

NATIONAL QUALITY FORUM

TO: NQF Members and Public

FR: NQF Staff

RE: Pre-voting review for *National Voluntary Consensus Standards for Care Coordination 2012*

DA: April 2, 2012

The lack of coordination and communication across settings and between episodes of care leads to increased medical errors, higher costs, and unnecessary suffering for patients and their families. NQF has undertaken several projects to provide guidance and measurement of care coordination, including a 2006 project that yielded an endorsed definition and framework for care coordination and a 2010 project that endorsed 10 performance measures and 25 care coordination preferred practices.

This current project, which builds on previous work by NQF in this area, was structured in two phases. The first phase included: (1) a commissioned paper on health information technology (HIT) and care coordination measurement, (2) an environmental scan identifying measurement gap areas, and (3) the development of a pathway forward for future measure development. The second phase consisted of the evaluation of 15 endorsed measures undergoing the endorsement maintenance review. A 26-member Steering Committee, representing a range of stakeholder perspectives, was appointed for this project. During the second phase of this project, the Committee recommended 12 of the 15 measures as suitable for endorsement.

This draft technical report, *National Voluntary Consensus Standards for Care Coordination 2012*, details the work of both phases of this project. The draft includes the ratings and underlying rationale for the Committee's recommendations regarding the measures (in the measure evaluation summary tables) as well as detailed measure specifications (in Appendix A). The report is posted on the NQF website, along with the following additional information:

- [materials from Phase I](#)
- [measure submission forms](#) and
- [meeting and call materials](#) from the Steering Committee's discussions.

Pursuant to section II.A of the Consensus Development Process v. 1.9, this draft document, along with the accompanying material, is being provided to you at this time for purposes of review and comment only, and is not intended to be used for voting purposes. You may post general comments as well as comments on the individual measure evaluations on the [NQF website](#). Comments related to the first phase of the project and the recommendations for future measure development should be posted under general comments. You may also view the comments of others on the NQF website. Thank you for your interest in NQF's work.

All comments must be submitted no later than 6:00 pm ET, May 1, 2012.

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NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR CARE COORDINATION 2012

DRAFT TECHNICAL REPORT FOR COMMENT

April 2, 2012

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NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR CARE COORDINATION 2012 Draft Technical Report

When all of a patient's health care providers coordinate their efforts, it helps ensure that the patient gets the care and support he needs and wants, when and how he needs and wants it. Effective care coordination models have begun to show that they can deliver better quality and lower costs in settings that range from small physician practices to large hospital centers.

National Strategy for Quality Improvement in Health Care, 2011

BACKGROUND and CONTEXT

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

Because poorly coordinated care regularly leads to unnecessary suffering for patients, as well as avoidable readmissions and emergency department visits, increased medical errors, and higher costs, coordination of care is increasingly recognized as critical for improvement of patient outcomes and the success of healthcare systems. For example, individuals with chronic conditions and multiple comorbidities—and their families and caregivers—often find it difficult to navigate our complex and fragmented healthcare system. As this ever-growing group transitions from one care setting to another, poor outcomes resulting from incomplete or inaccurate transfer of information, poor communication, and a lack of follow-up care become more likely. Yet the sharing of information across settings and between providers through electronic health records (EHRs) could reduce the unnecessary and costly duplication of patient services,¹ while the number of serious medication events could be reduced through patient education and the reconciliation of medication lists.² The Agency for Healthcare Research and Quality estimates that adverse medication events cause more than 770,000 injuries and deaths each year, more than half of which affect those over age 65.³ The cost of treating patients who are harmed by these events is estimated to be as high as \$5 billion annually.⁴ Furthermore, the Institute of Medicine has found that care coordination initiatives such as patient

¹ “Evidence on the Costs and Benefits of Health Information Technology,” 2008, The Congressional Budget Office, May 2008, <<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/91xx/doc9168/05-20-healthit.pdf>>.

² Pronovost P, Weast B, Schwarz M, et al.. 2008. “Medication Reconciliation: A Practical Tool to Reduce the Risk of Medication Errors,” Journal of Critical Care, 18(4):201-5.

³ Daniel Budnitz, “National Surveillance of Emergency Department Visits for Outpatient Adverse Drug Events,” Journal of the American Medical Association, 2006.

⁴ “Reducing and Preventing Adverse Drug Events to Decrease Hospital Costs,” 2001, U.S. Dept. of Health and Human Services, Agency for Healthcare Research and Quality, March, 2001. <<http://www.ahrq.gov/qual/aderia/aderia.htm>>

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education and the development of new provider payment models could result in an estimated \$240 billion in savings.⁵

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

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

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

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

In its role as the convener of the National Priorities Partnership (NPP), NQF supports the priorities and goals identified by the Department of Health and Human Services' (HHS) National Quality Strategy.⁸ NPP has long supported care coordination as a national priority. In 2010, NPP convened a Care Coordination workgroup that identified actions to achieve reductions in 30-day readmissions. Workgroup members identified barriers to achieving this goal and discussed opportunities to leverage health information technology and build system capacity. In preparation for this workshop, NQF

⁵ IOM, *Roundtable on Value & Science-Driven health Care: The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Serious Summary*, Washington, DC: National Academies Press, 2010.

⁶ "NQF-Endorsed Definition and Framework for Measuring Care Coordination," 2006, The National Quality Forum, May 2006, <<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=972>>.

⁷ "Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination," 2010, The National Quality Forum, Oct. 2010, <<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=935>>.

⁸ "Report to Congress: National Strategy for Quality Improvement in Health Care," 2011, The Department of Health and Human Services, March 2011, <<http://www.healthcare.gov/law/resources/reports/quality03212011a.html>>.

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commissioned a background paper: *Aligning Our Efforts to Achieve Care Coordination*.⁹ This paper offered an overview of the national state of care coordination activities and recommended high-level drivers of change.

Another vital aspect of effective care coordination is the consideration of those with multiple chronic conditions (MCCs). NQF recently convened the MCC Steering Committee to develop a measure a person-centric [Multiple Chronic Conditions Framework](#), identifying high-leverage measure concepts for performance measurement, and offering a conceptual model and guiding principles for measuring the quality of care delivered to those with MCC's. The framework is intended to signal to measure developers critical gaps in performance measurement and suggest a roadmap for new delivery models (e.g., accountable care organizations, patient-centered medical homes) that aim to provide patient-centered care across multiple settings.

Meanwhile, NQF's Measure Applications Partnership (MAP) was tasked by HHS to examine quality issues affecting the heterogeneous Medicare-Medicaid dual eligible beneficiary population and to provide input on an appropriate measurement strategy. In October 2011, MAP identified five high-leverage opportunity areas in which measurement can have the most significant positive effects. Care coordination is one of those areas, along with quality of life, screening and assessment, mental health and substance use, and structural measures. In October 2011, MAP put forward a report, [Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries](#), detailing a set of available measures considered core for use with this population, nearly half of which are related to care coordination.

Finally, the HIT team at NQF has recently initiated a project to assess the readiness of electronic data and health IT systems to perform the data capture, normalization, and standardization necessary to support care coordination measurement. The expert panel convened for this project will identify key data requirements to effectively measure care coordination and transitions, and will set up criteria for analyzing the extent to which organizations currently manage and evaluate care coordination outcomes. A subsequent environmental analysis will examine data readiness and areas of need. For example, the scan will identify availability and actual use of infrastructure, comprehensiveness and appropriateness of standards, and data storage. Recommendations for standards selection and harmonization are expected to result from this initiative.

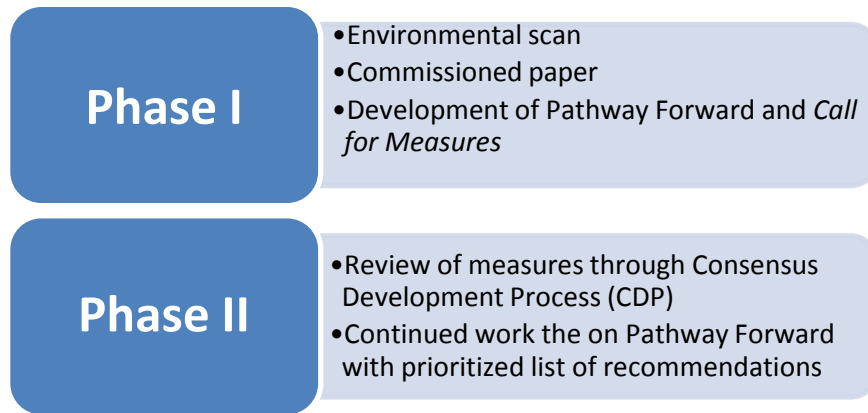
NQF's Current Care Coordination Project

NQF supports measurement approaches that cross all settings within the healthcare delivery system and that contribute to improved patient outcomes. However, the measurement of care coordination is fraught with difficulty. Who are the accountable entities, and at what point does their accountability begin and end? How can information from different settings, such as hospitals and ambulatory care, be easily shared? And, perhaps most important: how might systems measure truly effective care coordination, and not merely a transfer of information?

In 2011, NQF initiated the current project to address these measurement concepts through the development of a Pathway Forward for meaningful measures of care coordination and the evaluation of care coordination measures. The project was structured in two phases:

⁹ "Aligning Our Efforts to Achieve Care Coordination: National Priorities and Goals," 2008, [National Priorities Partnership](http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70345), Nov. 2008, <<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70345>>.

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The first phase of the project provided a unique opportunity for a 26-member Steering Committee to address the lack of cross-cutting measures of care coordination in the NQF measures portfolio and to identify a Pathway Forward to advance the field of care coordination measurement. The Committee first examined the current landscape of care coordination measurement and identified gap areas. Their work was strengthened by the development of a commissioned paper examining electronic capabilities to support care coordination measurement and the findings of an environmental scan. The Pathway Forward and *Call for Measures* released for the second phase of the project reflected the expert opinions of the Committee and addressed gap areas illuminated by the scan and the commissioned paper.

In the second phase of the project, the Committee evaluated 15 measures of care coordination. The remainder of this report details the work of both phases of the current project.

PHASE ONE

Commissioned Paper: *Health Information Technology to Support Care Coordination and Care Transitions*

Central to improving care coordination measurement is the ability of HIT systems to support a smooth transfer of information between settings and providers. To better understand these capabilities, NQF commissioned researchers from Brigham and Women's Hospital in Boston, Massachusetts, to author a paper. The goals of this paper were to:

- Identify current capacity to quantify and measure aspects of care coordination;
- Identify current capabilities and data needs of EHR's to support care coordination measurement; and
- Discuss potential barriers to furthering the capabilities of EHR's to support care coordination measurement.

The authors of the paper structured their discussion using the seven constructs for measuring integrated patient care proposed by Singer and colleagues.¹⁰ Using this framework, the authors described data needs for care coordination and addressed current capabilities of clinical information systems to fulfill

¹⁰ Singer SJ, Burgers J, Friedberg M, Rosenthal MB, Leape L, Schneider E. Defining and measuring integrated patient care: promoting the next frontier in health care delivery. *Med Care Res Rev* 2011;68:112-27. The constructs include coordination within care team; coordination across care teams; coordination between care teams and community resources; continuous familiarity with patient over time; continuous proactive responsive action between visits; patient centered; and shared responsibility.

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those needs. They outlined both organizational and technical barriers to improving the capabilities of HIT and health information exchange. Finally, they proposed strategies to address each barrier. The authors stressed the importance of the continued development of core care coordination standards, incentivizing those standards industry-wide, and developing tools that can be used to electronically capture all of the elements in these standards.

The Committee did note, however, the importance of questioning whether information collected and transferred across systems meaningfully measures care coordination in the first place. They emphasized a fundamental principle of measure development: that the concept must address meaningful components of care coordination before it ultimately becomes an electronic measure.

The findings of the commissioned paper are intended to aid organizations as they plan for increased HIT capacity to support care coordination. The paper may additionally be used by measure developers to identify areas where measure development is currently feasible, and areas where future work may be needed. The Committee referred to the findings of the paper as they deliberated on the nature of the Pathway Forward for care coordination measure development.

Environmental Scan: Current Measures of Care Coordination & Gap Areas

To better understand the current landscape of care coordination measures, an environmental scan also was commissioned in the first phase of this project. The scan, like the paper, was compiled by researchers from Brigham and Women's Hospital. It attempted to identify all measures of care coordination that 1) are either published or presumed to be currently in use and 2) that meet the NQF-endorsed definition of care coordination. Accordingly, both broad-based and condition-specific measures were included, as were measures derived from electronic sources, claims, or paper surveys; measures of screening practices, single intervention responses, readmissions, and emergency department throughput were excluded from the scan.

The author reviewed primary literature, including the [AHRQ Care Coordination Measures Atlas](#), as well as consulting databases such as the [Quality Measures Clearinghouse](#) and the [National Guideline Clearinghouse](#).¹¹ All identified measures were mapped to the domains within the NQF and the AHRQ care coordination frameworks to demonstrate gap areas.

The scan identified a total of 124 measures. Of these 124 measures:

- 30 were NQF-endorsed;
- 86 had published specifications;
- 46 were condition-specific;
- 32 were electronically measured; and
- 45 were survey-based.

When mapping these measures to the NQF domains, it became clear that there was a lack of measures that could truly evaluate transitions and communication between numerous settings. Also, while many of the measures fell within the Care Planning domain, most were measures of patient experience and

¹¹ McDonald KM, Schultz E, Albin L, Pineda N, Lonhard J, Sundaram V, Smith-Spangler C, Burstrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Standord University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.

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did not examine critical care coordination activities such as the establishment of accountability and the communication of critical information.

The findings of the scan, though not surprising, highlighted the need for cross-cutting measure development. The author also concluded that there are significant gaps in measures that incorporate community-level involvement or examine coordination for vulnerable populations.

Vision of the Care Coordination Pathway Forward

In order to set the Pathway Forward to advance the field, and to inform the specifics of the *Call for Measures* for the second phase of the project, Committee members considered several aspects that are critical for future measurement of care coordination.

The Committee emphasized the need to think of care coordination measurement in terms of incremental build, understanding that it is a rapidly evolving field. As NQF-endorsed measures are implemented and then re-evaluated under the NQF measure maintenance policy, the potential exists for measures to outlive their usefulness as the field evolves. Deliberations, therefore, were not limited to what is only currently possible or supported by HIT infrastructure, but also addressed the ideal state of care coordination measurement as it develops in the future.

In discussing the broader themes relating to care coordination measures, the Committee considered a number of issues, such as: the role of broader-based measures as opposed to condition-specific ones, care coordination for high-risk populations, potential outcome measures of care coordination, and the role of risk-adjustment and stratification in care coordination measurement.

The following aspects of care coordination measurement were identified as essential components of the Pathway Forward:

- **Cross-Cutting Measurement - Not Limited by Condition or Setting**
 - Future care coordination measures should move beyond clinical settings and begin capturing other vital components of care coordination, including: patient and family involvement, church programs, community programs, and care provided in the home. The majority of care coordination is not a physician function, but a multi-disciplinary one, and measures must reflect these diverse and numerous roles involved in coordinating care.
 - While there still remains a need for condition-specific measures, the field should begin moving away from approaches targeting individual conditions alone, and toward more broad-based measures.
 - Care coordination should be examined beyond the perspective of a disease or injury. Prevention and wellness plans, for example, are also vital components of care coordination.

- **Close link to Outcomes**
 - Care coordination measures should be as proximal as possible to patient-centered outcomes. However, there exists an ongoing need to balance evidence and outcomes standards with innovation in order to avoid excluding newer measures where benefits significantly outweigh risks.

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- When considering outcomes of care coordination, it is also important to note the possible ambiguity in determining with which components of care those outcomes should be associated.
- **Process Measures**
 - As the field of measurement is moving towards outcome measures, process measures such as appointment-making continue to remain important indicators of care coordination. For example, a meaningful measure may be one that ensures a follow-up appointment or visit is completed successfully.
 - Process and adherence measures could potentially be rolled into a bundle to indicate the level of coordination of one's care.
- **High-Risk Populations**
 - All patients require some aspect of care coordination; however, there are certain high-risk populations for whom more in-depth and complex coordination is needed. Measures should strive to identify these high-risk populations through stratification by such elements as prior number of emergency-department visits or medication usage.
 - Measures also may be solely focused on high-risk populations due to differences in the infrastructure needed to support these groups.
 - Measures that allow for risk-adjustment of outcomes are needed, particularly when reported at a population level or used for comparative purposes. Stratification by such units as number of visits to the emergency department or medication usage could identify high-risk populations and support appropriate, targeted care. However, there is also concern with risk-adjusting too extensively, potentially masking sub-optimal care or hindering the identification of disparities.
- **Shared Plan of Care**
 - An ideal way of standardizing the care coordination process is through the use of a shared Plan of Care, which would be applicable to all patients, including the healthiest and those with chronic conditions.
 - A Plan of Care may be considered that which would be updated on an ongoing basis and would not be owned by any one discipline, but driven by all care team members, including the patient, who would have the ability to access in its current state and upload home health information.
 - Measureable outcomes of goals are essential components of a Plan of Care.
 - The Plan of Care could additionally address issues of accountability, assigning different parties to various components of the Plan. However, there is difficulty in determining who is ultimately accountable for the Plan of Care.
- **Cost**
 - Understanding the resource utilization associated with coordinating care will be increasingly relevant as reimbursement strategies are aligned with these functions. There is a need for measures that could begin to identify cost savings potentials of care coordination activities.

Also, as part of the discussion of the Pathway Forward, Committee members shared their knowledge of existing measures that should be considered in the second phase of the project; however, no new measures with adequate testing were identified. To ensure that care coordination measures submitted

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to NQF are meaningful and appropriate, the Committee agreed that the *Call for Measures* for this and future projects should reflect the high-priority areas discussed above. Also, the Committee agreed that specifications for EHRs should be included in measures submissions to the extent possible.

PHASE TWO

The second phase of the project focused on evaluating, through NQF's Consensus Development Process, 15 measures that were scheduled for maintenance review. Despite targeted outreach and an extended *Call for Measures* period, no new measures were submitted to this project.¹²

To facilitate the evaluation, measures were apportioned into three sub-committee workgroups for preliminary review prior to consideration by the full Committee at the in-person meeting on February 28-29, 2012. A summary of the evaluation results is shown below, followed by a description of overarching issues that emerged from the evaluation process, summaries of the Committee's discussions and ratings of the measures, and, finally, recommendations for future measure development.

Care Coordination Endorsement Maintenance Summary

Measures under consideration	Maintenance	New	Total
Total under consideration	15	0	15
Withdrawn from consideration	0	0	0
Recommended	12	0	12
Not recommended	3	0	3
Reasons for not recommending	Importance—3		

Overarching Issues

During the Committee's discussion of the measures, several issues arose that were applicable to more than one measure. These overarching issues, which were factored into the Committee's ratings and recommendations as appropriate, are discussed below but are not repeated in detail for each individual measure in the measure evaluation summary tables.

Limited evidence base

According to NQF measure evaluation criteria, in order to pass the evidence subcriterion of the Importance to Measure and Report criterion, measure submissions must include explicit, transparent information on the quantity, quality, and consistency of the body of evidence. However, several measures had only limited empirical evidence to inform the measure specifications and/or link the measure focus to a desired health outcome. For several such measures, the Committee considered invoking an exception to the evidence criterion, and in fact, did invoke it for one measure (this exception allows the Committee to overlook deficiencies in the quantity, quality, and consistency of the evidence and instead to decide if the potential benefits to patients clearly outweigh potential harms). Notwithstanding limitations of the evidence base, the Committee confirmed—based on their

¹² In an effort to gain insight as to why no new measures were submitted to the project and to identify barriers and challenges to developing care coordination measures, NQF staff subsequently circulated a short information-gathering survey to measure developers. Several developers noted that the idea of accountability—and the extent to which a provider can realistically affect the processes or outcomes being measured—makes the development of care coordination measures difficult. Developers also noted the challenges—including the high costs associated with fully specifying and testing a measure—associated with integrating data from multiple settings and/or providers.

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clinical and professional expertise—the importance of many of the measure concepts evaluated in this project.

Reliability and Validity

NQF measure evaluation criteria direct that measures must demonstrate adequate reliability and validity to pass the Scientific Acceptability of Measure Properties criterion. The reliability rating includes evaluation of the precision of measure specifications and reliability testing, while the validity rating includes evaluation of validity testing and testing related to potential threats to validity (e.g., risk adjustment and exclusions). The Committee noted that several measures were specified for multiple data sources (e.g., claims, electronic records, paper records), but testing was completed for only one source, often using relatively small samples and/or data from only one site or system. Similarly, some measures were specified for multiple levels of analysis (e.g., clinician, health plan) but were tested for only one level, or were specified for several care settings but tested in only one setting.

Feasibility

The Committee expressed concern regarding the burden of data collection for practices that do not have electronic systems and therefore must rely on manual abstraction from paper records. However, they also noted that even for practices with electronic systems, some of the measures might require extensive manipulation of EHR data to calculate the measure.

Terminology and lack of standardized definitions

For several measures, the Committee noted a lack of precision and/or consistency in terminology in measure titles, descriptions, or specifications. Examples include use of the term “inpatient facility” without additional explanatory narrative (which to some may connote only the hospital setting) and use of the term “physician” when other clinical providers are included in the measure. Relatedly, the Committee also noted that several terms used for care coordination are not universally well-defined (e.g., medication review, medication reconciliation, and advance care plan).

Competing and Related Measures

Measures that the Committee has recommended as suitable for endorsement must also be compared to any competing or related measures. Competing measures are those with the same measure focus and the same target population, while related measures are those with the same measure focus or the same target population. Using NQF [guidance](#) for these comparisons, the Committee must vote to select a superior measure(s) and/or to determine whether measures are harmonized enough for final recommendation for endorsement.

To frame their consideration of competing and related measures, the Committee first addressed the question of the need for cross-cutting versus condition-specific measures of care coordination. In general, the Committee supported the development of cross-cutting measures over that of condition-specific measures. They noted that cross-cutting measures have the potential to be more person-centric than condition-specific measures, more useful for those with multiple chronic conditions, and more appropriate for efficiency and patient-reported outcomes measures. They also commented on the potentially overwhelming number of condition-specific measures. However, the Committee also noted that condition-specific measures may be justified for certain high-risk or high-volume conditions and/or for conditions that have very strong evidence-based guidelines.

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For this project, the Committee addressed a total of 10 measures (seven from the current Care Coordination project and three that were evaluated in other projects) that have been identified as competing and/or related measures, as follows.

- The medication review measure (#0553) is competing with a medication documentation measure (#0419) that was reviewed in the recent Patient Safety project. On a conceptual level, both of these measures address documentation of medications in the medical record, and both target ambulatory care/post-acute care patients. The measures differ in the following ways:

0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
Includes medication review and documentation of a medication list in the medical record	Includes documenting of medications, including all prescriptions, over-the-counters, herbals, vitamin/mineral/dietary supplements and must contain the name, dosages, frequency, and route
Includes patients age 65 years and older	Includes patients age 18 years and older
Measured at least once in the measurement period—but an outpatient visit is not required	Measured at each outpatient encounter
Can be fulfilled by a provider with proscribing privileges or a clinical pharmacist	Can be fulfilled by an “eligible professional”

In their discussions, most Committee members favored challenging the developers to combine these two measures. They noted that medication review is a best practice that should be encouraged for all age groups. One member also noted that medication review is something needed at each encounter, although another suggested that the measure also should gauge the occurrence of medication review when prescriptions are filled by phone. Another member also suggested that developers consider the possibility of stratifying the combined measure (e.g., for certain high risk groups, such as older patients or those with cognitive impairment).

