NATIONAL QUALITY FORUM

Identifying a Core Set of Rural-Relevant Measures for Hospital and Ambulatory Settings

February 28, 2018

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Contents

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DRAFT REPORT #1 OF THE MAP RURAL HEALTH WORKGROUP

Executive Summary

Residents of rural areas—more than 59 million Americans or approximately 19 percent of the U.S. population—may be more disadvantaged overall than those in urban or suburban areas, particularly with respect to educational attainment, income level, health status, substance use, and access to the healthcare delivery system.

Rural providers, in turn, face many challenges in reporting quality measurement data and implementing care improvement efforts to address the needs of their populations. Often, rural providers serve a relatively low number of patients in their catchment areas. This affects the reliability, validity, and utility of performance metrics that might otherwise be available to them for measuring their performance in care provision. Moreover, because many rural hospitals and clinician practices and post-acute care and long term care facilities are small, providers often have limited time, staff, and infrastructure for quality improvement activities, including data collection, management, monitoring, analysis, reporting (including the availability and use of interoperable electronic health records), and long-term efforts in quality improvement.

The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP) as a public-private partnership of healthcare stakeholders. To improve the quality, affordability, and community impact of healthcare, MAP provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. MAP also helps to identify gaps in measure development and encourages measure alignment across public and private programs, settings, levels of analysis, and populations. In September 2017, HHS contracted with the NQF to convene a MAP Rural Health Workgroup. This 25-member, multistakeholder group serves in an advisory capacity to the MAP Coordinating Committee (Appendix A). The current charge of the MAP Rural Health Workgroup is to:

- identify core sets of the best available rural-relevant measures to address the needs of the rural population;
- identify and prioritize rural-relevant gaps in measurement;
- provide recommendations regarding alignment and coordination of measurement efforts across programs, care settings, specialties, and sectors (both public and private); and
- provide recommendations to address a specific measurement topic relevant to individuals in rural areas.

To identify a core set of rural-relevant measures, the MAP Rural Health Workgroup identified several criteria to help narrow the list of potentially appropriate measures. Specifically, the Workgroup agreed that measures in the core set should be NQF-endorsed, cross-cutting, resistant to low case-volume, and

address transitions in care. The Workgroup also agreed on the potential inclusion of measures that address mental health, substance abuse, medication reconciliation, diabetes, hypertension, chronic obstructive pulmonary disease, hospital readmissions, perinatal conditions, and the pediatric population. The Workgroup identified measures for the draft core set through an initial quantitative process that scored measures based on their adherence to the selection criteria, followed by iterative qualitative evaluations and consensus-building discussions on individual measures. To date, the Workgroup has reviewed 39 of 74 measures identified for potential inclusion in the core set of measures. The Workgroup narrowed the list of 39 measures to 19 and will discuss the remaining 35 measures in an upcoming webinar.

The Workgroup also has identified and prioritized measurement gaps relevant to rural clinicians and hospitals. Gaps considered most critical include measures of access, transitions in care, cost, alcohol and drug use, and outcome measures.

This report—the first in a series of three—describes the selection criteria and processes used to generate the draft core set of measures to date, lists the measures, and describes the measurement gap areas identified by the Workgroup. In May 2018, NQF will release a second report that documents the Workgroup's continued efforts to refine the draft core set. In August 2018, NQF will release a final report. The Workgroup anticipates recommending two core sets of measures, one for ambulatory and one for inpatient hospital settings, each including up to 20 measures. The draft core set described in this report will provide the foundation for the two core sets.

Introduction and Purpose

The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP) as a public-private partnership of healthcare stakeholders. To improve the quality, affordability, and community impact of healthcare, MAP provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. MAP also helps to identify gaps in measure development and encourages measure alignment across public and private programs, settings, levels of analysis, and populations. In September 2017, the Department of Health and Human Services (DHHS) contracted with the NQF to convene a MAP Rural Health Workgroup. This 25-member, multistakeholder group serves in an advisory capacity to the MAP Coordinating Committee (Appendix A). The current charge of the MAP Rural Health Workgroup is to:

- identify core sets of the best available rural-relevant measures to address the needs of the rural population;
- identify and prioritize rural-relevant gaps in measurement;
- provide recommendations regarding alignment and coordination of measurement efforts across programs, care settings, specialties, and sectors (both public and private); and
- provide recommendations to address a specific measurement topic relevant to individuals in rural areas.

To accomplish these tasks, the Workgroup will draw on the foundational work of the NQF Rural Health Committee that was funded by HHS in 2014 to identify challenges in healthcare performance measurement for rural providers and to make recommendations for mitigating these challenges. As part of its work, the 2014 Committee drafted an initial set of guiding principles for the selection of rural-relevant measures and provided specific guidance for the number and types of measures that would be appropriate for a core set of rural-relevant measures.

The MAP Rural Health Workgroup will conduct its work over the course of eight webinars and produce a final report of recommendations in August 2018. This interim report presents a draft core set of rural-relevant measures appropriate for the hospital and ambulatory settings and describes the selection criteria and processes used by the Workgroup to identify measures included in the draft core set. This report also includes a prioritized list of measurement gaps.

In August 2018, NQF will release a final report. The Workgroup anticipates recommending two core sets of measures, one for ambulatory and one for inpatient hospital settings, each including up to 20 measures. The draft core set described in this report will provide the foundation for the two core sets.

Draft Core Set of Measures

Measure Selection Criteria

The Workgroup began the process of identifying a draft core set of measures by articulating initial criteria for selecting measures. To arrive at these criteria, members considered the guiding principles for measure selection that were developed in NQF's 2015 Rural Health Project. Over the course of two webinars, the Workgroup agreed on use of the following selection criteria:

- **NQF endorsement**. The Workgroup determined that measures included in the core set should be NQF-endorsed. Limiting core set measures to those that are NQF-endorsed addresses several of the 2015 guiding principles for measure selection: Preferred measures are supported by empirical evidence demonstrating clinical effectiveness and a link to desired health outcomes, demonstrate opportunity for improvement, rely on data that are readily available and/or can be collected without undue burden, and are suitable for use in internal quality improvement efforts, as well as in accountability applications.
- **Cross-cutting**. Cross-cutting measures are neutral with respect to condition or type of procedure or service. Selection of cross-cutting measures for a core set will help address the challenges of heterogeneity among rural providers and residents, as these measures will apply to most providers and their patients. Also, because cross-cutting measures are not condition- or procedure-specific, low case-volume should be less likely, even for geographically isolated providers or those with small practice sizes. For the purposes of this project, measures that assess preventive screening of broad populations also are considered cross-cutting.
- **Resistant to low case-volume**. Many rural providers, including critical access hospitals, small clinician practices, and those serving in frontier areas, may not have enough patients to achieve reliable and valid results for many measures. Echoing the 2015 Rural Health Committee's recommendations to explicitly consider low case-volume in the context of mandating participation of rural providers in CMS pay-for-performance programs, the Workgroup emphasized that measures in the core set should apply to most rural providers in terms of having a large enough patient population for reliable and valid measurement.
- **Measures that address transitions in care settings**. Because many rural providers do not provide specialized care for high-acuity patients, transfers to other settings and providers are common. Workgroup members agreed that measures assessing the quality and coordination of transitions in care must be included in a core set of rural-relevant measures. For this project, transitions of care are defined as, "the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another" [1]

