures withdrawn from consideration	1	--	1
Reasons for not recommending	Importance – 2 Scientific Acceptability – 2 Overall – 4 Competing Measure – 0	Importance – 1 Scientific Acceptability – 1 Overall – 2 Competing Measure – 0	

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments 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 from January 9-January 23, 2017 for the seven measures under review. There were no pre-evaluation comments received.

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

According to NQF measure evaluation criteria, both process measures and intermediate clinical outcome measures should be supported by a systematic review and grading of the body of empirical evidence demonstrating that the measured process or intermediate clinical outcome leads to a desired health outcome. Four of the measures in this project focused on medication reconciliation and transition records, and were supported by expert opinion only. For some measures, developers presented evidence tangential to the measure focus that was not graded; for some measures, developers did not summarize the quantity, quality, and consistency of the evidence. While developers augmented systematic reviews with brief descriptions of additional studies, these did not always match the measure focus. Because the Committee confirmed the importance of the measure concepts, Committee members invoked the exception to the evidence subcriterion for the four measures not supported by empirical evidence.

Lack of Uptake of Measures and Unavailability of Data

Many of the measures evaluated in this project are not in use and planned use is unclear. This hindered the measure developers' ability to provide current performance information as well as information addressing improvement over time, both of which receive increased emphasis in NQF's new maintenance process for evaluating previously endorsed measures.

Need for Better Measures

Committee members noted that the measurement world has changed dramatically since the Committee first started evaluating measures several years ago. The Committee highlighted the need for measures that "raise the bar" to further improve care and demand a higher level of performance. In addition, the Committee noted a need for more measures of outcomes that matter to patients and families. Committee members also acknowledged the challenges of building strong measures around care coordination.

Summary of Measure Evaluation

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

0326 Advance Care Plan (National Committee for Quality Assurance): Recommended

Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. **Measure Type**: Process; **Level of Analysis**:

Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Clinician Office/Clinic; **Data Source**: Claims (Only), EHRs Hybrid

The aim of advance care planning is to ensure that care near the end of life aligns with the patient's wishes. The measure, initially endorsed in 2007 and re-endorsed in 2012, is in use in the CMS Medicare Physician Quality Reporting System (PQRS) and the Quality Payment Program Merit-Based Incentive Payment System (MIPS). The Committee noted the lack of standard defined components that make up the care plan as well as the lack of disparities information. Developers indicated performance data has increased over time. The Committee noted the small number of testing sites used to conduct testing, but agreed the results indicated strong reliability of the measure. To demonstrate validity of the measure, an expert panel met to assess face validity of the measure concept. The Committee agreed that the provided testing information continues to be sufficient in meeting this criterion. In the future, the Committee would like to see a measure that addresses planning documented in the record that aligns with patient preferences. Overall, the Committee recognized the importance of documenting an advance care plan and recommended the measure for continued endorsement.

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (PCPI Foundation): Not Recommended

Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories. **Measure Type**: Process; **Level of Analysis**: Facility, Integrated Delivery System; **Setting of Care**: Hospital: Acute Care Facility, Ambulatory Surgery Center, Hospital: Critical Care, Hospital, Behavioral Health: Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF; **Data Source**: EHRs Hybrid, Paper Records.

The goal of medication reconciliation is to prevent communication errors and ensure the patient has a correct list of medications to prevent adverse drug events because of unintended changes in medication, changes in medication dosage or omission of medications. This measure was endorsed in 2010 and again in 2012. The Committee acknowledged the absence of updated, empirical evidence for this measure, but agreed to invoke an exception to the evidence criterion because this measure is important and the evidence presented is still relevant. Although the California Department of Health Care Services administered this measure in the CMS Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program in 2016, performance results are not yet available. While the Committee recognized the importance of reconciling medications, the Committee did not recommend the measure for endorsement due to the absence of performance scores and disparities data.

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) (PCPI Foundation): Not Recommended

Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s), received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements. **Measure Type**: Process; **Level of Analysis**: Facility, Integrated Delivery System;

Setting of Care: Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF; **Data Source**: EHRs Hybrid, Paper Records

This measure assesses the transmission of a transition record to patients at the time of discharge from an in-patient facility. The intent of the measure is to reduce communication gaps, help patients comply with treatment plans, and improve patient outcomes by providing detailed discharge information. Originally endorsed in 2010 and re-endorsed in 2012, this measure is in use in the CMS Inpatient Psychiatric Facility Quality Reporting Program (IPFQR).

The evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. However, the evidence is not specific to the focus of the measure. Committee members agreed that empirical evidence is not needed to hold providers accountable for the measure and agreed to invoke the exception to the evidence subcriterion. The Committee was unable to reach consensus on the performance gap subcriterion, noting concerns with the lack of current data on opportunity for improvement. Committee members were concerned about the generalizability of the testing, as testing of the measure was performed using data from only one site's electronic health record (EHR). Ultimately, the Committee did not accept the reliability testing and did not recommend the measure for endorsement.

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (PCPI Foundation): Not Recommended

Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, of patients, regardless of age, for which a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge. **Measure Type**: Process; **Level of Analysis**: Facility, Integrated Delivery System; **Setting of Care**: Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF; **Data Source**: EHRs Hybrid, Paper Records

This measure assesses the transmission of transition record to a patient's primary care physician or other healthcare professional within 24 hours of discharge from an in-patient facility. The intent of this measure is to improve the continuity of care and reduce hospital readmissions by ensuring that the patient's discharge information is available at the first post-discharge physician visit. Originally endorsed in 2010 and re-endorsed in 2012, the measure is currently in use in the CMS IPFQR and PRIME programs.

The evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. However, the evidence is not specific to the focus of the measure. Committee members agreed that empirical evidence is not needed to hold providers accountable for the measure and agreed to invoke the exception to the evidence subcriterion. The Committee was unable to reach consensus on the performance gap subcriterion, noting concerns with

the lack of current data on opportunity for improvement. Committee members were concerned about the generalizability of the testing, as testing of the measure was performed using data from only one site's electronic health record (EHR). Ultimately, the Committee did not accept the reliability testing and did not recommend the measure for endorsement.

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care) (PCPI Foundation): Not Recommended

Description: Percentage of discharges from an emergency department (ED) to ambulatory care or home health care, in which the patient, regardless of age, or their caregiver(s), received a transition record at the time of ED discharge including, at a minimum, all of the specified elements. **Measure Type**: Process; **Level of Analysis**: Facility, Integrated Delivery System; **Setting of Care**: Emergency Department; **Data Source**: EHRs Hybrid, Paper Records

This measure assesses the transmission of a transition record to patients at the time of discharge from an emergency department. The intent of the measure is to reduce communication gaps, help patients comply with treatment plans, and improve patient outcomes by providing detailed discharge information. Originally endorsed in 2010 and re-endorsed in 2012, this measure is not publicly reported or used in any known accountability programs.

The evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. However, the evidence is not specific to the focus of the measure. Similar to measures #0647 and #0648, Committee members agreed that empirical evidence is not needed to hold providers accountable for the measure. Therefore, the Committee agreed to invoke the exception to the evidence subcriterion. The Committee expressed concerns with the lack of current data provided on opportunity for improvement. Because there were no performance scores available, the Committee was unable to determine if there are opportunities for improvement. Ultimately, the measure did not pass the performance gap subcriterion and the Committee did not recommend the measure for endorsement.

3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit (University Hospitals Cleveland Medical Center): Not Recommended

Description: This measure describes the incidence rate of emergency department visits for children ages 2 to 21 who are being managed for identifiable asthma. This measure characterizes care that precedes Emergency Department visits for children ages 2 to 21 who can be identified as having asthma, using the specified definitions. We sought to identify children with ongoing asthma who should be able to be identified by their health care providers and/or health care plans as having asthma. The operational definition of an identifiable asthmatic is a child who has utilized health care services that suggest the health care system has enough information to conclude that the child has an asthma diagnosis that requires ongoing care. Specifically, this measure identifies the use of primary care services and medications prior to ED visits and/or hospitalizations for children with asthma. **Measure Type**: Composite; **Level of Analysis**: Population : Community, County or City, Population : Regional and State; **Setting of Care**: Clinician Office/Clinic, Emergency Department, Hospital; **Data Source**: Claims (Only)

Visits to the ED for asthma care are a potentially preventable health service that may serve as a marker for both insufficiency of primary care and insufficiency of clinical management of asthma. The evidence base for this composite measure is the connection to the primary care system, including use of primary care services and medications prior to an ED visit/hospitalization for children with asthma. The Committee agreed that the evidence presented through the graded Guidelines from the National Asthma Education and Prevention Programs (NAEPP) supported all three components of the measure, and the additional studies supported the use of primary care visits and prescribing of medication in the reduction of ED use/hospitalization.

The performance rate for the measure was 16.5% based on 2009-2011 data from New York State (NYS) Medicaid. The additional data on disparities from NYS Medicaid, specifically by race, urbanicity, and poverty gap, demonstrated that the measure varies based on these populations. The developer described the three components of this all-or-none measure as "key determinants" of connections to the primary care system that can occur prior to ED visits/hospitalizations. Several Committee members stated that this measure is a "good start" and the components are available and feasible to obtain. However, because the developer was unable to provide reliability testing at the measure score level (a requirement for composite measures), the Committee did not recommend the measure for endorsement. The developer may be able to conduct the required testing by the time of the post-comment call.

3171 Percentage of Asthma ED visits followed by Evidence of Care Connection (University Hospitals Cleveland Medical Center): Not Recommended

Description: This measure seeks to capture important aspects of follow up after ED visits for asthma, including prompt follow up with primary care clinicians and prescription fills for controller medications. This measure characterizes care that follows Emergency Department (ED) visits with a primary or secondary diagnosis of asthma for children ages 2 to 21 that occur in the Reporting Year and who are enrolled in the health plan for two consecutive months following the ED visit. **Measure Type**: Composite; **Level of Analysis**: Population : Community, County or City, Population : Regional and State; **Setting of Care**: Clinician Office/Clinic, Emergency Department, Hospital; **Data Source**: Claims (Only)

Visits to the ED for asthma care are a potentially preventable health service that may serve as a marker for both insufficiency of primary care and insufficiency of clinical management of asthma. This measure describes the connection with the primary care system (timely visits to primary care providers and filling of controller asthma medications) following ED visits for children with asthma.

The composite measure includes two components: visit(s) to a primary care provider that occurred within 14 days following the ED visit, and one fill of an asthma controller medication within 2 months after the ED visit. The Committee agreed that the evidence from the graded Guidelines of the National Asthma Education and Prevention Programs (NAEPP) supported the two components of the measure, and the additional studies supported use of primary care visits and prescribing of medication reducing ED use/hospitalization. This measure passed on evidence. The performance rate for the measure was 16.5% based on 2009-2011 data from New York State (NYS) Medicaid. However, the Committee raised concerns about the accuracy of these data. The developer suggested that further data would clarify the information on this measure and stated that he could provide this data at the post-comment call.

Additionally, there were data on disparities specifically by race, urbanicity and poverty that demonstrated differences in these population groups. For this measure, the Committee did not reach consensus on the performance gap criterion.

One member suggested that some patients may receive medications in locations that do not bill for these prescription refills such as an ED and another member offered that some patients might not need a refill as early as two months. Other members discussed the importance of an asthma care plan and feasibility of obtaining one. Additionally, one member suggested that the measure may improve if the two components in this measure were constructed as an “Or” instead of an “And”. Due to the multiple concerns by members of the Committee on the components and because the measure was an all-or-none composite, the measure failed on 1c. Composite construct. Because the measure failed on a must pass criteria, the Committee did not continue the review.

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Appendix A: Details of Measure Evaluation

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

Measures Recommended

0326 Advance Care Plan

Submission | Specifications

Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Numerator Statement: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Denominator Statement: All patients aged 65 years and older.