- Three medication reconciliation measures (#0097, #0554, and #0646) were viewed as competing with each other (and are related to measure 0553 and 0419). On a conceptual level, all three of these measures address medication reconciliation among patients discharged from an inpatient facility. The measures differ in the following ways:

0097 Medication Reconciliation	0054 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients
Includes patients age 65 years and older	Includes patients age 65 years and older	Includes all patients
Timeframe is 60 days	Timeframe is 30 days	Timeframe is each discharge
Can be fulfilled by a physician in a physician office	Can be fulfilled by a provider with proscribing privileges, clinical pharmacist, or nurse, and an outpatient visit is not required	Facility-level measure

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Committee members grappled with the distinctions between medication review and medication reconciliation in these three measures and the two discussed above, and emphasized that the overarching goal for care coordination is for patients to be involved in the process and understand which medications they should be taking (especially after hospital discharge). Although they challenged the developers to construct a measure that would capture the transfer of relevant information to all involved (both patients and providers), they recognized the inherent difficulties due to different patient denominators.

- Five transition record measures (#0647, #0648, #0649, #0558, and #0557) have been identified as competing and/or related. On a conceptual level, all five of these measures address the provision of transition records for patients discharged from an inpatient setting. Note that measures 0558 and 0557 were not reviewed in the current Care Coordination project. An additional measure (#0338) was initially identified as a competing/related measure and discussed by the Committee; since that discussion, however, this measure was evaluated in an NQF project examining pulmonary measures, and was not recommended as suitable for endorsement. Thus, it will not be considered further in this project. The five transition record measures differ in the following ways:

0647 Transition Record with Specified Elements Received by Discharged Patients	0648 Timely Transmission of Transition Record	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges)	0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0557 HBIPS-6 Post discharge continuing care plan created
Transition record is given to the patient	Transition record is given to the next provider	Transition record is given to the patient	Transition record is given to the next provider	Transition record is created
Includes all patients discharged from an inpatient facility	Includes all patients discharged from an inpatient facility	Includes all patients discharged from the ED	Includes patients discharged from a hospital-based inpatient psychiatric setting	Includes patients discharged from a hospital-based inpatient psychiatric setting

In their discussion of the transition record measures, Committee members noted that a strength of measure 0648 (as compared to 0558) was the specification of a time frame for when the transition record should be sent. Committee members noted that transition records should always be shared with the patient, but also cautioned that the information that should be transmitted to the patient (particularly information that aids in self-care management) may be different from what is transmitted to the next provider.

Side-by-side tables of specifications for these measures are presented in Appendix C.

Measure developers have been granted additional time to respond jointly (as appropriate) to questions surrounding the competing and related measures during the public and member comment period. The Committee will vote on superior measures and on whether measures are harmonized enough to recommend for endorsement following comment.

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Measure Summaries - Recommended

0097 Medication Reconciliation
<p>Status: Maintenance, Original Endorsement: May 01, 2007 , Most Recent Endorsement: Jan 25, 2012</p> <p>Description: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.</p> <p>Numerator Statement: Patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented</p> <p>The medical record must indicate that the physician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of a inpatient facility discharge medication.</p> <p>Denominator Statement: All patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care</p> <p>Exclusions: N/A</p> <p>Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A</p> <p>Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Integrated Delivery System, Population : County or City</p> <p>Type of Measure: Process</p> <p>Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Registry, Paper Records</p> <p>Measure Steward: National Committee for Quality Assurance Other Organizations: This measure was developed with the cooperation of the American Geriatrics Society, the National Committee for Quality Assurance and the American Medical Association.</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p> <p>1. Importance to Measure and Report <i>(based on decision logic): Yes</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence)</p> <p>1a. Impact: H-19; M-7; L-0; I-0 1b. Performance Gap: H-21; M-4; L-1; I-0 1c. Evidence: Y-17; N-3; I-6</p> <p>Rationale: Although much of the Steering Committee’s concern with this measure centered around the lack of evidence linking the process of medication reconciliation with improved patient outcomes, members cited professional knowledge and judgment to confirm that medication reconciliation is linked with the reduction of medical errors and polypharmacy, and improved patient outcomes.</p>
<p>2. Scientific Acceptability of Measure Properties <i>(based on decision logic): Yes</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)</p> <p>2a. Reliability: H-7; M-18; L-1; I-0 2b. Validity: H-3; M-21; L-2; I-0</p> <p>Rationale: The Committee questioned the 60-day timeframe associated with the measure, noting that patients may be readmitted within 60 days. Developers explained that while a 30-day timeframe had been proposed initially, the sample size of patients with outpatient visits within 30 days of discharge was too small for accurate measurement and therefore the timeframe was expanded to 60 days. Committee members also commented that the measure description should reflect that additional clinical providers (not just physicians) can be included in this measure. One Steering Committee member asked for clarification about whether e-measure specifications are available for this measure, and the developer explained that they are currently working to develop e-measure specifications. Another Committee member noted that HL7 standards do not currently include a “reconciled medication list” element (only a “medication list” element) and that e-measure specifications for this measure will not be possible until additional elements are included in the HL7 standards.</p>
<p>3. Usability: H-7; M-17; L-2; I-0 <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i></p> <p>Rationale: Although this measure is included in PQRS, relatively few physicians reported on this measure in 2007.</p>
<p>4. Feasibility: H-7; M-16; L-3; I-0 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</i></p> <p>Rationale: Steering Committee members were concerned with the burden of data collection and commented on the lack of more recent PQRS data that might indicate an increased rate of reporting of this measure. Developers explained that PQRS data are difficult to obtain from CMS.</p>

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0097 Medication Reconciliation

Steering Committee Recommendation on Overall Suitability for Endorsement (*pending decisions on related/competing measures*): **Y-25; N-1**

Rationale: Despite concerns over the lack of evidence and the low reporting rate of the measure, the Committee found this measure to be suitable for endorsement.

0171 Acute care hospitalization (risk-adjusted)

Status: Maintenance, Original Endorsement: Mar 31, 2009 , Most Recent Endorsement: Jan 31, 2012

Description: Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.

Numerator Statement: Number of home health stays for patients who have a Medicare claim for an unplanned admission to an acute care hospital in the 60 days following the start of the home health stay.

Denominator Statement: Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.

Exclusions: The following are excluded: home health stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window (60 days following the start of the home health stay) or until death; home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim; home health stays in which the patient receives service from multiple agencies during the first 60 days; and home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the start of the home health stay.

Adjustment/Stratification: Statistical risk model Multinomial logit with outcomes of “No acute event”, “Emergency Department without Hospitalization”, and “Acute Care Hospitalization”.

Risk factors include:

Prior Care Setting –

The main categories are community (i.e., no prior care setting), outpatient emergency room, inpatient-acute (IP-acute), inpatient rehabilitation facility (IRF), psychiatric facility, long-term care facility (LTC), and skilled nursing facility (SNF). The hierarchy of setting is SNF, most recent inpatient stay, and outpatient ER. Acumen used the five cohorts from the Yale Hospital-Wide All-Cause Unplanned Readmission Measure to segregate the IP-acute category. The five cohorts are:

1. Surgery/Gynecology: admissions likely cared for by surgical or gynecological teams, based on AHRQ procedure categories;
2. Cardiorespiratory: admissions treated by the same care teams with very high readmission rates, such as for pneumonia, chronic obstructive pulmonary disease, and heart failure;
3. Cardiovascular: admissions treated by separate cardiac or cardiovascular team in large hospitals, such as for acute myocardial infarctions;
4. Neurology: admissions for neurological conditions, such as stroke, that may be treated by a separate neurology team in large hospitals; and
5. Medicine: admissions for all other non-surgical patients.

These cohorts were designed to account for differences in readmission risk for surgical and non-surgical patients. Finally, the IP-acute categories and the SNF category were further refined by length of stay. Each of the five IP-acute categories are separated into stays of length 0 to 3 days, 4 to 8 days, and 9 or more days, while the SNF categories are split into stays of length 0 to 13, 14 to 41, and 42 and more days. A patient cared for in both a skilled nursing facility and an inpatient hospital during the 30 days prior to starting home health care is included in the skilled nursing categories and not the inpatient categories. The length of stay is determined from the last inpatient or skilled nursing stay prior to beginning home health care.

Age and Gender Interactions –

Age is subdivided into 12 bins for each gender: aged 0-34, 35-44, 45-54, five-year age bins from 55 to 95, and a 95+ category. Using a categorical age variable allows the model to account for the differing effects of age and gender. Age is determined based on the patient’s age at Stay_Start_Date.

CMS Hierarchical condition categories (HCCs) –

HCCs were developed for the risk adjustment model used in determining capitation payments to Medicare Advantage plans and are calculated using Part A and B Medicare claims. While the CMS-HHC model uses a full year of claims data to calculate HCCs, for these measures, we use only 6 months of data to limit the number of home health stays excluded due to missing HCC data. All 2008 HCCs and CCs that are not hierarchically ranked that were statistically significant predictors of ACH and ED use are included in the model.

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0171 Acute care hospitalization (risk-adjusted)
<p>Details of the CMS-HCC model and the code lists for defining the HCCs can be found here: https://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp A description of the development of the CMS-HCC model can be found here: https://www.cms.gov/HealthCareFinancingReview/Downloads/04Summerpg119.pdf ESRD and Disability Status – Original End Stage Renal Disease (ESRD) and current ESRD status are included as risk factors. Original disabled status and male, and original disabled status and female, are also included. Medicare beneficiaries with ESRD or disabled status represent a fundamentally different health profile. Interaction Terms – All interaction terms included in the 2008 and 2012 HCC risk adjustment models that were statistically significant predictors of ED Use and ACH were included. Interaction terms account for the additional effect two risk factors may have when present simultaneously, which is more than the additive effect of each factor separately. N/A - not stratified Level of Analysis: Facility Type of Measure: Outcome Data Source: Administrative claims Measure Steward: Centers for Medicare & Medicaid Services Other Organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12 1. Importance to Measure and Report <i>(based on decision logic): Yes</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence) 1a. Impact: H-14; M-9; L-0; I-0 1b. Performance Gap: H-13; M-9; L-0; I-1 1c. Evidence: <u>Rationale:</u> The Committee deemed this to be an important measure; however, they acknowledged the difficulty in “parsing” attribution for hospitalization between different providers and settings, especially since this is an “all-cause” measure that does not require the reason for hospitalization to be related to the reason for home health care. Because this is an outcome measure, the Committee was not required to vote on the evidence subcriterion. Developers noted that the measure takes a broad view of the impact that home health care can have on patient outcomes and pointed to the exclusion of planned hospitalizations; they also emphasized that they do not expect a zero-percent hospitalization rate. Because this is an outcome measure, the Committee was not required to vote on the evidence subcriterion.</p>
<p>2. Scientific Acceptability of Measure Properties <i>(based on decision logic): Yes</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-14; M-10; L-0; I-0 2b. Validity: H-11; M-12; L-1; I-0 <u>Rationale:</u> The Committee expressed support for excluding planned hospitalizations from the numerator and for accounting for previous care settings in the risk model. When asked about the methods of reliability and validity testing and the exclusion of low-utilization payment adjustment (LUPA) episodes from the measure, developers clarified that they used the observed rate for their reliability testing, and acknowledged this testing to be “necessary but maybe not completely sufficient”. Further—to justify use of payment error audits as an appropriate method for validity testing—developers posited that there is no reason to believe that hospitals would be more likely to have erroneous claims for home health patients than for others. They also explained the exclusion of LUPAs as a decision made so as not to unfairly penalize an agency that may have had less time to impact a patient’s condition or that did in fact make a clinically appropriate decision to refer a patient to the hospital. Also, in response to a Committee member’s query, developers verified that “present on admission” information is not used in the measure, nor is the patient’s hospice or palliative care status.</p>
<p>3. Usability: H-11; M-13; L-0; I-0 <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i> <u>Rationale:</u> A previous version of this measure (that is based on OASIS data) is currently reported on Home Health Compare. One Committee member noted that the complexity of the risk adjustment used for this measure may make its implications less understandable to the public.</p>
<p>4. Feasibility: H-17; M-7; L-0; I-0 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</i> <u>Rationale:</u> Committee members noted that although the claims data that this measure is based on are routinely gathered, specialized knowledge (e.g., to apply the risk adjustment methodology) is necessary to compute the</p>

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0171 Acute care hospitalization (risk-adjusted)

measure score.

Steering Committee Recommendation on Overall Suitability for Endorsement: Y-24; N-0

Rationale: Although not perceived as a strong measure of care coordination per se, the Steering Committee agreed that this measure meets NQF criteria and is suitable for endorsement.

0173 Emergency Department Use without Hospitalization

Status: Maintenance, Original Endorsement: Mar 31, 2009 , Most Recent Endorsement: Jan 31, 2012

Description: Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.

Numerator Statement: Number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay.

Denominator Statement: Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.

Exclusions: The following are excluded: home health stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window (60 days following the start of the home health stay) or until death; home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim; home health stays in which the patient receives service from multiple agencies during the first 60 days; and home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior the start of the home health stay.

Adjustment/Stratification: Statistical risk model Multinomial logit with outcomes of “No acute event”, “Emergency Department use but no Hospitalization”, and “Acute Care Hospitalization”.

Risk factors include:

Prior Care Setting –

The main categories are community (i.e., no prior care setting), outpatient emergency room, inpatient-acute (IP-acute), inpatient rehabilitation facility (IRF), psychiatric facility, long-term care facility (LTC), and skilled nursing facility (SNF). The hierarchy of setting is SNF, most recent inpatient stay, and outpatient ER. Acumen used the five cohorts from the Yale Hospital-Wide All-Cause Risk Standardization Readmission Measure to segregate the IP-acute category. The five cohorts are:

1. Surgery/Gynecology: admissions likely cared for by surgical or gynecological teams, based on AHRQ procedure categories;
2. Cardiorespiratory: admissions treated by the same care teams with very high readmission rates, such as for pneumonia, chronic obstructive pulmonary disease, and heart failure;
3. Cardiovascular: admissions treated by separate cardiac or cardiovascular team in large hospitals, such as for acute myocardial infarctions;
4. Neurology: admissions for neurological conditions, such as stroke, that may be treated by a separate neurology team in large hospitals; and
5. Medicine: admissions for all other non-surgical patients.

These cohorts were designed to account for differences in readmission risk for surgical and non-surgical patients.

Finally, the IP-acute categories and the SNF category were further refined by length of stay. Each of the five IP-acute categories are separated into stays of length 0 to 3 days, 4 to 8 days, and 9 or more days, while the SNF categories are split into stays of length 0 to 13, 14 to 41, and 42 and more days. A patient cared for in both a skilled nursing facility and an inpatient hospital during the 30 days prior to starting home health care is included in the skilled nursing categories and not the inpatient categories. The length of stay is determined from the last inpatient or skilled nursing stay prior to beginning home health care.

Age and Gender Interactions –

Age is subdivided into 12 bins for each gender: aged 0-34, 35-44, 45-54, five-year age bins from 55 to 95, and a 95+ category. Using a categorical age variable allows the model to account for the differing effects of age and gender. Age is determined based on the patient’s age at Stay_Start_Date.

CMS Hierarchical condition categories (HCCs) –

HCCs were developed for the risk adjustment model used in determining capitation payments to Medicare Advantage plans and are calculated using Part A and B Medicare claims. While the CMS-HHC model uses a full year of claims data to calculate HCCs, for these measures, we use only 6 months of data to limit the number of home health stays excluded due to missing HCC data. All 2008 HCCs and CCs that are not hierarchically ranked

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<p>0173 Emergency Department Use without Hospitalization</p>
<p>that were statistically significant predictors of ACH and ED use are included in the model. Details of the CMS-HCC model and the code lists for defining the HCCs can be found here: https://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp A description of the development of the CMS-HCC model can be found here: https://www.cms.gov/HealthCareFinancingReview/Downloads/04Summerpg119.pdf ESRD and Disability Status – Original End Stage Renal Disease (ESRD) and current ESRD status are included as risk factors. Original disabled status and male, and original disabled status and female, are also included. Medicare beneficiaries with ESRD or disabled status represent a fundamentally different health profile. Interaction Terms – All interaction terms included in the 2008 and 2012 HCC risk adjustment models that were statistically significant predictors of ED Use and ACH were included. Interaction terms account for the additional effect two risk factors may have when present simultaneously, which is more than the additive effect of each factor separately. Measure is not stratified. Level of Analysis: Facility Type of Measure: Outcome Data Source: Administrative claims Measure Steward: Centers for Medicare & Medicaid Services Other Organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12 1. Importance to Measure and Report <i>(based on decision logic): Yes</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence) 1a. Impact: H-14; M-10; L-0; I-0 1b. Performance Gap: H-12; M-11; L-1; I-0 1c. Evidence: <u>Rationale:</u> There was some disagreement within the Committee regarding the impact of the measure in light of the fact that only 10 percent of home health patients who utilize the ED are not admitted (this would include approximately 230,000 ED visits, which is a very small percentage of total ED visits in the U.S.). Committee members noted that there are many drivers for ED use (e.g., cultural, legal, etc.) that may be outside of the control of home health agencies. There was also some concern that this measure might be somewhat misconstrued because in many cases, ED utilization is an appropriate response, even if the patient is not admitted. The developer reminded the Committee that variation in performance rates signals the likelihood that home health agencies can impact ED usage rates. Because this is an outcome measure, the Committee was not required to vote on the evidence subcriterion.</p>
<p>2. Scientific Acceptability of Measure Properties <i>(based on decision logic): Yes</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-13; M-10; L-1; I-0 2b. Validity: H-8; M-14; L-2; I-0 <u>Rationale:</u> This measure uses the same risk adjustment methodology, reliability/validity testing, and denominator exclusions as measure 0171. One Committee member asked for clarification about whether observation stays are included in this measure and the developer confirmed that they are included. Another Committee member asked if characteristics of the ED or the neighborhood were accounted for in the measure, and the developer stated that neither was included in the measure. Another Committee asked if the measure examined only potentially avoidable ED visits, and the developer clarified that this measure is an all-cause measure.</p>
<p>3. Usability: H-5; M-18; L-1; I-0 <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i> <u>Rationale:</u> One Committee member noted that, because of the time required for risk-adjustment, the measure may be less useful for internal quality improvement investigations. The developer informed the Committee that some testing has been done by CMS to ensure that the meaning of the measure, as represented on Home Health Compare, is understandable to the public.</p>
<p>4. Feasibility: H-14; M-9; L-1; I-0 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</i> <u>Rationale:</u></p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement: Y-23; N-1 Rationale: Although the Committee was concerned that clinical, legal, or cultural factors outside of the control of the home health agency also can influence ED use, and that the measure itself might encourage “cherry picking” of</p>

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patients, they agreed that this measure meets NQF criteria and is suitable for endorsement

0326 Advance Care Plan
<p>Status: Maintenance, Original Endorsement: Nov 05, 2007 , Most Recent Endorsement: Jan 25, 2012</p> <p>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</p> <p>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</p> <p>Denominator Statement: All patients aged 65 years and older</p> <p>Exclusions: N/A</p> <p>Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A</p> <p>Level of Analysis: Clinician : Individual</p> <p>Type of Measure: Process</p> <p>Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry</p> <p>Measure Steward: National Committee for Quality Assurance Other Organizations: This measure was developed with the cooperation of the American Geriatrics Society, the National Committee for Quality Assurance and the American Medical Association.</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p> <p>1. Importance to Measure and Report <i>(based on decision logic): Yes</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence) 1a. Impact: H-23; M-3; L-0; I-0 1b. Performance Gap: H-20; M-4; L-0; I-2 1c. Evidence: Y-15; N-4; I-7 <u>Rationale:</u> The Committee expressed strong support of the importance of advance care planning for this population. There was overall agreement on both a gap in performance as well as an overall low performance for this measure, although there was a desire by some members of the Committee to see performance statistics for various population subgroups (e.g., underserved groups. Cognitively impaired, etc.). Committee members also suggested that while there is strong evidence for the value of advanced care planning overall, there is less evidence linking advanced care planning to desired outcomes such as improved quality of life or potential cost savings.</p>
<p>2. Scientific Acceptability of Measure Properties <i>(based on decision logic): Yes</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-6; M-11; L-5; I-4 2b. Validity: H-2; M-11; L-7; I-6 <u>Rationale:</u> There was considerable difference of opinion between Committee members regarding the reliability and validity of the measure (note that there was a tie for validity). Much of the concern with this measure was related to how the measure is specified. Committee members were confused about what is actually being measured (i.e., that a “conversation” occurred, that various components of an advanced care plan, such as an advanced directive, durable power of attorney, etc.—have been documented, or some combination). They were also concerned about the time frame of the measure, since it seems to be measuring, on an annual basis, whether or not an advanced care plan is documented in the medical record—but is not measuring whether the plan has been updated, or at least discussed, at least annually. While the developer clarified that this measure holds the physician accountable for the documentation, Committee members maintained it is often other providers (e.g., nurse, social worker) who often have advanced care conversations with patients. Additionally, Committee members were concerned that advanced care planning conversations are actually occurring, but for some reason, they are not being captured with this measure through the use of CPT-II codes. There was also considerable discussion about the testing of the measure, and although the developer described inter-rater reliability testing done based on manual record abstraction, some Committee members were not convinced that adequate testing had been done to assure that reporting of a CPT-II code does in fact reflect actual documentation of advanced care planning in the medical record.</p>
<p>3. Usability: H-4; M-14; L-8; I-0 <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i> <u>Rationale:</u> Developers noted that the reporting rate submitted by the developer was based on all physicians, and that specialists or those with few patients age 65 years or older in their practice likely would not choose to report on this measure.</p>

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<p>4. Feasibility: H-2; M-12; L-10; I-2 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</i></p> <p>Rationale: There was disagreement among Committee members about the feasibility of this measure due to uncertainties about the specificity of the measure, its reliance on the use of CPT-II codes, the relatively low reporting rate of the measure in the 2008 PQRI, and reservations about capturing appropriate data elements in electronic systems.</p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement: Y-18; N-8</p> <p>Rationale: Committee members recommended this measure as suitable for endorsement at this time because of the importance of the topic; however, the Committee strongly expressed their desire for better measures of advanced care planning.</p>

0494 Medical Home System Survey
<p>Status: Maintenance, Original Endorsement: Aug 29, 2008 , Most Recent Endorsement: Jan 25, 2012</p> <p>Description: The following 6 composites are generated from the Medical Home System Survey (MHSS). Each measure is used to assess a particular domain of the patient-centered medical home.</p> <p>Measure 1: Improved access and communication Measure 2: Care management using evidence-based guidelines Measure 3: Patient tracking and registry functions Measure 4: Support for patient self-management Measure 5: Test and referral tracking Measure 6: Practice performance and improvement functions</p> <p>Numerator Statement: The composite measures do not have a typical numerator. Each composite is composed of elements; each element is made up of individual factors. The composite score is calculated by adding the element scores. The element scores are based on the proportion of individual factors with a satisfactory “yes” response (see Standards documentation for details).</p> <p>Note: In the calculation algorithm, the measurement domains are termed “composites,” the measures within each domain are referred to as “elements,” and the items within a measure, or measure subcomponents, are referred to as “factors.”</p> <p>Denominator Statement: N/A</p> <p>Exclusions: None</p> <p>Adjustment/Stratification: No risk adjustment or risk stratification None N/A</p> <p>Level of Analysis: Clinician : Group/Practice</p> <p>Type of Measure: Structure</p> <p>Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Healthcare Provider Survey, Management Data, Other, Paper Records, Patient Reported Data/Survey</p> <p>Measure Steward: National Committee for Quality Assurance Other Organizations:</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p> <p>1. Importance to Measure and Report (based on decision logic): Yes (1a. High Impact: 1b. Performance Gap 1c. Evidence)</p> <p>1a. Impact: H-10; M-11; L-1; I-0 1b. Performance Gap: H-6; M-13; L-3; I-0 1c. Evidence: Y-15; N-2; I-5</p> <p>Rationale: The Committee agreed that the impact of a medical home is substantial, citing its inclusion in health reform regulations and alignment with both meaningful use and the preferred practices for care coordination endorsed by NQF in 2010. The Committee noted that while there is a fairly robust body of evidence that includes good quality studies, early evaluations of the medical home model have not yet shown, for the most part, significant impacts on health outcomes. Developers reminded the Committee that some more recent studies have shown some improved patient outcomes for diabetes care, as well as improvements in patient, physician, and staff satisfaction, and, in North Carolina, reduced hospitalizations and emergency room visits.</p>
<p>2. Scientific Acceptability of Measure Properties (based on decision logic): Yes (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)</p> <p>2a. Reliability: H-2; M-17; L-3; I-0 2b. Validity: H-1; M-11; L-8; I-2</p> <p>Rationale: The Committee had an extensive discussion about whether this measure is actually a performance measure or is instead a collection of documentation of clinical processes to enable a certification or recognition</p>

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0494 Medical Home System Survey

award. Some Committee members expressed discomfort with the idea that this measure does not really work like a traditional performance measure (that is, “failing” or not doing well on this measure would not necessarily mean that a practice is not performing as an effective medical home). Developers clarified that there is no pass/fail for this measure, but instead, there are scores for the various elements that can reflect how well a practice is doing in terms of achieving those structures and processes that many experts believe are associated with the medical home model. They also explained that while this measure is the tool used for the NCQA Medical Home certification program, it is not the same thing as the certification program; rather, the intent behind the submission of this measure is to put the tool in the public domain for use as a way to help practices understand their progress towards becoming a medical home and/or their readiness to apply for NCQA (or other) certification.

