NATIONAL QUALITY FORUM

TO: Care Coordination Steering Committee

FR: Karen Johnson and Lauralei Dorian

SU: Post-comment conference call scheduled for May 17, 2012

DA: May 10, 2012

The purpose of the upcoming call is to:

- review and discuss the comments received on the care coordination measures, and
- determine what responses and/or course of action may be needed.

Steering Committee Action:

- Review this briefing memo
- Review the comments received and draft responses (see Excel file).
- Identify any suggested changes to the draft responses or additions to the meeting agenda (please send to Karen Johnson (kjohnson@qualityforum.org).

Please use the following information to access the conference call line and online webinar:

Date/Time: Thursday, May 17, 2012, 3-5 pm ET

Dial-in Information: Please dial **1-800-316-8317** and, when prompted, provide the operator with conference code **3476872**.

*All committee and speaker phone lines will be open. Please place your phone on mute when not speaking. Do not put your phone on hold during the call. Press *0 at any time to receive operator assistance.*

Webinar Information: To access the live webinar, follow this link:
http://www.MyEventPartner.com/QualityForum334

Review of Comments

The 30-day public/member comment period for the Care Coordination draft report closed on May 2, 2012. We received a total of 41 comments from 13 member organizations; these organizations represent a variety of stakeholders, as follows:

- 8 comments from the Health Plan council
- 10 comments from the Health Professionals council
- 22 comments from the Purchasers council
- 1 comments from the Supplier and Industry council

The Steering Committee will discuss these comments and on a conference call scheduled for **Thursday, May 17, 2012, 3-5 pm ET.**

We have included the comments that we received in the attached Excel spreadsheet. This file contains the commenter and council (if any), comment, topic, and draft responses for the Committee's consideration. Some specific questions to the Committee are highlighted in yellow.

The majority of the comments that require discussion focused on the issue of harmonization of related measures and selection of the best from among competing measures. We will also address those measures with the most significant issues that arose from the comments. During the call, we will ask you to discuss the action items listed in each topic area. You will use a Survey Monkey tool to vote on these action items after the call. The Steering Committee's final responses will be posted on the NQF project page.

Also, note that we referred some of the comments to the developers when appropriate. We have included the developer's responses in the Excel file as well.

COMPETING MEASURES

The following measures were evaluated individually and determined to be suitable for endorsement, pending resolution of competing measures and harmonization.

Measures are competing when—conceptually—they address the same measure focus and the same target population (or subset of the target population). The measure specifications do not have to be identical to be reviewed as competing measures. The goal is for NQF to endorse measures with the broadest applicability when possible, rather than endorsing separate measures for subsets of the target population, levels of analysis, data sources, or settings. However, when separate measures are needed to cover relevant populations, levels of analysis, or settings, those measures should be completely harmonized.

Although the Steering Committee cannot independently make changes to measure specifications, it can decide whether or not to recommend measures for endorsement based on developer responses to suggestions and questions. Rather than continuing the endorsement of multiple similar (but somewhat different) measures, NQF asks the Steering Committee to select the superior measures for endorsement.

For the following three sets of competing measures, the developers did not wish to combine the measures and have not made changes to harmonize the measures at this time. We have a call scheduled with developers prior to the Committee's call. We will provide an update of those discussions on the call.

Measure group #1

0553: Care for Older Adults – Medication Review
0419: Documentation of Current Medications in the Medical Record

According to NQF guidance, measure 0553 is competing with measure 0419 (*note that this measure is currently being evaluated in an NQF patient safety complications 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** **(NCQA)**	**0419** **Documentation of Current Medications in the Medical Record** **(CMS)**
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 prior discussions, most Committee members favored challenging the developers to combine these two measures, noting 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).

Developer responses
Developers were asked a series of questions regarding these measures and provided the following joint responses:

1) ***If indicated, what could be done to have just one measure (which could be stratified by subpopulation if needed)?***
   Given the differences in data sources and clinical processes being measured, these measures cannot be combined into a single measure.