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification

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

Setting of Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Claims (Only), EHRs Hybrid

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING [02/22/2017]

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

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

1a. Evidence: **Previous Evidence Evaluation Accepted;** 1b. Performance Gap: **H-4; M-12; L-1; I-0**

<u>Rationale</u>:

- In the 2012 evaluation, the developer provided evidence by the National Hospice and Palliative Care Organization (NHPCO) that an advance care plan (ACP) positively impacts the quality of end of life care.
- For the current review, the developers referenced a 2014 systematic review that evaluates the effect of ACP on hospitalization and length of stays. Evidence from the 21 studies showed that use of an ACP is linked to a decreased rate of hospitalizations.
- Committee members acknowledged the importance of ACP, and referenced updated information. This additional information supported the prior evidence. The Committee agreed that the updated evidence is directionally the same since the last NQF endorsement evaluation. The Committee accepted the prior evaluation of this criterion without further discussion or vote because the evidence is still relevant.
- Some Committee members expressed concern that there is missing disparities information.
- The Committee strongly encouraged the developer to collect and provide the disparities information in the future, but noted this lack of information does not change the evidence supporting the performance gap, which showed increased performance rates from 62.3% to 67.2% on documentation of the advance care plan from 2012 to 2014.

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: **Previous Reliability Evaluation Accepted;** 2b. Validity: **Previous Validity Evaluation Accepted**

<u>Rationale</u>:

0326 Advance Care Plan

- The Developers did not provide updated reliability testing for this maintenance review. Committee members noted that the previous testing is from a small sample of records from only four sites of care. However, the results indicated strong reliability with an overall kappa score of 0.97.
- Although the Committee noted that the previous testing was based a small number of testing sites to conduct testing, they agreed the results indicated strong reliability of the measure and the Committee accepted prior evaluation of the reliability subcriterion without further discussion.
- The Committee accepted a motion to carry over votes from the previous evaluation on reliability.
- An expert panel of 33 members assessed face validity of the measure. The panel rated their agreement based on the statement, "the scores obtained from the measure as specified will accurately differentiate quality across providers." Results from the expert panel indicated an average rating of 4.35 on a 5-point scale.
- Several Committee members noted that a significant reconsideration of validity was not warranted unless there is evidence that the use of CPT codes for ACP have changed substantially since testing was first conducted.
- The Committee accepted a motion to carry over votes from the previous evaluation on validity.

3. Feasibility: H-1; M-13; 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:

- This measure is currently in use in the CMS Medicare Physician Quality Reporting System (PQRS); Committee members expressed no concerns with the measure's feasibility.

4. Usability and Use: H-1; M-14; L0-; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is in use in both CMS' Medicare PQRS and the Quality Payment Program Merit-Based Incentive Payment System (MIPS). Members noted that the results from the measures used in an accountability program could advance goals of high quality healthcare.
- The developers noted an increased rate of performance (62.3% to 67.2%) from the eligible physicians who reported continuously from 2012-2014, which suggests physicians are initiating and documenting discussion of ACP with patients, family, and caregivers at a higher rate.
- The Committee did not voice concerns about unintended consequences or potential harms to patients as a result of this measure.

5. Related and Competing Measures

- This measure is related to two other measures:
  - 1626: Patients Admitted to ICU who Have Care Preferences Documented
  - 1641: Hospice and Palliative Care –Treatment Preferences

The Committee discussed some pertinent issues including that the information on advance care planning moves across settings. The suggestion that harmonization of the these measures through standardizing the terminology at the numerator level between all three measures might allow for capturing information across the continuum of care regarding an individual's preferences in their advanced care decisions and planning. The Committee suggested that this could be the first step towards making a plan portable.

Standing Committee Recommendation for Endorsement: **Y-15; N-0**

6. Public and Member Comment

- NQF received two post-evaluation comments supporting the Committee's recommendation to endorse the measure. However, one commenter noted that claims data do not reliably capture the care plan and the physician does not always bill for this service. Another commenter suggested being mindful of implementation challenges and any unintended consequences.

0326 Advance Care Plan
Developer Response: We appreciate your support of endorsement for #0326: Advance Care Plan as a clinician/group practice level measure. We understand the challenges of retrieving this information through claims data and have expanded the list of codes that count toward the numerator for this measure. This list includes the CPT II codes: 1123F, 1124F and the CPT codes 99497, or 99497 and 99498. Medicare began allowing reimbursement for advance care planning discussions through codes 99497 and 99498 effective January 1, 2016. We expect this will encourage more physicians to record these codes when providing this service.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

Measures Not Recommended

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Submission | Specifications
Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories **Numerator Statement**: Discharges in which the patient or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications TO BE TAKEN by Patient - Continued* Medications prescribed before inpatient stay that patient should continue to take after discharge, AND - Changed* Medications prescribed before inpatient stay with a change in dosage or directions after discharge that differs from what the patient was taking prior to the inpatient stay, AND - New* Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge * Prescribed dosage, instructions, and intended duration must be included for each continued, changed and new medication listed Medications NOT TO BE TAKEN by Patient - Discontinued Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND - Allergies and Adverse Reactions Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued **Denominator Statement**: All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care **Exclusions**: Patients who died Patients who left against medical advice (AMA) or discontinued care **Adjustment/Stratification**: No risk adjustment or risk stratification **Level of Analysis:** Facility, Integrated Delivery System

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Setting of Care: Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: The measure does not meet the Importance to Measure and Report criteria

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

1a. Evidence: **H-0; M-0; L-1; I-15**; 1b. Performance Gap: **H-0; M-3; L-4; I-9;** Revote**: H-0; M-6; L-4; I-6;** Evidence Exception: **Y-13; N-3**

Rationale:

- During the 2012 review, the developer cited the evidence base from the 2006 Transitions of Care Consensus Conference (TOCCC) development of principles, guidelines, and standards. The developer did not provide a systematic review of the body of evidence that matches the measure focus or reconciled medication lists at the time of discharge, or on the quantity, quality, or consistency of the evidence provided. The TOCCC expert opinion based guidelines were ungraded and were based on evidence related to transitions of care between the inpatient and outpatient settings.
- For the current evaluation, the developer attested that there have been no changes in the evidence since the 2012 review. During the Committee review, a Committee member identified several studies (Mueller et al., 2012, Vedel and Khanassov 2015, Kansagara 2015, Michaelsen 2015, and Mekonnen et al., 2016) that were relevant to the measure focus. However, the developer noted that the updated studies were discussing different types of interventions and not specifically discussing the current measure— reconciled medication list received by the patient.
- The Committee acknowledged the absence of updated, empirical evidence for this measure. However, the measure is important and the evidence presented is still relevant. The Committee agreed to invoke the exception to the evidence subcriterion.
- The developer stated there are no available performance scores. The California Department of Health Care Services administered this measure in the CMS Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program in 2016. The developers noted that there is a two-year delay before data is available to measure developers.
- The developer provided additional evidence during the in-person meeting regarding medication discrepancies by gender (Lindquist et al., 2013). Although the developer provided disparities data, the Committee agreed that there was still insufficient evidence on disparities.
- Due to the absence of performance scores and insufficient disparities data, this measure ultimately did not pass the performance gap subcriterion.

2. Scientific Acceptability of Measure Properties:

(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:

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

(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:

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

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

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5. Related and Competing Measures

- No related or competing measures noted.

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

Rationale

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6. Public and Member Comment

- NQF received three post-evaluation comments regarding this measure. One of the commenters supported the decision of the Committee not to endorse the measure. Two of the commenters supported the measure.

  Committee Response: The Committee recognizes the importance of transitions of care measures and encourages the developer to monitor the performance of these measures. The Committee did not recommend the four transition of care measures for continued endorsement because the developer did not provide updated performance data and sufficient reliability testing data for each measure as required per NQF's current measure evaluation criteria. The Committee recognizes the importance of these transition of care measures in the coordination of care. The Committee notes that the performance gap requirements include demonstrating quality problems and opportunity for improvement. As part of NQF's endorsement maintenance process, there is an increased emphasis on data for current performance, gaps in care, and variation. The Committee encourages the developer to continue collecting data to demonstrate that the measures meet NQF criteria for performance gap, which is a must-pass subcriterion. The Committee looks forward to the possibility of re-evaluating these important transitions of care measures in the future.

  NQF Response: Performance scores on the measure as specified are required for maintenance of endorsement per NQF criteria. In addition, the developer did not submit disparities data as required by NQF. Please note that NQF does not require additional testing for maintenance measures if prior testing is adequate; however, prior testing must meet current NQF evaluation criteria.

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

8. Appeals

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)

Submission | Specifications

Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s), received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements

Numerator Statement: Discharges in which the patient or their caregiver(s) received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements:

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)

Inpatient Care
- Reason for inpatient admission, AND
- Major procedures and tests performed during inpatient stay and summary of results, AND
- Principal diagnosis at discharge

Post-Discharge/ Patient Self-Management
- Current medication list, AND
- Studies pending at discharge (eg, laboratory, radiological), AND
- Patient instructions

Advance Care Plan
- Advance directives or surrogate decision maker documented OR
- Documented reason for not providing advance care plan

Contact Information/Plan for Follow-up Care
- 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND
- Contact information for obtaining results of studies pending at discharge, AND
- Plan for follow-up care, AND
- Primary physician, other healthcare professional, or site designated for follow-up care

Denominator Statement: All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: <u>This measure did not reach consensus on the Importance to Measure and Report criteria</u>

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

1a. Evidence: **H-0; M-0; L-1; I-15**; 1b. Performance Gap: **H-0; M-8; L-3; I-4;**

Evidence Exception: **Y-15; N-1**

<u>Rationale</u>:

- For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and were based on evidence related to transitions of care between the inpatient and outpatient settings.
- One Committee member noted that, although the evidence provided is not specific to the measure focus, it does support that the process of providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee noted that communication of essential patient

information is critical to continuity of appropriate and quality care. Committee members stated that this should be a basic standard of practice and agreed that empirical evidence is not needed to hold providers accountable for the measure. Considering the absence of empirical evidence provided to support this important measure concept, the Committee agreed to invoke the exception to the evidence subcriterion.

- The developer was not able to provide any data on current performance of the measure. To demonstrate opportunity for improvement, the developer provided a summary of data from the literature showing that delayed or insufficient transfer of discharge information between hospital-based providers and primary care physicians remains common. However, Committee members noted that the data from the literature was not recent.
- The developer also summarized a prospective study that tracked the frequency of occurrence of certain elements that are included within the measure. Although performance scores varied on whether the required elements were provided to patients or not, Committee members noted that the sample size of the study was small (1 facility and 377 patients) and remained concerned that data was not provided on the measure as specified. Performance scores on the measure as specified (current and over time) at the specified level of analysis are required for maintenance of endorsement. The Committee was unable to reach consensus on the performance gap subcriterion.

2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-0; M-4; L-6; I-5;** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**

<u>Rationale</u>:

- For the 2012 endorsement evaluation, data from a report automatically generated from one EHR was compared to manual abstraction from patient records to calculate parallel forms of reliability for the measure. One overall statistic was provided (88% agreement, kappa=.69). Because it was unclear what the overall statistic was referring to, the developer provided additional testing results on each data element prior to the meeting (numerator, denominator and exceptions).
- Committee members noted concerns about the generalizability of the validity testing, as the empirical testing of the measure was done using data from only one site's EHR, which was customized to facilitate the review and printing of the transition record. The developers clarified that the measure was not specified as an eMeasure because every facility may have a different template for a transition record in their EHR. The Committee noted that the measure is most likely to be implemented in EHRs, much has changed around EHRs since the time the testing was conducted, and there is much variation in terms of how things are documented within EHRs.
- The Committee encouraged developers to conduct updated testing that would include multiple sites to demonstrate how the measure would perform on a national scale versus just one facility. The Committee did not find the reliability testing provided sufficient to pass the reliability subcriterion.

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

(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>:

-

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

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

<u>Rationale</u>:

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5. Related and Competing Measures

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)

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **No**

Rationale

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6. Public and Member Comment

- NQF received three post-evaluation comments regarding this measure. One of the commenters supported the decision of the Committee not to endorse the measure. Two of the commenters supported the measure.