Some Committee members suggested that this measure be better addressed through an evaluation of its six components individually; however, others maintained that it is more meaningful if taken as a whole. Committee members also noted that processes/programs by other organizations exist for identifying/recognizing a medical home and were concerned that endorsement of this measure would preclude future endorsement of medical home measures. However, NQF staff clarified that endorsement of this measure would NOT preclude other submissions of measures of medical home. Also, while a few Committee members compared this measure to the measures based on the CAHPS survey, NQF staff emphasized that NQF does not endorse the CAHPS survey but instead has endorsed measures derived from the CAHPS survey. The developers have agreed to change the title of this measure in order to clarify that, if endorsed, NQF is endorsing the measures, not the actual Medical Home System Survey.

One member commented that because the measure relies on self-report, the infrequent conformatory analyses make the inter-rater reliability problematic. Because the reliability testing results provided by the developer were based on the 2008 version of their survey (rather than on the 2011 update submitted in this measure), more clarification about the overlap between the 2008 version and the 2011 version was requested. Developers reported a substantial overlap between the two versions, saying that approximately 79% of the factors in the 2008 version were included in the 2011 version. When asked about analysis to support internal consistency of the elements/factors in the measure, developers explained that results of tests for internal consistency (which were not submitted) were not meaningful because this measure is not trying to measure a latent construct, but is instead measuring different components of a medical home. Although developers have not yet performed additional analysis of validity for the 2011 version of the survey, NQF staff noted that developers update their NQF submissions annually and can provide additional testing results at that time. The Committee acknowledged the work of the expert panel convened by the developers that provided opinion as to the face validity of the items included in the measure. After questions from the Committee about how scores were assigned to the elements included in the measure, the developers explained that an expert panel applied a Delphi process to determine the weighting of importance of the elements.

3. Usability: H-5; M-11; L-6; I-0

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

Rationale: NCQA publicly reports an aggregate score (level 1,2, or 3) for practices that pass the NCQA recognition program (note that the assignment of this level is a proprietary component of the NCQA recognition program and is not included as part of the scoring for this measure as specified). However, the developers stated that they would not oppose public reporting of the component/element scores of this measure that is consistent with the composite measure framework. Also, one member questioned this measure’s usefulness for quality improvement efforts for practices that already function as medical homes.

4. Feasibility: H-3; M-11; L-8; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale: Some Committee members expressed concern about the feasibility of the measure. They noted that the data required may not be routinely gathered or available in an electronic format, and that data collection would be difficult and expensive. However, others noted that it is not so much the data collection itself that is difficult; rather, it is the work to support the development of the documentation that is difficult. The developers agreed that the process of becoming a medical home is arduous, but noted that their focus groups have found that the process of pulling together the documentation required in this measure actually helps practices become a medical home.

Steering Committee Recommendation on Overall Suitability for Endorsement: Y-14; N-8

Rationale: Although there were concerns about the difficulties in collecting data for this measure and the fit of

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this measure as a performance metric, the Committee stressed the importance of the medical home model and the role of this measure in advancing this model of healthcare delivery.
0526 Timely Initiation of Care
<p>Status: Maintenance, Original Endorsement: Mar 31, 2009 , Most Recent Endorsement: Mar 31, 2009</p> <p>Description: Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.</p> <p>Numerator Statement: Number of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.</p> <p>Denominator Statement: All home health episodes other than those covered by generic denominator exclusions.</p> <p>Exclusions: No measure-specific exclusions.</p> <p>Adjustment/Stratification: No risk adjustment or risk stratification N/A - process measure - not risk adjusted. Not stratified.</p> <p>Level of Analysis: Facility</p> <p>Type of Measure: Process</p> <p>Data Source: Electronic Clinical Data</p> <p>Measure Steward: Centers for Medicare & Medicaid Services Other Organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p> <p>1. Importance to Measure and Report <i>(based on decision logic): Yes</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence) 1a. Impact: H-13; M-11; L-0; I-0 1b. Performance Gap: H-6; M-14; L-3; I-1 1c. Evidence: Y-24; N-0; I-0 <u>Rationale:</u> On average, approximately 11 percent of home health patients do not receive their first home visit in the timeframe specified by the measure. Although only one article was cited as evidence for this measure, the Committee agreed that it was strong study. However, Committee members agreed to apply the exception for evidence, with unanimous consensus that the potential benefits of timely initiation of care would outweigh any potential harms.</p>
<p>2. Scientific Acceptability of Measure Properties <i>(based on decision logic): Yes</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-15; M-8; L-1; I-0 2b. Validity: H-8; M-15; L-0; I-1 <u>Rationale:</u> To test validity of the measure, developers analyzed the relationship between timely initiation of care and two other home health quality measures (acute care hospitalization and improvement in bathing). However, they found that timely initiation of care was associated with a higher likelihood of acute care hospitalization. In a workgroup call prior to the in-person Steering Committee meeting, the developers reported that a CMS-convened expert panel suggested that this unexpected result might be driven by the fact that this measure is collected only for those patients for whom home health care was actually provided (i.e., they wouldn't have hospitalization data for patients who did not get home care). During that call, workgroup members suggested that the denominator statement/exclusions should be modified so as to clarify that the measure is not capturing the complete set of patients for whom home healthcare was recommended.</p>
<p>3. Usability: H-18; M-6; L-0; I-0 <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i> <u>Rationale:</u> This measure is publicly reported on Home Health Compare. It is also reported in Home Health Outcome Based Quality Improvement (OBQI) reports and used in home health quality initiatives.</p>
<p>4. Feasibility: H-23; M-1; L-0; I-0 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</i> <u>Rationale:</u> The Committee expressed no concerns regarding the feasibility of this measure.</p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement: Y-24; N-0 Rationale: After applying the exception for evidence, the Steering Committee agreed that this measure meets NQF criteria as suitable for endorsement.</p>

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0553 Care for Older Adults – Medication Review
<p>Status: Maintenance, Original Endorsement: Aug 05, 2009 , Most Recent Endorsement: Jan 25, 2012</p> <p>Description: Percentage of adults 66 years and older who had a medication review; a review of all a member’s medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.</p> <p>Numerator Statement: At least one medication review (Table COA-B)conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Table COA-C)</p> <p>Table COA-B Codes to identify medication review: Medication review (CPT 90862, 99605, 99606), (CPT-II 1160F)</p> <p>Table COA-C Codes to Identify Medication List (CPT-II 1159F)</p> <p>Denominator Statement: All patients 66 and older as of December 31 of the measurement year</p> <p>Exclusions: N/A</p> <p>Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A</p> <p>Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State</p> <p>Type of Measure: Process</p> <p>Data Source: Administrative claims, Electronic Clinical Data, Paper Records</p> <p>Measure Steward: National Committee for Quality Assurance Other Organizations:</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p> <p>1. Importance to Measure and Report <i>(based on decision logic): Yes</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence) 1a. Impact: H-19; M-7; L-0; I-0 1b. Performance Gap: H-14; M-12; L-0; I-0 1c. Evidence: Y-18; N-5; I-3 <u>Rationale:</u> The Committee expressed some concern about the mixed results from the body of evidence. Developers explained these mixed results by noting that the cited studies used varying definitions of medication review and examined medication review as only one of a bundle of interventions (with the “bundle” differering across studies). The Committee also commented on the statistics presented by the developer, noting the indication of improvement in performance from 2008 to 2010.</p>
<p>2. Scientific Acceptability of Measure Properties <i>(based on decision logic): Yes</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-9; M-14; L-2; I-1 2b. Validity: H-5; M-17; L-2; I-2 <u>Rationale:</u> Committee members noted the lack of specificity in the definition of a medication review and a concern that this might be a “checkbox” measure. Developers clarified that this measure includes both a medication list as well as a discussion about the medications. Committee members also questioned the optional exclusions allowed for health plans; developers noted that this was a mistake in the original submission materials and clarified that there are no exclusions for this measure.</p>
<p>3. Usability: H-7; M-17; L-2; I-0 <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i> <u>Rationale:</u> This is a HEDIS measure and is publicly reported.</p>
<p>4. Feasibility: H-3; M-19; L-4; I-0 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)</i> <u>Rationale:</u> Committee members noted that medical record abstraction likely would be necessary to compute this measure. The developer clarified that they have specified this measure at the health plan level, but noted that plans may compute the measure at the clinician level.</p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement <i>(pending decisions on related/competing measures): Y-25; N-1</i> Rationale: Despite concerns about the lack of specificity in the definition of medication review, the Committee found this measure to be suitable for endorsement.</p>

0554 Medication Reconciliation Post-Discharge
<p>Status: Maintenance, Original Endorsement: Aug 05, 2009 , Most Recent Endorsement: Jan 25, 2012</p> <p>Description: The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.</p>

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<p>0554 Medication Reconciliation Post-Discharge</p>
<p>Numerator Statement: Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through administrative or medical record review on or within 30 days of discharge.</p> <p>Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record, on or within 30 days after discharge.</p> <p>Denominator Statement: All discharges from an in-patient setting for health plan members who are 66 years and older as of December 31 of the measurement year.</p> <p>Exclusions: Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.</p> <p>If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count the only the readmission discharge or the discharge from the facility to which the member was transferred.</p> <p>Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A</p> <p>Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional</p> <p>Type of Measure: Process</p> <p>Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records</p> <p>Measure Steward: National Committee for Quality Assurance Other Organizations:</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p> <p>1. Importance to Measure and Report <i>(based on decision logic): Yes</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence)</p> <p>1a. Impact: H-20; M-6; L-0; I-0 1b. Performance Gap: H-15; M-11; L-0; I-0 1c. Evidence: Y-20; N-4; I-2</p> <p>Rationale: The Committee noted the limited evidence base for this measure, but reiterated their support for a medication reconciliation measure. Although the data provided by developers reflects a substantial gap in performance, the developers did not adequately describe how the data were collected and did not provide any data on disparities to illustrate a gap in performance.</p>
<p>2. Scientific Acceptability of Measure Properties <i>(based on decision logic): Yes</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)</p> <p>2a. Reliability: H-9; M-15; L-2; I-0 2b. Validity: H-6; M-18; L-2; I-0</p> <p>Rationale: The Committee expressed confusion about why this measure is specified for those ages 66 and older while measure 0097 is specified for patients ages 65 and older. The developer explained that this is done to ensure that the patient was eligible for Medicare during the entire measurement year. The Committee also expressed confusion about the exclusion of discharges from the denominator. The developer clarified that they have specified this measure for the health plan level and explained that, although there was much debate prior to the decision, these exclusions were incorporated so as not to “double ding” health plans. There was also an extended discussion between Committee members and the developers concerning whether additional health plan data reflecting medication reconciliation (but stored external to the medical record) would be counted in the measure. Developers clarified that only reconciliations that are documented in the medical record are counted.</p>
<p>3. Usability: H-9; M-16; L-1; I-0 <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i></p> <p>Rationale: This is a HEDIS measure and is publically reported.</p>
<p>4. Feasibility: H-6; M-16; L-3; I-1 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</i></p> <p>Rationale: Developers noted that, as a HEDIS measure, this measure is routinely audited. However, Committee members noted that the developers did not provide results from these audits, nor did they discuss the extent and implications of missing data.</p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement <i>(pending decisions on related/competing measures): Y-25; N-1</i></p> <p>Rationale: Despite concerns over the lack of evidence and some confusion over measure specifications, the Committee found this measure to be suitable for endorsement.</p>

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<p>0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
<p>Status: Maintenance, Original Endorsement: May 05, 2010 , Most Recent Endorsement: May 05, 2010</p> <p>Description: Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories</p> <p>Numerator Statement: Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications to be TAKEN by patient:</p> <ul style="list-style-type: none"> - Continued* <p>Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND</p> <ul style="list-style-type: none"> - New* <p>Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge</p> <p>* Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed</p> <p>Medications NOT to be Taken by patient:</p> <ul style="list-style-type: none"> - Discontinued <p>Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND</p> <ul style="list-style-type: none"> - Allergies and Adverse Reactions <p>Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued</p> <p>Denominator Statement: All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.</p> <p>Time Window: Each time a patient is discharged from an inpatient facility</p> <p>Exclusions: Patients who died Patients who left against medical advice (AMA) or discontinued care</p> <p>Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p> <p>Level of Analysis: Facility, Integrated Delivery System</p> <p>Type of Measure: Process</p> <p>Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records</p> <p>Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other Organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p> <p>1. Importance to Measure and Report <i>(based on decision logic): Yes</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence) 1a. Impact: H-23; M-1; L-0; I-0 1b. Performance Gap: H-18; M-6; L-0; I-0 1c. Evidence: Y-21; N-3; I-0</p> <p>Rationale: Committee members strongly supported the clinical importance of medication reconciliation. There was some concern about the adequacy of the evidence because few (if any) studies have focused exclusively on the impact of medication reconciliation. However, several studies cited by the developers have found that medication reconciliation—as one component in a bundle of patient education interventions—can reduce adverse drug events and hospital readmissions; Committee members described these studeis as “strong evidence” for medication reconcilliaton.</p>
<p>2. Scientific Acceptability of Measure Properties <i>(based on decision logic): Yes</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-2; M-17; L-4; I-1 2b. Validity: H-1; M-17; L-4; I-2</p> <p>Rationale: Committee members noted that the sample size used for validity testing was small (n=100), that empirical testing was performed using EHR data from only one site, that validity using chart abstraction from paper records was not tested, and that none of the sampled records included patients discharged from a nursing facility. They also discussed the use of the terms “allergies”, “adverse reactions”, and “adverse events” in the</p>

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<p>numerator specifications and clarified that an adverse reaction is a subcategory of an adverse event, and that adverse events would not be recorded in an “allergy” field in an EHR. Committee members also expressed concern that the indication(s) for medications was not included as one of the elements in the reconciled medication; one member commented that the lack of indication would be “a big miss.”</p>
<p>3. Usability: H-10; M-13; L-0; I-1 <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i> Rationale: This measure is used in the Highmark Quality Blue Pay for Performance program (63 participating hospitals in 2011). Aggregate results are publicly reported.</p>
<p>4. Feasibility: H-5; M-16; L-2; I-1 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</i> Rationale: Developers expressed their belief that inclusion of the indication(s) for the medication in the reconciled medication list would adversely impact the feasibility of the measure by substantially increasing the burden of data collection and scoring of the measure.</p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement <i>(pending decisions on related/competing measures): Y-24; N-0</i> Rationale: Although there were some concerns about the details of the measure specifications and validity testing, the Committee found this to be a high-impact measure with a strong evidence base.</p>

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)
<p>Status: Maintenance, Original Endorsement: May 05, 2010 , Most Recent Endorsement: May 05, 2010 Description: Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a 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: Patients or their caregiver(s) who 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:</p> <p>Inpatient Care</p> <ul style="list-style-type: none"> • Reason for inpatient admission, AND • Major procedures and tests performed during inpatient stay and summary of results, AND • Principal diagnosis at discharge <p>Post-Discharge/ Patient Self-Management</p> <ul style="list-style-type: none"> • Current medication list, AND • Studies pending at discharge (eg, laboratory, radiological), AND • Patient instructions <p>Advance Care Plan</p> <ul style="list-style-type: none"> • Advance directives or surrogate decision maker documented OR Documented reason for not providing advance care plan <p>Contact Information/Plan for Follow-up Care</p> <ul style="list-style-type: none"> • 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 health care professional, or site designated for follow-up care <p>Denominator Statement: All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care. Exclusions: Patients who died. Patients who left against medical advice (AMA) or discontinued care. Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p>

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<p>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)</p>
<p>Level of Analysis: Facility, Integrated Delivery System Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other Organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12 1. Importance to Measure and Report <i>(based on decision logic): Yes</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence) 1a. Impact: H-16; M-6; L-0; I-0 1b. Performance Gap: H-10; M-10; L-1; I-2 1c. Evidence: Y-18; N-4; I-0 Rationale: Because this is a fairly new measure, data on performance gap was demonstrated primarily via references to the literature; however, data from the Highmark Quality Blue Pay for Performance program for 2011 suggests that performance is low (10% in quarter 1, 17% in quarter 2, and 38% in quarter 3). Developers relied mainly on a clinical guideline as the evidence base; however, they also cited references linking provision of discharge information/patient education to improved patient self-management /compliance and reduced hospital readmissions. Committee members questioned, however, whether the right elements have been included in the list of specified elements.</p>
<p>2. Scientific Acceptability of Measure Properties <i>(based on decision logic): Yes</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-2; M-14; L-4; I-3 2b. Validity: H-1; M-12; L-5; I-5 Rationale: Developers tested data element validity for 100 patients by comparing data from a report automatically generated from an EHR to a visual inspection of the full EHR. However, they supplied only overall statistics (88% agreement, kappa=.69) rather than statistics for each data element. They also provided results of a systematic assessment of face validity. The committee asked and received clarification that, to be counted in the numerator, the transition record must include all of the specified data elements, and the transition record must be reviewed with the patient and then given to the patient. Voting results on validity was split due to two main concerns. First, 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 (note that e-measure specifications have not been provided because every facility may have a different template for a transition record in their EHR). Second, there was some uncertainty among Committee members as to whether additional testing is needed to illustrate measure validity if data are collected via manual abstraction from paper records. Steering Committee members suggested that developers be cautious about the terminology used in the measure specifications (particularly the term “inpatient”, which some may erroneously interpret as hospital inpatient only).</p>
<p>3. Usability: H-14; M-6; L-3; I-0 <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i> Rationale: This measure is used in the Highmark Quality Blue Pay for Performance program (63 participating hospitals in 2011). Aggregate results are publicly reported.</p>
<p>4. Feasibility: H-8; M-11; L-3; I-1 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</i> Rationale: Committee members were somewhat divided on how difficult it might be to derive this measure from EHRs. However, there was general agreement that deriving this measure via chart abstraction (for organizations that do not have electronic systems) would be time consuming and expensive.</p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement <i>(pending decisions on related/competing measures): Y-23; N-0</i> Rationale: Although there were concerns about the need for additional validity testing and the burden of data collection for paper-based organizations, overall, the Committee found this to be an important measure with a relatively solid evidence base that met NQF evaluation criteria.</p>

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<p>0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p>Status: Maintenance, Original Endorsement: May 05, 2010 , Most Recent Endorsement: May 05, 2010</p> <p>Description: Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge</p> <p>Numerator Statement: Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge</p> <p>Denominator Statement: All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care</p> <p>Exclusions: Patients who died Patients who left against medical advice (AMA) or discontinued care</p> <p>Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p> <p>Level of Analysis: Facility, Integrated Delivery System</p> <p>Type of Measure: Process</p> <p>Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records</p> <p>Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other Organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p> <p>1. Importance to Measure and Report (based on decision logic): Yes (1a. High Impact: 1b. Performance Gap 1c. Evidence)</p> <p>1a. Impact: H-23; M-0; L-0; I-0 1b. Performance Gap: H-15; M-8; L-0; I-0 1c. Evidence: Y-18; N-5; I-0</p> <p>Rationale: Data on performance gap was demonstrated primarily via references to the literature. Data from the Highmark Quality Blue Pay for Performance program for 2011 suggest that performance is not optimal (30% in quarter 1, 50% in quarter 2, and 80% in quarter 3); however, developers did not provide distributional statistics to show the extent of variation in the measure.</p>
<p>2. Scientific Acceptability of Measure Properties (based on decision logic): Yes (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)</p> <p>2a. Reliability: H-2; M-16; L-3; I-2 2b. Validity: H-2; M-15; L-3; I-2</p> <p>Rationale: Steering Committee members were concerned that the reliability testing results (kappa=.49, 95% CI: 0.05-0.93) were substantially lower than what was found for measure 0647. Developers suggested that the small sample size (n=100) might contribute to the low reliability statistic; they also explained that the testing site used an automatic fax to transmit the transition record and suggested that the date of the fax may not have been stored long-term in the EHR. Some committee members were concerned that reliability/validity testing did not include testing of manual abstraction from paper records. Developers did clarify that the testing included checking that the transmitted records contained a standardized list of elements (that is, if some of the elements were missing, that record would not be included in the numerator of the measure). Also, because the specifications were unclear, Steering Committee members requested confirmation from the developer that this measure includes the same standardized set of elements as measure 0647.</p>
<p>3. Usability: H-10; M-8; L-2; I-2 (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</p> <p>Rationale: This measure is used in the Highmark Quality Blue Pay for Performance program (63 participating hospitals in 2011), and aggregate results are publicly reported. Developers clarified that this measure requires a written transition record; Steering Committee members noted that verbal hand-offs also may be done in practice and that future measure development should consider broadening the measure to reflect this.</p>
<p>4. Feasibility: H-5; M-15; L-2; I-1 (4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</p> <p>Rationale: As with measure 0647, Committee members felt that deriving this measure via chart abstraction (for organizations that do not have electronic systems) might be time consuming and expensive.</p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement (pending decisions on</p>