2) ***If both measures are needed, please indicate the justification for having two measures.***
   - #0419 and #0553 overlap but measure different clinical processes in the numerator.
   - #0419 measures whether a current medication list was documented by a provider at the time of each visit. This measure requires a list of ALL prescriptions to include over-the-counter, herbals. Vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route. It is to be reported at each visit during the 12 month calendar year 1/1-12/31. CMS has multiple codes assigned to this measure to identify the denominator based on the individual eligible provider visits.
   - #0553 measures both documentation of the current medication list AND review for appropriateness by a prescribing practitioner at least once a year. NCQA has determined "review or appropriateness" cannot be identified through the numerator code (G8427) used in measure #0419. Therefore, NCQA will continue to use a combination of medical record review or CPT coding (CPT 90862, 99605, 99606, CPT-II 1160F) to identify whether medication review occurred.

3) ***If having two measures is justified, please indicate how these two measures might be harmonized.***
   - NCQA Changes to #0553: NCQA cannot make any changes to the HEDIS measure specification for #0553 without approval from the NCQA Committee for Performance Measurement. During the next measure review period for this measure we can propose the following changes to #0553.
     - Use similar language to defined "medication list" (i.e. "All prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route")
     - Add the code used in the numerator of #0419 (G8427) to identify documentation of the medication list to the numerator of #0553. To fulfill the numerator requirement this code would have to be present with either additional CPT coding or medical record review to document that a medication review occurred in addition to documentation of the medication list in the medical record.
   - CMS Changes to #0419: CMS feels that both measures are important but very different in the population that is targeted. The only recommendation regarding harmonization would be to combine the codes from 0553 (CPT 90862, 99605, 99606, CPT-II 1160F) into 0419. CMS will explore this possibility but cannot guarantee the change will be made.

Member comments

We received four comments pertaining to this measure group. Those comments support either combining conceptually similar measures (2 general comments) or aligning/harmonizing the measures (1 general comment and one specifically targeted to 0553). One additional comment regarding the feasibility of measure 0553 was received (pertaining to the potential need for chart audits by most practices to compute this measure). In addition, during the comment period, a member of the NQF board raised similar concerns regarding multiple measures that are not harmonized.

Patient Safety Complications Steering Committee recommendation
The Steering Committee for the Patient Safety Complications project also reviewed measures 0097, 0554, and 0646 (although not 0553) as part of their evaluation of measure 0419. In general, that Committee saw those measures as related but not competing. However, they agreed that, in the future, they would like to see a *single medication reconciliation measure* that applies across populations, settings, and care transitions. Thus, Patient Safety Complications Steering Committee has already recommended measure 0419, and this measure has been voted upon by the membership. ***The CSAC will consider this measure in the near future, pending the Care Coordination Steering Committee's decision on measure 0553.***

Steering Committee consideration
Because measure 0553 and 0419 are competing measures, and the developers do not want to combine the measures, NQF guidelines require that the Committee compare the measures and select, if possible, the superior measure. ***Note, however, that because measure 0419 is in another project, the Care Coordination Steering Committee can only act on measure 0553 at this time.***

ACTION ITEM: After reviewing the developer's responses, can the Committee recommend #0553 or #0419 as the superior measure?

Option #1: Recommend 0553 as the superior measure
Implications:

- Measure 0553 will go forward from the SC as recommended for endorsement, and the CSAC will resolve
- No immediate effect on measure #0419; however, the recommendation will be shared with the CSAC, who is considering this measure in the on-going patient safety complications project

Option #2: Recommend 0419 as the superior measure
Implications:

- Measure 0553 will NOT be recommended for endorsement by the SC
- No immediate effect on measure 0419; however, the recommendation will be shared with the CSAC, who is considering this measure in the on-going patient safety project

Option #3: Neither measure is clearly superior: measures should be combined or completely harmonized
Implications:

- Measure 0553 will go forward from the SC as recommended for endorsement, and the CSAC will resolve
- No immediate effect on measure 0419; however, the recommendation will be shared with the CSAC, who is considering this measure in the on-going patient safety complications project
- The SC can recommend combining the measures or identify key points for harmonization

Measure group #2

0097: Medication Reconciliation
0554: Medication Reconciliation Post-Discharge
0646: Reconciled Medication List Received by Discharged Patients