Given the broad scope of care provided by rural clinicians and hospitals, the Workgroup also supported, albeit to a lesser extent, inclusion of measures that address specific conditions or services that are particularly relevant to rural populations. These include:

- **Mental health.** The Workgroup strongly supported inclusion of measures related to mental health. While members agreed that inclusion of measures of access to mental health services would be ideal, they also noted both the importance of screening for mental health issues and its relevance in day-to-day primary care, and placed particular emphasis on screening for depression.
- **Substance abuse.** Given the high prevalence of tobacco, alcohol, and other drug use and abuse–including opioids—in many rural areas, the Workgroup agreed that the core set of measures should include measures that address this facet of care.
- **Medication reconciliation.** Medication errors are an important safety concern for all patients, particularly those with multiple comorbidities. Medication reconciliation is a cross-cutting

activity that is a core function of good care coordination, and is especially critical when care hand-offs or transitions occur.

- **Diabetes, hypertension, and chronic obstructive pulmonary disease (COPD).** The Workgroup recognized these chronic conditions as highly prevalent in rural areas, requiring high levels of healthcare utilization and contributing to high costs of care for rural residents.
- **Hospital readmissions, and perinatal and pediatric conditions and services.** The Workgroup was somewhat supportive of including readmission measures and measures applicable to perinatal conditions or services and those applicable to children and adolescents. Members recognized readmission measures as outcome measures that reflect deteriorating health status no longer amenable to outpatient support, although they noted the need for appropriate risk-adjustment for such measures and the potential for low case-volume for condition-specific readmission measures. Members also recognized the primary care needs of children and women of childbearing age in the rural ambulatory settings, but noted the potential for low case-volume and/or nonprovision of services for these groups in rural hospitals.

Measure Selection Process

The Workgroup's process for identifying a draft core set of measures included an initial quantitative component followed by iterative qualitative evaluations and consensus-building discussions.

Environmental Scan of Measures

NQF staff began the quantitative process for selecting draft core set measures by updating the environmental scan of measures created as part of the 2015 Rural Health project.[2] This process included adding newly endorsed measures to the scan and updating the endorsement status to reflect changes in NQF's portfolio of measures since 2015, refreshing information regarding use of measures in various federal quality improvement programs, and including information on other measures identified through recent NQF measurement activities around home and community-based services, telehealth, disparities, Medicaid-focused measurement, emergency department transitions of care, and diagnostic quality and safety.

Based on the Workgroup's desire to focus on NQF-endorsed measures for populating the core set, staff narrowed the updated measure scan to a list of currently endorsed measures that apply to hospital and ambulatory care settings and reflect assessment at the hospital, clinician, or integrated delivery system levels of analysis. Staff then tagged the measures to indicate those that address the selection criteria articulated by the Workgroup, as described above.

Quantitative Methodology for Selecting Core Set Measures

NQF staff then developed a tiered weighting system that reflected the Workgroup's preferences and support for the selection criteria as described above. Table 1 shows the tiered selection criteria. NQF staff used this system to assign a score to each measure, then used the scores to help identify a "strawman" draft core set for Workgroup discussion.

Table 1. Tiered Selection Criteria and Weights Used to Assign Measure Scores

Tiered selection criteria applied to relevant NQF-endorsed measures	Weight
Tier 1: Cross-cutting	25%
Tier 1: Resistant to the low case-volume challenge	25%
Tier 1: Transitions of care	20%
Tier 2 • Mental health • Substance abuse • Medication reconciliation	15%
Tier 3 • Diabetes • Hypertension • Chronic obstructive pulmonary disease (COPD)	10%
Tier 4 • Readmissions • Perinatal • Pediatrics	5%

To obtain a score for each measure, staff first tagged each measure with a "1" or "0" to indicate whether or not the measure is cross-cutting or resistant to low case-volume, assesses transitions of care, or reflects conditions or topics included in tiers 2 to 4. Staff then calculated a score for each measure using the percentage weights noted in Table 1 above.

Of the 608 measures that are currently NQF-endorsed, 444 meet the requirements for a rural-relevant draft core set in terms of care setting and level of analysis. Of these, 284 had a nonzero score, thus addressing one of the Workgroup's selection criteria. Staff used the 75th percentile of the nonzero scores (≥0.50) as a cut-point to further narrow the list of measures to those that most closely reflected the preferences of the Workgroup (i.e., a higher score indicates that a particular measure addresses more and/or more preferred selection criteria of the Workgroup). This step resulted in 119 measures. After review of these measures, staff identified a "strawman" draft core set of 44 measures for Workgroup consideration, based on earlier discussions with the Workgroup as well as information gleaned from NQF's 2015 Rural Health Project.

Qualitative Process for Selecting Core Set Measures

In the January 2018 webinar, NQF staff presented the 44-measure "strawman" draft core set to the Workgroup. During the discussion, the Workgroup identified several additional themes that it wants to consider as it refines its recommendations for a core set of rural-relevant measures:

- **Ease and cost of data collection**. Workgroup members noted that rural providers may have differing abilities to collect and report measure data, and core set measures therefore must be feasible for the majority of rural providers.
- **Use in federal or other programs**. The Workgroup suggested considering use of measures in federal or other programs as a way to align measures across various programs. NQF staff had previously identified measures currently in use in CMS quality improvement programs, but Workgroup members may know of other users of particular measures.
- **Consideration of potential unintended consequences.** The Workgroup agreed that potential unintended consequences to rural residents and providers should be assessed as part of identifying the core set of measures.
- **Balancing measure types**. Members inquired as to the balance of the measure types included in the strawman core set and suggested that outcome measures receive a higher rating than others, given CMS's preferences for using outcome measures.
- **Consideration of the set and its ability to describe the overall quality of the measured entity**. Workgroup members noted that as they get closer to finalizing the core set of measures, they should consider whether the set, in its entirety, adequately addresses the quality of the spectrum of care provided to rural residents in hospital and ambulatory settings.

Because of project time constraints, staff did not try to tag and re-score measures based on the above themes. Instead, immediately following the webinar, staff asked Workgroup members to identify any additional measures that they would like to consider for inclusion in the draft core set, beyond the 44 measures in the "strawman" draft core set. Members identified 30 additional measures, bringing the total up to 74 measures for further detailed consideration (Appendix B).