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<p>0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p><i>related/competing measures): Y-22; N-0</i></p> <p>Rationale: Although there were concerns about the need for additional reliability testing and the burden of data collection for paper-based organizations, the Committee found this to be an important measure that met NQF criteria as suitable for endorsement.</p>
<p>0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)</p> <p>Status: Maintenance, Original Endorsement: May 05, 2010 , Most Recent Endorsement: May 05, 2010</p> <p>Description: Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements</p> <p>Numerator Statement: Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements:</p> <ul style="list-style-type: none"> • Major procedures and tests performed during ED visit, AND • Principal diagnosis at discharge OR chief complaint, AND • Patient instructions, AND • Plan for follow-up care (OR statement that none required), including primary physician, other health care 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 <p>Denominator Statement: All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health care</p> <p>Exclusions: Patients who died Patients who left against medical advice (AMA) or discontinued care Patients who declined receipt of transition record</p> <p>Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p> <p>Level of Analysis: Facility, Integrated Delivery System</p> <p>Type of Measure: Process</p> <p>Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records</p> <p>Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other Organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine</p> <p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p> <p>1. Importance to Measure and Report (<i>based on decision logic</i>): Yes (1a. High Impact: 1b. Performance Gap 1c. Evidence)</p> <p>1a. Impact: H-16; M-6; L-0; I-0 1b. Performance Gap: H-14; M-7; L-1; I-0 1c. Evidence: Y-15; N-7; I-0</p> <p>Rationale: There was some concern that the evidence presented pertained to transfer of information after an inpatient stay rather than transfer of information after an emergency department visit. Developers responded by noting that there is very little evidence that specifically addresses transfer of information from the ER; this this was confirmed by a Committee member.</p> <p>2. Scientific Acceptability of Measure Properties (<i>based on decision logic</i>): Yes (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)</p> <p>2a. Reliability: H-1; M-14; L-7; I-1 2b. Validity: H-2; M-14; L-6; I-1</p> <p>Rationale: Some Committee members were concerned that this measure was tested using the same inpatient sample as used in measures 0647 and 0648, and were unsure if the testing results would be similar for ED. Committee members also noted that it may be difficult to define an “emergency department”; however, developers clarified that urgent care and observational care is not included in this measure.</p> <p>3. Usability: H-11; M-9; L-3; I-0 (<i>Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement</i>)</p> <p>Rationale: This measure is used in the Highmark Quality Blue Pay for Performance program (63 participating</p>

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<p>0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)</p>
<p>hospitals in 2011). Aggregate results are publicly reported.</p>
<p>4. Feasibility: H-12; M-8; L-3; I-0 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</i> Rationale: There was some discussion among the members about the appropriateness of having fewer standard data elements in this measure compared to what was required for measure 0647; however, the general consensus was that the specified elements are obtainable, achievable, and transmissible in an ED setting. Also, as with measures 0647 and 0648, Committee members felt that deriving this measure via chart abstraction would be time consuming and expensive.</p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement (pending decisions on related/competing measures): Y-23; N-0 Rationale: Although the evidence base was more limited for this measure than for the other transition record measures, the Committee found this to be a useful measure for improving care coordination.</p>

Measure Summaries - Not Recommended

<p>0511 Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy</p>
<p>Status: Maintenance, Original Endorsement: Oct 28, 2008 , Most Recent Endorsement: Oct 28, 2008 Description: Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT) that were performed Numerator Statement: Final reports that include physician documentation of correlation with existing relevant* imaging studies (eg, x-ray, MRI, CT) Definition: *Relevant imaging studies are defined as studies that correspond to the same anatomical region in question. Denominator Statement: All final reports for patients, regardless of age, undergoing bone scintigraphy Note: Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material) from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report. Exclusions: System reason for not documenting correlation with existing relevant imaging studies in final report (eg, no existing relevant imaging study available, patient did not have a previous relevant imaging study) Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Level of Analysis: Clinician : Group/Practice, Clinician : Individual Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry, Paper Records Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other Organizations: Society of Nuclear Medicine</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p>
<p>1. Importance to Measure and Report (based on decision logic): No (1a. High Impact: 1b. Performance Gap 1c. Evidence) 1a. Impact: H-1; M-9; L-7; I-6 1b. Performance Gap: H-4; M-9; L-1; I-9 1c. Evidence: Y-5; N-18; I-0 Rationale: While the Committee acknowledged the need to correlate bone scintigraphy results with results from other (relevant) imaging studies, they considered the focus of the measure as too narrow (i.e., targeted to bone scintigraphy rather than any radiology study). The Committee was also concerned that there seemed to be little or no evidence to support the assumption that correlation with relevant studies would improve patient outcomes and/or reduce unnecessary treatment.</p>
<p>2. Scientific Acceptability of Measure Properties (based on decision logic): (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: 2b. Validity: Rationale:</p>

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0511 Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
<p>3. Usability: <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i></p> <p><u>Rationale:</u></p>
<p>4. Feasibility: <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)</i></p> <p><u>Rationale:</u></p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement: No Rationale: The measure did not pass the criterion of Importance to Measure and Report.</p>

0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care
<p>Status: Maintenance, Original Endorsement: Mar 31, 2009 , Most Recent Endorsement: Jan 31, 2012</p> <p>Description: Percentage of short term home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems.</p> <p>Numerator Statement: Number of home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems.</p> <p>Denominator Statement: Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.</p> <p>Exclusions: - Episodes in which the patient was not on any medications since the last OASIS assessment. - Episodes ending in patient death. Note: The information needed to calculate this measure is not collected if the home health episode ends in death. The measure cannot be calculated in excluded cases due to data limitations. - Long-term episodes (as indicated by the presence of a follow-up assessment between admission and transfer or discharge). Note: This exclusion was added at the request of NQF reviewers during initial consideration of the measure in 2008. To avoid excessive burden to agencies related to reviewing records longer than 60 days, this implementation measure reports on care provided since the last OASIS assessment. However, restricting the measure to care since the most recent OASIS assessment raised concerns among NQF Steering Committee members that measures might not accurately reflect care for longer-stay patients, as some interventions may have been implemented prior to the most recent OASIS assessment. In response, measure specifications were changed so that home care episodes that require a recertification are not included in publicly-reported measures on implementation of evidence-based practices. The reports that CMS provides for agency use in quality improvement activities include separate break-outs for short-term episodes and long-term episodes, as well as a combined “all episodes” measure.</p> <p>Adjustment/Stratification: No risk adjustment or risk stratification N/A - process measure - not risk adjusted N/A - measure not stratified.</p> <p>Level of Analysis: Facility</p> <p>Type of Measure: Process</p> <p>Data Source: Electronic Clinical Data</p> <p>Measure Steward: Centers for Medicare & Medicaid Services Other Organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research</p>
<p>STEERING COMMITTEE MEETING 2/28/12 – 2/29/12</p> <p>1. Importance to Measure and Report <i>(based on decision logic): No</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence)</p> <p>1a. Impact: H-5; M-13; L-5; I-1 1b. Performance Gap: H-6; M-9; L-8; I-1 1c. Evidence: Y-7; N-16; I-0</p> <p><u>Rationale:</u> Committee members were concerned that this measure is too distal to the desired outcome, especially given that it does not include a “teach-back” component to assure patient understanding. One Committee member noted that some of the studies cited as evidence pertained to nurse pharmacist teams, which would not be typical in the home setting. Another member argued that the predictive analysis done to demonstrate measure validity (which in fact did not demonstrate the expected relationship between the measure and two other outcome measures) actually established the unimportance of the measure.</p>

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0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care
2. Scientific Acceptability of Measure Properties <i>(based on decision logic):</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: 2b. Validity: <u>Rationale:</u>
3. Usability: <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i> <u>Rationale:</u>
4. Feasibility: <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)</i> <u>Rationale:</u>
Steering Committee Recommendation on Overall Suitability for Endorsement: No Rationale: The measure did not pass the criterion of Importance to Measure and Report.

0645 Biopsy Follow-up
Status: Maintenance, Original Endorsement: May 05, 2010 , Most Recent Endorsement: May 05, 2010 Description: Percentage of patients who are undergoing a biopsy whose biopsy results have been reviewed by the biopsying physician and communicated to the primary care/referring physician and the patient. Numerator Statement: Patients who are undergoing a biopsy whose biopsy results have been reviewed by the biopsying physician and communicated to the primary care/referring physician and the patient, denoted by entering said physician’s initials into a log, as well as by documentation in the patient’s medical record. Denominator Statement: All patients undergoing a biopsy. Exclusions: Patients not undergoing a biopsy. Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A Level of Analysis: Clinician : Group/Practice, Clinician : Individual Type of Measure: Process Data Source: Electronic Clinical Data : Registry, Paper Records Measure Steward: American Academy of Dermatology Other Organizations:
STEERING COMMITTEE MEETING 2/28/12 – 2/29/12 1. Importance to Measure and Report <i>(based on decision logic): No</i> (1a. High Impact: 1b. Performance Gap 1c. Evidence) 1a. Impact: H-9; M-10; L-4; I-2 1b. Performance Gap: H-2; M-10; L-4; I-9 1c. Evidence: Y-10; N-14; I-0 <u>Rationale:</u> Only three articles were cited as evidence for this measure by the developer, but the Committee did not choose to invoke the exception to the evidence criterion. However, developers did not provide information about the methods used in the articles or the consistency of the findings. Further, although the measure was backed by a clinical practice guideline, one Committee member noted that it was unclear if the guideline was based on research or on expert opinion. Some Committee members, however, noted that even without empirical evidence, it is intuitive that reporting of biopsy results is appropriate and beneficial.
2. Scientific Acceptability of Measure Properties <i>(based on decision logic):</i> (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: 2b. Validity: <u>Rationale:</u>
3. Usability: <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i> <u>Rationale:</u>
4. Feasibility: <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)</i> <u>Rationale:</u>
Steering Committee Recommendation on Overall Suitability for Endorsement: No Rationale: The measure did not pass the criterion of Importance to Measure and Report.

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Recommendations for Future Measure Development

In addition to the recommendations made by the Steering Committee during the first phase of the project to inform the *Call for Measures*, the Committee also made numerous recommendations for future development of care coordination measures during the second phase of the project. These recommendations emerged from their measure evaluation deliberations, as well as from a structured exercise in which they considered how the 25 NQF-endorsed Care Coordination Preferred Practices could be used to help shape measure development and promote organizational progress toward better care coordination. Not surprisingly, there was substantial overlap in the recommendations from these two efforts; however, results from both are presented below.

Recommendations made as part of the measure evaluation process

During the measure evaluation process, including the discussions of relating/competing measures, the Committee identified several areas where additional measure development is needed.

1. Measure maturity

A theme voiced throughout the measure evaluation process was the description by the Committee of many of the measures as “baby steps” in the measurement of care coordination. Accordingly, the Committee called for measures that would reflect “the other side of the handshake” in care coordination, per the examples below:

- Measures should assess not only whether a hospital transmitted a discharge record to the next provider, but also whether the next provider actually received that record and took appropriate action.
- Measures should assess not only that education, a discharge record, or medication review was provided, but whether a patient actually understood the information (e.g., via teach-back).

The Committee also encouraged more complexity in care coordination measures. For example, developers should construct measures that go beyond gauging whether or not medication reconciliations were performed to also measure whether the resulting list is “the right list”. To this end, the Committee supported the development of composite measures, “longitudinal” measures that evaluate practices over time, and measures that utilize multiple data sources.

2. Using measurement to drive practice

The Committee also recognized that measurement development itself could be used to advance both policy and practice. Operationally, this may entail the development and use of standardized measure definitions prior to the formation of a strong evidence base or the implementation of easily-retrieved data elements from electronic health records (recognizing that if measures exist, the evidence may follow or that EHR vendors may implement certain measurement concepts, definitions, or strategies only after they have been defined in a standardized way by industry quality and measurement experts).

3. Other recommendations

The Committee also offered several specific recommendations for the measures evaluated in this project, as follows:

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- Measure 0326: Increase the precision of the measure specifications by defining what is meant by an advance cared plan and making the measure reflect an ongoing conversation rather than just a static document.
- Measure 0494: Consider harmonizing the factors/elements within the survey to the extent possible with relevant NQF-endorsed measures and preferred practices.
- Measure 0646: Add medication indication to the list of elements in the reconciled medication list.
- Measure 0649: Create a “sister measure” to assess the provision of a transition record to the next provider for those discharged from the ED.
- Measure 0511: As written, this measure was not recommended as suitable for endorsement; however, the Steering Committee expressed interest in a broader measure that would encourage providers to correlate all tests (not just bone scans) with all available tests (not just imaging studies).

Recommendations made as part of a structured exercise

Following the evaluation of the maintenance measures, the Committee took part in a structured exercise in which they identified and discussed specific strategies to advance the development of measures. This discussion resulted in the identification of several essential care coordination measurement concepts (see table below).

<p><u>Patient Engagement</u></p> <ul style="list-style-type: none"> • Co-management of patient care, co-awareness, co-acknowledgement • Capturing patient and caregiver decisions that are important along the continuum of care (e.g., measures of adherence/outcomes/communication). • Capturing data and documenting linkages between a patient’s need/goal and relevant interventions in a standardized way and linked to relevant interventions (e.g., if the patient’s goal is to die at home, how do we document the relevant interventions to ensure it is met?) • Capturing patient burden more appropriately – patients shouldn’t be consulted on things that would burden him or her. • Assessment of caregiver support / burden. • Structuring measures around incentives to improve participation • Patient survey’s intended to capture patient engagement and understanding of next steps? • Assessment of follow up activities (e.g., follow-up visits, home care provided) • Functional status outside the home/ quality of life 	<p><u>Accountability</u></p> <ul style="list-style-type: none"> • Identifying roles between the patient, care giver and provider and documentation for expectations; including healthcare providers as well as entities outside the healthcare system (i.e., schools). • Measuring effectiveness of the healthcare team • Team awareness and self-awareness. Are healthcare providers cognizant of the fact that they are part of a team? • Care team/provider reported outcomes • Measures addressing payment models that facilitate or support care coordination/ measures that can include funding mechanisms (e.g., ACO measures) <p><u>Health Information Technology</u></p> <ul style="list-style-type: none"> • Tele-health standards that support decision making and automated processes (e.g., who gets the data, who is accountable, automated notification parameters). • Meaningful use concepts transmitted into foundational quality measures (e.g. use of EHR certification to verify the content for medication reconciliation, then focus on developing a quality 	<p><u>Plan-of-Care</u></p> <ul style="list-style-type: none"> • Established continuity within the plan of care (i.e., initiation of care plan, transmission between patient and providers, receipt of care plan and acknowledgement of acceptance of receiving care plan). • Accessibility and functionality of plan of care • Identifying the elements and components of the plan of care • Survey tool to assess the functionality of a plan of care (e.g., intervention points that the measure could include). • Capabilities of stratification or risk-adjustment for high-risk population and impact of transitions. <p><u>Communication</u></p> <ul style="list-style-type: none"> • Language and health literacy • Limited English Proficiency populations understanding their role within the care coordination process • Accountability and timeliness of communication between patient and providers • Measuring connections within the communication timeline (i.e., communication was made, received and understood). • Measuring outcomes of an activity,
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	<p>measure)</p> <p>Outcomes</p> <ul style="list-style-type: none"> • Patient reported outcomes (e.g., did patient get the follow-up care that is needed, were the patient’s needs met, was their care coordinated?) • Assessment of the differences in outcomes if steps in the process are changed? • Measures that bundle steps in process with the desired outcomes 	<p>contact, or communication between parties. (e.g., the measure will be a RESULT of that activity).</p> <ul style="list-style-type: none"> • 4 item measure for teach back <ol style="list-style-type: none"> 1. Diagnosis 2. New and changed meds 3. Signs/symptoms – incorporate in discharge instructions 4. Who to call
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The Committee was asked to prioritize these measurement concepts. These top five concepts, listed below, represent the key recommendations for future measure development:

- Patient reported outcomes (e.g., did patient get the follow-up care that is needed? were the patient’s needs met? was their care coordinated?)
- Capturing data and documenting linkages between a patient’s need/goal and relevant interventions in a standardized way and linked to relevant interventions (e.g., if the patient’s goal is to die at home, how do we document the relevant interventions to ensure it is met?)
- Established continuity within the plan of care (i.e., initiation of care plan, transmission between patient and providers, receipt of care plan and acknowledgement of acceptance of receiving care plan)
- Accessibility and functionality of plan of care
- Measurement of adverse events that could be markers of poor care coordination

Finally, the Committee was asked to propose potential future uses for the 25 [Care Coordination Preferred Practices](#) endorsed in 2010. The Committee suggested that the Practices could potentially:

- Serve as the foundation for a self-assessment tool for health professionals and institutions wanting to know how they are doing in the care coordination field, similar to the development of the [Leapfrog Safe Practices](#)
- Operate as a tool for public reporting
- Function as an accreditation tool, similar to the NCQA Medical Home System Survey
- Be further publicized as a mechanism for other organizations to improve their care coordination practices
- Signal measure developers of the key elements involved in effective care coordination

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Appendix A – Measure Specifications

NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR CARE COORDINATION: ENDORSEMENT MAINTENANCE 2012 APPENDIX A: MEASURE SPECIFICATIONS

The following tables present detailed specifications for the fifteen measures evaluated in this project. All information included has been derived directly from measure sources/developers without modification or alteration (except when the measure developed agreed to such modification during the NQF Consensus Development Process) and is current as of April 2, 2012. All NQF-endorsed voluntary consensus standards are open source, meaning they are fully accessible and disclosed. Measures stewards include the American Academy of Dermatology, the American Medical Association-Physician Consortium for Performance Improvement, Centers for Medicare and Medicare Services, and the National Committee for Quality Assurance,

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0097 Medication Reconciliation	
Status	Maintenance, Original Endorsement: May 01, 2007, Most Recent Endorsement: Jan 25, 2012 Time-limited
Steward	National Committee for Quality Assurance Other organizations: This measure was developed with the cooperation of the American Geriatrics Society, the National Committee for Quality Assurance and the American Medical Association.
Description	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Registry, Paper Records None URL http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/geriatrics-ws.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Integrated Delivery System, Population : County or City
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office
Numerator Statement	Patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented The medical record must indicate that the physician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of a inpatient facility discharge medication.
Numerator Details	Time Window: Ambulatory visits within 60 days of a discharge from an inpatient facility CPT II Category II code 1111F: Discharge medications reconciled with the current medication list in the outpatient medical record Level 1 EHR specifications in development
Denominator Statement	All patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care
Denominator Details	Time Window: Discharges from an inpatient facility within the last 60 days (eg, hospital, skilled nursing facility, or rehabilitation facility) CPT service codes 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404 AND CPT Category II code 1110F: Patient discharged from an inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days OR Documentation in the medical record of a discharge from an inpatient facility within the last 60 days Note: only patients who were discharged from an inpatient facility within the last 60 days will be included in the denominator of this measure.
Exclusions	N/A
Exclusion Details	N/A
Risk Adjustment	N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Calculation for Performance For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator and Denominator. Step 1: Determine the eligible population. The eligible population is all the patients aged 65 years and older. Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above.

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	0097 Medication Reconciliation
	<p>Step 3: Determine the number of patients who meet the numerator criteria as specified in section 2a1.3 above. The numerator includes all patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented</p> <p>Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2 Attachment PCPI Sample Calculation Algorithm.pdf</p>
Copyright/Disclaimer	<p>Physician Performance Measures (Measures) and related data specifications, developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (the Consortium) and the National Committee for Quality Assurance (NCQA) pursuant to government sponsorship under subcontract 6205-05-054 with Mathematica Policy Research, Inc. under contract 500-00-0033 with Centers for Medicare & Medicaid Services.</p> <p>These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.</p> <p>The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the Consortium) or NCQA. Neither the AMA, NCQA, Consortium nor its members shall be responsible for any use of the Measures.</p> <p>THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.</p> <p>© 2004-6 American Medical Association and National Committee for Quality Assurance. All Rights Reserved.</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>CPT® contained in the Measures specifications is copyright 2005 American Medical Association G codes and associated descriptions included in these Measure specifications are in the public domain.</p> <p>These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.</p> <p>THE MEASURES AND SEPCIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.</p>

	0171 Acute care hospitalization (risk-adjusted)
Status	Maintenance, Original Endorsement: Mar 31, 2009, Most Recent Endorsement: Jan 31, 2012 Time-limited
Steward	Centers for Medicare & Medicaid Services Other organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research
Description	Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.
Type	Outcome
Data Source	Administrative claims Denominator: Medicare Home Health Claims Numerator: Medicare Inpatient Claims Exclusions: Medicare Home Health Claims, Medicare Enrollment Data Risk Factors: Medicare Enrollment Data, Medicare Part A & B Claims URL Identification of Short Term Hospitals: https://www.cms.gov/transmittals/downloads/R29SOMA.pdf General Medicare Data Documentation: http://www.resdac.org/ddvh/index.asp URL Claims: http://www.resdac.org/ddvh/dd_via2.asp Enrollment: http://www.resdac.org/ddde/dd_de.asp
Level	Facility
Setting	Home Health
Numerator Statement	Number of home health stays for patients who have a Medicare claim for an unplanned admission to an acute care hospital in the 60 days following the start of the home health stay.
Numerator Details	<p>Time Window: 60 days following the start of the home health stay.</p> <p>The 60 day time window is calculated by adding 60 days to the “from” date in the first home health claim in the series of home health claims that comprise the home health stay. Acute care hospitalization occurs (and the home health stay is included in the numerator) if the patient has at least one Medicare inpatient claim from short term or critical access</p>

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0171 Acute care hospitalization (risk-adjusted)	
hospitals (identified by CMS Certification Number ending in 0001-0879, 0800-0899, or 1300-1399) during the 60 day window.	
Inpatient claims for planned hospitalizations are excluded from the measure numerator. Planned hospitalizations are defined using the same criteria as the Yale Hospital-Wide All-Cause Unplanned Readmission Measure. Specifically, admissions are categorized as “planned” based on AHRQ Procedure and Condition CCS as well as other sets of ICD-9-CM procedure codes. These admissions are excluded unless they have a discharge condition category considered “acute or complication of care,” which is defined using AHRQ Condition CCS. The definitions of AHRQ CCS can be found here:	
http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp#download	
The AHRQ CCS that define planned hospitalizations are found below and are AHRQ Procedure CCS unless otherwise noted.	
AHRQ CCS	Description
45	PTCA
254	Rehabilitation (Condition CCS)
84	Cholecystectomy and common duct exploration
157	Amputation of lower extremity
44	CABG
78	Colorectal resection
51	Endarterectomy; vessel of head and neck
113	Transurethral resection of prostate
99	Other OR Gastrointestinal therapeutic procedures
48	Insertion; revision; replacement; removal of cardiac pacemaker or cardioverter/defibrillator
45	Maintenance chemotherapy (Condition CCS)
211	Therapeutic radiology for cancer treatment
3	Laminectomy; excision intervertebral disc
43	Heart valve procedures
152	Arthroplasty knee
158	Spinal fusion
55	Peripheral vascular bypass
52	Aortic resection; replacement or anastomosis
36	Lobectomy or pneumonectomy
153	Hip replacement; total and partial
60	Embolectomy and endarterectomy of lower limbs
85	Inguinal and femoral hernia repair
104	Nephrectomy; partial or complete
1	Incision and excision of CNS
124	Hysterectomy; abdominal and vaginal
167	Mastectomy
10	Thyroidectomy; partial or complete
114	Open prostatectomy
74	Gastrectomy; partial and total
119	Ooporectomy; unilateral and bilateral
154	Arthroplasty other than hip or knee
ICD-9-CM procedure codes 30.5, 31.74, 34.6	Radial laryngectomy, revision of tracheostomy, scarification of pleura
166	Lumpectomy; quadrantectomy of breast
64	Bone marrow transplant
105	Kidney transplant
176	Other organ transplantation
ICD-9-CM procedure codes 94.26, 94.27	Electroshock therapy
Discharge AHRQ Condition CCS considered “acute or complication of care” are listed below.	
AHRQ CCS	Description
237	Complications of device; implant or graft
106	Cardiac dysrhythmias
Condition CCS 207, 225, 226, 227, 229, 230, 231, 232	Fracture
100	Acute myocardial infarction

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0171 Acute care hospitalization (risk-adjusted)	
238 108 2 146 105 109 145 233 116 122 131 157 201 153 130 97 127 55 159 245 139 160 112	Complications of surgical procedures or medical care Congestive heart failure; nonhypertensive Septicemia (except in labor) Diverticulosis and diverticulitis Conduction disorders Acute cerebrovascular disease Intestinal obstruction without hernia Intracranial injury Aortic and peripheral arterial embolism or thrombosis Pneumonia (except that caused by TB or sexually transmitted disease) Respiratory failure; insufficiency; arrest (adult) Acute and unspecified renal failure Infective arthritis and osteomyelitis (except that caused by TB or sexually transmitted disease) Gastrointestinal hemorrhage Pleurisy; pneumothorax; pulmonary collapse Peri-; endo-; and myocarditis; cardiomyopathy Chronic obstructive pulmonary disease and bronchiectasis Fluid and electrolyte disorders Urinary tract infection Syncope Gastroduodenal ulcer (except hemorrhage) Calculus of urinary tract Transient cerebral ischemia
Denominator Statement	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
Denominator Details	<p>Time Window: 12-month observation period, updated quarterly.</p> <p>A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days. Each home health payment episode is associated with a Medicare home health (HH) claim, so home health stays are constructed from claims data using the following procedure.</p> <ol style="list-style-type: none"> 1. First, retrieve HH claims with a “from” date (FROM_DT) during the 12-month observation period or the 120 days prior to the beginning of the observation period and sequence these claims by “from” date for each beneficiary. 2. Second, drop claims with the same “from” date and “through” date (THROUGH_DT) and claims listing no visits and no payment. Additionally, if multiple claims have the same “from” date, keep only the claim with the most recent process date. 3. Third, set Stay_Start_Date(1) equal to the “from” date on the beneficiary’s first claim. Step through the claims sequentially to determine which claims begin new home health stays. If the claim “from” date is more than 60 days after the “through” date on the previous claim, then the claim begins a new stay. If the claim “from” date is within 60 days of the “through” date on the previous claim, then the claim continues the stay associated with the previous claim. 4. Fourth, for each stay, set Stay_Start_Date(n) equal to the “from” date of the first claim in the sequence of claims defining that stay. Set Stay_End_Date(n) equal to the “through” date on the last claim in that stay. Confirm that Stay_Start_Date(n+1) – Stay_End_Date(n) > 60 days for all adjacent stays. 5. Finally, drop stays that begin before the 12-month observation window. <p>Note the examining claims from the 120 days before the beginning of the 12-month observation period is necessary to ensure that stays beginning during the observation period are in fact separated from previous home health claims by at least 60 days.</p>
Exclusions	The following are excluded: home health stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window (60 days following the start of the home health stay) or until death; home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim; home health stays in which the patient receives service from multiple agencies during the first 60 days; and home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the start of the home health stay.
Exclusion Details	<ol style="list-style-type: none"> 1. Home health stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window (60 days following the start of the home health stay) or until death. <ul style="list-style-type: none"> • Both enrollment status and beneficiary death date are identified using the Medicare Enrollment Database (EDB).