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 (NCQA)	**0554 Medication Reconciliation Post-Discharge (NCQA)**	**0646 Reconciled Medication List Received by Discharged Patients (AMA/PCPI)**
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
Accountable professional: Physician in a physician office	Accountable professional: Provider with prescribing privileges, clinical pharmacist, or nurse	Accountable professional: Unknown
Setting: Outpatient	Setting: Outpatient (outpatient visit not required)	Setting: Hospital
Documented in medical record	Documented in medical record	Provided to patient
Clinician level of analysis	Health plan level of analysis	Facility level of analysis
Data source: Administrative claims	Data source: Administrative claims	Data source: Administrative claims for denominator; medical record for numerator

Committee members grappled with the distinctions between medication review and medication reconciliation, but again, noted that medication reconciliation is a best practice that should be encouraged for all age groups. 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. The committee also recognized the need to address both patients and providers.

Developer responses
Developers were asked a series of questions regarding these measures and provided the following joint responses:

1) ***If indicated, what could be done to have just one measure (or, at most, two measures)? (e.g., how might one measure is applied to both settings?)***
   - Given the differences in data sources and clinical processes being measured, these measures cannot be combined into a single measure.
   - NCQA and AMA/PCPI will work to align the numerators for #0554 and #0097 over the coming year. Given the realities of how these measures are used for public reporting (#0554 at the health plan level; #0097 at the physician level) the denominators for these measures cannot be harmonized.

2) ***If multiple measures are needed, describe how one or more is superior to the other(s) and/or why multiple measures is justified.***
   - No one of these three measures can be deemed superior. They refer to multiple steps in the process of medication reconciliation.
   - #0646 is medication reconciliation at the time of discharge performed by the inpatient provider and communicated to the patient.
   - #0556/#0097 is medication reconciliation post discharge performed by the usual care provider and documented in the medical record.
   - All measures are necessary to document that medication reconciliation occurs at both discharge and post-discharge.

3) ***If multiple measures are justified, indicate how the measures can be harmonized.***
   - NCQA changes to #0097: This measure is jointly owned by AMA/PCPI and NCQA. No changes can be made to this measure without approval from the AMA/PCPI measurement workgroup. During the next measure review period for this measure we can propose the following changes to better align measure #0097 and #0554.
     - Align time-frame for reconciliation to 30 days post-discharge
     - Align text of numerator to define medication reconciliation identically between the two measures

Member comments

We received four comments pertaining to harmonization of this measure group. All four of those comments recommend a 30-day timeframe for #0097. One commenter also noted the need for measure 0554 to harmonize with 0097 on age. Note that the developer explained that the age specifications for 0097 and 0554 are different to because of the need to ensure that, for measure 0554, the patient was eligible for Medicare during the entire measurement year. In addition, during the comment period, a member of the NQF board raised similar concerns regarding multiple measures that are not harmonized.

Steering Committee consideration

Because these are competing measures, and because the developers have not yet tried to harmonize the measures, NQF guidelines require that the Committee compare the measures and select, if possible, the superior measures. Note that, other than the timeframe of 60 days, measure 0097 could be considered a subset of 0554 because a physician is a provider with proscribing with privileges; however, the developer states that 0554 is only measured at the level of the health plan.

ACTION ITEM #1: After reviewing the developer's responses, can the Committee recommend #0097 or #0554 as the superior measure?

Option #1: Recommend 0097 as the superior measure
Implications:

- Measure 0097 will go forward from the SC as recommended for endorsement
- Measure 0554 will NOT be recommended for endorsement by the SC

Option #2: Recommend 0554 as the superior measure
Implications:

- Measure 0554 will go forward from the SC as recommended for endorsement
- Measure 0097 will NOT be recommended for endorsement

Option #3: Neither 0097 or 0554 is clearly superior: measures should be combined or completely harmonized
Implications:

- Measure 0097 will NOT be recommended for endorsement
- Measure 0554 will NOT be recommended for endorsement
- The developer will be asked to combine the measures and re-submit to NQF at a later date

ACTION ITEM #2: Given that the developers do not think it is possible to combine 0646 with 0097/0554, does the Committee want to let stand their original determination that 0646 meets criteria and is suitable for endorsement?