Committee Response: The Committee recognizes the importance of transitions of care measures and encourages the developer to monitor the performance of these measures. The Committee did not recommend the four transition of care measures for continued endorsement because the developer did not provide updated performance data and sufficient reliability testing data for each measure as required per NQF's current measure evaluation criteria. The Committee recognizes the importance of these transition of care measures in the coordination of care. The Committee notes that the performance gap requirements include demonstrating quality problems and opportunity for improvement. As part of NQF's endorsement maintenance process, there is an increased emphasis on data for current performance, gaps in care, and variation. The Committee encourages the developer to continue collecting data to demonstrate that the measures meet NQF criteria for performance gap, which is a must-pass subcriterion. The Committee looks forward to the possibility of re-evaluating these important transitions of care measures in the future.

NQF Response: Performance scores on the measure as specified are required for maintenance of endorsement per NQF criteria. In addition, the developer did not submit disparities data as required by NQF. Please note that NQF does not require additional testing for maintenance measures if prior testing is adequate; however, prior testing must meet current NQF evaluation criteria.

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

8. Appeals

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Submission | Specifications

Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, of patients, regardless of age, for which a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge

Numerator Statement: Discharges in which a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge

Denominator Statement: All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Adjustment/Stratification: No risk adjustment or risk stratification

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: <u>The measure did not reach consensus on the Importance to Measure and Report criteria</u>

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

1a. Evidence: **H-0; M-0; L-1; I-14**; 1b. Performance Gap: **H-0; M-7; L-1; I-7;**

Evidence Exception: **Y-13; N-2**

<u>Rationale</u>:

- For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and were based on evidence related to transitions of care between the inpatient and outpatient settings.
- Committee members agreed that the evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee recognized that the evidence is not specific to the focus of the measure. Considering the absence of empirical evidence provided to support this important measure concept, the Committee agreed to invoke the exception to the evidence subcriterion.
- Similar to measure 0647, the developer was not able to provide any data on current performance of the measure. To demonstrate opportunity for improvement, the developer provided a summary of data from the literature showing that delayed or insufficient transfer of discharge information between hospital-based providers and primary care physicians remains common. However, Committee members noted that the data from the literature was not recent.
- A Committee member noted that, although no performance data was provided for this specific measure, data does exist that demonstrates there are performance gaps in this area of measurement. The Committee was unable to reach consensus on the performance gap subcriterion.

2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u>

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

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

<u>Rationale</u>:

- For the 2012 endorsement evaluation, data from a report automatically generated from one EHR was compared to manual abstraction from patient records to calculate parallel forms of reliability for the measure. One overall statistic was provided (95% agreement, kappa=.49). Because it was unclear what the overall statistic was referring to, the developer provided additional testing results on each data element prior to the Committee's meeting (numerator, denominator and exceptions).
- The Committee agreed to apply the previous discussion about the reliability testing for measure #0647 to this measure, as the testing methodology was the same. The Committee remained concerned about the small sample size (1 facility and 377 patients) and did not pass the measure on the reliability subcriterion.

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

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

(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:

-

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

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

-

5. Related and Competing Measures

- No related or competing measures noted.

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

Rationale

-

6. Public and Member Comment

- NQF received three post-evaluation comments regarding this measure. One of the commenters supported the decision of the Committee not to endorse the measure. Two of the commenters supported the measure.

  Committee Response: The Committee recognizes the importance of transitions of care measures and encourages the developer to monitor the performance of these measures. The Committee did not recommend the four transition of care measures for continued endorsement because the developer did not provide updated performance data and sufficient reliability testing data for each measure as required per NQF's current measure evaluation criteria. The Committee recognizes the importance of these transition of care measures in the coordination of care. The Committee notes that the performance gap requirements include demonstrating quality problems and opportunity for improvement. As part of NQF's endorsement maintenance process, there is an increased emphasis on data for current performance, gaps in care, and variation. The Committee encourages the developer to continue collecting data to demonstrate that the measures meet NQF criteria for performance gap, which is a must-pass subcriterion. The Committee looks forward to the possibility of re-evaluating these important transitions of care measures in the future.

  NQF Response: Performance scores on the measure as specified are required for maintenance of endorsement per NQF criteria. In addition, the developer did not submit disparities data as required by NQF. Please note that NQF does not require additional testing for maintenance measures if prior testing is adequate; however, prior testing must meet current NQF evaluation criteria.

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

8. Appeals

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Submission | Specifications

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Description: Percentage of discharges from an emergency department (ED) to ambulatory care or home health care, in which the patient, regardless of age, or their caregiver(s), received a transition record at the time of ED discharge including, at a minimum, all of the specified elements

Numerator Statement: Discharges in which the patient or their caregiver(s) received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements:

- Summary of major procedures and tests performed during ED visit, AND
- Principal clinical diagnosis at discharge which may include the presenting chief complaint, AND
- Patient instructions, AND
- Plan for follow-up care (OR statement that none required), including primary physician, other healthcare professional, or site designated for follow-up care, AND
- List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each

Denominator Statement: All discharges for patients, regardless of age, from an emergency department (ED) to ambulatory care (home/self care) or home health care

Exclusions: Exclusions:

Patients who died

Patients who left against medical advice (AMA) or discontinued care

Exceptions:

Patients who declined receipt of transition record

Patients for whom providing the information contained in the transition record would be prohibited by state or federal law

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Emergency Department

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: <u>The measure does not meet the Importance to Measure and Report criteria</u>

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

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

Evidence Exception: **Y-11; N-4**

<u>Rationale</u>:

- For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and were based evidence related to transitions of care between the inpatient and outpatient settings.
- Committee members agreed that the evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee recognized that the evidence is not specific to the focus of the measure. Considering the absence of empirical evidence provided to support this important measure concept, the Committee agreed to invoke the exception to the evidence subcriterion.

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
• Similar to measures #0647 and #0648, the developer was not able to provide any data on current performance of the measure. The Committee was also concerned that data looking at emergency department discharges related to this measure were not available to support an opportunity for improvement. Ultimately, the measure did not pass the performance gap subcriterion.
2. Scientific Acceptability of Measure Properties: (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: •
3. Feasibility: H-X; M-X; L-X; I-X *(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: •
4. Usability and Use: H-X; M-X; L-X; I-X *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* Rationale: •
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-X**; **N-X** Rationale •
6. Public and Member Comment • NQF received three post-evaluation comments regarding this measure. One of the commenters supported the decision of the Committee not to endorse the measure. Two of the commenters supported the measure. **Committee Response:** The Committee recognizes the importance of transitions of care measures and encourages the developer to monitor the performance of these measures. The Committee did not recommend the four transition of care measures for continued endorsement because the developer did not provide updated performance data and sufficient reliability testing data for each measure as required per NQF's current measure evaluation criteria. The Committee recognizes the importance of these transition of care measures in the coordination of care. The Committee notes that the performance gap requirements include demonstrating quality problems and opportunity for improvement. As part of NQF's endorsement maintenance process, there is an increased emphasis on data for current performance, gaps in care, and variation. The Committee encourages the developer to continue collecting data to demonstrate that the measures meet NQF criteria for performance gap, which is a must-pass subcriterion. The Committee looks forward to the possibility of re-evaluating these important transitions of care measures in the future. **NQF Response:** Performance scores on the measure as specified are required for maintenance of endorsement per NQF criteria. In addition, the developer did not submit disparities data as required by NQF. Please note that NQF does not require additional testing for maintenance measures if prior testing is adequate; however, prior testing must meet current NQF evaluation criteria.

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

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

8. Appeals

3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit

Submission | Specifications

Description: This measure describes the incidence rate of emergency department visits for children ages 2 to 21 who are being managed for identifiable asthma. This measure characterizes care that precedes Emergency Department visits for children ages 2- 21 who can be identified as having asthma, using the specified definitions. The developers sought to identify children with ongoing asthma who should be able to be identified by their healthcare providers and/or healthcare plans as having asthma. The operational definition of an identifiable asthmatic is a child who has utilized healthcare services that suggest the healthcare system has enough information to conclude that the child has an asthma diagnosis that requires ongoing care. Specifically, this measure identifies the use of primary care services and medications prior to ED visits and/or hospitalizations for children with asthma.

Numerator Statement: Evidence of connection to the primary care medical system prior to first ED visit and/or hospitalization that has a primary or secondary diagnosis of asthma among children whom our specifications identify with asthma.

Denominator Statement: All first ED visits and/or hospitalizations, in which asthma was a primary or secondary diagnosis in children age 2-21 who meet criteria for being managed for identifiable asthma in the assessment period and have been enrolled for the 6 consecutive months prior to the ED visit/admission.

Exclusions: Children with specific concurrent or pre-existing diagnosis, as specified in S.9.

Children who have not been consecutively enrolled with the reporting entity for at least six months prior to the index reporting month.

Children who do not meet the denominator criteria.

Adjustment/Stratification: Other Stratification for reasons beyond risk adjustment

Level of Analysis: Population : Community, County or City, Population : Regional and State

Setting of Care: Clinician Office/Clinic, Emergency Department, Hospital

Type of Measure: Composite

Data Source: Claims (Only)

Measure Steward: University Hospitals Cleveland Medical Center

STANDING COMMITTEE MEETING 02/22/2017

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

(1a. Evidence, 1b. Performance Gap; 1c. Composite)

1a. Evidence: **H-1; M-10; L-5; I-1**; 1b. Performance Gap: **H-4; M-11; L-1; I-1;** 1c. Composite Performance Measure-Quality Construct: **H-1; M-10; L-6; I-0**

<u>Rationale</u>:

- The evidence base for this composite measure is the connection to the primary care system, including use of primary care services and medications prior to an ED visit/hospitalization for children with asthma. Composite measures require that the evidence subcriteria (1a.) is met is for each component.
- The Guidelines from the National Asthma Education and Prevention Programs (NAEPP) provided graded evidence for regular follow up and the medication management approach. Specifically, evidence supporting periodic assessment and ongoing monitoring (at 1-6 month) intervals of asthma control were recommended (graded at a category B and C). Secondly, evidence (graded at a category A), was provided

to support the daily use of long-term control medications on a long-term basis to achieve and maintain control of persistent asthma. Lastly, evidence that supports Short Acting Beta Agonist (SABAs) as the drug of choice for treating acute asthma symptoms and exacerbations is graded at a category A.

- The developer provided three additional studies that support the use of primary care; primary care with medication management; and asthma guidelines to improve care and reduce ED use, especially in minority children.
- The Committee discussed the strength of the evidence for each component based on the guideline-based care for asthma and concluded that the evidence is strong.
- The performance rate for the measure was 16.5% based on 2009-2011 data from New York State (NYS) Medicaid.
- The Committee agreed this demonstrated a substantial opportunity for improvement.
- Additionally, data on disparities specifically by race, urbanicity and poverty demonstrated differences in these population groups.
- The developer described the three components of this all-or-none measure as "key determinants" of connections to the primary care system that can occur prior to ED visits/hospitalizations.
- The Committee discussed whether the measure could be broader and include other elements such as the effects of the environment. Members also discussed whether these are the best components for the construct. Other Committee members commented that this measure is a "good start" and the components are available and feasible to obtain.

2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u>

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

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

<u>Rationale</u>:

- NQF requires composite measures be tested for reliability at the measure score level. The developer indicated that testing is complete at both the county and plan level through data in New York State. However, the developer was unable to provide this testing during the in-person meeting.
- The developer stated that he plans to obtain this data to present to the Committee at the post comment call. Because measure level testing was not available, the measure did not pass on reliability.
- The review of the measure did not continue because reliability is must pass criteria.

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

(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>:

-

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

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

<u>Rationale</u>:

-

5. Related and Competing Measures

- No related or competing measures noted.

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

<u>Rationale</u>

-

6. Public and Member Comment

3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit

- NQF received two comments expressing their concern with the developer's intent to present reliability testing results to the Committee at the post-comment call. The developer did not provide measure score reliability testing data as required for composite measures. The commenters recommend a second public and member commenting period if new data are presented.

  Committee Response: Thank you for your comment. During the comment period, the developer did not submit new data as stated at the in-person meeting. Due to the lack of new data, the measures will not undergo further review. Because measure level testing was unavailable, The measures as currently specified do not meet NQF's measure evaluation criteria and are not recommended for endorsement. The Committee looks forward to re-evaluating these measures in the future.