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	<p>2. Home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim.</p> <ul style="list-style-type: none"> • Exclude the stay if LUPAIND = L for the first claim in the home health stay. <p>3. Home health stays in which the patient receives service from multiple agencies during the first 60 days.</p> <ul style="list-style-type: none"> • Define Initial_Provider = PROVIDER on the first claim in the home health stay. • If Initial_Provider does not equal PROVIDER for a subsequent claim in the home health stay AND if the “from” date of the subsequent claim is within 60 days of Stay_Start_Date, then exclude the stay. <p>4. Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the start of the home health stay.</p> <ul style="list-style-type: none"> • Enrollment status is identified using the Medicare Enrollment Database (EDB).
Risk Adjustment	<p>Statistical risk model Multinomial logit with outcomes of “No acute event”, “Emergency Department without Hospitalization”, and “Acute Care Hospitalization”.</p> <p>Risk factors include: Prior Care Setting – The main categories are community (i.e., no prior care setting), outpatient emergency room, inpatient-acute (IP-acute), inpatient rehabilitation facility (IRF), psychiatric facility, long-term care facility (LTC), and skilled nursing facility (SNF). The hierarchy of setting is SNF, most recent inpatient stay, and outpatient ER. Acumen used the five cohorts from the Yale Hospital-Wide All-Cause Unplanned Readmission Measure to segregate the IP-acute category. The five cohorts are:</p> <ol style="list-style-type: none"> 1. Surgery/Gynecology: admissions likely cared for by surgical or gynecological teams, based on AHRQ procedure categories; 2. Cardiorespiratory: admissions treated by the same care teams with very high readmission rates, such as for pneumonia, chronic obstructive pulmonary disease, and heart failure; 3. Cardiovascular: admissions treated by separate cardiac or cardiovascular team in large hospitals, such as for acute myocardial infarctions; 4. Neurology: admissions for neurological conditions, such as stroke, that may be treated by a separate neurology team in large hospitals; and 5. Medicine: admissions for all other non-surgical patients. <p>These cohorts were designed to account for differences in readmission risk for surgical and non-surgical patients. Finally, the IP-acute categories and the SNF category were further refined by length of stay. Each of the five IP-acute categories are separated into stays of length 0 to 3 days, 4 to 8 days, and 9 or more days, while the SNF categories are split into stays of length 0 to 13, 14 to 41, and 42 and more days. A patient cared for in both a skilled nursing facility and an inpatient hospital during the 30 days prior to starting home health care is included in the skilled nursing categories and not the inpatient categories. The length of stay is determined from the last inpatient or skilled nursing stay prior to beginning home health care.</p> <p>Age and Gender Interactions – Age is subdivided into 12 bins for each gender: aged 0-34, 35-44, 45-54, five-year age bins from 55 to 95, and a 95+ category. Using a categorical age variable allows the model to account for the differing effects of age and gender. Age is determined based on the patient’s age at Stay_Start_Date.</p> <p>CMS Hierarchical condition categories (HCCs) – HCCs were developed for the risk adjustment model used in determining capitation payments to Medicare Advantage plans and are calculated using Part A and B Medicare claims. While the CMS-HHC model uses a full year of claims data to calculate HCCs, for these measures, we use only 6 months of data to limit the number of home health stays excluded due to missing HCC data. All 2008 HCCs and CCs that are not hierarchically ranked that were statistically significant predictors of ACH and ED use are included in the model.</p> <p>Details of the CMS-HCC model and the code lists for defining the HCCs can be found here: https://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp A description of the development of the CMS-HCC model can be found here: https://www.cms.gov/HealthCareFinancingReview/Downloads/04Summerpg119.pdf</p> <p>ESRD and Disability Status – Original End Stage Renal Disease (ESRD) and current ESRD status are included as risk factors. Original disabled status and male, and original disabled status and female, are also included. Medicare beneficiaries with ESRD or disabled status represent a fundamentally different health profile.</p> <p>Interaction Terms – All interaction terms included in the 2008 and 2012 HCC risk adjustment models that were statistically significant predictors of ED Use and ACH were included. Interaction terms account for the additional effect two risk factors may</p>

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	0171 Acute care hospitalization (risk-adjusted)
	have when present simultaneously, which is more than the additive effect of each factor separately. Attachment NQF_CBM_RiskAdjustment_24Feb2012.pdf
Stratification	N/A - not stratified
Type Score	Rate/proportion better quality = lower score
Algorithm	<ol style="list-style-type: none"> 1. Construct Home Health Stays from HH Claims (see 2a1.7 for details) 2. Identify numerator window (60 days following Stay_Start_Date) for each stay and exclude stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window or until patient death. 3. Exclude stays that begin with a LUPA or that involve a provider change during the numerator window 4. Link stays to enrollment data by beneficiary. 5. Exclude stays for patients who are not continuously enrolled in fee-for-service Medicare during the 6 months prior to Stay_Start_Date. 6. Calculate demographic risk factors for each stay (age, gender, etc.) using enrollment data. 7. Link to Part A and Part B claims for 6 months prior to Stay_Start_Date for each beneficiary 8. Calculate prior care setting indicators, HCCs, and HCC interactions. 9. Link to Inpatient (IP) claims from Short Stay and Critical Access hospitals (excluding planned hospitalizations - see 2a1.3 for details) for numerator window (60 days following Stay_Start_Date) 10. Set Hospital Admission indicator (Hosp_Admit = 1) if any IP claims are linked to the stay in step 9. 11. Using coefficients from the multinomial logit risk model and risk factors calculated in steps 6 and 8, calculate the predicted probability of being included in the measure numerator for each stay (Pred_Hosp). Additionally calculate the average of Pred_Hosp across all stays that are included in the measure denominator (not excluded in steps 3 or 5) and call this value National_pred_Hosp. 12. Calculate observed and risk adjusted rates for each home health agency (Initial_Provider): <ol style="list-style-type: none"> a. Calculate the observed rate of Acute Care Hospitalization as the fraction all (non-excluded) HH Stays with that agency as Initial_Provider that are also included in the measure numerator (Hosp_Admit = 1). Call the value Agency_obs_Hosp. b. Calculate the agency predicated rate of Acute Care Hospitalization by taking the average of Pred_Hosp across all (non-excluded) stays with that agency as Initial_Provider. Call this value Agency_pred_Hosp. c. Calculate the risk adjusted rate of Acute Care Hospitalization using the following formula: $\text{Agency_riskadj_Hosp} = \text{National_pred_Hosp} + (\text{Agency_obs_Hosp} - \text{Agency_pred_Hosp})$ If an agency's calculated risk adjusted rate is negative, that agency will have a publicly reported rate of 0% Attachment PlannedHospitalizationExclusion_Acumen_10Feb2012.pdf
Copyright/Disclaimer	

	0173 Emergency Department Use without Hospitalization
Status	Maintenance, Original Endorsement: Mar 31, 2009, Most Recent Endorsement: Jan 31, 2012 Time-limited
Steward	Centers for Medicare & Medicaid Services Other organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research
Description	Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.
Type	Outcome
Data Source	Administrative claims Denominator: Medicare Home Health Claims Numerator: Medicare Inpatient and Outpatient Claims Exclusions: Medicare Home Health Claims, Medicare Enrollment Data Risk Factors: Medicare Enrollment Data, Medicare Part A & B Claims URLS: Identification of ED visits: http://www.resdac.org/Tools/TBs/TN-003_EmergencyRoominClaims_508.pdf Identification of Short Term Hospitals: https://www.cms.gov/transmittals/downloads/R29SOMA.pdf General Medicare Data Documentation: http://www.resdac.org/ddvh/index.asp URL SEE URLS IN 2a1.26. URL Claims: http://www.resdac.org/ddvh/dd_via2.asp Enrollment: http://www.resdac.org/ddde/dd_de.asp
Level	Facility

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0173 Emergency Department Use without Hospitalization	
Setting	Home Health
Numerator Statement	Number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay.
Numerator Details	<p>Time Window: 60 days following the start of the home health stay.</p> <p>The 60 day time window is calculated by adding 60 days to the “from” date in the first home health claim in the series of home health claims that comprise the home health stay. If the patient has any Medicare outpatient claims with any ER revenue center codes (0450-0459, 0981) during the 60 day window AND if the patient has no Medicare inpatient claims for an unplanned admission to an acute care hospital (identified by the CMS Certification Number on the IP claim ending in 0001-0879, 0800-0899, or 1300-1399) during the 60 day window, then the stay is included in the measure numerator.</p>
Denominator Statement	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
Denominator Details	<p>Time Window: 12-month observation period, updated quarterly.</p> <p>A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days. Each home health payment episode is associated with a Medicare home health (HH) claim, so home health stays are constructed from claims data using the following procedure.</p> <ol style="list-style-type: none"> 1. First, retrieve HH claims with a “from” date (FROM_DT) during the 12-month observation period or the 120 days prior to the beginning of the observation period and sequence these claims by “from” date for each beneficiary. 2. Second, drop claims with the same “from” date and “through” date (THROUGH_DT) and claims listing no visits and no payment. Additionally, if multiple claims have the same “from” date, keep only the claim with the most recent process date. 3. Third, set Stay_Start_Date(1) equal to the “from” date on the beneficiary’s first claim. Step through the claims sequentially to determine which claims begin new home health stays. If the claim “from” date is more than 60 days after the “through” date on the previous claim, then the claim begins a new stay. If the claim “from” date is within 60 days of the “through” date on the previous claim, then the claim continues the stay associated with the previous claim. 4. Fourth, for each stay, set Stay_Start_Date(n) equal to the “from” date of the first claim in the sequence of claims defining that stay. Set Stay_End_Date(n) equal to the “through” date on the last claim in that stay. Confirm that Stay_Start_Date(n+1) – Stay_End_Date(n) > 60 days for all adjacent stays. 5. Finally, drop stays that begin before the 12-month observation window. <p>Note the examining claims from the 120 days before the beginning of the 12-month observation period is necessary to ensure that stays beginning during the observation period are in fact separated from previous home health claims by at least 60 days.</p>
Exclusions	The following are excluded: home health stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window (60 days following the start of the home health stay) or until death; home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim; home health stays in which the patient receives service from multiple agencies during the first 60 days; and home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior the start of the home health stay.
Exclusion Details	<ol style="list-style-type: none"> 1. Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 60 days following the start of the home health stay or until death. <ul style="list-style-type: none"> • Both enrollment status and beneficiary death date are identified using the Medicare Enrollment Database (EDB). 2. Home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim. <ul style="list-style-type: none"> • Exclude the stay if LUPAIND = L for the first claim in the home health stay. 3. Home health stays in which the patient receives service from multiple agencies during the first 60 days. <ul style="list-style-type: none"> • Define Initial_Provider = PROVIDER on the first claim in the home health stay. • If Intial_Provider does not equal PROVIDER for a subsequent claim in the home health stay AND if the “from” date of the subsequent claim is within 60 days of Stay_Start_Date, then exclude the stay. 4. Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the start of the home health stay. <ul style="list-style-type: none"> • Enrollment status is identified using the Medicare Enrollment Database (EDB).
Risk Adjustment	<p>Statistical risk model</p> <p>Multinomial logit with outcomes of “No acute event”, “Emergency Department use but no Hospitalization”, and “Acute Care Hospitalization”.</p> <p>Risk factors include:</p>

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0173 Emergency Department Use without Hospitalization	
	<p>Prior Care Setting – The main categories are community (i.e., no prior care setting), outpatient emergency room, inpatient-acute (IP-acute), inpatient rehabilitation facility (IRF), psychiatric facility, long-term care facility (LTC), and skilled nursing facility (SNF). The hierarchy of setting is SNF, most recent inpatient stay, and outpatient ER. Acumen used the five cohorts from the Yale Hospital-Wide All-Cause Risk Standardization Readmission Measure to segregate the IP-acute category. The five cohorts are:</p> <ol style="list-style-type: none"> 1. Surgery/Gynecology: admissions likely cared for by surgical or gynecological teams, based on AHRQ procedure categories; 2. Cardiorespiratory: admissions treated by the same care teams with very high readmission rates, such as for pneumonia, chronic obstructive pulmonary disease, and heart failure; 3. Cardiovascular: admissions treated by separate cardiac or cardiovascular team in large hospitals, such as for acute myocardial infarctions; 4. Neurology: admissions for neurological conditions, such as stroke, that may be treated by a separate neurology team in large hospitals; and 5. Medicine: admissions for all other non-surgical patients. <p>These cohorts were designed to account for differences in readmission risk for surgical and non-surgical patients. Finally, the IP-acute categories and the SNF category were further refined by length of stay. Each of the five IP-acute categories are separated into stays of length 0 to 3 days, 4 to 8 days, and 9 or more days, while the SNF categories are split into stays of length 0 to 13, 14 to 41, and 42 and more days. A patient cared for in both a skilled nursing facility and an inpatient hospital during the 30 days prior to starting home health care is included in the skilled nursing categories and not the inpatient categories. The length of stay is determined from the last inpatient or skilled nursing stay prior to beginning home health care.</p> <p>Age and Gender Interactions – Age is subdivided into 12 bins for each gender: aged 0-34, 35-44, 45-54, five-year age bins from 55 to 95, and a 95+ category. Using a categorical age variable allows the model to account for the differing effects of age and gender. Age is determined based on the patient's age at Stay_Start_Date.</p> <p>CMS Hierarchical condition categories (HCCs) – HCCs were developed for the risk adjustment model used in determining capitation payments to Medicare Advantage plans and are calculated using Part A and B Medicare claims. While the CMS-HHC model uses a full year of claims data to calculate HCCs, for these measures, we use only 6 months of data to limit the number of home health stays excluded due to missing HCC data. All 2008 HCCs and CCs that are not hierarchically ranked that were statistically significant predictors of ACH and ED use are included in the model.</p> <p>Details of the CMS-HCC model and the code lists for defining the HCCs can be found here: https://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp A description of the development of the CMS-HCC model can be found here: https://www.cms.gov/HealthCareFinancingReview/Downloads/04Summerpg119.pdf</p> <p>ESRD and Disability Status – Original End Stage Renal Disease (ESRD) and current ESRD status are included as risk factors. Original disabled status and male, and original disabled status and female, are also included. Medicare beneficiaries with ESRD or disabled status represent a fundamentally different health profile.</p> <p>Interaction Terms – All interaction terms included in the 2008 and 2012 HCC risk adjustment models that were statistically significant predictors of ED Use and ACH were included. Interaction terms account for the additional effect two risk factors may have when present simultaneously, which is more than the additive effect of each factor separately.</p> <p>Attachment NQF_CBM_RiskAdjustment_24Feb2012-634656974096796183.pdf</p>
Stratification	Measure is not stratified.
Type Score	Rate/proportion better quality = lower score
Algorithm	<ol style="list-style-type: none"> 1. Construct Home Health Stays from HH Claims (see 2a1.7 for details) 2. Identify numerator window (60 days following Stay_Start_Date) for each stay and exclude stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window or until patient death. 3. Exclude stays that begin with a LUPA or that involve a provider change during the numerator window 4. Link stays to enrollment data by beneficiary. 5. Exclude stays for patients who are not continuously enrolled in fee-for-service Medicare during the 6 months prior to Stay_Start_Date. 6. Calculate demographic risk factors for each stay (age, gender, etc.) using enrollment data. 7. Link to Part A and Part B claims for 6 months prior to Stay_Start_Date for each beneficiary

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0173 Emergency Department Use without Hospitalization	
	<p>8. Calculate prior care setting indicators, HCCs, and HCC interactions.</p> <p>9. Link to Inpatient (IP) claims from Short Stay and Critical Access hospitals(excluding planned hospitalizations) for the numerator window (60 days following Stay_Start_Date) – see specifications for the home health Acute Care Hospitalization (NQF 0171) measure for details.</p> <p>10. Set Hospital Admission indicator (Hosp_Admit = 1) if any IP claims are linked to the stay in step 9. These stays are not included in the ED Use without Hospitalization measure numerator.</p> <p>11. Link to Outpatient claims with revenue center codes indicating Emergency Department use for the numerator window (60 days following Stay_Start_Date).</p> <p>12. Set Outpatient ED Use indicator (OP_ED = 1) if any outpatient claims are linked to the stay in step 11.</p> <p>13. Flag stays for inclusion in the measure numerator (ED_noHosp = 1) if OP_ED =1 and NOT Hosp_Admit = 1.</p> <p>14. Using coefficients from the multinomial logit risk model and risk factors calculated in steps 6 and 8, calculate the predicted probability of being included in the measure numerator for each stay (Pred_ED_noHosp). Additionally calculate the average of Pred_ED_noHosp across all stays that are included in the measure denominator (not excluded in steps 3 or 5) and call this value National_pred_ED.</p> <p>15. Calculate observed and risk adjusted rates for each home health agency (Initial_Provider):</p> <p>a. Calculate the observed rate of Emergency Department Use without Hospitalization as the fraction all (non-excluded) HH Stays with that agency as Initial_Provider that are also included in the measure numerator (ED_noHosp = 1). Call the value Agency_obs_ED.</p> <p>b. Calculate the agency predicated rate of Emergency Department use without Hospitalization by taking the average of Pred_ED_noHosp across all (non-excluded) stays with that agency as Initial_Provider. Call this value Agency_pred_ED.</p> <p>c. Calculate the risk adjusted rate of Emergency Department use without Hospitalization using the following formula: $Agency_riskadj_ED = National_pred_ED + (Agency_obs_ED - Agency_pred_ED)$. If an agency's calculated risk adjusted rate is negative, that agency will have a publicly reported rate of 0% URL ALGORITHM IS INCLUDED IN 2a1.20</p>
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0326 Advance Care Plan	
Status	Maintenance, Original Endorsement: Nov 05, 2007, Most Recent Endorsement: Jan 25, 2012 Time-limited
Steward	National Committee for Quality Assurance Other organizations: This measure was developed with the cooperation of the American Geriatrics Society, the National Committee for Quality Assurance and the American Medical Association.
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	Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry None URL http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/geriatrics-ws.pdf
Level	Clinician : Individual
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Home Health, Hospice, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
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	<p>Time Window: A twelve month measurement year</p> <p>Report the CPT Category II codes designated for this numerator:</p> <p>1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record</p> <p>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</p> <p>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</p>

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	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	<p>Time Window: A twelve month measurement year</p> <p>Denominator Criteria (Eligible Cases): Patients aged = 65 years on date of encounter 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, 99387, 99397, 99401, 99402, 99403, 99404</p> <p>*Clinicians indicating the place of service as the emergency department will not be included in this measure.</p>
Exclusions	N/A
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>Step 1: Determine the eligible population. The eligible population is all the patients aged 65 years and older.</p> <p>Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above.</p> <p>Step 3: Determine the number of patients who meet the numerator criteria as specified in section 2a1.3 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.</p> <p>Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2 Attachment PCPI Sample Calculation Algorithm-634613645501283368.pdf</p>
Copyright/Disclaimer	<p>Physician Performance Measures (Measures) and related data specifications, developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (the Consortium) and the National Committee for Quality Assurance (NCQA) pursuant to government sponsorship under subcontract 6205-05-054 with Mathematica Policy Research, Inc. under contract 500-00-0033 with Centers for Medicare & Medicaid Services.</p> <p>These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.</p> <p>The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the Consortium) or NCQA. Neither the AMA, NCQA, Consortium nor its members shall be responsible for any use of the Measures.</p> <p>THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. © 2004-6 American Medical Association and National Committee for Quality Assurance. All Rights Reserved. Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>CPT® contained in the Measures specifications is copyright 2005 American Medical Association G codes and associated descriptions included in these Measure specifications are in the public domain.</p> <p>These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.</p> <p>THE MEASURES AND SEPCIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.</p>