Staff then asked the Workgroup to review this second iteration of a draft core set, this time indicating their desire to include each measure (responses were yes/no/maybe) and providing feedback on concerns regarding ease of use/feasibility for rural providers, potential for unintended consequences, and current use of measures in quality improvement or accountability programs, as well as other or overall concerns or comments about the measures.

Consensus Agreement Exercise

During its February 14, 2018 webinar, the Workgroup began an in-depth discussion of the 74 measures, with the dual purpose of narrowing down the number of draft core set measures and providing a rationale for inclusion or exclusion. The Workgroup reviewed measures grouped by condition or topic, and from each group, they selected the measures determined to be most appropriate for a core set of rural-relevant measures. The Workgroup considered the following questions, based on prior discussion and feedback after the January 2018 webinar:

- Is the measure susceptible to low case-volume?
- Is the measure "topped out" (i.e., has little room for further improvement), or would it likely be topped out soon?
- Is the measure risk-adjusted appropriately for rural providers?
- Would the data collection burden outweigh the benefit of the measure for rural residents and providers?

- Will the measure affect patient health outcomes in a meaningful way?
- Are there unintended consequences associated with the measure for rural residents or providers?
- Does the measure assess care for the appropriate entities (i.e., at either the facility level of analysis for measures used in a hospital setting or at a clinician level of analysis for measures used in an ambulatory setting)?

The Workgroup was able to review only 39 of the 74 measures from the draft core set. Of the 39 measures reviewed, members selected 19 measures for potential inclusion in the draft core set as shown in Table 2.

Table 2. Measures Selected for Potential Inclusion in Draft Core Set

NQF #	Measure Title	Condition/Topic
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child	Experience with Care
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Substance Use – Tobacco
0032	Cervical Cancer Screening (CCS)	Screening
0038	Childhood Immunization Status (CIS)	Immunization
0041	Preventive Care and Screening: Influenza Immunization	Immunization
0097	Medication Reconciliation Post-Discharge	Medication: Use, Review, and Reconciliation
0166	HCAHPS (Adult Hospital CAHPS measures)	Experience with Care
0291	Emergency Transfer Communication Measure	Transitions
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Mental Health (Depression)
0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Screening
0431	Influenza Vaccination Coverage Among Healthcare Personnel	Immunization
0711	Depression Remission at Six Months	Mental Health (Depression)
0729	Optimal Diabetes Care	Diabetes
1407	Immunizations for Adolescents	Immunization
1659	Influenza Immunization	Immunization
1661	SUB-1 Alcohol Use Screening	Substance Use — Alcohol, Other Drugs
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Substance Use – Alcohol, Other Drugs
2548	Child Hospital CAHPS (HCAHPS)	Experience with Care
2803	Tobacco Use and Help with Quitting Among Adolescents	Substance Use – Tobacco

The Workgroup will review the remaining 35 measures in a future webinar:

Table 3. Measures Still to be Considered for Potential Inclusion in the Draft Core Set

NQF #	Measure Title	Condition/Topic
0018	Controlling High Blood Pressure	Other
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Pediatrics
0047	Asthma: Pharmacologic Therapy for Persistent Asthma	Pediatrics
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	Patient Safety – Falls
0138	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	Healthcare Associated Infections (HAI)
0139	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Healthcare Associated Infections (HAI)
0141	Patient Fall Rate	Patient Safety – Falls
0202	Falls with injury	Patient Safety – Falls
0326	Advance Care Plan	Palliative
0371	Venous Thromboembolism Prophylaxis	Patient Safety
0420	Pain Assessment and Follow-Up	Palliative
0439	STK-06: Discharged on Statin Medication	Other
0469	PC-01 Elective Delivery	Perinatal
0471	PC-02 Cesarean Birth	Perinatal
0476	PC-03 Antenatal Steroids	Perinatal
0495	Median Time from ED Arrival to ED Departure for Admitted ED Patients	Emergency Department Timing
0496	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Emergency Department Timing
0497	Admit Decision Time to ED Departure Time for Admitted Patients	Emergency Department Timing
0531	Patient Safety for Selected Indicators (modified version of PSI90)	Patient Safety
0533	Postoperative Respiratory Failure Rate (PSI 11)	Post-procedure outcomes
0661	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation within 45 minutes of ED Arrival	Other
0709	Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year	Patient Safety
1392	Well-Child Visits in the First 15 Months of Life	Pediatrics
1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Pediatrics

NQF #	Measure Title	Condition/Topic
1550	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Patient Safety
1641	Hospice and Palliative Care – Treatment Preferences	Palliative
1716	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Healthcare Associated Infections (HAI)
1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Healthcare Associated Infections (HAI)
1789	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Readmission
2393	Pediatric All-Condition Readmission Measure	Readmission
2455	Heart Failure: Post-Discharge Appointment for Heart Failure Patients	Other
2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Post-procedure outcomes
2720	National Healthcare Safety Network (NHSN) Antimicrobial Use Measure	Patient Safety
2877	Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Risk Adjustment for Stroke Severity	Post-procedure outcomes
2903	Contraceptive Care – Most & Moderately Effective Methods	Perinatal

Prioritizing Measurement Gaps

In its January 2018 webinar, the Workgroup also discussed and identified measurement gap areas. The Workgroup first reviewed the measurement gaps that were identified in the 2015 rural health report. These included transitions of care (both appropriateness and timeliness of transfers); alcohol and drug treatment; access and timeliness of care; cost measures; population health at the geographic level (regional or community); and advance directives and/or end-of-life measures. The Workgroup then highlighted the following additional measurement gap areas:

- Access to care
    - The Workgroup agreed that access to care is an important measurement gap, but cautioned that measuring access should be done with careful consideration for potential unintended consequences. For example, members discussed measures of timeliness of care, recognizing their usefulness as indicators of access, but also the potential unintended effect of penalizing a provider if wait time is increased due to the need to transfer a patient to another facility.
    - The Workgroup acknowledged that telehealth could address lack of access to care and noted the absence of measures specific to telehealth. However, while members agreed that measures should include telehealth as an option for care delivery, the focus should be on measuring access to care more generally.

- Disparities in care
    - The Workgroup discussed the need for measures to assess disparities in care, and questioned whether such measures exist. NQF staff noted that measures submitted to NQF for endorsement sometimes have information regarding disparities, but these data are not easily extractable from the measure submissions received and thus not easily tagged as such for their consideration.
- Differing values of patients and providers
    - Members noted that the patients and providers often value different things. They pointed to recent research by the University of Utah indicating that while access and cost are most important to patients, providers often are more interested in their patients' health outcomes and their own adherence to standards of care. Members suggested that the core set include measures that address these different values.
- Outcome measures, particularly patient-reported outcomes
    - Some Workgroup members believed that the "strawman" draft core set of 44 measures did not include enough outcome measures in general, and particularly not enough measures reflecting the "patient's voice." However, other members cautioned against inclusion of "overly specialized" outcome measures in the core set due to concerns about applicability and low case-volume.