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

8. Appeals

3171 Percentage of Asthma ED visits followed by Evidence of Care Connection

Submission | Specifications

Description: This measure seeks to capture important aspects of follow up after ED visits for asthma, including prompt follow up with primary care clinicians and prescription fills for controller medications. This measure characterizes care that follows Emergency Department (ED) visits with a primary or secondary diagnosis of asthma for children ages 2-21 that occur in the Reporting Year and who are enrolled in the health plan for two consecutive months following the ED visit.

The developer stated visits were stratified into those that occurred for children who can or cannot be identified as having asthma, using the specified definitions. Identifiable asthmatic was operationalized as a child who has utilized healthcare services that suggest the healthcare system has enough information to conclude that the child has an asthma diagnosis that requires ongoing care. A 2 year look back period before the reporting year was also incorporated into the measure.

Specifically, this measure describes the connection with the primary care system (timely visits to primary care providers and filling of controller asthma medications) following ED visits for children with asthma.

Numerator Statement: Evidence of connection to the primary care medical system following ED visits that have a primary or secondary diagnosis of asthma among children, overall and stratified by whether the child had identifiable asthma at the time of the ED visit.

Denominator Statement: All ED visits in which asthma was a primary or secondary diagnosis in children who are continuously enrolled for at least the 2 months following the ED visit.

Exclusions: Children with concurrent or pre-existing diagnosis.

Children who have not been consecutively enrolled with the reporting entity for at least two months following the ED visit.

Children who do not meet the denominator criteria.

Adjustment/Stratification: Other Strtification for reasons other then risk adjustment

Level of Analysis: Population : Community, County or City, Population : Regional and State

Setting of Care: Clinician Office/Clinic, Emergency Department, Hospital

Type of Measure: Composite

Data Source: Claims (Only)

Measure Steward: University Hospitals Cleveland Medical Center

STANDING COMMITTEE MEETING 02/22/2017

3171 Percentage of Asthma ED visits followed by Evidence of Care Connection

1. Importance to Measure and Report: <u>The measure does not meet the Importance to Measure and Report criteria</u>

(1a. Evidence, 1b. Performance Gap; 1c. Composite)

1a. Evidence: **H-2; M-14; L-1; I-0**; 1b. Performance Gap: **H-0; M-8; L-2; I-6;** 1c. Composite: **H-0; M-6; L-9; I-2**

<u>Rationale</u>:

- This composite measure includes two components: visit(s) to a primary care provider that occurred within 14 days following the ED visit and have at least one fill of an asthma controller medication within 2 months after the ED visit (including the day of visit).
- The Guidelines from the National Asthma Education and Prevention Programs (NAEPP) provided graded evidence for regular follow up and the medication management approach. Specifically, evidence supporting periodic assessment and ongoing monitoring (at 1-6 month) intervals of asthma control was graded at a category B and C. Evidence (graded at a category A) was provided to support the daily use of long-term control medications on a long-term basis to achieve and maintain control of persistent asthma.
- The developer provided additional studies that support the use of primary care for asthma management. The studies focused on primary care with medication management; asthma guidelines to improve care and reduce ED use, especially in minority children; and several studies support that after an exacerbation, follow-up with a primary care physician is central for ongoing management.
- During the Committee discussion, one member noted that a strength of the measure is that it assesses a subsequent event of care provided --a substantive event.
- The performance rate for the measure was 16.5% based on 2009-2011 data from New York State (NYS) Medicaid. However, the Committee raised concerns about the accuracy of these data. The developer suggested that further data would clarify the information on this measure and stated that he could provide this data at the post-comment call.
- Additionally, data on disparities specifically by race, urbanicity and poverty demonstrated differences in these population groups.
- The developer described the two components of this all-or-none measure as "key determinants" of connections to the primary care system that can occur following ED visits for children with asthma.
- The Committee discussed the components of the composite measure. One member suggested that some patients may receive medications in locations that do not bill for these prescription refills such as an ED and another member offered that some patients might not need a refill as early as two months. Other members discussed the importance of an asthma care plan and feasibility of obtaining one. Additionally, one member suggested that the measure may improve if the two components in this measure were constructed as an "Or" instead of an "And". Due to the multiple concerns by members of the Committee on the components and because the measure was an all-or-none composite, the measure failed on 1c. Composite construct. Because the measure failed on a must pass criteria, the Committee did not continue the review.

2. Scientific Acceptability of Measure Properties

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

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

<u>Rationale</u>:

-

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

(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>:

-

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

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

3171 Percentage of Asthma ED visits followed by Evidence of Care Connection
Rationale: •
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-X**; **N-X** Rationale •
6. Public and Member Comment • NQF received two comments expressing their concern with the developer's intent to present reliability testing results to the Committee at the post-comment call. The developer did not provide measure score reliability testing data as required for composite measures. The commenters recommend a second public and member commenting period if new data are presented. **Committee Response:** Thank you for your comment. During the comment period, the developer did not submit new data as stated at the in-person meeting. Due to the lack of new data, the measures will not undergo further review. Because measure level testing was unavailable, The measures as currently specified do not meet NQF's measure evaluation criteria and are not recommended for endorsement. The Committee looks forward to re-evaluating these measures in the future.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

Measures Withdrawn from Consideration

A single measure previously endorsed by NQF has not been re-submitted for maintenance of endorsement during the endorsement evaluation process. Endorsement for this measure will be removed.

Measure	Reason for withdrawal
0526 Timely Initiation of Care	Developer states, "the measure currently exhibits limited variability and would likely fail the 1b. Performance Gap section of the NQF endorsement process."

Appendix B: NQF Care Coordination Portfolio and Related Measures

*Denotes measures that are applicable to care coordination, but will are not included in the Care Coordination Portfolio.

Communication

Measure Number	Measure Title
0291	Emergency Transfer Communication
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)

Transitions or Handoffs

Measure Number	Measure Title
0097	Medication Reconciliation
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
0553	Care for Older Adults – Medication Review
0646	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
2456	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
3170 *New for Review*	Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit
3171 *New for Review*	Percentage of Asthma ED visits followed by Evidence of Care Connection

Proactive Plan of Care and Follow-Up

Measure Number	Measure Title
0326	Advance Care Plan
1626*	Patients Admitted to ICU who Have Care Preferences Documented
1641*	Hospice and Palliative Care – Treatment Preferences

Appendix C: Care Coordination Portfolio—Use in Federal Programs

NQF #	Title	Federal Programs: Finalized as of February 14, 2017
0097	Medication Reconciliation	Medicare Physician Quality Reporting System (PQRS), Merit-Based Incentive Payment System (MIPS) Program, Physician Compare, Physician Feedback/Quality and Resource Use Reports (QRUR), Physician Value-Based Payment Modifier (VBM), Medicare Shared Savings Program (MSSP)
0171	Acute care hospitalization (risk-adjusted)	Home Health Quality Reporting, Home Health Value Based Purchasing
0173	Emergency Department Use without Hospitalization	Home Health Quality Reporting, Home Health Value Based Purchasing
0291	Emergency transfer Communication	No federal program usage specified for this measure.
0326	Advance Care Plan*	Home Health Value Based Purchasing, Merit-Based Incentive Payment System (MIPS) Program, Medicare Physician Quality Reporting System (PQRS), Physician Feedback/Quality and Resource Use Reports (QRUR), Physician Value-Based Payment Modifier (VBM)
0487	EHR with EDI prescribing used in encounters where a prescribing event occurred	No federal program usage specified for this measure.
0495	Median time from ED arrival to ED departure for admitted ED patients	Hospital Compare, Hospital Inpatient Quality Reporting, Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0496	Median time from ED arrive to ED departure for discharged ED patients	Hospital Compare, Hospital Outpatient Quality Reporting, Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0497	Admit decision time to ED departure time for admitted patients	Hospital Compare, Hospital Inpatient Quality Reporting, Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0553	Care for Older Adults – Medication Review	Medicare Part C Star Rating
0646	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)*	No federal program usage specified for this measure.
0647	Transition Record with Specified Elements Received by Discharged Patients (Discharged from an Inpatient Facility to Home/Self Care or Any other Site of Care)*	Hospital Compare, Inpatient Psychiatric Facility Quality Reporting

0648	Timely Transmission of Transition Record (Discharged from an Inpatient Facility to Home/Self Care or Any other Site of Care)*	Hospital Compare, Inpatient Psychiatric Facility Quality Reporting, Medicaid
0649	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharged to Ambulatory Care or Home Health Care)*	No federal program usage specified for this measure.
2456	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	No federal program usage specified for this measure.

Appendix D: Project Standing Committee and NQF Staff

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Appendix E: Measure Specifications

	0326 Advance Care Plan
Steward	National Committee for Quality Assurance
Description	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.
Type	Process
Data Source	Claims (Only), EHRs Hybrid None No data collection instrument provided. No data dictionary
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Clinician Office/Clinic
Numerator Statement	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.
Numerator Details	Report the CPT Category II codes designated for this numerator: - 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record - 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan Documentation that patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan may also include, as appropriate, the following: That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient´s beliefs and thus harmful to the physician-patient relationship.
Denominator Statement	All patients aged 65 years and older.
Denominator Details	Denominator Criteria (Eligible Cases): Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439 *Clinicians indicating the place of service as the emergency department will not be included in this measure.
Exclusions	N/A
Exclusion details	N/A
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population. The eligible population is all patients aged 65 years and older.

	0326 Advance Care Plan
	Step 2: Determine number of patients meeting the denominator criteria as specified in Question S.7. above. Step 3: Determine the number of patients who meet the numerator criteria as specified in Question S.5. above. The numerator includes all patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2. Rate/proportion
Copyright / Disclaimer	5.1 Identified measures: 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) 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: NQF#0647 targets all age groups and focuses specifically on transition of care to another facility or to the home. This measure, NQF#0326, focuses specifically on older adults and creating an advanced care plan or identifying a designated surrogate decision maker to dictate care to be provided, including but not limited to transitions. 5b.1 If competing, why superior or rationale for additive value: N/A

	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Steward	PCPI
Description	Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories
Type	Process
Data Source	EHRs Hybrid, Paper Records See attached data collection tool. Available in attached appendix at A.1 No data dictionary
Level	Facility, Integrated Delivery System
Setting	Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF
Numerator Statement	Discharges in which the patient or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications TO BE TAKEN by Patient - Continued* Medications prescribed before inpatient stay that patient should continue to take after discharge, AND - Changed* Medications prescribed before inpatient stay with a change in dosage or directions after discharge that differs from what the patient was taking prior to the inpatient stay, AND - New* Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge * Prescribed dosage, instructions, and intended duration must be included for each continued, changed and new medication listed Medications NOT TO BE TAKEN by Patient - Discontinued Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND - Allergies and Adverse Reactions Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued
Numerator Details	Time Period for Data Collection: At each discharge during measurement period Numerator Instructions: • For the purposes of this measure, “medications” includes prescription, over-the-counter, and herbal products. Generic and proprietary names should be provided for each medication, when available. • Given the complexity of the medication reconciliation process and variability across inpatient facilities in documentation of that process, this measure does not require that the medication list be organized under the “taken/NOT taken” headings OR the specified sub-categories, provided that the status of each medication (continued, changed, new, or discontinued) is specified within the list AND any allergic reactions are identified. For Administrative:

	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	Numerator Elements to be identified through medical record abstraction: see Sample Data Collection Tool attached in Appendix A.1. This measure may also be implemented in EHRs: This measure does not lend itself to a "traditional specification" for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for medication reconciliation and the information required for this measure is based on individualized patient information unique to one episode of care (i.e., inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure. Producing the Reconciled Medication List: Facilities that have implemented an EHR system should utilize their system to develop a standardized template for the Reconciled Medication List. A standardized template will ensure that all required data elements specified in the measure are included whenever a Reconciled Medication List is generated from the EHR. Each facility has the autonomy to customize the format of the Reconciled Medication List, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution. Systematic External Reporting that the Reconciled Medication List was provided to patient: In order to report, at the facility level, which of the discharged patients have received a Reconciled Medication List, a discrete data field and code indicating the patient received a reconciled medication list at discharge may be needed in the EHR. Each facility should determine the most effective way to identify whether or not the patient received the reconciled medication list. Transmitting the Reconciled Medication List: This performance measure does not require that the Reconciled Medication List be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model (https://ecqi.healthit.gov/qdm). RxNorm has been named as the recommended vocabulary for medications and can be used to identify the medications to which the allergies exist. Allergies (non-substance) and Adverse Reactions to medications should be expressed using SNOMED-CT. The use of recognized interoperability standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR.
Denominator Statement	All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care
Denominator Details	Time Period for Data Collection: At each discharge during measurement period Note: Facilities are responsible for determining the appropriate use of codes. For Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0114 (Hospital Inpatient (Including Medicare Part A), Interim - Last Claim) • 0121 (Hospital Inpatient (Medicare Part B only), Admit through Discharge Claim)