	0494 Medical Home System Survey
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0494 Medical Home System Survey	
Status	Maintenance, Original Endorsement: Aug 29, 2008, Most Recent Endorsement: Jan 25, 2012 Time-limited
Steward	National Committee for Quality Assurance
Description	<p>The following 6 composites are generated from the Medical Home System Survey (MHSS). Each measure is used to assess a particular domain of the patient-centered medical home.</p> <p>Measure 1: Improved access and communication Measure 2: Care management using evidence-based guidelines Measure 3: Patient tracking and registry functions Measure 4: Support for patient self-management Measure 5: Test and referral tracking Measure 6: Practice performance and improvement functions</p>
Type	Structure
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Healthcare Provider Survey, Management Data, Other, Paper Records, Patient Reported Data/Survey The Medical Home System Survey asks for physician or practice self-report of processes and structures with accompanying documentation. The documentation required for each factor varies. Examples of documentation include: written evidence of documented process within a practice, record of response times for phone calls and electronic messages, examples of patient records, patient education materials, reports from electronic system for patient health information, and screen shots of electronic resources. A complete list of documentation can be found in the attached Standards documentation.
Level	Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office
Numerator Statement	<p>The composite measures do not have a typical numerator. Each composite is composed of elements; each element is made up of individual factors. The composite score is calculated by adding the element scores. The element scores are based on the proportion of individual factors with a satisfactory “yes” response (see Standards documentation for details).</p> <p>Note: In the calculation algorithm, the measurement domains are termed “composites,” the measures within each domain are referred to as “elements,” and the items within a measure, or measure subcomponents, are referred to as “factors.”</p>
Numerator Details	<p>Time Window: The numerator time window is 3 months. Practices must show that measured factors have been in place for at least 3 months. Data should be no more than 12 months old.</p> <p>The MHSS is comprised of 6 composites which contain 27 elements. Each element is made up of individual factors (or measurement items) which can be answered yes/no. The number of factors in an element varies. To calculate the composite score, determine the proportion of factors met in each element (0%, 25%, 50%, 75%, 100%). The proportion of factors met is multiplied by the points allotted for each element. The composite score is the sum of points for all the elements in the composite (See Standards documentation for further detail.)</p> <p>Composite 1) Enhance access and continuity – Total Possible Points 20 Element 1A) Access during office hours (4 factors – 4 points) Element 1B) After-hours access (5 factors – 4 points) Element 1C) Electronic access (6 factors – 2 points) Element 1D) Continuity (3 factors – 2 points) Element 1E) Medical home responsibilities (4 factors – 2 points) Element 1F) Culturally and linguistically appropriate services (4 factors – 2 points) Element 1G) The practice team (8 factors – 4 points)</p> <p>Composite 2) Identify and manage patient populations – Total Possible Points 16 Element 2A) Patient information (12 factors – 3 points) Element 2B) Clinical data (9 factors – 4 points) Element 2C) Comprehensive health assessment (9 factors – 4 points) Element 2D) Use data for population management (4 factors – 5 points)</p> <p>Composite 3) Plan and manage care – Total Possible Points 17 Element 3A) Implement evidence-based guidelines (3 factors – 4 points) Element 3B) Identify high-risk patients (2 factors – 3 points) Element 3C) Care management (7 factors – 4 points)</p>

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	<p>Element 3D) Medication management (6 factors – 3 points) Element 3E) Use of electronic prescribing (6 factors – 3 points) Composite 4) Provide self-care support and community resources – Total Possible Points 9 Element 4A) Support self-care process (6 factors – 6 points) Element 4B) Provide referrals to community resources (4 factors – 3 points) Composite 5) Track and coordinate care – Total Possible Points 18 Element 5A) Test tracking and follow-up (10 factors – 6 points) Element 5B) Referral tracking and follow-up (7 factors – 6 points) Element 5C) Coordinate with facilities and manage care transitions (8 factors – 6 points) Composite 6) Measure and improve performance – Total Possible Points 20 Element 6A) Measure performance (4 factors – 4 points) Element 6B) Measure Patient/Family Experience (4 factors – 4 points) Element 6C) Demonstrate continuous quality improvement (4 factors – 4 points) Element 6D) Tracking results over time (3 factors – 3 points) Element 6E) Report performance (3 factors – 3 points) Element 6F) Report data externally (4 factors – 2 points)</p>
Denominator Statement	N/A
Denominator Details	<p>Time Window: The target population is eligible outpatient primary care practices.</p> <p>The practice must provide primary care for all of the patients in its practice, not just selected patients. A practice is one or more clinicians who practice together and provide patient care at a single geographic location. Practicing together means that, for all the clinicians in a practice:</p> <ul style="list-style-type: none"> • The practice care team follows the same procedures and protocols • Medical records for all patients treated at the practice site, whether paper or electronic, are available to and shared by all clinicians, as appropriate • The same systems—electronic and paper-based—and procedures support both clinical and administrative functions, for example: scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up
Exclusions	None
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	N/A
Type Score	Weighted score/composite/scale better quality = higher score
Algorithm	<p>Step 1: The score for each element is calculated separately. The score for each element is based on the proportion of factors the practice meets; 0%,25%,50%,75%,100% multiplied by the points allotted to the element. Within each element the number of factors varies and the importance of individual factors varies. Some factors are considered “must-pass” in order to achieve a score of 50% or higher on a particular element.</p> <p>For example: Element D: Medication Management – 3 points The practice manages medication in the following ways. Factor 1: Review and reconciles medications with patients/families for more than 50 percent of care transitions. Yes/No Factor 2: Reviews and reconciles medications with patients/families for more than 80 percent of care transitions. Yes/No Factor 3: Provides information about new prescriptions to more than 80 percent of patients/families. Yes/No Factor 4: Assesses patient/family understanding of medications for more than 50 percent of patients with date of assessment. Yes/No Factor 5: Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment. Yes/No Factor 6: Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates. Yes/No</p> <p>Element Scoring: A practice meeting 5-6 of the factors, including factor 1, receives 100% of the points = 3 A practice meeting 3-4 of the factors, including factor 1, receives 75% of the points = 2.25</p>

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	<p>A practice meeting 2 factors, including factor 1, receives a score 50% of the points = 1.5 A practice meeting only factor 1 receives 25% of the points = 0.75 A practice meeting no factors or does not meet factor 1 receives 0% of the points = 0 Step 2: The composite score is calculated by summing the points award to each element. For example: Composite 3: Plan and Manage Care Element 3A) Implement evidence-based guidelines – 4 points * proportion of factors met Element 3B) Identify high-risk patients – 3 points * proportion of factors met Element 3C) Care management – 4 points * proportion of factors met Element 3D) Medication management – 3 points * proportion of factors met Element 3E) Use of electronic prescribing - 3 points* proportion of factors met A practice meeting 50% of 3A factors, 100% of 3B factors, 75% of 3C factors, 100% of 3D factors, and 25% of 3E factors would have the following composite score: $2 + 3 + 3 + 3 + 0.75 = 11.75$ out of 17 possible points.</p> <p>The detailed score for each element can be found in the attached Standards documentation.</p>
Copyright/Disclaimer	<p>© 2012 by the National Committee for Quality Assurance 1100 13th Street, NW, Suite 1000 Washington, DC 20005 These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. THE MEASURES AND SEPCIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.</p>

0511 Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	
Status	Maintenance, Original Endorsement: Oct 28, 2008, Most Recent Endorsement: Oct 28, 2008 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement Other organizations: Society of Nuclear Medicine
Description	Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT) that were performed
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry, Paper Records Not Applicable Attachment NQF_0511_Value Sets_Updated_Dec_2011.xls
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Imaging Facility, Other ANY SETTING WHERE BONE SCINTIGRAPHY IS PERFORMED
Numerator Statement	<p>Final reports that include physician documentation of correlation with existing relevant* imaging studies (eg, x-ray, MRI, CT) Definition: *Relevant imaging studies are defined as studies that correspond to the same anatomical region in question.</p>
Numerator Details	<p>Time Window: Once for each final report during the measurement period</p> <p>Numerator Definition: Relevant Imaging Studies – Studies that correspond to the same anatomical region in question. For EHR: See attached for eMeasure. For Claims/Administrative: Report CPT Category II Code: 3570F: Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (eg, x-ray, MRI, CT) corresponding to the same anatomical region in question</p>
Denominator Statement	<p>All final reports for patients, regardless of age, undergoing bone scintigraphy Note: Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material)from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report.</p>

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0511 Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	
Denominator Details	<p>Time Window: [ex: 12 consecutive months] Each final report during 12 consecutive month measurement period</p> <p>For EHR: See attached for eMeasure. Submission form did not allow for submission of zip file, so complete eMeasure will be emailed to NQF staff</p> <p>For Claims/Administrative: CPT Codes: 78300, 78305, 78306, 78315, 78320</p>
Exclusions	System reason for not documenting correlation with existing relevant imaging studies in final report (eg, no existing relevant imaging study available, patient did not have a previous relevant imaging study)
Exclusion Details	<p>To report system reason exception for claims/administrative: Documentation of system reason(s) for not documenting correlation with existing relevant imaging studies in final report (e.g., no existing relevant imaging study available, patient did not have a previous relevant imaging study)</p> <ul style="list-style-type: none"> • Append modifier to CPT Category II Code: 3570F-3P <p>System Exception Note: Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material) from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report.</p> <p>The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0511, exceptions may include system reason(s) for not documenting correlation with existing relevant imaging studies in final report (eg, no existing relevant imaging study available, patient did not have a previous relevant imaging study).</p> <p>Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For Claims/Administrative specifications, Append modifier to CPT Category II code: 3570F-3P</p>
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>No risk adjustment or risk stratification.</p>
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: system reason(s) (eg, no existing relevant imaging study available, patient did not have a previous relevant imaging study)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. -- Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

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	0511 Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
	If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in data dictionary/code table attachment 2a1.30.
Copyright/Disclaimer	<p>Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians. These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.</p> <p>Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain.</p> <p>Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.</p> <p>THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND © 2007 American Medical Association. All Rights Reserved</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>THE SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.</p>

	0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care
Status	Maintenance, Original Endorsement: Mar 31, 2009, Most Recent Endorsement: Jan 31, 2012 Time-limited
Steward	Centers for Medicare & Medicaid Services Other organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research
Description	Percentage of short term home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems.
Type	Process
Data Source	Electronic Clinical Data OASIS-C URL https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQIOASISAllTimePoint.pdf URL https://www.cms.gov/OASIS/Downloads/oasisp200.zip
Level	Facility
Setting	Home Health
Numerator Statement	Number of home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems.
Numerator Details	<p>Time Window: Time Window: Current CMS systems report data on episodes that end within a rolling 12 month period, updated quarterly.</p> <p>Number of home health patient episodes of care where at end of episode: - (M2015) Patient/Caregiver Drug Education Intervention = 1 (yes)</p>
Denominator Statement	Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.

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0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care	
Denominator Details	<p>Time Window: Time Window: Current CMS systems report data on episodes that end within a rolling 12 month period, updated quarterly.</p> <p>Number of home health patient episodes of care, defined as: A start/resumption of care assessment ((M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care)) paired with a corresponding discharge/transfer assessment ((M0100) Reason for Assessment = 6 (Transfer to inpatient facility – not discharged), 7 (Transfer to inpatient facility – discharged), 8 (Death at home), or 9 (Discharge from agency)), other than those covered by denominator exclusions.</p>
Exclusions	<ul style="list-style-type: none"> - Episodes in which the patient was not on any medications since the last OASIS assessment. - Episodes ending in patient death. Note: The information needed to calculate this measure is not collected if the home health episode ends in death. The measure cannot be calculated in excluded cases due to data limitations. - Long-term episodes (as indicated by the presence of a follow-up assessment between admission and transfer or discharge). Note: This exclusion was added at the request of NQF reviewers during initial consideration of the measure in 2008. To avoid excessive burden to agencies related to reviewing records longer than 60 days, this implementation measure reports on care provided since the last OASIS assessment. However, restricting the measure to care since the most recent OASIS assessment raised concerns among NQF Steering Committee members that measures might not accurately reflect care for longer-stay patients, as some interventions may have been implemented prior to the most recent OASIS assessment. In response, measure specifications were changed so that home care episodes that require a recertification are not included in publicly-reported measures on implementation of evidence-based practices. The reports that CMS provides for agency use in quality improvement activities include separate break-outs for short-term episodes and long-term episodes, as well as a combined “all episodes” measure.
Exclusion Details	<p>Measure Specific Exclusions: Number of home health patient episodes of care where at end of episode: - (M0100) Reason for Assessment = 8 (Death at home) PLUS Number of home health patient episodes of care where at end of episode: - (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge) AND: - (M2015) Patient/Caregiver Drug Education Intervention = NA (Patient not taking any drugs) PLUS Number of home health patient episodes of care where at least one assessment with (M0100) Reason for Assessment = 4 (Recertification follow-up reassessment) or 5 (Other follow-up) was completed between the start and end of the episode of care.</p> <p>Generic Exclusions: Medicare-certified home health agencies are currently required to collect and submit OASIS data only for adult (aged 18 and over) non-maternity Medicare and Medicaid patients who are receiving skilled home health care. Therefore, maternity patients, patients less than 18 years of age, non-Medicare/Medicaid patients, and patients who are not receiving skilled home services are all excluded from the measure calculation. However, the OASIS items and related measures could potentially be used for other adult patients receiving services in a community setting, ideally with further testing. The publicly-reported data on CMS’ Home Health Compare web site also repress cells with fewer than 20 observations, and reports for home health agencies in operation less than six months.</p>
Risk Adjustment	<p>No risk adjustment or risk stratification N/A - process measure - not risk adjusted</p>
Stratification	N/A - measure not stratified.
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>Calculation algorithm available in the Technical Specifications at: https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQITechnicalDocOfMeasures.pdf URL https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQITechnicalDocOfMeasures.pdf</p>
Copyright/Disclaimer	
0526 Timely Initiation of Care	
Status	Maintenance, Original Endorsement: Mar 31, 2009, Most Recent Endorsement: Mar 31, 2009 Time-limited
Steward	Centers for Medicare & Medicaid Services Other organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research

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0526 Timely Initiation of Care	
Description	Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.
Type	Process
Data Source	Electronic Clinical Data OASIS-C URL https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQIOASISCAIITimePoint.pdf URL https://www.cms.gov/OASIS/Downloads/oasisp200.zip
Level	Facility
Setting	Home Health
Numerator Statement	Number of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.
Numerator Details	<p>Time Window: Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly.</p> <p>Number of home health patient episodes of care where at start of episode:</p> <ul style="list-style-type: none"> - (M0100) Reason for Assessment = 1 (Start of care) AND - (M0030) Start of care date equals (M0102) Physician-ordered Start of Care Date, or - (M0030) Start of care date minus (M0104) Date of Referral is less than 3 days, or - (M0030) Start of care date minus (M1005) Inpatient Discharge Date is less than 3 days <p>PLUS</p> <p>Number of home health patient episodes of care where at start of episode:</p> <ul style="list-style-type: none"> - (M0100) Reason for Assessment = 3 (Resumption of care) AND - (M0032) Resumption of care date equals (M0102) Physician-ordered Resumption of Care Date, or - (M0032) Resumption of care date minus (M0104) Date of Referral is less than 3 days, or - (M0032) Resumption of care date minus (M1005) Inpatient Discharge Date is less than 3 days
Denominator Statement	All home health episodes other than those covered by generic denominator exclusions.
Denominator Details	<p>Time Window: Time Window: Current CMS systems report data on episodes that end within a rolling 12 month period, updated quarterly.</p> <p>Number of home health patient episodes of care, defined as: A start/resumption of care assessment OASIS-C((M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care)) paired with a corresponding discharge/transfer assessment ((M0100) Reason for Assessment = 6 (Transfer to inpatient facility – not discharged), 7 (Transfer to inpatient facility – discharged), 8 (Death at home), or 9 (Discharge from agency)), other than those covered by generic denominator exclusions.</p>
Exclusions	No measure-specific exclusions.
Exclusion Details	<p>Measure-Specific Exclusions: None</p> <p>Generic Exclusions: Medicare-certified home health agencies are currently required to collect and submit OASIS data only for adult (aged 18 and over) non-maternity Medicare and Medicaid patients who are receiving skilled home health care. Therefore, maternity patients, patients less than 18 years of age, non-Medicare/Medicaid patients, and patients who are not receiving skilled home services are all excluded from the measure calculation. However, the OASIS items and related measures could potentially be used for other adult patients receiving services in a community setting, ideally with further testing. The publicly-reported data on CMS' Home Health Compare web site also repress cells with fewer than 20 observations, and reports for home health agencies in operation less than six months.</p>
Risk Adjustment	No risk adjustment or risk stratification N/A - process measure - not risk adjusted.
Stratification	Not stratified.
Type Score	Rate/proportion better quality = higher score
Algorithm	Calculation algorithm available in the Technical Specifications at: https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQITechnicalDocOfMeasures.pdf URL https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQITechnicalDocOfMeasures.pdf
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0553 Care for Older Adults – Medication Review	
Status	Maintenance, Original Endorsement: Aug 05, 2009, Most Recent Endorsement: Jan 25, 2012 Time-limited
Steward	National Committee for Quality Assurance
Description	Percentage of adults 66 years and older who had a medication review; a review of all a member's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Paper Records NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). URL http://www.ncqa.org/tabid/370/default.aspx
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State
Setting	Ambulatory Care : Clinician Office, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	At least one medication review (Table COA-B) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Table COA-C) Table COA-B Codes to identify medication review: Medication review (CPT 90862, 99605, 99606), (CPT-II 1160F) Table COA-C Codes to Identify Medication List (CPT-II 1159F)
Numerator Details	Time Window: The measurement year 1) Administrative Specification (if available): At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record, as documented through administrative data. The claim/encounter for a member's medication review and medication list must be on the same date of service. Codes to identify medication review: Medication review (CPT 90862, 99605, 99606), (CPT-II 1160F) Codes to Identify Medication List (CPT-II 1159F) 2) Medical Record Specification (if necessary): Documentation must come from the same medical record and must include the following. <ul style="list-style-type: none"> • A medication list in the medical record, and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed • Notation that the member is not taking any medication and the date when it was noted A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Prescribing practitioner is defined as a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.
Denominator Statement	All patients 66 and older as of December 31 of the measurement year
Denominator Details	Time Window: The measurement year Use administrative data and medical records for of members 66 years and older as of December 31 of the measurement year.
Exclusions	N/A
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. Step 2. Search administrative systems to identify numerator events for all members in the eligible population. Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The

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	organization is not required to search for optional exclusions. Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being measured. Step 5. Calculate the rate.
Copyright/Disclaimer	© 2012 by the National Committee for Quality Assurance 1100 13th Street, NW, Suite 1000 Washington, DC 20005 These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. THE MEASURES AND SEPCIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

	0554 Medication Reconciliation Post-Discharge
Status	Maintenance, Original Endorsement: Aug 05, 2009, Most Recent Endorsement: Jan 25, 2012 Time-limited
Steward	National Committee for Quality Assurance
Description	The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). URL http://www.ncqa.org/tabid/370/default.aspx
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional
Setting	Ambulatory Care : Clinician Office
Numerator Statement	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through administrative or medical record review on or within 30 days of discharge. Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record, on or within 30 days after discharge.
Numerator Details	Time Window: The measurement year 1) Administrative (when available): Medication reconciliation (Table MRP-A) conducted by prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. A member had a medication reconciliation if a claim/encounter contains a code in Table MRP-A. Table MRP-A: Codes to Identify Medication Reconciliation Medication Reconciliation: CPT Category II: 1111F 2) Medical Record (as necessary): Documentation in the medical record must include evidence of medication reconciliation, and the date on which it was performed. The following evidence meets criteria: <ul style="list-style-type: none"> • Notation that medications prescribed or ordered upon discharge were reconciled with the current medications (in outpatient record) by the appropriate practitioner type, or • A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type or • Notation that no medications were prescribed or ordered upon discharge Only documentation in the outpatient record chart meets the intent of the measure, but an in-person, outpatient visit is not required
Denominator Statement	All discharges from an in-patient setting for health plan members who are 66 years and older as of December 31 of the measurement year.
Denominator Details	Time Window: The measurement year (one calendar year) 1) Administrative (when available): An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator is based on episodes, not members. Members may appear more than once in the sample. If members

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0554 Medication Reconciliation Post-Discharge	
	have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. 2) Medical Record (as necessary): The denominator is based on episodes, not members. Members may appear more than once in the sample. The denominator is based on the discharge date found in the administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.
Exclusions	Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count the only the readmission discharge or the discharge from the facility to which the member was transferred.
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement. Step 2. Search administrative systems to identify numerator events for all members in the eligible population. Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions. Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being measured. Step 5. Calculate the rate.
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0645 Biopsy Follow-up	
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010 Time-limited
Steward	American Academy of Dermatology
Description	Percentage of patients who are undergoing a biopsy whose biopsy results have been reviewed by the biopsying physician and communicated to the primary care/referring physician and the patient.
Type	Process
Data Source	Electronic Clinical Data : Registry, Paper Records This measure was approved for inclusion in the 2012 PQRS program - only to be reported via an electronic registry. The AAD currently administers a PQRS registry and planned to add the biopsy measure as one of the reportable measures through the AAD's 2012 system. Since the testing of this measure needed to occur prior to 2012, the AAD issued a "demo" version of what the biopsy measure section of the registry would look like (it has been uploaded as a reference). The various sites that participated in the AAD's testing project manually entered information into this "demo" version of the electronic registry. Attachment BiopsyChartAbstraction2011.docx
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Ambulatory Care : Clinician Office
Numerator Statement	Patients who are undergoing a biopsy whose biopsy results have been reviewed by the biopsying physician and communicated to the primary care/referring physician and the patient, denoted by entering said physician's initials into a log, as well as by documentation in the patient's medical record.
Numerator	Time Window: Measurement year.