Prioritization Exercise

Due to time constraints during its February 14 webinar, the Workgroup was not able to prioritize the measurement gap areas it had previously identified. However, the Workgroup reiterated concerns about appropriate risk-adjustment for outcome measures used to assess rural providers, recognizing inadequate risk-adjustment as a gap in measurement. Also, as part of the core-set measure discussion, Workgroup members realized that several measures they initially considered for inclusion in the core set are actually specified and endorsed to assess care provided by health plans and integrated delivery systems rather than for clinicians or hospitals. Thus, the Workgroup recognized that when a measure does not assess care at the desired level of analysis, this is also a gap in measurement. Finally, the Workgroup agreed that the cost measures initially considered for potential inclusion in the draft core set are not appropriate for rural providers, which therefore presents a gap in terms in cost-of-care measurement.

Because this prioritization is one of the required deliverables of the Workgroup, staff relied on a post-webinar survey to elicit the Workgroup's decisions. Specifically, staff asked Workgroup members to rank the top three measurement gap areas. The Workgroup identified the following as the highest priority measurement gap areas (from most to least important):

1. Access to care (including timeliness of care)
2. Transitions in care
3. Cost
4. Substance use measures, particularly those focused on alcohol and opioids
5. Outcome measures

Of note, the draft core set of measures identified to date includes a transition measure and three substance abuse measures.

Conclusion and Next Steps

This report describes the MAP Rural Health Workgroup's efforts to date to identify a core set of rural-relevant measures applicable to the hospital and ambulatory care settings. The Workgroup will continue to refine the draft core set over the next four Workgroup webinars, taking into account comments that will be submitted during the upcoming public comment period. By the end of this project, the Workgroup anticipates recommending two core sets of measures (one for ambulatory and one for inpatient hospital settings), each including up to 20 measures. NQF also will give the Workgroup at least one more opportunity to provide input on the list of prioritized measurement gaps.

[1] Agency for Healthcare Research and Quality (AHRQ). Chartbook on Care Coordination website. https://www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/carecoordination/carecoord-measures1.html. Last accessed February 2018.

[2] National Quality Forum (NQF). *Performance Measurement for Rural Low-Volume Providers*. Washington, DC: NQF; 2015. Available at https://www.qualityforum.org/Publications/2015/09/Rural_Health_Final_Report.aspx. Last accessed February 2018.

Appendix A: MAP Rural Health Workgroup and NQF Staff

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Appendix B: Draft Core Set of Rural-Relevant Measures

NQF # and Measure Title	Reviewed by Workgroup on Feb 14 2018 webinar	Included in Draft Core Set to date	Category	Measure Description	Measure Type	Level of Analysis	Care Setting
0291 EMERGENCY TRANSFER COMMUNICATION MEASURE	Yes	Yes	Transitions	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that REQUIRED information was communicated to the receiving facility prior to departure (SUBSECTION 1) OR WITHIN 60 MINUTES OF TRANSFER (SUBSECTION 2-7)	Process	Facility	Inpatient/ Hospital
0228 3-Item Care Transition Measure (CTM-3)	Yes	No	Transitions	The CTM-3 is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among adult patients discharged from general acute care hospitals within the past 30 days.	Outcome: PRO-PM	Facility	Inpatient/ Hospital
0290 Median Time to Transfer to Another Facility for Acute Coronary Intervention	Yes	No	Transitions	This measure calculates the median time from emergency department (ED) arrival to time of transfer to another facility for acute coronary intervention (ACI) for ST-segment myocardial infarction (STEMI) patients that require a percutaneous coronary intervention (PCI). The measure is calculated using chart-abstracted data, on a rolling quarterly basis, and is publically reported, in aggregate, for one calendar year. The measure has been publically reported, annually by CMS as a component of its Hospital Outpatient Quality Reporting (HOQR) Program since 2008.	Process	Facility, Other	Inpatient/ Hospital
0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Yes	Yes	Mental Health (Depression)	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Process	Clinician: Group/Practice, Clinician: Individual, Other, Population: Community, County or City, Population: Regional and State	Inpatient/ Hospital, Outpatient Services, Post-Acute Care
0418e Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Yes	No	Mental Health (Depression)	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Process	Clinician: Group/Practice, Clinician: Individual	Outpatient Services
1885 Depression Response at Twelve Months-Progress Towards Remission	Yes	No	Mental Health (Depression)	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at twelve months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.	Outcome: PRO-PM	Clinician: Group/Practice, Facility	Outpatient Services
0711 Depression Remission at Six Months	Yes	Yes	Mental Health (Depression)	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator.	Outcome: PRO-PM	Clinician: Group/Practice, Facility	Outpatient Services
0710 Depression Remission at Twelve Months	Yes	No	Mental Health (Depression)	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.	Outcome: PRO-PM	Clinician: Group/Practice, Facility	Outpatient Services
0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Yes	Yes	Substance Use - Tobacco	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Process	Clinician: Group/Practice, Clinician: Individual	Other, Outpatient Services
1651 TOB-1 Tobacco Use Screening	Yes	No	Substance Use - Tobacco	Hospitalized patients age 18 years and older who are screened within the first day of admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days.	Process	Facility, Other	Inpatient/ Hospital

NQF # and Measure Title	Reviewed by Workgroup on Feb 14 2018 webinar	Included in Draft Core Set to date	Category	Measure Description	Measure Type	Level of Analysis	Care Setting
1656 TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	Yes	No	Substance Use - Tobacco	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age an older to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment at discharge. Treatment at discharge includes a referral to outpatient counseling and a prescription for one of the FDA-approved tobacco cessation medications. Refer to section 2a1.10 Stratification Details/Variables for the rationale for the addition of the subset measure. These measures are intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB 2 Tobacco Use Treatment Provided or Offered During the Hospital Stay; TOB-4 Tobacco Use: Assessing Status After Discharge [temporarily suspended]).	Process	Facility, Other	Inpatient/ Hospital
2803 Tobacco Use and Help with Quitting Among Adolescents	Yes	Further discussion required	Substance Use - Tobacco	Percentage of adolescents 12 to 20 years of age during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	Process	Clinician: Group/Practice	Outpatient Services
1661 SUB-1 Alcohol Use Screening	Yes	Yes	Substance Use - Alcohol, Other Drugs	Hospitalized patients 18 years of age and older who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge [temporarily suspended]).	Process	Facility, Other	Inpatient/ Hospital
2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Yes	Yes	Substance Use - Alcohol, Other Drugs	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user	Process	Clinician: Group/Practice, Clinician: Individual	Other, Outpatient Services
1664 SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Yes	No	Substance Use - Alcohol, Other Drugs	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included. These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge [temporarily suspended]).	Process	Facility, Other	Inpatient/ Hospital
0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Yes	No	Substance Use - Alcohol, Other Drugs	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. - Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. - Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Process	Health Plan, Integrated Delivery System	Emergency Department and Services, Inpatient/ Hospital, Outpatient Services
2940 Use of Opioids at High Dosage in Persons Without Cancer	Yes	No	Substance Use - Alcohol, Other Drugs	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	Process	Health Plan, Other, Population: Regional and State	Other, Outpatient Services
0022 Use of High-Risk Medications in the Elderly (DAE)	Yes	No	Medication: Use, Review, and Reconciliation	There are two rates for this measure: - The percentage of patients 65 years of age and older who received at least one high-risk medication. - The percentage of patients 65 years of age and older who received at least two prescriptions for the same high-risk medication. For both rates, a lower rate represents better performance.	Process	Health Plan, Integrated Delivery System	Outpatient Services
0553 Care for Older Adults (COA) – Medication Review	Yes	No	Medication: Use, Review, and Reconciliation	Percentage of adults 66 years and older who had a medication review during the measurement year; a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Process	Health Plan, Integrated Delivery System	Inpatient/ Hospital, Outpatient Services, Post-Acute Care