	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	• 0124 (Hospital Inpatient (Medicare Part B only), Interim - Last Claim) • 0181 (Hospital - Swing Beds, Admit through Discharge Claim) • 0184 (Hospital - Swing Beds, Interim - Last Claim) • 0211 (Skilled Nursing-Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient (Including Medicare Part A), Interim - Last Claim) • 0221 (Skilled Nursing-Inpatient (Medicare Part B only), Admit through Discharge Claim) • 0224 (Skilled Nursing- Inpatient (Medicare Part B only), Interim - Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim - Last Claim) AND Discharge Status (Form Locator 17) • 01 (Discharged to home or self care (routine discharge) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to a facility that provides custodial or supportive care) • 05 (Discharged/transferred to a designated cancer center or children's hospital) • 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care) • 21 (Discharged/transferred to court/law enforcement) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 69 (Discharged/transferred to a designated disaster alternative care site) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list) • 81 (Discharged to home or self care with a planned acute care hospital inpatient readmission) • 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission) • 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission) • 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)

	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	• 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission) • 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission) • 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission) • 88 (Discharged/transferred to a federal healthcare facility with a planned acute care hospital inpatient readmission • 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission) • 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission) • 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission) • 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission) • 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission) • 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission) • 95 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission) OR UB-04 (Form Locator 04 - Type of Bill): • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim - Last Claim) AND UB-04 (Form Locator 42 - Revenue Code): • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) AND Discharge Status (Form Locator 17) • 01 (Discharged to home or self care (routine discharge) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to a facility that provides custodial or supportive care) • 05 (Discharged/transferred to a designated cancer center or children's hospital • 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care) • 21 (Discharged/transferred to court/law enforcement) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice – home)

	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	• 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 69 (Discharged/transferred to a designated disaster alternative care site) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list) • 81 (Discharged to home or self-care with a planned acute care hospital inpatient readmission) • 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission) • 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission) • 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission) • 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission) • 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission) • 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission) • 88 (Discharged/transferred to a federal healthcare facility with a planned acute care hospital inpatient readmission • 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission) • 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission) • 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission) • 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission) • 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission) • 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission) • 95 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission) This measure may also be implemented in EHRs:

	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	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.
Exclusions	Patients who died Patients who left against medical advice (AMA) or discontinued care
Exclusion details	Time Period for Data Collection: At each discharge during measurement period According to the PCPI methodology, exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (i.e., the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure Reconciled Medication List Received by Discharged Patients, exclusions include patients who died and patients who left against medical advice or discontinued care. Exclusions, including applicable value sets, are included in the measure specifications. Additional details by data source are as follows: For Administrative Data: UB-04 (Form Locator 17 - Discharge Status): • 07 (Left against medical advice or discontinued care) • 20 (Expired) • 40 (Expired at home) • 41 (Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)) • 42 (Expired - place unknown) This measure may also be implemented in EHRs: Discharges meeting denominator exclusions criteria should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification
Stratification	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1. Find the patients who meet the initial population (i.e., the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator. (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. Find the patients who qualify for denominator exclusions and subtract from the denominator. 4. From the patients within the denominator, find the patients who meet the numerator criteria (i.e., the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	If the patient does not meet the numerator, this case represents a quality failure. Rate/proportion
Copyright / Disclaimer	5.1 Identified measures: 0293 : Medication Information 0097 : Medication Reconciliation Post-Discharge 0419 : Documentation of Current Medications in the Medical Record 0553 : Care for Older Adults (COA) – Medication Review 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Overall, our measure differs from existing medication reconciliation measures in that it focuses on whether or not a reconciled medication list was provided to discharged patients rather than just on whether or not reconciliation was performed. We feel that our measure better reflects the patient-focused aspect of medication reconciliation. In addition, our measure is intended for implementation at the facility-level, whereas 0097 and 0553 are intended for use at the health plan and integrated delivery system-level, while 0419 is intended for EP-level reporting. In addition, 0553 focuses on elderly patients, whereas our measure includes all adult patients. Given the differences in focus and measurement-level, we feel that our measure is complementary to other measures related to medication reconciliation and management by focusing on the patient receipt of a reconciled medication list. 5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no existing NQF-endorsed measures that address both the same target population and measure focus.

	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)
Steward	PCPI
Description	Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s), received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements
Type	Process
Data Source	EHRs Hybrid, Paper Records See attached data collection tool. No data dictionary
Level	Facility, Integrated Delivery System
Setting	Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF
Numerator Statement	Discharges in which the patient or their caregiver(s) received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements: Inpatient Care - Reason for inpatient admission, AND - Major procedures and tests performed during inpatient stay and summary of results, AND - Principal diagnosis at discharge Post-Discharge/ Patient Self-Management - Current medication list, AND - Studies pending at discharge (eg, laboratory, radiological), AND - Patient instructions Advance Care Plan - Advance directives or surrogate decision maker documented OR - Documented reason for not providing advance care plan Contact Information/Plan for Follow-up Care - 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND - Contact information for obtaining results of studies pending at discharge, AND - Plan for follow-up care, AND - Primary physician, other healthcare professional, or site designated for follow-up care
Numerator Details	Time Period for Data Collection: At each discharge during measurement period Numerator Element Definitions: - Transition record: a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other healthcare professional providing follow-up care. Electronic format may be provided only if acceptable to patient. - Current medication list: all medications to be taken by patient after discharge, including all continued and new medications

	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)
	- Advance directives: e.g., written statement of patient wishes regarding future use of life-sustaining medical treatment - Documented reason for not providing advance care plan: documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship - Contact information/ plan for follow-up care: For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the “receiving” facilities. - Plan for follow-up care: may include any post-discharge therapy needed (eg, oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc. - Primary physician or other healthcare professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or healthcare professional For Claims/Administrative: Numerator Elements to be identified through medical record abstraction: see Sample Data Collection Tool attached in Appendix A.1. 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 the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (i.e., inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure. Producing the Transition Record with Specified Elements Facilities that have implemented an EHR should utilize their system to produce a standardized template that providers will complete to generate the Transition Record. A standardized template will ensure that all data elements specified in the performance measure are included each time a Transition Record is prepared. Each facility has the autonomy to customize the format of the Transition Record, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution Transmitting the Transition Record with Specified Elements This performance measure does not require that the Transition Record be transmitted to the next provider(s) of care. However, if the Transition Record 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. In addition, the use of recognized interoperability standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR. Systematic External Reporting of the Transition Record

	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)
	In order to report, at the facility level, which of the discharged patients have received a Transition Record, a discrete data field and code indicating the patient received a Transition Record at discharge may be needed in the EHR.
Denominator Statement	All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care
Denominator Details	Time Period for Data Collection: At each discharge during measurement period Note: Facilities are responsible for determining the appropriate use of codes. For Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0114 (Hospital Inpatient (Including Medicare Part A), Interim - Last Claim) • 0121 (Hospital Inpatient (Medicare Part B only), Admit through Discharge Claim) • 0124 (Hospital Inpatient (Medicare Part B only), Interim - Last Claim) • 0181 (Hospital - Swing Beds, Admit through Discharge Claim) • 0184 (Hospital - Swing Beds, Interim - Last Claim) • 0211 (Skilled Nursing-Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient (Including Medicare Part A), Interim - Last Claim) • 0221 (Skilled Nursing-Inpatient (Medicare Part B only), Admit through Discharge Claim) • 0224 (Skilled Nursing- Inpatient (Medicare Part B only), Interim - Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim - Last Claim) AND Discharge Status (Form Locator 17) • 01 (Discharged to home or self care (routine discharge) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to a facility that provides custodial or supportive care) • 05 (Discharged/transferred to a designated cancer center or children's hospital) • 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care) • 21 (Discharged/transferred to court/law enforcement) • 43 (Discharged/transferred to a federal healthcare 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)

	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)
	• 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 69 (Discharged/transferred to a designated disaster alternative care site) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list) • 81 (Discharged to home or self care with a planned acute care hospital inpatient readmission) • 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission) • 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission) • 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission) • 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission) • 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission) • 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission) • 88 (Discharged/transferred to a federal healthcare facility with a planned acute care hospital inpatient readmission • 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission) • 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission) • 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission) • 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission) • 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission) • 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission) • 95 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission) OR UB-04 (Form Locator 04 - Type of Bill): • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim - Last Claim) AND

	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)
	UB-04 (Form Locator 42 - Revenue Code): • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) AND Discharge Status (Form Locator 17) • 01 (Discharged to home or self care (routine discharge) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to a facility that provides custodial or supportive care) • 05 (Discharged/transferred to a designated cancer center or children's hospital • 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care) • 21 (Discharged/transferred to court/law enforcement) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 69 (Discharged/transferred to a designated disaster alternative care site) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list) • 81 (Discharged to home or self-care with a planned acute care hospital inpatient readmission) • 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission) • 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission) • 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission) • 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission) • 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission) • 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)

	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)
	• 88 (Discharged/transferred to a federal healthcare facility with a planned acute care hospital inpatient readmission • 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission) • 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission) • 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission) • 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission) • 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission) • 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission) • 95 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission) This measure may also be implemented in EHRs: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.
Exclusions	Patients who died Patients who left against medical advice (AMA) or discontinued care
Exclusion details	Time Period for Data Collection: At each discharge during measurement period According to the PCPI methodology, exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (i.e., the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure Transition Record with Specified Elements Received by Discharged Patients, exclusions include patients who died and patients who left against medical advice or discontinued care. Exclusions, including applicable value sets, are included in the measure specifications. Additional details by data source are as follows: For Administrative: UB-04 (Form Locator 17 - Discharge Status): • 07 (Left against medical advice or discontinued care) • 20 (Expired) • 40 (Expired at home) • 41 (Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)) • 42 (Expired - place unknown) This measure may also be implemented in EHRs: Discharges meeting denominator exclusions criteria should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.
Risk Adjustment	No risk adjustment or risk stratification

	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)
	No risk adjustment or risk stratification
Stratification	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator. (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. Find the patients who qualify for denominator exclusions and subtract from the denominator. 4. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. If the patient does not meet the numerator, this case represents a quality failure. Rate/proportion
Copyright / Disclaimer	5.1 Identified measures: 0291 : EMERGENCY TRANSFER COMMUNICATION MEASURE 0293 : Medication Information 0297 : Procedures and Tests 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: While our measure focuses of the receipt of a transition record by patients who are discharged from an inpatient facility, measure 0291 focuses on the timely transfer of information to the receiving facility for patients who are transferred from the ED to another facility and 0293 and 0297 focus specifically on the communication of medication information and procedure/test information, respectively, for patients who are transferred from the ED to another facility. We feel that the measures are complementary in addressing the quality of care transitions. 5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no existing NQF-endorsed measures that address both the same target population and measure focus.