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0645 Biopsy Follow-up	
Details	<p>This measure is to be reported once per measurement year for patients who are seen for an office visit and have a biopsy performed during the reporting period. Note: While this measure is only required to be reported once per eligible</p> <p>Patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and the patient by the physician performing the biopsy. The physician performing the biopsy must also acknowledge and/or document the communication in a biopsy tracking log and document in the patient’s medical record. [NUMERATOR INSTRUCTIONS] To satisfy this measure, the biopsying physician must:</p> <ul style="list-style-type: none"> • Review the biopsy results with the patient • Communicate those results to the primary care/referring physician • Track communication in a log • Document tracking process in the patient’s medical record <p>The components of a tracking log incorporate the following:</p> <ul style="list-style-type: none"> • Initials of physician performing the biopsy • Patient name • Date of biopsy • Type of biopsy • Biopsy result • Date of biopsy result
Denominator Statement	All patients undergoing a biopsy.
Denominator Details	<p>Time Window: Measurement year.</p> <p>All patients undergoing a biopsy Eligible Cases: All patients regardless of age on date of encounter AND Patient encounter during the reporting period (CPT): CPT procedure codes for biopsies include: 49000(Biopsy, abdomen); 60540(Biopsy, adrenal gland); 60541(Biopsy, adrenal gland); 60542(Biopsy, adrenal gland); 60543(Biopsy, adrenal gland); 60544(Biopsy, adrenal gland); 60545(Biopsy, adrenal gland); 46606(Biopsy, anal endoscopy); 27613(Biopsy, ankle); 27614(Biopsy, ankle); 27620(Biopsy, ankle); 25065(Biopsy, arm; lower); 25066(Biopsy, arm; lower); 24065(Biopsy, arm; upper); 24066(Biopsy, arm; upper); 37609(Biopsy, temporal artery); 69105(external auditory canal); 21920(Biopsy, back or flank); 21921(Biopsy, back or flank); 21922(Biopsy, back or flank); 21923(Biopsy, back or flank); 21924(Biopsy, back or flank); 21925(Biopsy, back or flank); 47553(Biopsy, bile duct endoscopy); 52354(Biopsy, bladder; cystourethroscope); 52224(Biopsy, bladder; cystourethroscope); 52250(Biopsy, bladder; cystourethroscope); 75970(Biopsy, blood vessel; transcatheter); 20220(Biopsy, bone); 20221(Biopsy, bone); 20222(Biopsy, bone); 20223(Biopsy, bone); 20224(Biopsy, bone); 20225(Biopsy, bone); 20226(Biopsy, bone); 20227(Biopsy, bone); 20228(Biopsy, bone); 20229(Biopsy, bone); 20230(Biopsy, bone); 20231(Biopsy, bone); 20232(Biopsy, bone); 20233(Biopsy, bone); 20234(Biopsy, bone); 20235(Biopsy, bone); 20236(Biopsy, bone); 20237(Biopsy, bone); 20238(Biopsy, bone); 20239(Biopsy, bone); 20240(Biopsy, bone); 20241(Biopsy, bone); 20242(Biopsy, bone); 20243(Biopsy, bone); 20244(Biopsy, bone); 20245(Biopsy, bone); 38221(Biopsy, bone marrow); 61140(Biopsy, brain); 61750(Biopsy, brain; stereotactic); 61751(Biopsy, brain; stereotactic); 61575(Biopsy, brainstem); 61576(Biopsy, brainstem); 19100(Biopsy, breast); 19101(Biopsy, breast); 19102(Biopsy, breast); 19103(Biopsy, breast); 19295(Biopsy, metallic localization clip placement); 77031(Biopsy, metallic localization clip placement; stereostatic localization); 31717(Biopsy, bronchi; catheterization); 31625(Biopsy, bronchi; endoscopic); 31626(Biopsy, bronchi; endoscopic); 31627(Biopsy, bronchi; endoscopic); 31628(Biopsy, bronchi; endoscopic); 31629(Biopsy, bronchi; endoscopic); 31632(Biopsy, bronchi; endoscopic); 31633(Biopsy, bronchi; endoscopic); 31717(Brush biopsy, bronchi); 52007(Brush biopsy, renal pelvis); 52007(Brush biopsy, ureter); 52204(Brush biopsy, ureter; with cystourethroscope); 26100(Biopsy, carpometacarpal joint; synovium); 57454(Biopsy, cervix); 57455(Biopsy, cervix); 57460(Biopsy, cervix); 57500(Biopsy, cervix); 57520(Biopsy, cervix); 59015(Biopsy, chorionic villus); 44025(Biopsy, colon); 44100(Biopsy, colon); 44389(Biopsy, colon; endoscopy); 45380(Biopsy, colon; endoscopy); 45391(Biopsy, colon; endoscopy); 45392(Biopsy, colon; endoscopy); 44322(Biopsy, colon; colostomy; cecostomy); 45305(Biopsy, colon-sigmoid; endoscopy); 45331(Biopsy, colon-sigmoid; endoscopy); 68100(Biopsy, conjunctiva); 65410(Biopsy, cornea); 44010 (Biopsy, duodenum); 69100(Biopsy, ear; external); 24065(Biopsy, elbow); 24066(Biopsy, elbow); 24101(Biopsy, elbow); 24100(Biopsy, elbow; synovium); 89290(Biopsy, embryo blastomere);</p>

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<p>89291(Biopsy, embryo blastomere); 58100(Biopsy, endometrium); 58101(Biopsy, endometrium); 58102(Biopsy, endometrium); 58103(Biopsy, endometrium); 58104(Biopsy, endometrium); 58105(Biopsy, endometrium); 58106(Biopsy, endometrium); 58107(Biopsy, endometrium); 58108(Biopsy, endometrium); 58109(Biopsy, endometrium); 58110(Biopsy, endometrium); 58558(Biopsy, endometrium); 54800(Biopsy, epididymis); 54865(Biopsy, epididymis); 43202(Biopsy, esophagus; endoscopy); 3150F(Biopsy, esophagus; forceps); 67346(Biopsy, eye muscle); 67810(Biopsy, eyelid); 43261(Biopsy, gallbladder; endoscopy); 43239(Biopsy, upper gastrointestinal; endoscopy); 26100(Biopsy, hand joint; synovium); 93505(Biopsy, heart); 27040(Biopsy, hip); 27041(Biopsy, hip); 27052(Biopsy, hip; joint); 42802(Biopsy, hypopharynx); 44382(Biopsy, Ileum; endoscopy); 26110(Biopsy, interphalangeal joint; finger); 28054(Biopsy, interphalangeal joint; toe); 28050(Biopsy, intertarsel joint; toe); 44020(Biopsy, small intestine); 44361(Biopsy, small intestine; endoscopy); 44377(Biopsy, small intestine; endoscopy); 50200(Biopsy, kidney); 50201(Biopsy, kidney); 50202(Biopsy, kidney); 50203(Biopsy, kidney); 50204(Biopsy, kidney); 50205(Biopsy, kidney); 50555(Biopsy, kidney; endoscopic); 50556(Biopsy, kidney; endoscopic); 50557(Biopsy, kidney; endoscopic); 50574(Biopsy, kidney; endoscopic); 50575(Biopsy, kidney; endoscopic); 50576(Biopsy, kidney; endoscopic); 52354(Biopsy, kidney; endoscopic); 27323(Biopsy, knee); 27324(Biopsy, knee); 27330(Biopsy, knee, knee joint; synovium); 68510(Biopsy, lacrimal gland); 68525(Biopsy, lacrimal sac); 31510(Biopsy, larynx; endoscopy); 31576(Biopsy, larynx; endoscopy); 27613(Biopsy, leg; lower); 27614(Biopsy, leg; lower); 27323(Biopsy, leg; upper); 27324(Biopsy, leg; upper); 40490(Biopsy, lip); 47000(Biopsy, liver); 47001 (Biopsy, liver); 47100(Biopsy, liver); 32405(Biopsy, lung; needle); 32095(Biopsy, lung; thoracotomy); 32096(Biopsy, lung; thoracotomy); 32097(Biopsy, lung; thoracotomy); 32098(Biopsy, lung; thoracotomy); 32099(Biopsy, lung; thoracotomy); 32100(Biopsy, lung; thoracotomy); 38500(Biopsy, lymph nodes); 38501(Biopsy, lymph nodes); 38502(Biopsy, lymph nodes); 38503(Biopsy, lymph nodes); 38504(Biopsy, lymph nodes); 38505(Biopsy, lymph nodes); 38506(Biopsy, lymph nodes); 38507(Biopsy, lymph nodes); 38508(Biopsy, lymph nodes); 38509(Biopsy, lymph nodes); 38510(Biopsy, lymph nodes); 38511(Biopsy, lymph nodes); 38512(Biopsy, lymph nodes); 38513(Biopsy, lymph nodes); 38514(Biopsy, lymph nodes); 38515(Biopsy, lymph nodes); 38516(Biopsy, lymph nodes); 38517(Biopsy, lymph nodes); 38518(Biopsy, lymph nodes); 38519(Biopsy, lymph nodes); 38520(Biopsy, lymph nodes); 38521(Biopsy, lymph nodes); 38522(Biopsy, lymph nodes); 38523(Biopsy, lymph nodes); 38524(Biopsy, lymph nodes); 38525(Biopsy, lymph nodes); 38526(Biopsy, lymph nodes); 38527(Biopsy, lymph nodes); 38528(Biopsy, lymph nodes); 38529(Biopsy, lymph nodes); 38530(Biopsy, lymph nodes); 38792(Biopsy, lymph nodes; injection procedure for identification of sentinel node); 38570(Biopsy, lymph nodes; laparoscopic); 38571(Biopsy, lymph nodes; laparoscopic); 38572(Biopsy, lymph nodes; laparoscopic); 38505(Biopsy, lymph nodes; needle); 38500(Biopsy, lymph nodes; open); 38510(Biopsy, lymph nodes; open); 38511(Biopsy, lymph nodes; open); 38512(Biopsy, lymph nodes; open); 38513(Biopsy, lymph nodes; open); 38514(Biopsy, lymph nodes; open); 38515(Biopsy, lymph nodes; open); 38516(Biopsy, lymph nodes; open); 38517(Biopsy, lymph nodes; open); 38518(Biopsy, lymph nodes; open); 38519(Biopsy, lymph nodes; open); 38520(Biopsy, lymph nodes; open); 38521(Biopsy, lymph nodes; open); 38522(Biopsy, lymph nodes; open); 38523(Biopsy, lymph nodes; open); 38524(Biopsy, lymph nodes; open); 38525(Biopsy, lymph nodes; open); 38526(Biopsy, lymph nodes; open); 38527(Biopsy, lymph nodes; open); 38528(Biopsy, lymph nodes; open); 38529(Biopsy, lymph nodes; open); 38530(Biopsy, lymph nodes; open); 38500(Biopsy, lymph nodes; open; superficial); 39400(Biopsy, mediastinum); 32405(Biopsy, mediastinum; needle); 26105(Biopsy, metacarpophalangeal joint); 28052(Biopsy, metatarsophalangeal joint); 40808(Biopsy, mouth); 41108(Biopsy, mouth); 20200(Biopsy, muscle); 20201(Biopsy, muscle); 20202(Biopsy, muscle); 20203(Biopsy, muscle); 20204(Biopsy, muscle); 20205(Biopsy, muscle); 20206(Biopsy, muscle); 11755(Biopsy, nail); 42804(Biopsy, nasopharynx); 42805(Biopsy, nasopharynx); 42806(Biopsy, nasopharynx); 21500(Biopsy, neck); 64795(Biopsy, nerve); 31237(Biopsy, nose; endoscopic); 30100(Biopsy, nose; intranasal); 89290(Biopsy, oocyte polar body); 89291(Biopsy, oocyte polar body); 61332(Biopsy, orbit); 67400(Biopsy, orbit; exploration); 67450(Biopsy, orbit; exploration); 67415(Biopsy, orbit; fine needle aspiration); 42800(Biopsy, oropharynx); 58900(Biopsy, ovary); 42100(Biopsy, palate); 48100(Biopsy, pancreas); 27040(Biopsy, pelvis); 27041(Biopsy, pelvis); 54100(Biopsy, penis); 54105(Biopsy, penis; deep structures); 62269(Biopsy, percutaneous needle; spinal cord); 56605(Biopsy, perineum); 56606(Biopsy, perineum); 47561(Biopsy, peritoneum; endoscopic); 42800(Biopsy, pharynx); 42801(Biopsy, pharynx); 42802(Biopsy, pharynx); 42803(Biopsy, pharynx); 42804(Biopsy, pharynx); 42805(Biopsy, pharynx); 42806(Biopsy, pharynx); 32400(Biopsy, pleura; needle); 32401(Biopsy, pleura; needle); 32402(Biopsy, pleura; needle); 32095(Biopsy, thoracotomy); 32096(Biopsy, thoracotomy); 32097(Biopsy, thoracotomy); 32098(Biopsy, thoracotomy); 32099(Biopsy, thoracotomy); 32100(Biopsy, thoracotomy); 32402(Biopsy, pleural; open); 55700(Biopsy, prostate); 55701(Biopsy, prostate); 55702(Biopsy, prostate); 55703(Biopsy, prostate); 55704(Biopsy, prostate); 55705(Biopsy, prostate); 55706(Biopsy, prostate); 45100(Biopsy, rectum); 49010(Biopsy, retroperitoneal area); 27050(Biopsy, sacroiliac joint); 42405(Biopsy, salivary gland); 23066(Biopsy, shoulder; deep); 23065(Biopsy, shoulder; soft tissue); 23100(Biopsy, shoulder joint); 23101(Biopsy, shoulder joint); 31050(Biopsy, sinus; sphenoid); 31051(Biopsy, sinus; sphenoid); 11100(Biopsy, skin lesion); 11101(Biopsy, skin lesion); 63275(Biopsy,</p>

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	spinal cord); 63276(Biopsy, spinal cord); 63277(Biopsy, spinal cord); 63278(Biopsy, spinal cord); 63279(Biopsy, spinal cord); 63280(Biopsy, spinal cord); 63281(Biopsy, spinal cord); 63282(Biopsy, spinal cord); 63283(Biopsy, spinal cord); 63284(Biopsy, spinal cord); 63285(Biopsy, spinal cord); 63286(Biopsy, spinal cord); 63287(Biopsy, spinal cord); 63288(Biopsy, spinal cord); 63289(Biopsy, spinal cord); 63290(Biopsy, spinal cord); 62269(Biopsy, spinal cord; percutaneous); 63615(Biopsy, spinal cord; stereotaxis); 43605(Biopsy, stomach); 28050(Biopsy, tarsometatarsal joint; synovial); 54500(Biopsy, testis); 54501(Biopsy, testis); 54502(Biopsy, testis); 54503(Biopsy, testis); 54504(Biopsy, testis); 54505(Biopsy, testis); 21550(Biopsy, thorax); 42800(Biopsy, throat); 42801(Biopsy, throat); 42802(Biopsy, throat); 42803(Biopsy, throat); 42804(Biopsy, throat); 42805(Biopsy, throat); 42806(Biopsy, throat); 41100(Biopsy, tongue); 41101(Biopsy, tongue); 41102(Biopsy, tongue); 41103(Biopsy, tongue); 41104(Biopsy, tongue); 41105(Biopsy, tongue); 37200(Biopsy, transcatheter); 52354(Biopsy, ureter); 50955(Biopsy, ureter; endoscopic); 50956(Biopsy, ureter; endoscopic); 50957(Biopsy, ureter; endoscopic); 50974(Biopsy, ureter; endoscopic); 50975(Biopsy, ureter; endoscopic); 50976(Biopsy, ureter; endoscopic); 52204(Biopsy, urethra); 52354(Biopsy, urethra); 53200(Biopsy, urethra); 58100(Biopsy, uterus; endometrial); 58101(Biopsy, uterus; endometrial); 58102(Biopsy, uterus; endometrial); 58103(Biopsy, uterus; endometrial); 58104(Biopsy, uterus; endometrial); 58105(Biopsy, uterus; endometrial); 58106(Biopsy, uterus; endometrial); 58107(Biopsy, uterus; endometrial); 58108(Biopsy, uterus; endometrial); 58109(Biopsy, uterus; endometrial); 58110(Biopsy, uterus; endometrial); 58558(Biopsy, uterus; endoscopic); 42100(Biopsy, uvula); 57100(Biopsy, vagina); 57101(Biopsy, vagina); 57102(Biopsy, vagina); 57103(Biopsy, vagina); 57104(Biopsy, vagina); 57105(Biopsy, vagina); 57421(Biopsy, vagina); 20250(Biopsy, vertebral body); 20251(Biopsy, vertebral body); 56605(Biopsy, vulva); 56606(Biopsy, vulva); 56821(Biopsy, vulva); 23101(Biopsy, vulva; acromioclavicular joint); 23100(Biopsy, vulva; glenohumeral joint); 23101(Biopsy, vulva; sternoclavicular joint); 52354(Biopsy, vulva; w/cystourethroscopy); 25065(Biopsy, wrist); 25066(Biopsy, wrist); 25100(Biopsy, wrist); 25101(Biopsy, wrist)
Exclusions	Patients not undergoing a biopsy.
Exclusion Details	Patients not undergoing a biopsy.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	
Algorithm	<p>1. Identify target population (patients undergoing a biopsy during the measurement year): in order to identify the target population, practices must establish an internal process (i.e. query their practice management system or EHR for the applicable biopsy codes the practitioner performs).</p> <p>2. Identify those instances where the quality action was performed in its entirety (measure met): Biopsy Results Reviewed and Communicated to the Patient and the Patient’s Primary Care/Referring Physician, Communication Tracked in a Log, and Tracking Process Documented in the Patient’s Medical Record. Biopsy results reviewed, communicated, tracked, and documented</p> <p>3. Identify instances that should be considered exclusions: Documentation of Patient OR System Reason(s) for not Performing up to Three of the Four Components of the Numerator Details: Reviewing, Communicating, Tracking, and/or Documenting Biopsy Results, Patient not Eligible (e.g., patient asks that biopsy results not be communicated to the primary care/referring physician, patient does not have a primary care/referring physician or is a self-referred patient) Clinician documented reason that patient’s biopsy results were not reviewed</p> <p>4. Identify instances where none of the quality actions were performed (measure not met): Biopsy Results not Reviewed, not Communicated to the Patient and the Patient’s Primary Care/Referring Physician, Communication not Tracked in a Log, and/or Tracking Process not Documented in the Patient’s Medical Record. Biopsy results not reviewed, communicated, tracked, or documented</p> <p>The calculation of this measure would be as follows: $\frac{\text{measure met (minus) measure not met}}{\text{denominator target population (minus) valid exclusions [system, patient reasons]}}$</p>
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	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
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	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement Other organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine
Description	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0646_AMA PCPI_MEDRECONCILIATION_DataCollectionTool.pdf
Level	Facility, Integrated Delivery System
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	<p>Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories:</p> <p>Medications to be TAKEN by patient:</p> <ul style="list-style-type: none"> - Continued* <p>Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND</p> <ul style="list-style-type: none"> - New* <p>Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge</p> <p>* Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed</p> <p>Medications NOT to be Taken by patient:</p> <ul style="list-style-type: none"> - Discontinued <p>Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND</p> <ul style="list-style-type: none"> - Allergies and Adverse Reactions <p>Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued</p>
Numerator Details	<p>Time Window: At each discharge during measurement period</p> <p>Numerator Definitions:</p> <ul style="list-style-type: none"> • 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, new, or discontinued) is specified within the list AND any allergic reactions are identified. <p>For EHR:</p> <p>This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for medication reconciliation and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>Producing the Reconciled Medication List</p> <p>Facilities that have implemented an EHR system should utilize their system to develop a standardized template for the Reconciled Medication List. A standardized template will ensure that all required data elements specified in the measure are included whenever a Reconciled Medication List is generated from the EHR. Each facility has the autonomy to customize the format of the Reconciled Medication List, based on clinical workflow, policies and procedures, and the patient population treated at</p>

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	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	<p>the individual institution.</p> <p>Systematic External Reporting that the Reconciled Medication List was provided to patient</p> <p>In order to report, at the facility level, which of the discharged patients have received a Reconciled Medication List, a discrete data field and code indicating the patient received a reconciled medication list at discharge may be needed in the EHR. Each facility should determine the most effective way to identify whether or not the patient received the reconciled medication list.</p> <p>Transmitting the Reconciled Medication List</p> <p>This performance measure does not require that the Reconciled Medication List be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum. RxNorm has been named as the recommended vocabulary for medications and can be used to identify the medications to which the allergies exist. Allergies (non-substance) and Adverse Events to medications should be expressed using SNOMED-CT. The use of industry standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR.</p> <p>For Claims/Administrative: Numerator Action to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>
Denominator Statement	<p>All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.</p> <p>Time Window: Each time a patient is discharged from an inpatient facility</p>
Denominator Details	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p> <p>For Claims/Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)

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	<ul style="list-style-type: none"> • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
Exclusions	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p>
Exclusion Details	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>No risk adjustment or risk stratification.</p>
Stratification	<p>We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p>
Type Score	<p>Rate/proportion better quality = higher score</p>
Algorithm	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of

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	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	<p>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</p> <p>4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation.</p> <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>
Copyright/Disclaimer	<p>Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians. These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.</p> <p>Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.</p> <p>THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND</p> <p>© 2009 American Medical Association. All Rights Reserved</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>CPT® contained in the Measures specifications is copyright 2008 American Medical Association.</p>

	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)
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement Other organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine
Description	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a 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	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0647_AMA PCPI_CARETRANS TransitionRecordINPT_DataCollectionTool.pdf
Level	Facility, Integrated Delivery System
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	Patients or their caregiver(s) who 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

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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)	
	<ul style="list-style-type: none"> • Reason for inpatient admission, AND • Major procedures and tests performed during inpatient stay and summary of results, AND • Principal diagnosis at discharge <p>Post-Discharge/ Patient Self-Management</p> <ul style="list-style-type: none"> • Current medication list, AND • Studies pending at discharge (eg, laboratory, radiological), AND • Patient instructions <p>Advance Care Plan</p> <ul style="list-style-type: none"> • Advance directives or surrogate decision maker documented OR Documented reason for not providing advance care plan <p>Contact Information/Plan for Follow-up Care</p> <ul style="list-style-type: none"> • 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 health care professional, or site designated for follow-up care
Numerator Details	<p>Time Window: At each discharge during measurement period</p> <p>Numerator Definitions: Numerator Element Definitions:</p> <p>a. 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 health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.</p> <p>b. Current medication list: all medications to be taken by patient after discharge, including all continued and new medications</p> <p>c. Advance directives: eg, written statement of patient wishes regarding future use of life-sustaining medical treatment</p> <p>d. 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</p> <p>e. 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.</p> <p>f. 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.</p> <p>g. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional</p> <p>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.</p> <p>As the quality measures arena moves forward with EHR reporting, the Care Transitions measures will be aligned with the ONC Health IT Standards Committee (HITSC) recommendations that certain vocabulary standards be used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum.</p> <p>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.</p> <p>Systematic External Reporting of the Transition Record 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.</p>

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	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)
	For Claims/Administrative: Numerator Action to be identified through medical record abstraction: See Sample Data Collection Tool attached.
Denominator Statement	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.
Denominator Details	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p> <p>For Claims/Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge))

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	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)
	<ul style="list-style-type: none"> • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
Exclusions	<p>Patients who died.</p> <p>Patients who left against medical advice (AMA) or discontinued care.</p>
Exclusion Details	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 - Expired-place unknown
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>No risk adjustment or risk stratification.</p>
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care.]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>
Copyright/Disclaimer	Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians. These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all

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	<p>potential applications. The Consortium encourages the testing and evaluation of its Measures. Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium.</p> <p>Neither the Consortium nor its members shall be responsible for any use of these Measures. THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND © 2009 American Medical Association. All Rights Reserved</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>CPT® contained in the Measures specifications is copyright 2008 American Medical Association.</p>

	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement Other organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine
Description	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0648_AMA PCPI_CARETRANS TimelyTransmissionTransitionRecord_DataCollectionTool.pdf
Level	Facility, Integrated Delivery System
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge
Numerator Details	<p>Time Window: Within 24 hours of each discharge during measurement period</p> <p>Numerator Definitions:</p> <p>a. 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 health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.</p> <p>b. Transmitted: transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR)</p> <p>c. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional</p> <p>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</p>

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	<p>0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
	<p>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.</p> <p>Transmitting the Transition Record with Specified Elements The Transition Record should be transmitted to the next provider(s) of care in accordance with current recommended standards for interoperability as determined by the Meaningful Use (CMS EHR Incentive) requirements. The use of industry standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR.</p> <p>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.</p> <p>For Claims/Administrative: Numerator Elements to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>
Denominator Statement	<p>All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care</p>
Denominator Details	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p> <p>For Claims/Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p>

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0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	
	<p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children's hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
Exclusions	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p>
Exclusion Details	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>No risk adjustment or risk stratification.</p>
Stratification	<p>We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p>
Type Score	<p>Rate/proportion better quality = higher score</p>
Algorithm	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients

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	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	<p>who died OR Patients who left against medical advice (AMA) or discontinued care]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation.</p> <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>
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	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement Other organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine
Description	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0649_AMA PCPI_CARETRANS TransitionRecordEDDisch_DataCollectionTool.pdf
Level	Facility, Integrated Delivery System
Setting	Ambulatory Care : Clinic/Urgent Care, Hospital/Acute Care Facility
Numerator Statement	<p>Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements:</p> <ul style="list-style-type: none"> • Major procedures and tests performed during ED visit, AND • Principal diagnosis at discharge OR chief complaint, AND • Patient instructions, AND • Plan for follow-up care (OR statement that none required), including primary physician, other health care 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