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0419 Documentation of Current Medications in the Medical Record	Yes	No	Medication: Use, Review, and Reconciliation	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration	Process	Clinician: Group/Practice, Clinician: Individual	Outpatient Services
0097 Medication Reconciliation Post-Discharge	Yes	Yes	Medication: Use, Review, and Reconciliation	The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.	Process	Clinician: Group/Practice, Clinician: Individual, Health Plan, Integrated Delivery System	Outpatient Services
2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	Yes	No	Medication: Use, Review, and Reconciliation	This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult patient. The time frame is the hospitalization period. At the time of admission, the admission orders are compared to the preadmission medication list (PAML) compiled by trained pharmacist (i.e., the gold standard) to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This process is repeated at the time of discharge where the discharge medication list is compared to the PAML and medications ordered during the hospitalization.	Outcome	Facility	Inpatient/ Hospital
0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Yes	Yes	Screening	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25	Process	Clinician: Group/Practice, Clinician: Individual, Other, Population: Community, County or City, Population: Regional and State	Home Care, Other, Outpatient Services
0032 Cervical Cancer Screening (CCS)	Yes	Yes	Screening	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: - Women age 21–64 who had cervical cytology performed every 3 years. - Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	Process	Health Plan, Integrated Delivery System	Outpatient Services
0034 Colorectal Cancer Screening (COL)	Yes	No	Screening	The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.	Process	Health Plan, Integrated Delivery System	Outpatient Services
2372 Breast Cancer Screening	Yes	No	Screening	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	Process	Health Plan, Integrated Delivery System	Outpatient Services
0038 Childhood Immunization Status (CIS)	Yes	Further discussion required	Immunization	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine.	Process	Health Plan, Integrated Delivery System	Outpatient Services
0041 Preventive Care and Screening: Influenza Immunization	Yes	Further discussion required	Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Process	Clinician: Group/Practice, Clinician: Individual	Home Care, Other, Outpatient Services, Post-Acute Care
1659 Influenza Immunization	Yes	Further discussion required	Immunization	Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	Process	Facility	Inpatient/ Hospital
1407 Immunizations for Adolescents	Yes	Further discussion required	Immunization	The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday.	Process	Health Plan, Integrated Delivery System	Outpatient Services
0431 INFLUENZA VACCINATION COVERAGE AMONG HEALTHCARE PERSONNEL	Yes	Further discussion required	Immunization	Percentage of healthcare personnel (HCP) who receive the influenza vaccination.	Process	Facility	Inpatient/ Hospital, Outpatient Services, Post-Acute Care

NQF # and Measure Title	Reviewed by Workgroup on Feb 14 2018 webinar	Included in Draft Core Set to date	Category	Measure Description	Measure Type	Level of Analysis	Care Setting
0166 HCAHPS	Yes	Further discussion required	Experience with Care	HCAHPS (NQF #0166) is a 32-item survey instrument that produces 11 publicly reported measures: 7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and care transition); and 4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital)	Outcome	Facility	Inpatient/ Hospital
0005 CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child	Yes	Further discussion required	Experience with Care	The Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months. The survey includes standardized questionnaires for adults and children. All questionnaires can be used in both primary care and specialty care settings. The adult survey is administered to patients aged 18 and over. The child survey is administered to the parents or guardians of pediatric patients under the age of 18. Patients who have had at least one visit during the past 12-months are eligible to be surveyed. CG-CAHPS Survey Version 1.0 was endorsed by NQF in July 2007 (NQF #0005). The development of the survey is through the CAHPS consortium and sponsored by the Agency for Healthcare Research and Quality. The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at https:cahps.ahrq.gov/surveys-guidance/cg/about/index.html. The Adult CG-CAHPS Survey includes one global rating item and39 items in which 13 items can be organized into three composite measures and one global item for the following categories of care or services provided in the medical office: 1. Getting Timely Appointments, Care, and Information (5 items) 2. How Well Providers Communicate With Patients (6 items) 3. Helpful, Courteous, and Respectful Office Staff (2 items) 4. Overall Rating of Provider (1 item) The Child CG-CAHPS Survey includes one global rating item and 54 items in which 24 items can be organized into five composite measures and one global item for the following categories of care or services provided in the medical office,: 1. Getting Timely Appointments, Care, and Information (5 items) 2. How Well Providers Communicate With Patients (6 items) 3. Helpful, Courteous, and Respectful Office Staff (2 items) 4. Overall Rating of Provider (1 item) 5. Provider´s Attention to Child´s Growth and Development (6 items) 6. Provider´s Advice on Keeping Your Child Safe and Healthy (5 items)	Outcome: PRO-PM	Clinician: Group/Practice, Clinician: Individual	Outpatient Services