Option #1: Yes, the measure is recommended for endorsement
Option #2: No, the measure is not recommended for endorsement

Measure group #3

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)

[Note: We are foregoing discussion of 0557 and 0558 (the post-discharge plan measures for psychiatric patients) because these measures will be evaluated in a behavioral health project later in the year.]

On a conceptual level, all three of these measures address the provision of transition records for patients discharged from an inpatient setting. They differ in the following ways:

0647 Transition Record with Specified Elements Received by Discharged Patients (PCPI)	0648 Timely Transmission of Transition Record (PCPI)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges) (PCPI)
Transition record is given to the patient	Transition record is given to the next provider	Transition record is given to the patient
Includes all patients discharged from an inpatient facility	Includes all patients discharged from an inpatient facility	Includes all patients discharged from the ED

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.

Developer response
The developer was asked a series of questions regarding these measures and provided the following responses:

1) ***To influence outcomes, a transition record should be created and then given to both patients and providers. What is the rational for parsing those activities into three measures?***
   The rational for having three separate measures on the transition record is to address three different performance gaps: First, multiple studies have shown that patients do not get the information they need to manage their care. Second, in particular patients do not receive their reconciled medication list. Third, primary care providers do not receive the transition record in a timely fashion. Therefore, it is important to have a measure focused specifically on the patient receiving their transition record (0647), and in particular their reconciled medication list (0646). It is also important to have a measure focusing on the primary care physician receiving the transition record in a timely fashion (0648). To combine the three measures would result in a measure with limited feasibility; in addition, it would be difficult, if not impossible, to pinpoint which component had caused the measure failure. A composite measure may be possible but very complicated to create and score. Regarding 0649, this measure focuses only on the Emergency Department (ED), where discharges are very different than from inpatient hospital stays due to varied presentations and shorter timeframes. In the ED situation, the sorts of problems being transitioned are highly variable, and often the points in the trajectory of care when a transition occurs are similarly highly variable, that prescribing a standard set of data points would likely be wasteful or even potentially harmful (e.g., attention would be directed to some irrelevant data, and away from what is really important). Therefore, as was discussed and agreed upon by several members of the NQF Care Coordination

Steering Committee, the requirements for the transition record from the ED are less stringent.

2) ***The definition and essential components of a transition record should be harmonized. What does the evidence indicate should be included in the specifications?***

We know that studies show that the lack of information provided from the hospital inpatient stay compromises post-discharge care. Providing patients with a detailed transition record is directly related to preventing medication errors, adverse events, patient harm, and hospital readmissions. Providing detailed discharge information enhances patients' preparation to self-manage post-discharge care and comply with treatment plans. Additionally, randomized trials have shown that many hospital readmissions can be prevented by patient education, predischarge assessment, and domiciliary aftercare (Benbassat, et al, 2000). One recent study found that patients participating in a hospital program providing detailed, personalized instructions at discharge, including a review of medication routines and assistance with arranging follow-up appointments, had 30% fewer subsequent emergency visits and hospital readmissions than patients who received usual care at discharge (Jack, et al, 2009). ACP, SGIM, SHM, AGS, ACEP and SAEM's Transitions of Care Consensus Policy Statement indicates that all transitions must include a transition record. There is a minimal set of data elements that should always be part of the transition record: principal diagnosis and problem list, medication list (reconciliation) including OTC/ herbals, allergies and drug interactions, clearly identifies the medical home/transferring coordinating physician/institution and their contact information, patient's cognitive status, test results/pending results (TOCCC, 2009). In addition, the Joint Commission indicates that at the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, or services to the patient about the following: the reason for the patient's discharge or transfer, the patient's physical and psychosocial status, a summary of care, treatment, and services it provided to the patient, the patient's progress toward goals, and a list of community resources or referrals made or provided to the patient (Joint Commission, 2009).

3) ***The essential components for a transition record should have broad applicability across patient conditions. How can one measure be constructed that would be applied across multiple patient conditions?***

Our measures are not specific to particular conditions or patient ages, and therefore have broad applicability across patients.