	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Steward	PCPI
Description	Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, of patients, regardless of age, for which a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge
Type	Process
Data Source	EHRs Hybrid, Paper Records See attached data collection tool. Available in attached appendix at A.1 No data dictionary
Level	Facility, Integrated Delivery System
Setting	Hospital : Acute Care Facility, Ambulatory Surgery Center, Hospital : Critical Care, Hospital, Behavioral Health : Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home / SNF
Numerator Statement	Discharges in which a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge
Numerator Details	Time Period for Data Collection: Within 24 hours of each discharge during measurement period Numerator Element Definitions: - Transition record: a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other healthcare professional providing follow-up care. Electronic format may be provided only if acceptable to patient. - Transmitted: transition record may be transmitted to the facility or physician or other healthcare professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR) - Primary physician or other healthcare professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or healthcare professional For Administrative: Numerator Elements to be identified through medical record abstraction: See Sample Data Collection Tool attached in Appendix A.1. 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 a transition record 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. Transmitting the Transition Record with Specified Elements: The Transition Record should be transmitted to the next provider(s) of care in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model (https://ecqi.healthit.gov/qdm). The use of recognized interoperability standards for the

	transmission of the Transition Record information will ensure that the information can be received into the destination EHR. Systematic External Reporting that the Transition Record was transmitted within 24 hours of discharge: To systematically identify the transition records that were transmitted within 24 hours of discharge, a discrete data field and code may be needed in the EHR. This discrete data field will facilitate external reporting of the information.
Denominator Statement	All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care
Denominator Details	Time Period for Data Collection: At each discharge during measurement period Note: Facilities are responsible for determining the appropriate use of codes. For Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0114 (Hospital Inpatient (Including Medicare Part A), Interim - Last Claim) • 0121 (Hospital Inpatient (Medicare Part B only), Admit through Discharge Claim) • 0124 (Hospital Inpatient (Medicare Part B only), Interim - Last Claim) • 0181 (Hospital - Swing Beds, Admit through Discharge Claim) • 0184 (Hospital - Swing Beds, Interim - Last Claim) • 0211 (Skilled Nursing-Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient (Including Medicare Part A), Interim - Last Claim) • 0221 (Skilled Nursing-Inpatient (Medicare Part B only), Admit through Discharge Claim) • 0224 (Skilled Nursing- Inpatient (Medicare Part B only), Interim - Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim - Last Claim) AND Discharge Status (Form Locator 17) • 01 (Discharged to home or self care (routine discharge) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to a facility that provides custodial or supportive care) • 05 (Discharged/transferred to a designated cancer center or children's hospital) • 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care) • 21 (Discharged/transferred to court/law enforcement) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed)

	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	• 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 69 (Discharged/transferred to a designated disaster alternative care site) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list) • 81 (Discharged to home or self care with a planned acute care hospital inpatient readmission) • 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission) • 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission) • 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission) • 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission) • 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission) • 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission) • 88 (Discharged/transferred to a federal healthcare facility with a planned acute care hospital inpatient readmission • 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission) • 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission) • 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission) • 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission) • 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission) • 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission) • 95 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission) OR UB-04 (Form Locator 04 - Type of Bill): • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim - Last Claim)

	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	AND UB-04 (Form Locator 42 - Revenue Code): • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) AND Discharge Status (Form Locator 17) • 01 (Discharged to home or self care (routine discharge) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to a facility that provides custodial or supportive care) • 05 (Discharged/transferred to a designated cancer center or children's hospital • 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care) • 21 (Discharged/transferred to court/law enforcement) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 69 (Discharged/transferred to a designated disaster alternative care site) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list) • 81 (Discharged to home or self-care with a planned acute care hospital inpatient readmission) • 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission) • 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission) • 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission) • 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission) • 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission) • 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)

	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	• 88 (Discharged/transferred to a federal healthcare facility with a planned acute care hospital inpatient readmission • 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission) • 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission) • 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission) • 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission) • 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission) • 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission) • 95 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission) This measure may also be implemented in EHRs: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.
Exclusions	Patients who died Patients who left against medical advice (AMA) or discontinued care
Exclusion details	Time Period for Data Collection: At each discharge during measurement period According to the PCPI methodology, exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (ie, the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), exclusions include patients who died, and patients who left against medical advice (AMA) or discontinued care. Additional details by data source are as follows: For Administrative Data: UB-04 (Form Locator 17 - Discharge Status): • 07 (Left against medical advice or discontinued care) • 20 (Expired) • 40 (Expired at home) • 41 (Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)) • 42 (Expired - place unknown) For EHR: Discharges meeting denominator exclusions criteria should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification

	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Stratification	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator. (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. Find the patients who qualify for denominator exclusions and subtract from the denominator. 4. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. If the patient does not meet the numerator, this case represents a quality failure. Rate/proportion
Copyright / Disclaimer	5.1 Identified measures: 0291 : EMERGENCY TRANSFER COMMUNICATION MEASURE 0293 : Medication Information 0297 : Procedures and Tests 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: While all three measures focus on the timely communication of key transition information, our measure focuses on patients who are discharged from an inpatient facility while 0291and 0293 focus on patients who are transferred from the ED to another facility. In addition, 0293 focuses specifically on the communication of medication information and 0297 focuses specifically on the communication of procedure and test information. We feel they are complementary in addressing the quality of care transitions. 5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no existing NQF-endorsed measures that address both the same target population and measure focus.

	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
Steward	PCPI
Description	Percentage of discharges from an emergency department (ED) to ambulatory care or home health care, in which the patient, regardless of age, or their caregiver(s), received a transition record at the time of ED discharge including, at a minimum, all of the specified elements
Type	Process
Data Source	EHRs Hybrid, Paper Records See attached data collection tool. Available in attached appendix at A.1 No data dictionary
Level	Facility, Integrated Delivery System
Setting	Emergency Department
Numerator Statement	Discharges in which the patient or their caregiver(s) received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: - Summary of major procedures and tests performed during ED visit, AND - Principal clinical diagnosis at discharge which may include the presenting chief complaint, AND - Patient instructions, AND - Plan for follow-up care (OR statement that none required), including primary physician, other healthcare professional, or site designated for follow-up care, AND - List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each
Numerator Details	Time Period for Data Collection: At each emergency department discharge during measurement period Numerator Element Definitions: - Transition record (for ED discharges): a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with, provided to and accepted by the patient in written, printed, or electronic format. Electronic format may be provided only if acceptable to patient. - Summary of any major tests and procedures performed during the emergency department encounter must be included in the transition record, but it is not the intention of the measure that a complete order set is provided to all patients. The types of procedures and tests included should be defined by each emergency department prior to measure implementation and may include fracture management, wound repair, incision and drainage (I & D), foreign body removal, joint reduction, joint aspiration, chest tube placement, emergency endotracheal intubation, central line placement, or lumbar punctures. Tests may include lab tests, scans, or x-rays that were performed. Major tests that have results pending should be included, since they were performed during the encounter and will require follow up after the patient leaves the ED. - Primary physician or other healthcare professional designated for follow-up care: may be primary care physician (PCP), medical specialist, or other physician or healthcare professional. If no physician, other healthcare professional, or site designated or available, patient may be provided with information on alternatives for obtaining follow-up care needed, which may include a list of community health services/other resources. For Administrative:

	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	Numerator Elements to be identified through medical record abstraction: See Sample Data Collection Tool attached in Appendix A.1. This measure may also be implemented in EHRs: The Care Transitions measures do not lend themselves to a "traditional specification" for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure. Given the fact that every facility may use a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, emergency department episode). We have provided guidance on how a facility should query the electronic health record for the information required for this measure. Producing the Transition Record with Specified Elements: Emergency departments that have implemented an EHR should establish a standardized template within their system that providers will use to generate the Transition Record. A standardized template will ensure that all data elements specified in the performance measure are included each time a Transition Record is prepared. Sample Transition Records were developed and are included in the Care Transitions Specifications. Each facility has the autonomy to customize the format of the Transition Record, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution. Systematic External Reporting of the Transition Record: In order to report, at the facility level, which of the patients discharged from the emergency department have received a Transition Record, a discrete data field and code indicating the patient received a Transition Record at discharge may be needed in the EHR. Transmitting the Transition Record with Specified Elements: This performance measure does not require that the Transition Record be transmitted to the next provider(s) of care. However, if the Transition Record is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model (https://ecqi.healthit.gov/qdm). In addition, the use of recognized interoperability standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR.
Denominator Statement	All discharges for patients, regardless of age, from an emergency department (ED) to ambulatory care (home/self care) or home health care
Denominator Details	Time Period for Data Collection: At each emergency department discharge during the measurement period For Administrative: Identify patients discharged from emergency department using the following: UB-04 (Form Locator 42 - Revenue Code): • 0450 (Emergency Room) AND UB-04 (Form Locator 17 - Discharge Status): • 01 (Discharged to home or self care (routine discharge)) • 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care)

	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	• 21 (Discharged/transferred to court/law enforcement) (Note: Only the above codes from UB-04 Form Locator 17 - Discharge Status should be included in the eligible population.) This measure may also be implemented in EHRs: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.
Exclusions	Exclusions: Patients who died Patients who left against medical advice (AMA) or discontinued care Exceptions: Patients who declined receipt of transition record Patients for whom providing the information contained in the transition record would be prohibited by state or federal law
Exclusion details	Time Period for Data Collection: At each emergency department discharge during measurement period The PCPI distinguishes between measure exceptions and measure exclusions. Measure exlcusions: Exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (ie, the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care), exclusions include patients who died, and patients who left against medical advice (AMA) or discontinued care. Measure exceeptions: Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed 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. For measure Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care), exceptions may include patients who declined receipt of transition record, and patients for whom providing the information contained in the transition record would be prohibited by state or federal law. 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.

	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	Additional details by data source are as follows: For Administrative: UB-04 (Form Locator 17 - Discharge Status): • 07 (Left against medical advice or discontinued care)* • 20 (Expired) • 40 (Expired at home) • 41 (Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)) • 42 (Expired - place unknown) This measure may also be implemented in EHRs: Discharges meeting denominator exclusions criteria should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored. Exception Definition: Documentation is required for patients who are excepted from the measure: • Patients who declined receipt of transition record. • Patients for whom providing the information contained in the transition record would be prohibited by state or federal law.
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification
Stratification	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator. (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. Find the patients who qualify for denominator exclusions and subtract from the denominator. 4. From the patients within the denominator (after denominator exclusions have been subtracted from the denominator), find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. 5. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: patients who declined receipt of transition record, and patients for whom providing the information contained in the transition record would be prohibited by state or federal law]. If the patient meets any exception criteria, they should be removed from the denominator for performance

	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	calculation. Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage of patients with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Rate/proportion
Copyright / Disclaimer	5.1 Identified measures: 0291 : EMERGENCY TRANSFER COMMUNICATION MEASURE 0293 : Medication Information 0297 : Procedures and Tests 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: While our measure focuses of the receipt of a transition record by patients who are discharged from an ED, measure 0291 focuses on the timely transfer of information to the receiving facility for patients who are transferred from the ED and 0293 and 0297 focus specifically on the communication of medication information and procedure/test information, respectively, for patients who are transferred from the ED to another facility. We feel that the measures are complementary in addressing the quality of care transitions. 5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no existing NQF-endorsed measures that address both the same target population and measure focus.