NQF # and Measure Title	Reviewed by Workgroup on Feb 14 2018 webinar	Included in Draft Core Set to date	Category	Measure Description	Measure Type	Level of Analysis	Care Setting
2548 Child Hospital CAHPS (HCAHPS)	Yes	Further discussion required	Experience with Care	The Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS) is a standardized survey instrument that asks parents and guardians (henceforth referred to as parents) of children under 18 years old to report on their and their child's experiences with inpatient hospital care. The performance measures of the Child HCAHPS survey consist of 39 items organized by overarching groups into the following 18 composite and single-item measures: Communication with Parent 1. Communication between you and your child's nurses (3 items) 2. Communication between you and your child's doctors (3 items) 3. Communication about your child's medicines (4 items) 4. Keeping you informed about your child's care (2 items) 5. Privacy when talking with doctors, nurses, and other providers (1 item) 6. Preparing you and your child to leave the hospital (5 items) 7. Keeping you informed about your child's care in the Emergency Room (1 item) Communication with Child 8. How well nurses communicate with your child (3 items) 9. How well doctors communicate with your child (3 items) 10.Involving teens in their care (3 items) Attention to Safety and Comfort 11.Preventing mistakes and helping you report concerns (2 items) 12.Responsiveness to the call button (1 item) 13.Helping your child feel comfortable (3 items) 14.Paying attention to your child's pain (1 item) Hospital Environment 15.Cleanliness of hospital room (1 item) 16.Quietness of hospital room (1 item) Global Rating 17.Overall rating (1 item) 18.Recommend hospital (1 item) We recommend that the scores for the Child HCAHPS composite and single-item measures be calculated using a top-box scoring method. The top box score refers to the percentage of respondents who answered survey items using the best possible response option. The measure time frame is 12 months. A more detailed description of the Child HCAHPS measure can be found in the Detailed Measure Specifications (Appendix A).	Outcome: PRO-PM	Facility	Inpatient/ Hospital
1604 Total Cost of Care Population-based PMPM Index	Yes	No	Cost/Resource Use	Total Cost of Care reflects a mix of complicated factors such as patient illness burden, service utilization and negotiated prices. Total Cost Index (TCI) is a measure of a primary care provider's risk adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. A Total Cost Index when viewed together with the Total Resource Use measure (NQF-endorsed #1598) provides a more complete picture of population based drivers of health care costs.	Cost/Resource Use	Clinician: Group/Practice, Population: Community, County or City	Emergency Department and Services, Home Care, Inpatient/ Hospital, Other, Outpatient Services, Post-Acute Care
1598 Total Resource Use Population-based PMPM Index	Yes	No	Cost/Resource Use	The Resource Use Index (RUI) is a risk adjusted measure of the frequency and intensity of services utilized to manage a provider group's patients. Resource use includes all resources associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. A Resource Use Index when viewed together with the Total Cost of Care measure (NQF-endorsed #1604) provides a more complete picture of population based drivers of health care costs.	Cost/Resource Use	Clinician: Group/Practice, Population: Community, County or City	Emergency Department and Services, Home Care, Inpatient/ Hospital, Other, Outpatient Services, Post-Acute Care
0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Yes	No	Diabetes	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	Outcome	Health Plan, Integrated Delivery System	Outpatient Services
2363 Glycemic Control - Hypoglycemia	Yes	No	Diabetes	The rate of hypoglycemic events following the administration of an anti-diabetic agent	Outcome	Facility	Inpatient/ Hospital

NQF # and Measure Title	Reviewed by Workgroup on Feb 14 2018 webinar	Included in Draft Core Set to date	Category	Measure Description	Measure Type	Level of Analysis	Care Setting
0729 Optimal Diabetes Care	Yes	Yes	Diabetes	The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, blood pressure, statin use, tobacco non-use and daily aspirin or anti-platelet use for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c less than 8.0, Blood Pressure less than 140 systolic and less than 90 diastolic, Statin use unless contraindications or exceptions, Tobacco-free (non-user) and for patients with diagnosis of ischemic vascular disease daily aspirin or antiplatelet use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.	Composite	Clinician: Group/Practice	Outpatient Services
2393 Pediatric All-Condition Readmission Measure	No	Requires Workgroup Review	Readmission	This measure calculates case-mix-adjusted readmission rates, defined as the percentage of admissions followed by 1 or more readmissions within 30 days, for patients less than 18 years old. The measure covers patients discharged from general acute care hospitals, including children's hospitals.	Outcome	Facility	Inpatient/ Hospital
1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	No	Requires Workgroup Review	Readmission	The measure estimates a hospital-level risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/gynecology; general medicine; cardiorespiratory; cardiovascular; and neurology, each of which will be described in greater detail below. The measure also indicates the hospital-level standardized risk ratios (SRR) for each of these five specialty cohorts. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of planned readmissions do not count in the readmission outcome. CMS annually reports the measure for patients who are 65 years or older, are enrolled in fee-for-service (FFS) Medicare, and hospitalized in non-federal hospitals.	Outcome	Facility	Inpatient/ Hospital
2903 Contraceptive Care – Most & Moderately Effective Methods	No	Requires Workgroup Review	Perinatal	The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception. The proposed measure is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use, and because of the strong association between type of contraceptive method used and risk of unintended pregnancy.	Outcome: Intermediate Clinical Outcome	Facility, Health Plan, Population: Regional and State	Other
0469 PC-01 Elective Delivery	No	Requires Workgroup Review	Perinatal	This measure assesses patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Birth, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)	Process	Facility, Other	Inpatient/ Hospital
0471 PC-02 Cesarean Birth	No	Requires Workgroup Review	Perinatal	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	Outcome	Facility, Other	Inpatient/ Hospital
0476 PC-03 Antenatal Steroids	No	Requires Workgroup Review	Perinatal	This measure assesses patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Birth, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	Process	Facility, Other	Inpatient/ Hospital
0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	No	Requires Workgroup Review	Pediatrics	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: - Body mass index (BMI) percentile documentation* - Counseling for nutrition - Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	Process	Health Plan, Integrated Delivery System	Outpatient Services

NQF # and Measure Title	Reviewed by Workgroup on Feb 14 2018 webinar	Included in Draft Core Set to date	Category	Measure Description	Measure Type	Level of Analysis	Care Setting
0047 Asthma: Pharmacologic Therapy for Persistent Asthma	No	Requires Workgroup Review	Pediatrics	Percentage of patients aged 5 years and older with a diagnosis of persistent asthma who were prescribed long-term control medication Three rates are reported for this measure: 1. Patients prescribed inhaled corticosteroids (ICS) as their long term control medication 2. Patients prescribed other alternative long term control medications (non-ICS) 3. Total patients prescribed long-term control medication	Process	Clinician: Group/Practice, Clinician: Individual	Outpatient Services
1392 Well-Child Visits in the First 15 Months of Life	No	Requires Workgroup Review	Pediatrics	The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.	Process	Health Plan, Integrated Delivery System	Outpatient Services
1516 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	No	Requires Workgroup Review	Pediatrics	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	Process	Health Plan, Integrated Delivery System	Outpatient Services
0326 Advance Care Plan	No	Requires Workgroup Review	Palliative	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.	Process	Clinician: Group/Practice, Clinician: Individual	Outpatient Services
0420 Pain Assessment and Follow-Up	No	Requires Workgroup Review	Palliative	Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Process	Clinician: Group/Practice, Clinician: Individual	Outpatient Services
1641 Hospice and Palliative Care – Treatment Preferences	No	Requires Workgroup Review	Palliative	Percentage of patients with chart documentation of preferences for life sustaining treatments.	Process	Clinician: Group/Practice, Facility	Home Care, Inpatient/ Hospital
0101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	No	Requires Workgroup Review	Patient Safety - Falls	This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates: A) Screening for Future Fall Risk: Percentage of patients aged 65 years and older who were screened for future fall risk at least once within 12 months B) Falls Risk Assessment: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months C) Plan of Care for Falls: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	Process	Clinician: Group/Practice, Clinician: Individual	Inpatient/ Hospital, Outpatient Services, Post-Acute Care
0141 Patient Fall Rate	No	Requires Workgroup Review	Patient Safety - Falls	All documented falls, with or without injury, experienced by patients on eligible unit types in a calendar quarter. Reported as Total Falls per 1,000 Patient Days. (Total number of falls / Patient days) X 1000 Measure focus is safety. Target population is adult acute care inpatient and adult rehabilitation patients.	Outcome	Clinician: Group/Practice, Facility	Inpatient/ Hospital
0202 Falls with injury	No	Requires Workgroup Review	Patient Safety - Falls	All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000 Measure focus is safety. Target population is adult acute care inpatient and adult rehabilitation patients.	Outcome	Clinician: Group/Practice, Facility	Inpatient/ Hospital
0371 Venous Thromboembolism Prophylaxis	No	Requires Workgroup Review	Patient Safety	This measure assesses the number of patients who received venous thromboembolism (VTE) prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission. This measure is part of a set of six nationally implemented prevention and treatment measures that address VTE (VTE-2: ICU VTE Prophylaxis, VTE-3: VTE Patients with Anticoagulation Overlap Therapy, VTE-4: VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring, VTE-5: VTE Warfarin Therapy Discharge Instructions and VTE-6: Hospital Acquired Potentially-Preventable VTE) that are used in The Joint Commission's accreditation process.	Process	Facility, Other	Inpatient/ Hospital