Member comments

We received two comments pertaining to this measure group. One pertained to 0647, and included additional measure suggestions. The other pertained to #0649, and noted concerns by CMS that has resulted in suspension of this measure from their Hospital Outpatient Quality Report program. The comment specifically stated:

> CMS recently implemented this measure in the Hospital Outpatient Quality Reporting program (OQR) beginning with 1/1/12 encounters. Shortly after data

collection began, several hospitals shared their concerns with CMS surrounding possible legal issues with the measure. Several hospitals were concerned that requiring a transition record for all patients discharged from the Emergency Department could potentially be in violation of state laws that protect privacy, especially when minors or domestic violence were concerned. CMS shared these concerns with the AMA, and AMA has revisited the specifications for this measures. They suggest adding language stating "Patients for whom providing the information contained in the transition record would be prohibited by state or federal law should be excluded". Other concerns raised by hospitals regarding the current specifications included the need to clearly define the population of patients targeted for the denominator, and more guidance regarding the term "major tests and procedures" which is used in the current specifications.

Steering Committee consideration
Because these are competing measures, and because the developers have done nothing to combine or harmonize the measures, NQF guidelines require that the Committee compare the measures and select, if possible, the superior measures or justify the need for multiple measures.

ACTION ITEM #1: Considering measures 0647 and 0649, is there a justifiable reason for a different transition record from ED (0649)?

Option #1: No, there is no need for a different ED transition record (measure 0649)
Implications:

- Measure 0647 will be recommended for endorsement
- Measure 0649 will NOT be recommended for endorsement

Option #2: Yes, there is a need for a different ED transition record (measure 0649)
Implications:

- Measure 0647 will be recommended for endorsement
- Measure 0649 will be recommended for endorsement

ACTION ITEM #2: Considering measures 0647 and 0648, does the Committee see a need for two separate measures on transition record (one to go to the patient and one to go to the next provider)?

Option #1: Yes, there is a need for separate measures (patient/next provider)
Implications:

- SC must provide justification for the multiple measures
- Measure 0647 will be recommended for endorsement if the specifications for the elements in the transition record are identical
- Measure 0648 will be recommended for endorsement if the specifications for the elements in the transition record are identical
- NQF will designate these two measures as paired measures (i.e., they must be used together)

Option #2: No, there is NOT a need for separate measures (patient/next provider)

- Measure 0647 will NOT be recommended for endorsement
- Measure 0648 will NOT be recommended for endorsement
- The developer will be asked to combine the measures and re-submit to NQF at a later date

MEASURE SPECIFIC COMMENTS

0326: Advance care plan

Measure evaluation form | Steering Committee evaluation summary

This measure received five comments, all of which expressed concerns about the measure. Three of the comments were critical of the measure as specified. These commenters voiced the concern that it is a "check-the-box" measure and as such, would not impact healthcare quality, outcomes, or costs. They suggested that the measure could be improved if it specified a list of elements to be included in the advance care plan and if it allowed additional providers (not just physicians) to document and discuss the advance care plan. The remaining two comments voiced the need for additional measures/elements around advance care planning, including:

- measuring whether the advance care plan was followed and updated accordingly
- identifying patient preferences in the advance care plan

***ACTION ITEM*: After reviewing the comments and the developer's responses, does the Committee wish to reconsider its recommendation of the measure?**

MEASURES NOT RECOMMENDED

We received only one comment on measures that were not recommended by the Committee.

0520: Drug Education on All Medications Provided to Patient/Caregiver During Episode

Measure evaluation form | Steering Committee evaluation summary

The steward for this measure (CMS) commented in response to the Committee's decision not to recommend it as suitable for endorsement. They state that drug education has been identified as a national priority for safe and effective patient care and argue that there is evidence of quality problems regarding drug education, opportunity for improvement, and reasons to measure and report drug education. They also emphasize its use as a publicly-reported measure on Home Health Compare.

ADDITIONAL DISCUSSION ON COMMENTS/RESPONSES

Three comments require additional input from the Committee. Questions for the Committee are highlighted in yellow in the Excel file. The relevant comment IDs are as follows:

- **2192**: Do you want to comment on the developer's response?
- **2222**: Do you want to comment on the recommendation regarding clinician-neutral language?
- **2227**: Do you agree with this definition of medication reconciliation?