	3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit
Steward	University Hospitals Cleveland Medical Center
Description	This measure describes the incidence rate of emergency department visits for children ages 2 to 21 who are being managed for identifiable asthma. This measure characterizes care that precedes Emergency Department visits for children ages 2- 21 who can be identified as having asthma, using the specified definitions. We sought to identify children with ongoing asthma who should be able to be identified by their healthcare providers and/or healthcare plans as having asthma. The operational definition of an identifiable asthmatic is a child who has utilized healthcare services that suggest the healthcare system has enough information to conclude that the child has an asthma diagnosis that requires ongoing care. Specifically, this measure identifies the use of primary care services and medications prior to ED visits and/or hospitalizations for children with asthma.
Type	Composite
Data Source	Claims (Only) n/a No data collection instrument provided. Attachment Asthma_III_11_23_16.xlsx
Level	Population : Community, County or City, Population : Regional and State
Setting	Clinician Office/Clinic, Emergency Department, Hospital
Numerator Statement	Evidence of connection to the primary care medical system prior to first ED visit and/or hospitalization that has a primary or secondary diagnosis of asthma among children whom our specifications identify with asthma.
Numerator Details	Evidence of connection to the primary care medical system prior to first ED visit and/or hospitalization that has a primary or secondary diagnosis of asthma among children whom our specifications identify with asthma, includes the following: (A)Visit(s) to a primary care clinician with a primary or secondary diagnosis of asthma that occurred within 6 months prior to an ED visit/hospital admission (but not on the day of the ED visit/admission, (B)Have at least one fill of a short acting beta agonist within 12 months prior to the ED visit/hospital admission and (C)Have at least one fill of an asthma controller medication within 6 months prior to the ED visit/hospital admission. This numerator excludes events occurring in patients who meet numerator but not denominator criteria (including 6 months of continuous enrollment).
Denominator Statement	All first ED visits and/or hospitalizations, in which asthma was a primary or secondary diagnosis in children age 2-21 who meet criteria for being managed for identifiable asthma in the assessment period and have been enrolled for the 6 consecutive months prior to the ED visit/admission.
Denominator Details	The assessment period includes the full year before the reporting year and each full calendar month before the month in which the ED visit (which is referred to as the reporting month). Descriptive definitions of identifiable asthma management are in S.2b. Specifications follow the descriptive definitions in S.2b. • Any prior hospitalization with asthma as primary or secondary diagnosis • Other qualifying events after the fifth birthday at time of event: a.One or more prior ambulatory visits with asthma as the primary diagnosis (this criterion implies an asthma ED visit in the reporting month), OR b.Two or more ambulatory visits with asthma as a diagnosis, OR

	3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit
	c.One ambulatory visit with asthma as a diagnosis AND at least One asthma related prescription, OR d.Two or more ambulatory visits with a diagnosis of bronchitis • Other qualifying events, any age: a.Three or more ambulatory visits with diagnosis of asthma or bronchitis, OR b.Two or more ambulatory visits with a diagnosis of asthma and/or bronchitis AND one or more asthma related prescriptions For eligibility purposes, asthma-related medicine refers to long acting beta agonist (alone or in combination) or inhaled corticosteroid (alone or in combination), anti- asthmatic combinations, methylxanthines (alone or in combination), and/or mast cell stabilizers.
Exclusions	Children with specific concurrent or pre-existing diagnosis, as specified in S.9. Children who have not been consecutively enrolled with the reporting entity for at least six months prior to the index reporting month. Children who do not meet the denominator criteria.
Exclusion details	Excluded are children who have NOT been continuously enrolled in the index plan for the 6 months immediately prior to the reporting month. Change(s) in eligibility criteria and/or benefit package or plan do(es) not relieve the reporting entity of the need to determine denominator eligibility – all available sources should be linked. For health plans, this includes utilizing any existing data sharing arrangements. For State Medicaid plans, this requires that the unit of analysis for eligibility assessment is the child, not the child-insurer pair. Children with concurrent or pre-existing: Chronic Obstructive Pulmonary Disease (COPD) diagnosis; Cystic Fibrosis diagnosis; Emphysema diagnosis Children who have not been consecutively enrolled with the reporting entity for at least six months prior to the index reporting month. Children who do not meet the denominator criteria.
Risk Adjustment	Other Stratification for reasons beyond risk adjustment Other Stratification for reasons beyond risk adjustment
Stratification	Stratification includes: (1) Visit(s) to a primary care clinician with a primary or secondary diagnosis of asthma that occurred within 6 months prior to an ED visit/hospital admission (but not on the day of the ED visit/admission) (A only) (2) Have at least one fill of a short acting beta agonist within 12 months prior to the ED visit/hospital admission (B only) (3) Have at least one fill of an asthma controller medication within 6 months prior to the ED visit/hospital admission (C only) (4) Have a prescription filled for both a rescue medication and a controller medication within the specified time frames (BOTH B and C only) (5)Have no prescriptions filled for rescue medications or controller medications within the specified time frames (NEITHER B nor C) (6) Have neither a qualifying primary care visit, nor had fills for both a rescue medication and a controller medication within the specified time frames (Neither A nor B nor C: Failure) Stratifications 4-6 could be calculated internally if desired.
Type Score	Rate/proportion better quality = higher score

	3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit
Algorithm	Step 1: Assess eligibility. For any given reporting month, assess eligibility on 2 criteria. Eligible children are those that meet both of the following: A.Identify the assessment period. We classify children as having identifiable asthma by evaluating services used during what we call the assessment period. The analysis period consists of the 2 year look back period plus all prior months in the Reporting Year. In other words if calendar year 2012 is the Reporting Year, the look back period would include calendar years 2010 and 2011. When looking for events in January 2011, the assessment period would include only CY 2009 and CY 2010. For February 2011, the assessment period would include CY 2010, CY 2011 and January 2012, and so on until for December the look back period would include CY 2010, CY 2011 and January-November, 2012. B. Analyze the data month by month in chronological order. 1.Exclude those children who have not been enrolled in the health plan for six consecutive months before the month of the ED visit; 2.Evaluate for the presence of identifiable asthma if any of the criteria described in a, b, or c below are satisfied, (along with an ED visit with the primary or secondary diagnosis of asthma): a.Any prior hospitalization with asthma as primary or secondary diagnosis b.Qualifying events after the fifth birthday at time of event: i.One or more prior ambulatory visits with asthma as the primary diagnosis OR ii.Two or more ambulatory visits with asthma as a diagnosis, OR iii.One ambulatory visit with asthma as a diagnosis AND at least One asthma related prescription, OR iv.Two or more ambulatory visits with a diagnosis of bronchitis c. Qualifying events, any age: i.Three or more ambulatory visits with diagnosis of asthma or bronchitis, OR ii.Two or more ambulatory visits with a diagnosis of asthma AND/OR iii.Bronchitis AND one or more asthma related prescriptions Step 2: Look for any qualifying events (eligible events) using the criteria for hospitalization and/or ED visits. For months in which each child is found to be eligible using both the criteria for identifiable asthma and the continuous enrollment criteria (Step 1), identify whether that is the first eligible event for the child in the reporting year. If so, include in the denominator. Step 3: The denominator is the number of children with identifiable asthma who had qualifying events. Use the first such event for each child when assessing each numerator. Step 4: Identify Numerator A. Numerator A is the number of eligible children with an ED visit and/or hospitalization who had a visit with primary care doctor with primary or secondary diagnosis of asthma within 6 months prior to the ED visit and/or hospitalization (and not including the day of the ED visit/admission). Step 5: Identify Numerator B. Numerator B is the number of eligible children with an ED visit and/or hospitalization who filled a prescription for a short acting beta agonist within the prior 12 months before the ED visit and/or hospitalization (and not including the day of the ED visit/admission). Step 6: Identify Numerator C. Numerator C is the number of eligible children with an ED visit and/or hospitalization who filled a prescription for a controller medication prescription within the prior 6 months before the ED visit and/or hospitalization (and not including the day of the ED visit/admission).

	3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit
	Step 7: Identify Numerator D. Numerator D is a composite of Numerator B and Numerator C. i. Criteria are satisfied for both B and C. ii. Criteria are satisfied for neither B nor C. Step 8: Identify Numerator E. Numerator E is a composite of Numerator A and Numerator D. i. Criteria are satisfied for both A and D. ii. Criteria are satisfied for neither A nor D. ** For Steps 4-8, report as 100 x (numerator/denominator) to 2 decimal place. Step 9. Repeat by strata: age, race/ethnicity, Urban Influence Code (UIC), county poverty level, insurance type, benefit type. Report by race/ethnicity within age strata and repeat that analysis by UIC, and by county poverty level. Report by insurance type and benefit type within race/ethnicity. Eliminate any strata with less than 50 person-months in any month's denominator. Step 10. Specification of Stratification Variables: i. Identify County equivalent of child's residence. If County and State or FIPS code are not in the administrative data, the zip codes can be linked to County indirectly, using the Missouri Census Data Center (http://mcdc.missouri.edu/). These data will link to County or County equivalents as used in various states. ii.Identify the Urban Influence Code[1] or UIC for the County of child's residence. (2013 urban influence codes available at: http://www.ers.usda.gov/data-products/urban-influence- codes.aspx#.UZUvG2cVoj8 . iii.Identify the Level of Poverty in the child's county of residence. The percent of all residents in poverty by county or county equivalent are available from the US Department of Agriculture at http://www.ers.usda.gov/data- products/county-level-data-sets/download-data.aspx . Our stratification standards are based on 2011 US population data that we have analyzed with SAS 9.3. Using child's state and county of residence (or equivalent) or FIPS code, use the variable PCTPOVALL_2011 to categorize into one of 5 Strata: 1.Lowest Quartile of Poverty if percent in poverty is <=12.5% 2.Second Quartile of Poverty if percent in poverty is >12.5% and <=16.5% 3.Third Quartile of poverty if percent in poverty is >16.5% and <=20.7% 4.First upper quartile (75th-90th) if percent in poverty is >20.7% and <=25.7% 5.Second upper quartile (>90th percentile) iv.Categorize age by age at the last day of the prior month. Aggregate into age categories ages 2-4, ages 5 through 11, ages 12-18, ages 19-21. v.Categorize Race/Ethnicity as Hispanic, non-Hispanic White, Non- Hispanic Black, non-Hispanic Asian/Pacific Islander, and Non-Hispanic Other. vi.Insurance as Private (Commercial), Public, None or Other vii.Benefit Type as HMO, PPO, FFS, PCCM, Other Rate/proportion
Copyright / Disclaimer	5.1 Identified measures: None 5a.1 Are specs completely harmonized? N/A 5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

	3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit
	5b.1 If competing, why superior or rationale for additive value: N/A

	3171 Percentage of Asthma ED visits followed by Evidence of Care Connection
Steward	University Hospitals Cleveland Medical Center
Description	This measure seeks to capture important aspects of follow up after ED visits for asthma, including prompt follow up with primary care clinicians and prescription fills for controller medications. This measure characterizes care that follows Emergency Department (ED) visits with a primary or secondary diagnosis of asthma for children ages 2-21 that occur in the Reporting Year and who are enrolled in the health plan for two consecutive months following the ED visit. We further stratify those visits into those that occurred for children who can or cannot be identified as having asthma, using the specified definitions. We are operationalizing an identifiable asthmatic as a child who has utilized healthcare services that suggest the healthcare system has enough information to conclude that the child has an asthma diagnosis that requires ongoing care. We incorporate a 2 year look back period before the reporting year. Specifically, this measure describes the connection with the primary care system (timely visits to primary care providers and filling of controller asthma medications) following ED visits for children with asthma.
Type	Composite
Data Source	Claims (Only) Administrative data with billing and diagnosis codes. No data collection instrument provided. Attachment Asthma_IV_11_27_16.xlsx
Level	Population : Community, County or City, Population : Regional and State
Setting	Clinician Office/Clinic, Emergency Department, Hospital
Numerator Statement	Evidence of connection to the primary care medical system following ED visits that have a primary or secondary diagnosis of asthma among children, overall and stratified by whether the child had identifiable asthma at the time of the ED visit.
Numerator Details	Numerator includes (1) Visit(s) to a primary care provider that occurred within 14 days following the ED visit. and (2) Have at least one fill of an asthma controller medication within 2 months after the ED visit (including the day of visit). Numerator Exclusions: Events occurring in patients who meet numerator but not denominator criteria (including 2 months of continuous enrollment following the month in which the ED visit occurred (minimum is 3 months total).
Denominator Statement	All ED visits in which asthma was a primary or secondary diagnosis in children who are continuously enrolled for at least the 2 months following the ED visit.
Denominator Details	Change(s) in eligibility criteria and/or benefit package or plan do(es) not relieve the reporting entity of the need to determine denominator eligibility – all available sources should be linked. For health plans, this includes utilizing any existing data sharing arrangements. For State Medicaid plans, this requires that the unit of analysis for eligibility assessment is the child, not the child-insurer pair. Descriptive definitions of identifiable asthma management are as follows. Specifications follow the descriptive definitions: • Any prior hospitalization with asthma as primary or secondary diagnosis • Other qualifying events after the fifth birthday at time of event: a. One or more prior ambulatory visits with asthma as the primary diagnosis (this criterion implies an asthma ED visit in the reporting month), OR b. Two or more ambulatory visits with asthma as a diagnosis, OR c. One ambulatory visit with asthma as a diagnosis AND at least One asthma related prescription, OR d. Two or more ambulatory visits with a diagnosis of bronchitis