NQF # and Measure Title	Reviewed by Workgroup on Feb 14 2018 webinar	Included in Draft Core Set to date	Category	Measure Description	Measure Type	Level of Analysis	Care Setting
1550 Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	No	Requires Workgroup Review	Patient Safety	The measure estimates a hospital-level risk-standardized complication rate (RSCR) associated with elective primary THA and TKA in Medicare Fee-For-Service beneficiaries who are 65 years and older. The outcome (complication) is defined as any one of the specified complications occurring from the date of index admission to 90 days post date of the index admission (the admission included in the measure cohort). The target population is patients 18 and over. CMS annually reports the measure for patients who are 65 years or older, are enrolled in fee-for-service (FFS) Medicare, and hospitalized in non-federal acute-care hospitals.	Outcome	Facility	Inpatient/ Hospital
2720 National Healthcare Safety Network (NHSN) Antimicrobial Use Measure	No	Requires Workgroup Review	Patient Safety	This measure assesses antimicrobial use in hospitals based on medication administration data that hospitals collect electronically at the point of care and report via electronic file submissions to CDC's National Healthcare Safety Network (NHSN). The antimicrobial use data that are in scope for this measure are antibacterial agents administered to adult and pediatric patients in a specified set of ward and intensive care unit locations: medical, medical/surgical, and surgical wards and units. The measure compares antimicrobial use that the hospitals report with antimicrobial use that is predicted on the basis of nationally aggregated data. The measure is comprised of a discrete set of ratios, Standardized Antimicrobial Administration Ratios (SAARs), each of which summarizes observed-to-predicted antibacterial use for one of 16 antibacterial agent-patient care location combinations. The SAARs are designed to serve as high value targets or high level indicators for antimicrobial stewardship programs (ASPs). SAAR values that are outliers are intended to prompt analysis of possible overuse, underuse, or inappropriate use of antimicrobials, subsequent actions aimed at improving the quality of antimicrobial prescribing, and impact evaluations of ASP interventions.	Process	Facility	Inpatient/ Hospital, Post-Acute Care
0531 Patient Safety for Selected Indicators (modified version of PSI90)	No	Requires Workgroup Review	Patient Safety	Patient Safety for Selected Indicators (modified version of PSI90) is a weighted average of the reliability-adjusted, indirectly standardized, observed-to-expected ratios for the following component indicators: PSI03 Pressure Ulcer Rate, PSI06 Iatrogenic Pneumothorax Rate, PSI08 Postoperative Hip Fracture Rate, PSI09 Postoperative Hemorrhage or Hematoma, PSI10 Physiologic and Metabolic Derangement, PSI11 Postoperative Respiratory Failure, PSI12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate, PSI13 Postoperative Sepsis Rate, PSI14 Postoperative Wound Dehiscence Rate, and PSI15 Accidental Puncture or Laceration Rate. The composite measure is a weighted average of the smoothed rates of the component indicators. The final weight for each component is the product of harm weights and volume weights (numerator weights). Harm weights are calculated by multiplying empirical estimates of excess harms associated with the patient safety event by utility weights linked to each of the harms. Excess harms are estimated using statistical models comparing patients with a safety event to those without a safety event in a CMS Medicare fee-for-service sample that allowed up to one year of follow-up from the discharge date for the hospital stay associated with the index event. Volume weights, the second part of the final weight, are calculated on the basis of the number of safety events for the component indicators in the all-payer reference population. Further details of the weighting methods are presented in S.28.	Composite	Facility	Inpatient/ Hospital

NQF # and Measure Title	Reviewed by Workgroup on Feb 14 2018 webinar	Included in Draft Core Set to date	Category	Measure Description	Measure Type	Level of Analysis	Care Setting
0709 Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.	No	Requires Workgroup Review	Patient Safety	Percent of adult population aged 18+ years who were identified as having at least one of the following six chronic conditions: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Heart Failure (HF), Hypertension (HTN), or Diabetes Mellitus (DM), were followed for at least one-year, and had one or more potentially avoidable complications (PACs) during the most recent 12 months. Please reference attached document labeled NQF_Chronic_Care_PACs_01_24_17.xls, in the tabs labeled PACs I-9 & I-10 for a list of code definitions of PACs relevant to each of the above chronic conditions. We define PACs as one of two types: (1) Type 1 PACs - PACs related to the index condition: Patients are considered to have a PAC, if they receive services during the episode time window for any of the complications directly related to the chronic condition, such as for acute exacerbation of the index condition, respiratory insufficiency in patients with Asthma or COPD, hypotension or fluid and electrolyte disturbances in patients with CAD, HF or diabetes etc. (2) Type 2 PACs - PACs related to Patient Safety or broader System Failures: Patients are also considered to have a PAC, if they receive services during the episode time window for any of the complications related to patient safety or health system failures such as for sepsis, infections, phlebitis, deep vein thrombosis, pressure sores etc. All relevant hospitalizations for patients with chronic conditions are considered potentially avoidable and flagged as PACs. This particularly applies to hospitalizations due to acute exacerbations of the index condition. For example, a hospitalization for diabetic emergency in a diabetic patient, or a hospitalization for acute pulmonary edema in a heart failure patient is considered a PAC. PACs are counted as a dichotomous (yes/no) outcome. If a patient had one or more PACs, they get counted as a "yes" or a 1. The summary tab in the enclosed workbook labeled NQF_Chronic_Care_PACs_01_24_17.xls gives the overview of the frequency and costs associated with each of these types of PACs for each of the six chronic conditions. Detailed drill-down tabs with graphs are also provided in the same workbook for each of the six chronic conditions to highlight high-frequency PACs. The Decision Tree tabs in the same workbook highlight the flow diagrams for the selection of patients into each chronic condition episode. The information is based on a two-year claims database from a commercial insurer with 3,258,706 covered lives and $25.9 billion in "allowed amounts" for claims costs. The database is an administrative claims database with medical as well as pharmacy claims. It is important to note that while the overall frequency of PAC hospitalizations is low (for all chronic care conditions summed together, PAC frequency was 1.6% for all PAC occurrences), they amount to over 52% of the PAC medical costs.	Outcome	Clinician: Group/Practice, Health Plan, Other, Population: Community, County or City, Population: Regional and State	Other, Outpatient Services
1717 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	No	Requires Workgroup Review	Healthcare Associated Infections (HAI)	Standardized infection ratio (SIR) and Adjusted Ranking Metric (ARM) of hospital-onset CDI Laboratory-identified events (LabID events) among all inpatients in the facility, excluding well-baby nurseries and neonatal intensive care units (NICUs).	Outcome	Facility, Other, Population: Regional and State	Emergency Department and Services, Inpatient/ Hospital, Post-Acute Care
0138 National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	No	Requires Workgroup Review	Healthcare Associated Infections (HAI)	Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (UTI) will be calculated among patients in bedded inpatient care locations, except level II or level III neonatal intensive care units (NICU). This includes acute care general hospitals, long-term acute care hospitals, rehabilitation hospitals, oncology hospitals, and behavior health hospitals.	Outcome	Facility, Other, Population: Regional and State	Home Care, Inpatient/ Hospital, Other, Post-Acute Care