ADDITIONAL AREAS FOR MEASURE DEVELOPMENT

Four comments included suggestions for additional measure development, as follows:

- Compliance with treatment plan
- Evaluation of actual medications in the home and pattern of administration
- Measures of comprehensive medication management (CMM). CMM specifically considers and reconsiders patient progress toward clinical goals; considers duration and potential side effects on patients taking multiple medications for chronic conditions; considers coordination of medication; and assures that medications are understood by the patient
- Inclusion of patient/family goals of care in transition records
- Time of day that transitions occur
- Whether or not advance care plan is followed

***ACTION ITEM*: Does the Committee wish to add these suggestions to the report?**

	0326 Advance Care Plan—Measure Specifications
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	**Time Window:** A twelve month measurement year Report the CPT Category II codes designated for this numerator: 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan Documentation that patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan may also include, as appropriate, the following: That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient´s beliefs and thus harmful to the physician-patient relationship.
Denominator Statement	All patients aged 65 years and older
Denominator Details	**Time Window:** A twelve month measurement year 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 *Clinicians indicating the place of service as the emergency department will not be included in this measure.
Exclusions	N/A
Exclusion	N/A

	0326 Advance Care Plan—Measure Specifications
Details	
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population. The eligible population is all the patients aged 65 years and older. Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above. 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. 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
Copyright/ Disclaimer	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. 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, 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. 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. 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. 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.

0326 Advance Care Plan—Steering Committee Summary

Status: Maintenance, Original Endorsement: Nov 05, 2007 , Most Recent Endorsement: Jan 25, 2012
Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
Numerator Statement: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
Denominator Statement: All patients aged 65 years and older
Exclusions: N/A
Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A
Level of Analysis: Clinician : Individual
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry
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.

STEERING COMMITTEE MEETING 2/28/12 – 2/29/12

1. Importance to Measure and Report *(based on decision logic):* **Yes**
(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**
Rationale: 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.

2. Scientific Acceptability of Measure Properties *(based on decision logic):* **Yes**
(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**
Rationale: 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.

0326 Advance Care Plan—Steering Committee Summary
3. Usability: H-4; M-14; L-8; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)* Rationale: 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.
4. Feasibility: H-2; M-12; L-10; I-2 *(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: There was disagreement among Committee members about the feasibility of this measure due to uncertainties about the specificity of the measure, it's 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.
Steering Committee Recommendation on Overall Suitability for Endorsement: Y-18; N-8 **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.

	0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care—Measure Specifications
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/HHQIOASISCAllTimePoint.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	**Time Window:** Time Window: Current CMS systems report data on episodes that end within a rolling 12 month period, updated quarterly. Number of home health patient episodes of care where at end of episode: - (M2015) Patient/Caregiver Drug Education Intervention = 1 (yes)
Denominator Statement	Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.
Denominator Details	**Time Window:** Time Window: Current CMS systems report data on episodes that end within a rolling 12 month period, updated quarterly. 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.
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

	0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care—Measure Specifications
	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	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. 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.
Risk Adjustment	No risk adjustment or risk stratification N/A - process measure - not risk adjusted
Stratification	N/A - measure 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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0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care—Steering Committee Summary

Status: Maintenance, Original Endorsement: Mar 31, 2009 , Most Recent Endorsement: Jan 31, 2012
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.
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.
Denominator Statement: Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.
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.
Adjustment/Stratification: No risk adjustment or risk stratification N/A - process measure - not risk adjusted N/A - measure not stratified.
Level of Analysis: Facility
Type of Measure: Process
Data Source: Electronic Clinical Data
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

STEERING COMMITTEE MEETING 2/28/12 – 2/29/12
1. Importance to Measure and Report *(based on decision logic):* **No**
(1a. High Impact: 1b. Performance Gap 1c. Evidence)
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**
Rationale: 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.

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:

0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care—Steering Committee Summary
3. Usability: (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)* Rationale:
4. Feasibility: *(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:
Steering Committee Recommendation on Overall Suitability for Endorsement: No **Rationale**: The measure did not pass the criterion of Importance to Measure and Report.