	3171 Percentage of Asthma ED visits followed by Evidence of Care Connection
	•Other qualifying events, any age: a. Three or more ambulatory visits with diagnosis of asthma or bronchitis, OR b. Two or more ambulatory visits with a diagnosis of asthma and/or bronchitis AND one or more asthma related prescriptions
Exclusions	Children with concurrent or pre-existing diagnosis. Children who have not been consecutively enrolled with the reporting entity for at least two months following the ED visit. Children who do not meet the denominator criteria.
Exclusion details	Children with concurrent or pre-existing: Chronic Obstructive Pulmonary Disease (COPD) diagnosis; Cystic Fibrosis diagnosis; Emphysema diagnosis Children who have not been consecutively enrolled with the reporting entity for at least two months following the ED visit. Children who do not meet the denominator criteria.
Risk Adjustment	Other Stratification for reasons other then risk adjustment Other Stratification for reasons other then risk adjustment
Stratification	Stratification includes: (1) Visit(s) to a primary care provider that occurred within 14 days following the ED visit. (A only) (2) Have at least one fill of an asthma controller medication within 2 months after the ED visit (including the day of visit). (B only) (3) No visit(s) to a primary care provider that occurred within 14 days following the ED visit and having no fills of an asthma controller medication within 2 months after the ED visit (including the day of the visit) (Neither A or B) (Failure) (4) No Visit(s)to a primary care provider that occurred within 30 days following the ED visit and having no fills of an asthma controller medication within 2 months after the ED visit (including the day of the visit) (Failure) Stratifications 3 and 4 could be calculated internally if desired.
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Look for any qualifying events (eligible events) using the criteria for ED visits. Step 2: Assess eligibility for events that occur in each month by confirming that the child was continuously enrolled for 2 months following the month in which the ED visit occurs (3 months total including the index month). Step 3: The denominator is all events identified in Step 1 who meet the continuous enrollment criteria in Step 2. Step 4: Find children with identifiable asthma among those with eligible events. Use the presence or absence of identifiable asthma as a stratification variable as specified below. A. Identify the assessment period. We classify children as having identifiable asthma by evaluating services used during what we call the assessment period. The analysis period consists of the 2 year look back period plus all prior months in the Reporting Year. In other words if calendar year 2012 is the Reporting Year, the look back period would include calendar years 2010 and 2011. When looking for events in January 2011, the assessment period would include only CY 2009 and CY 2010. For February 2011, the assessment period would include CY 2010, CY 2011 and January 2012, and so on until for December the look back period would include CY 2010, CY 2011 and January-November, 2012. B. Analyze the data month by month in chronological order.

	3171 Percentage of Asthma ED visits followed by Evidence of Care Connection
	1.Exclude those children who have not been enrolled in the health plan for the two months following the month of the ED visit; 2.Evaluate for the presence of identifiable asthma if any of the criteria described in a, b, or c below are satisfied, (along with an ED visit with the primary or secondary diagnosis of asthma): a.Any prior hospitalization with asthma as primary or secondary diagnosis b.Qualifying events after the fifth birthday at time of event: i.One or more prior ambulatory visits with asthma as the primary diagnosis OR ii.Two or more ambulatory visits with asthma as a diagnosis, OR iii.One ambulatory visit with asthma as a diagnosis AND at least One asthma related prescription, OR iv.Two or more ambulatory visits with a diagnosis of bronchitis c. Qualifying events, any age: i.Three or more ambulatory visits with diagnosis of asthma or bronchitis, OR ii.Two or more ambulatory visits with a diagnosis of asthma AND/OR iii.Bronchitis AND one or more asthma related prescriptions NOTE: For eligibility purposes, asthma-related medicine refers to long acting beta agonist (alone or in combination) or inhaled corticosteroid (alone or in combination), anti-asthmatic combinations, methylxanthines (alone or in combination), and/or mast cell stabilizers. Leukotriene inhibitors are excluded for this purpose. 3. Classify by yes or no whether or not the child met the criteria for identifiable asthma during the month of the visit. Step 5: Identify Numerator A. Numerator A is the number of eligible children seen in an outpatient visit by a primary care physician among those with primary care visits (See Table 1 and 2 for primary care physicians and PCP visit codes) within 14 days following the ED visit (plus some inpatient codes). Step 6: Identify Numerator B. Numerator B is the number of eligible children seen in an outpatient visit by a primary care physician among those with primary care visits (See Table 1 and 2 for primary care physicians and PCP visit codes) within 30 days following the ED visit (plus some inpatient codes). Step 7: Identify Numerator C. Numerator C is the number of eligible children that have at least one fill of a controller medication within 2 months following the ED visit (including the day of the visit) (See Table 3 for medications). ** For Steps 5-7, report as 100 x (numerator/denominator) to 2 decimal place. ** Step 8: Repeat by strata: presence of identifiable asthma, and both overall and within identifiable asthma category by age, race/ethnicity, Urban Influence Code (UIC), county poverty level, insurance type, benefit type. Report by race/ethnicity within age strata and repeat that analysis by UIC, and by county poverty level. Report by insurance type and benefit type within race/ethnicity. Eliminate any strata with less than 50 children. See Step 9 for specification of stratifying variables. Step 9: Specification of Stratification Variables: i.Record status with regard to having identifiable asthma as described in Step 4. ii.Identify County equivalent of child's residence. If County and State or FIPS code are not in the administrative data, the zip codes can be linked to County indirectly, using the Missouri Census Data Center (http://mcdc.missouri.edu/). These data will link to County or County equivalents as used in various states.

	3171 Percentage of Asthma ED visits followed by Evidence of Care Connection
	iii.Identify the Urban Influence Code or UIC for the County of child's residence. (2013 urban influence codes available at: http://www.ers.usda.gov/data-products/urban-influence- codes.aspx#.UZUvG2cVoj8 . iv.Identify the Level of Poverty in the child's county of residence. The percent of all residents in poverty by county or county equivalent are available from the US Department of Agriculture at http://www.ers.usda.gov/data-products/county-level-data-sets/download-data.aspx . Our stratification standards are based on 2011 US population data that we have analyzed with SAS 9.3. Using child's state and county of residence (or equivalent) or FIPS code, use the variable PCTPOVALL_2011 to categorize into one of 5 Strata: 1.Lowest Quartile of Poverty if percent in poverty is <=12.5% 2.Second Quartile of Poverty if percent in poverty is >12.5% and <=16.5% 3.Third Quartile of poverty if percent in poverty is >16.5% and <=20.7% 4.First upper quartile (75th-90th) if percent in poverty is >20.7% and <=25.7% 5.Second upper quartile (>90th percentile) v.Categorize age by age at the last day of the prior month. Aggregate into age categories ages 2-4, ages 5-11, ages 12-18, ages 19-21. vi.Categorize Race/Ethnicity as Hispanic, non-Hispanic White, Non-Hispanic Black, non-Hispanic Asian/Pacific Islander, and Non- Hispanic Other. vii.Insurance as Private (Commercial), Public, None or Other viii.Benefit Type as HMO, PPO, FFS, PCCM, Other Rate/proportion
Copyright / Disclaimer	5.1 Identified measures: None 5a.1 Are specs completely harmonized? N/A 5a.2 If not completely harmonized, identify difference, rationale, impact: N/A 5b.1 If competing, why superior or rationale for additive value: N/A

Appendix F: Related and Competing Measures

Comparison of NQF #0326, NQF #1626 and NQF #1641

	0326 Advance Care Plan	1626 Patients Admitted to ICU who Have Care Preferences Documented	1641 Hospice and Palliative Care – Treatment Preferences
Steward	National Committee for Quality Assurance	The RAND Corporation	University of North Carolina-Chapel Hill
Description	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Percentage of patients with chart documentation of preferences for life sustaining treatments.
Type	Process	Process	Process
Data Source	Claims (Only), EHRs Hybrid None No data collection instrument provided. No data dictionary	Paper Records Medical record abstraction tool	Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data
Level	Clinician: Group/Practice, Clinician: Individual	Facility	Clinician: Group/Practice, Facility
Setting	Clinician Office/Clinic	Hospital: Hospital	Hospice; Hospital: Hospital
Numerator Statement	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Patients in the denominator who had their care preferences documented within 48 hours of ICU admission or have documentation of why this was not done.	Patients whose medical record includes documentation of life sustaining preferences
Numerator Details	Report the CPT Category II codes designated for this numerator:	Edits indicated by [brackets] Patients whose medical record includes documentation of care preferences within 48	Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available due to patient loss of decisional capacity,

	0326 Advance Care Plan	1626 Patients Admitted to ICU who Have Care Preferences Documented	1641 Hospice and Palliative Care – Treatment Preferences
	- 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record - 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan Documentation that patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan may also include, as appropriate, the following: That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient´s beliefs and thus harmful to the physician-patient relationship.	hours of admission to ICU. Care preferences may include any of the following: - Code status, preferences for general aggressiveness of care, mechanical ventilation, hemodialysis, transfusion, or permanent feeding tube, OR - Documentation that a care preference discussion was attempted and/or reason why it was not done [Simply having an advance directive or other advance care planning document or POLST in the medical record does not satisfy this criterion. However, a notation in the record during the allotted time period referring to preferences or decisions within such a document satisfies this requirement.]	discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of various life-sustaining treatments such as resuscitation, ventilator support, dialysis, or use of intensive care or hospital admission. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as "Full Code" or "DNR/DNI" do not count in the numerator. Documentation using the POLST paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.
Denominator Statement	All patients aged 65 years and older.	All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.
Denominator Details	Denominator Criteria (Eligible Cases): Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342,	All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission. "Vulnerable" is defined as any of the following: - >74 years of age - Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001) - Poor prognosis/terminal illness defined as life expectancy of <6 months - Stage IV cancer	The Treatment Preferences quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke,

	0326 Advance Care Plan	1626 Patients Admitted to ICU who Have Care Preferences Documented	1641 Hospice and Palliative Care – Treatment Preferences
	99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439 *Clinicians indicating the place of service as the emergency department will not be included in this measure.		HIV/AIDS, and advanced renal or hepatic failure.
Exclusions	N/A	N/A	Patients with length of stay < 1 day in hospice or palliative care
Exclusion Details	N/A	N/A	Calculation of length of stay; discharge date is identical to date of initial encounter.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	N/A	N/A	N/A
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population. The eligible population is all patients aged 65 years and older. Step 2: Determine number of patients meeting the denominator criteria as specified in Question S.7. above. Step 3: Determine the number of patients who meet the numerator criteria as specified in Question S.5. above. The numerator includes all patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	1. Identify all vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission 2. Examine the medical record for evidence of a statement of patient care preferences OR attempt to elicit these or other reason why this was not done within 48 hours of ICU admission.	Chart documentation of life sustaining preferences: a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR who received specialty palliative care in an acute hospital b.Step 2- Exclude patients if length of stay is < 1 day. c.Step 3- Identify patients with documented discussion of preference for life sustaining treatments. Quality measure = Numerator: Patients with documented discussion in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2

	0326 Advance Care Plan	1626 Patients Admitted to ICU who Have Care Preferences Documented	1641 Hospice and Palliative Care – Treatment Preferences
	Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2. Rate/proportion		
Submission items	5.1 Identified measures: 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) 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: NQF#0647 targets all age groups and focuses specifically on transition of care to another facility or to the home. This measure, NQF#0326, focuses specifically on older adults and creating an advanced care plan or identifying a designated surrogate decision maker to dictate care to be provided, including but not limited to transitions. 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: No 5a.1 Are specs completely harmonized? N/A 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was part of the National Palliative Care Research Center (NPCRC) Key Palliative Measures Bundle during the original submission. At that time, a NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle was provided. 5b.1 If competing, why superior or rationale for additive value:	5.1 Identified measures: No 5a.1 Are specs completely harmonized? N/A 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle. 5b.1 If competing, why superior or rationale for additive value: Attachment

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