NQF # and Measure Title	Reviewed by Workgroup on Feb 14 2018 webinar	Included in Draft Core Set to date	Category	Measure Description	Measure Type	Level of Analysis	Care Setting
1716 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	No	Requires Workgroup Review	Healthcare Associated Infections (HAI)	Standardized infection ratio (SIR) and Adjusted Ranking Metric (ARM)of hospital-onset unique blood source MRSA Laboratory-identified events (LabID events) among all inpatients in the facility	Outcome	Facility, Other, Population: Regional and State	Emergency Department and Services, Inpatient/ Hospital, Post-Acute Care
0139 National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	No	Requires Workgroup Review	Healthcare Associated Infections (HAI)	Standardized Infection Ratio (SIR) and Adjusted Ranking Metric (ARM) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in bedded inpatient care locations. This includes acute care general hospitals, long-term acute care hospitals, rehabilitation hospitals, oncology hospitals, and behavioral health hospitals.	Outcome	Facility, Other, Population: Regional and State	Home Care, Inpatient/ Hospital, Other, Post-Acute Care
0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients	No	Requires Workgroup Review	Emergency Department Timing	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department	Process	Facility	Emergency Department and Services, Inpatient/ Hospital
0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients	No	Requires Workgroup Review	Emergency Department Timing	Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department.	Process	Facility	Emergency Department and Services, Inpatient/ Hospital
0497 Admit Decision Time to ED Departure Time for Admitted Patients	No	Requires Workgroup Review	Emergency Department Timing	Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status	Process	Facility	Emergency Department and Services, Inpatient/ Hospital
2539 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	No	Requires Workgroup Review	Post-procedure outcomes	Rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare fee-for-service (FFS) patients aged 65 years and older.	Outcome	Facility	Inpatient/ Hospital, Outpatient Services
2877 Hybrid hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute ischemic stroke hospitalization with risk adjustment for stroke severity	No	Requires Workgroup Review	Post-procedure outcomes	This hybrid measure estimates a hospital-level, 30-day risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal discharge diagnosis of acute ischemic stroke. Mortality is defined as death from any cause within 30 days of the index admission date for stroke patients. This measure is a newly developed measure with a cohort and outcome that is harmonized with the Centers for Medicare & Medicaid Services' (CMS's) current publicly reported claims-based stroke mortality measure, and includes the National Institutes of Health (NIH) Stroke Scale as an assessment of stroke severity in the risk-adjustment model. The measure is referred to as a hybrid because it is CMS's intention to calculate the measure using two data sources: Medicare fee-for-service (FFS) administrative claims and clinical electronic health record (EHR) data.	Outcome	Facility	Inpatient/ Hospital
0533 Postoperative Respiratory Failure Rate (PSI 11)	No	Requires Workgroup Review	Post-procedure outcomes	Postoperative respiratory failure (secondary diagnosis), mechanical ventilation, or reintubation cases per 1,000 elective surgical discharges for patients ages 18 years and older. Excludes cases with principal diagnosis for acute respiratory failure; cases with secondary diagnosis for acute respiratory failure present on admission; cases in which tracheostomy is the only operating room procedure or in which tracheostomy occurs before the first operating room procedure; cases with neuromuscular disorders, laryngeal or pharyngeal surgery, craniofacial anomalies that had a procedure for the face, esophageal resection, lung cancer, or degenerative neurological disorders; cases with a procedure on the nose, mouth, or pharynx; cases with respiratory or circulatory diseases; and obstetric discharges.	Outcome	Facility	Inpatient/ Hospital

NQF # and Measure Title	Reviewed by Workgroup on Feb 14 2018 webinar	Included in Draft Core Set to date	Category	Measure Description	Measure Type	Level of Analysis	Care Setting
0018 Controlling High Blood Pressure	No	Requires Workgroup Review	Other	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	Outcome	Health Plan, Integrated Delivery System	Outpatient Services
0439 STK-06: Discharged on Statin Medication	No	Requires Workgroup Review	Other	This measure captures the proportion of ischemic stroke patients who are prescribed a statin medication at hospital discharge. This measure is a part of a set of eight nationally implemented measures that address stroke care (STK-1: Venous Thromboembolism (VTE) Prophylaxis, STK-2: Discharged on Antithrombotic Therapy, STK-3: Anticoagulation Therapy for Atrial Fibrillation/Flutter, STK-4: Thrombolytic Therapy, STK-5: Antithrombotic Therapy By End of Hospital Day 2, STK-8: Stroke Education, and STK-10: Assessed for Rehabilitation) that are used in The Joint Commission's hospital accreditation and Disease-Specific Care certification programs.	Process	Facility, Other	Inpatient/ Hospital
2455 Heart Failure: Post-Discharge Appointment for Heart Failure Patients	No	Requires Workgroup Review	Other	Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified)	Process	Facility	Inpatient/ Hospital
0661 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation within 45 minutes of ED Arrival	No	Requires Workgroup Review	Other	This measure calculates the percentage of acute ischemic stroke or hemorrhagic stroke patients who arrive at the ED within two hours of the onset of symptoms and have a head computed tomography (CT) or magnetic resonance imaging (MRI) scan interpreted within 45 minutes of ED arrival.	Process	Facility	Emergency Department and Services, Inpatient/ Hospital