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0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	
Numerator Details	<p>Time Window: At each emergency department discharge during measurement period</p> <p>Numerator Definitions:</p> <p>a. 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 and provided to patient in written, printed, or electronic format. Electronic format may be provided only if acceptable to patient.</p> <p>b. Primary physician or other health care professional designated for follow-up care: may be primary care physician (PCP), medical specialist, or other physician or health care professional. If no physician, other health care 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.</p> <p>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, emergency department episode). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>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. 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.</p> <p>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.</p> <p>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 it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum. The use of industry standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR.</p> <p>For Claims/Administrative: Numerator Elements to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>
Denominator Statement	All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health care
Denominator Details	<p>Time Window: Each emergency department visit during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p> <p>For Claims/Administrative: Identify patients discharged from emergency department using the following: UB-04 (Form Locator 4 - Type of Bill): • 0131 (Hospital, Outpatient, Admit through Discharge Claim) AND UB-04 (Form Locator 42 - Revenue Code): • 0450 - Emergency Room AND UB-04 (Form Locator 17 - Discharge Status): • 01 - Discharged to home care or self care (routine discharge) • 06 - Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care</p>

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0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	
Exclusions	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p> <p>Patients who declined receipt of transition record</p>
Exclusion Details	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care* • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown <p>Exception Definition:</p> <p>*Note: For this measure only, it is anticipated that patients who declined receipt of transition record will also be coded with the 07 Discharge Status code.</p>
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>No risk adjustment or risk stratification.</p>
Stratification	<p>We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p>
Type Score	<p>Rate/proportion better quality = higher score</p>
Algorithm	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care OR Patients who declined receipt of transition record]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>
Copyright/Disclaimer	<p>Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians. These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.</p> <p>Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.</p> <p>THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND</p> <p>© 2009 American Medical Association. All Rights Reserved</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets</p>

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	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
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Appendix B – Steering Committee and NQF Staff

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Appendix C – Related and Competing Measures Comparison Tables

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Steward	National Committee for Quality Assurance	National Committee for Quality Assurance	American Medical Association - Physician Consortium for Performance Improvement
Description	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories
Type	Process	Process	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Registry, Paper Records None URL http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/geriatrics-ws.pdf	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). URL http://www.ncqa.org/tabid/370/default.aspx	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0646_AMA PCPI_MEDRECONCILIATION_DataCollectionTool.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Integrated Delivery System, Population : County or City	Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional	Facility, Integrated Delivery System
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office	Ambulatory Care : Clinician Office	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	Patients who had a reconciliation of the discharge medications with the current medication list in the medical record	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through	Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories:

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	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	<p>documented The medical record must indicate that the physician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of a inpatient facility discharge medication.</p>	<p>administrative or medical record review on or within 30 days of discharge. Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record, on or within 30 days after discharge.</p>	<p>Medications to be TAKEN by patient:</p> <ul style="list-style-type: none"> - Continued* <p>Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND</p> <ul style="list-style-type: none"> - New* <p>Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge</p> <p>* Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed</p> <p>Medications NOT to be Taken by patient:</p> <ul style="list-style-type: none"> - Discontinued <p>Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND</p> <ul style="list-style-type: none"> - Allergies and Adverse Reactions <p>Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued</p>
<p>Numerator Details</p>	<p>Time Window: Ambulatory visits within 60 days of a discharge from an inpatient facility</p> <p>CPT II Category II code 1111F: Discharge medications reconciled with the current medication list in the outpatient medical record</p> <p>Level 1 EHR specifications in development</p>	<p>Time Window: The measurement year</p> <p>1) Administrative (when available): Medication reconciliation (Table MRP-A) conducted by prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. A member had a medication reconciliation if a claim/encounter contains a code in Table MRP-A.</p> <p>Table MRP-A: Codes to Identify Medication Reconciliation</p> <p>Medication Reconciliation: CPT Category II: 1111F</p> <p>2) Medical Record (as necessary):</p>	<p>Time Window: At each discharge during measurement period</p> <p>Numerator Definitions:</p> <ul style="list-style-type: none"> • 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, new, or discontinued) is specified within the

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	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
		<p>Documentation in the medical record must include evidence of medication reconciliation, and the date on which it was performed. The following evidence meets criteria:</p> <ul style="list-style-type: none"> • Notation that medications prescribed or ordered upon discharge were reconciled with the current medications (in outpatient record) by the appropriate practitioner type, or • A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type or • Notation that no medications were prescribed or ordered upon discharge <p>Only documentation in the outpatient record chart meets the intent of the measure, but an in-person, outpatient visit is not required</p>	<p>list AND any allergic reactions are identified. For EHR: This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for medication reconciliation and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>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</p>

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	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
			<p>Reconciled Medication List be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum. RxNorm has been named as the recommended vocabulary for medications and can be used to identify the medications to which the allergies exist. Allergies (non-substance) and Adverse Events to medications should be expressed using SNOMED-CT. The use of industry standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR.</p> <p>For Claims/Administrative: Numerator Action to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>
Denominator Statement	All patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care	All discharges from an in-patient setting for health plan members who are 66 years and older as of December 31 of the measurement year.	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care. Time Window: Each time a patient is discharged from an inpatient facility
Denominator Details	<p>Time Window: Discharges from an inpatient facility within the last 60 days (eg, hospital, skilled nursing facility, or rehabilitation facility)</p> <p>CPT service codes 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342,</p>	<p>Time Window: The measurement year (one calendar year)</p> <p>1) Administrative (when available): An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator is based on episodes, not members. Members may appear more than once in the sample. If members have more</p>	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored. For Claims/Administrative: Identify patients discharged from inpatient facility using</p>

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	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	<p>99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404</p> <p>AND</p> <p>CPT Category II code 1110F: Patient discharged from an inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days</p> <p>OR</p> <p>Documentation in the medical record of a discharge from an inpatient facility within the last 60 days</p> <p>Note: only patients who were discharged from an inpatient facility within the last 60 days will be included in the denominator of this measure.</p>	<p>than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.</p> <p>2) Medical Record (as necessary):</p> <p>The denominator is based on episodes, not members. Members may appear more than once in the sample.</p> <p>The denominator is based on the discharge date found in the administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.</p>	<p>the following:</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home)

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			<ul style="list-style-type: none"> • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care

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	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
			facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
Exclusions	N/A	Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count the only the readmission discharge or the discharge from the facility to which the member was transferred.	Patients who died Patients who left against medical advice (AMA) or discontinued care

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	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Exclusion Details	N/A	N/A	For Claims/Administrative Data: UB-04 (Form Locator 17 - Discharge Status): <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown
Risk Adjustment	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	N/A	N/A	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	<p>Calculation for Performance</p> <p>For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator and Denominator.</p> <p>Step 1: Determine the eligible population. The eligible population is all the patients aged 65 years and older.</p> <p>Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above.</p> <p>Step 3: Determine the number of patients who meet the numerator criteria as specified in section 2a1.3 above. The numerator includes all patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented</p> <p>Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2</p> <p>Attachment PCPI Sample Calculation Algorithm.pdf</p>	<p>Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement.</p> <p>Step 2. Search administrative systems to identify numerator events for all members in the eligible population.</p> <p>Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.</p> <p>Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being</p>	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for

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	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
		measured. Step 5. Calculate the rate.	denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

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	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)
Steward	American Medical Association - Physician Consortium for Performance Improvement	American Medical Association - Physician Consortium for Performance Improvement
Description	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a 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	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge
Type	Process	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0647_AMA PCPI_CARETRANS TransitionRecordINPT_DataCollectionTool.pdf	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0648_AMA PCPI_CARETRANS TimelyTransmissionTransitionRecord_DataCollectionTool.pdf
Level	Facility, Integrated Delivery System	Facility, Integrated Delivery System
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	<p>Patients or their caregiver(s) who 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:</p> <p>Inpatient Care</p> <ul style="list-style-type: none"> • Reason for inpatient admission, AND • Major procedures and tests performed during inpatient stay and summary of results, AND • Principal diagnosis at discharge <p>Post-Discharge/ Patient Self-Management</p> <ul style="list-style-type: none"> • Current medication list, AND • Studies pending at discharge (eg, laboratory, radiological), AND • Patient instructions <p>Advance Care Plan</p> <ul style="list-style-type: none"> • Advance directives or surrogate decision maker documented <p>OR</p> <ul style="list-style-type: none"> • Documented reason for not providing advance care plan <p>Contact Information/Plan for Follow-up Care</p>	<p>Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge</p>

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	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)
	<ul style="list-style-type: none"> • 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 health care professional, or site designated for follow-up care 	
Numerator Details	<p>Time Window: At each discharge during measurement period</p> <p>Numerator Definitions: Numerator Element Definitions:</p> <p>a. 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 health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.</p> <p>b. Current medication list: all medications to be taken by patient after discharge, including all continued and new medications</p> <p>c. Advance directives: eg, written statement of patient wishes regarding future use of life-sustaining medical treatment</p> <p>d. 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</p> <p>e. 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.</p> <p>f. 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.</p> <p>g. Primary physician or other health care professional designated for</p>	<p>Time Window: Within 24 hours of each discharge during measurement period</p> <p>Numerator Definitions:</p> <p>a. 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 health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.</p> <p>b. Transmitted: transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR)</p> <p>c. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional</p> <p>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.</p> <p>Transmitting the Transition Record with Specified Elements The Transition Record should be transmitted to the next provider(s) of care in accordance with current recommended standards for</p>

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	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)
	<p>follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional For EHR:</p> <p>This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for 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.</p> <p>As the quality measures arena moves forward with EHR reporting, the Care Transitions measures will be aligned with the ONC Health IT Standards Committee (HITSC) recommendations that certain vocabulary standards be used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum.</p> <p>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.</p> <p>Systematic External Reporting of the Transition Record 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.</p> <p>For Claims/Administrative: Numerator Action to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>	<p>interoperability as determined by the Meaningful Use (CMS EHR Incentive) requirements. The use of industry standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR.</p> <p>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.</p> <p>For Claims/Administrative: Numerator Elements to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>
Denominator Statement	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

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	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)
Denominator Details	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p> <p>For Claims/Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) 	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p> <p>For Claims/Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing

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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)
<ul style="list-style-type: none"> • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) 	<p>bed)</p> <ul style="list-style-type: none"> • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed)

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	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)
	<ul style="list-style-type: none"> • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) 	<ul style="list-style-type: none"> • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
Exclusions	Patients who died. Patients who left against medical advice (AMA) or discontinued care.	Patients who died Patients who left against medical advice (AMA) or discontinued care
Exclusion Details	For Claims/Administrative Data: UB-04 (Form Locator 17 - Discharge Status): <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 - Expired-place unknown 	For Claims/Administrative Data: UB-04 (Form Locator 17 - Discharge Status): <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification.	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and

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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)
<p>denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges.</p> <p>3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator</p> <p>4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care.]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation.</p> <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>	<p>denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges.</p> <p>3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator</p> <p>4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care.]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation.</p> <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0557 HBIPS-6 Post discharge continuing care plan created
Steward	American Medical Association - Physician Consortium for Performance Improvement	The Joint Commission
Description	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including,	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults

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	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0557 HBIPS-6 Post discharge continuing care plan created
	at a minimum, all of the specified elements	Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-6: Post discharge continuing care plan created.	(Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge.
Type	Process	Process	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0649_AMA PCPI_CARETRANS TransitionRecordEDDisch_DataCollectionTool.pdf	Administrative claims, Electronic Clinical Data, Other, Paper Records	Administrative claims, Electronic Clinical Data, Other, Paper Records
Level	Facility, Integrated Delivery System	Facility	Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Hospital/Acute Care Facility	Behavioral Health/Psychiatric : Inpatient, Hospital/Acute Care Facility	Behavioral Health/Psychiatric : Inpatient, Hospital/Acute Care Facility
Numerator Statement	Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: <ul style="list-style-type: none"> • Major procedures and tests performed during ED visit, AND • Principal diagnosis at discharge OR chief complaint, AND • Patient instructions, AND • Plan for follow-up care (OR statement that none required), including primary physician, other health care 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 	Psychiatric inpatients for whom the post discharge continuing care plan was transmitted to the next level of care overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	Psychiatric inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).

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	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0557 HBIPS-6 Post discharge continuing care plan created
Numerator Details	<p>Time Window: At each emergency department discharge during measurement period</p> <p>Numerator Definitions:</p> <p>a. 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 and provided to patient in written, printed, or electronic format. Electronic format may be provided only if acceptable to patient.</p> <p>b. Primary physician or other health care professional designated for follow-up care: may be primary care physician (PCP), medical specialist, or other physician or health care professional. If no physician, other health care 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.</p> <p>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, emergency department episode). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p>	<p>Time Window: Episode of Care</p> <p>The following data elements are collected for the numerator: continuing care plan-discharge medications, continuing care plan-next level of care, continuing care plan –principal discharge diagnosis and continuing care plan -reason for hospitalization. Details on the data elements can be viewed in the specifications manual V2012A located at: http://manual.jointcommission.org.</p>	<p>Time Window: Episode of Care</p> <p>The following data elements are collected for the numerator: continuing care plan-discharge medications, continuing care plan-next level of care, continuing care plan –principal discharge diagnosis and continuing care plan -reason for hospitalization. Details on the data elements can be viewed in the data element dictionary included in the specifications manual V2012A located at: http://manual.jointcommission.org.</p>

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	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0557 HBIPS-6 Post discharge continuing care plan created
	<p>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. 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.</p> <p>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.</p> <p>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 it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the</p>		

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	<p>0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)</p>	<p>0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge</p>	<p>0557 HBIPS-6 Post discharge continuing care plan created</p>
	<p>National Quality Forum. The use of industry standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR. For Claims/Administrative: Numerator Elements to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>		
<p>Denominator Statement</p>	<p>All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health care</p>	<p>Psychiatric inpatient discharges overall and stratified by age group: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Included Population: Patients referred for next level of care with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders (Note, refer to Appendix A, Table 10.1 in the specifications manual V2012A at: http://manual.jointcommission.org)</p>	<p>Psychiatric inpatient discharges overall and stratified by age group: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Included Population: Patients referred for next level of care with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders (Note, refer to Appendix A, Table 10.1 in the specifications manual V2012A at: http://manual.jointcommission.org)</p>
<p>Denominator Details</p>	<p>Time Window: Each emergency department visit during 12 consecutive month measurement period For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored. For Claims/Administrative: Identify patients discharged from emergency department using the following: UB-04 (Form Locator 4 - Type of Bill):</p>	<p>Time Window: Episode of Care The following data elements are collected for the denominator: birthdate, discharge date, discharge status, ICD-9-CM other diagnosis codes, ICD-9-CM principal diagnosis code, patient referral to next level of care provider and psychiatric care setting. Details on the data elements can be viewed in the specifications manual V2012A located at: http://manual.jointcommission.org.</p>	<p>Time Window: Episode of Care The following data elements are collected for the denominator: birthdate, discharge date, discharge status, ICD-9-CM other diagnosis codes, ICD-9-CM principal diagnosis code, patient referral to next level of care provider and psychiatric care setting. Details on the data elements can be viewed in the element dictionary included in the data specifications manual V2012A located at: http://manual.jointcommission.org.</p>

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	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0557 HBIPS-6 Post discharge continuing care plan created
	<ul style="list-style-type: none"> • 0131 (Hospital, Outpatient, Admit through Discharge Claim) AND UB-04 (Form Locator 42 - Revenue Code): • 0450 - Emergency Room AND UB-04 (Form Locator 17 - Discharge Status): • 01 - Discharged to home care or self care (routine discharge) • 06 - Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care 		
Exclusions	Patients who died Patients who left against medical advice (AMA) or discontinued care Patients who declined receipt of transition record	Patients who expired Patients with an unplanned departure resulting in discharge due to elopement Patients or their guardians who refused aftercare Patients or guardians who refused to sign authorization to release information Patients with an unplanned departure resulting in discharge due to failing to return from leave	Patients who expired Patients with an unplanned departure resulting in discharge due to elopement Patients or their guardians who refused aftercare Patients or guardians who refused to sign authorization to release information Patients with an unplanned departure resulting in discharge due to failing to return from leave
Exclusion Details	For Claims/Administrative Data: UB-04 (Form Locator 17 - Discharge Status): <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care* • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown Exception Definition: *Note: For this measure only, it is anticipated that patients who declined receipt of transition record will also be coded with the 07 Discharge Status code.	The following data elements are used to exclude patients from the denominator population: discharge status and patient referral to next level of care provider. Details on the data elements can be viewed in the specifications manual V2012A located at: http://manual.jointcommission.org .	The following data elements are used to exclude patients from the denominator population: discharge status and patient referral to next level of care provider. Details on the data elements can be viewed in the data element dictionary included in the specifications manual V2012A located at: http://manual.jointcommission.org .
Risk	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification

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	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0557 HBIPS-6 Post discharge continuing care plan created
Adjustment	No risk adjustment or risk stratification.		
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.		
Type Score	Rate/proportion better quality = higher score		
Algorithm	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this 		

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	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0557 HBIPS-6 Post discharge continuing care plan created
	<p>measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care OR Patients who declined receipt of transition record]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation.</p> <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>		

	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
Steward	National Committee for Quality Assurance	Centers for Medicare & Medicaid Services
Description	<p>Percentage of adults 66 years and older who had a medication review; a review of all a member's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.</p>	<p>Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route</p>

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	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
Type	Process	Process
Data Source	Administrative claims, Electronic Clinical Data, Paper Records NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). URL http://www.ncqa.org/tabid/370/default.aspx	Administrative claims, Electronic Clinical Data : Registry Medicare Part B claims data URL NQF 0419 Endorsement Summary 012312 zip file of supporting documentation sent to H. Bossley & A. Lyzenga via email on 01/23/12 due to path submission error Attachment m130_attachment_partb_detail_line_item_format.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State	Clinician : Individual, Population : National
Setting	Ambulatory Care : Clinician Office, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Ambulatory Care : Clinician Office, Behavioral Health/Psychiatric : Outpatient, Dialysis Facility, Home Health, Other, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation Clinic, Hospital outpatient
Numerator Statement	At least one medication review (Table COA-B)conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Table COA-C) Table COA-B Codes to identify medication review: Medication review (CPT 90862, 99605, 99606), (CPT-II 1160F) Table COA-C Codes to Identify Medication List (CPT-II 1159F)	ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION. Eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route NUMERATOR NOTE: By reporting G8427, the eligible professional is attesting the documented current medication information is accurate and complete to the best of his/her knowledge and ability at the time of the patient encounter. This code may also be reported if there is documentation that no medications are currently being taken.
Numerator	Time Window: The measurement year	Time Window: This measure is to be reported at each

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	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
Details	<p>1) Administrative Specification (if available): At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record, as documented through administrative data. The claim/encounter for a member’s medication review and medication list must be on the same date of service. Codes to identify medication review: Medication review (CPT 90862, 99605, 99606), (CPT-II 1160F) Codes to Identify Medication List (CPT-II 1159F)</p> <p>2) Medical Record Specification (if necessary): Documentation must come from the same medical record and must include the following.</p> <ul style="list-style-type: none"> • A medication list in the medical record, and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed • Notation that the member is not taking any medication and the date when it was noted <p>A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Prescribing practitioner is defined as a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the</p>	<p>visit during the 12 month reporting period. Eligible professionals meet the intent of this measure by making a best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.</p> <p>For the purposes of calculating performance, the Numerator(A) is defined by providers reporting the clinical quality action was performed. For this measure, performing the clinical quality action is numerator HCPCS G8427.</p> <p>Current Medications with Name, Dosage, Frequency and Route Documented G8427: List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route</p>

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	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
	authority to prescribe medications.	
Denominator Statement	All patients 66 and older as of December 31 of the measurement year	<p>ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.</p> <p>All visits occurring during the 12 month reporting period for patients aged 18 years and older at the time of the encounter where one or more denominator CPT or HCPCS codes AND any of the 3 numerator HCPCS codes are reported on the claims submission for the encounter. All discussed coding is listed in "2a1.7. Denominator Details" section below.</p>
Denominator Details	<p>Time Window: The measurement year</p> <p>Use administrative data and medical records for of members 66 years and older as of December 31 of the measurement year.</p>	<p>Time Window: All visits occurring during the 12 month reporting period for patients aged 18 years and older at the time of the encounter.</p> <p>For the purposes of defining the denominator, the Performance Denominator(PD) is defined by the patient’s age, encounter date, denominator CPT or HCPCS codes and the provider reported numerator HCPCS codes described below (G8427, G8430 & G8428).</p> <p>Patients aged greater than or equal to 18 years on date of encounter AND Patient encounter during the reporting period (CPT or HCPCS):</p> <p>90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90816, 90817, 90818, 90819, 90821, 90822, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348,</p>

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	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
		<p>99349, 99350, G0101, G0108, G0270, G0402, G0438, G0439 AND Patient encounters with the following numerator HCPCS Code G8427, G8430, G8428. Current Medications with Name, Dosage, Frequency and Route Documented G8427: List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route Current Medications with Dosage not Documented, Patient not Eligible G8430: Provider documentation that patient is not eligible for medication assessment Current Medications with Name, Dosage, Frequency, Route not Documented, Reason not Specified G8428: Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) with drug name, dosage, frequency and route not documented by the provider, reason not specified</p>
Exclusions	N/A	<p>ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.</p> <p>A patient is not eligible or excluded (B) from the performance denominator (PD) if one or more of the following reason(s) exist:</p> <ol style="list-style-type: none"> 1. Patient refuses to participate 2. Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status 3. Patient cognitively impaired and no authorized representative(s), caregiver(s), and or other healthcare resources are available
Exclusion	N/A	For the purposes of identifying performance exclusions,

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	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
Details		Denominator Exclusions (B) are defined by providers reporting the exclusion clinical quality action. For this measure, the clinical exclusion code is numerator HCPCS G8430. Current Medications with Dosages not Documented, Patient not Eligible G8430: Provider documentation that patient is not eligible for medication assessment
Risk Adjustment	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification N/A
Stratification	N/A	This measure is not stratified. All eligible patients are subject to the same numerator criteria.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	<p>Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement.</p> <p>Step 2. Search administrative systems to identify numerator events for all members in the eligible population.</p> <p>Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.</p> <p>Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being measured.</p>	<p>This section provides details and formulas to calculate Performance and Denominator Exclusions.</p> <p>PERFORMANCE CALCULATION</p> <p>To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD) and Denominator Exclusions (B).</p> <p>Numerator (A): Number of patients meeting numerator criteria</p> <p>Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion</p> <p>Denominator Exclusions (B): Number of patients with valid exclusions</p> <p>The method of performance calculation is determined by the following:</p> <ol style="list-style-type: none"> 1) identify the patients who meet the eligibility criteria for the denominator (PD) which includes patients who are 18 years and older with encounters during the reporting period with any of denominator CPT or HCPCS codes and numerator HCPCS codes as listed in "2a1.7. Denominator Details". 2) identify which of those patients meet the numerator criteria (G8427) (A) 3) for those patients who do not meet the numerator

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	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
	Step 5. Calculate the rate.	criteria, determine whether an appropriate exclusion applies (G8430) (B) and subtract those patients from the denominator with the following calculation: Numerator (A)/[Performance Denominator (PD) - Denominator Exclusions (B)] DENOMINATOR EXCLUSIONS The Exclusion Calculation is: Denominator Exclusions (B)/Performance Denominator (PD) Attachment Calculation for Performance.docx