National Voluntary Consensus Standards for Patient Outcomes
Table of Measures Submitted-Phase 2
As of March 5, 2010

Measure Number	Title	Measure Description	Measure Steward - ALL RIGHTS RESERVED
OT2-002-09	Risk Adjusted Colorectal Surgery Outcome Measure © American College of Surgeons	This is a hospital based, risk adjusted, case mix adjusted morbidity and mortality composite outcome measure of adults 18+ years undergoing colorectal surgery.	© American College of Surgeons
OT2-003-09	30-day Post-hospital PNA Discharge ED measure	This measure estimates the percentage of Medicare beneficiaries age 65 years and older discharged from the hospital with the diagnosis of pneumonia (PNA) who had an Emergency Department (ED) visit within 30 days of the hospital discharge and prior to any hospital readmission.	Centers for Medicare and Medicaid Services (CMS)
OT2-004-09	30-day Post-hospital PNA Discharge Evaluation & Management Service Visit Measure	This measure estimates the percentage of Medicare beneficiaries age 65 years and older discharged from the hospital with a diagnosis of pneumonia (PNA) and receiving an evaluation and management (E&M) service within 30 days of hospital discharge and prior to a hospital readmission or ED visit.	Centers for Medicare and Medicaid Services (CMS)

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OT2-005-09	30-Day Post-Hospital PNA (Pneumonia) Discharge Care Transition Composite Measure	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of PNA for three types of events: readmissions, ED visits and evaluation and management (E&M) services.

These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase II project's call for measures. Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation. | Centers for Medicare and Medicaid Services (CMS) |
| OT2-006-09 | Medicare Health Outcomes Survey - Physical Component Summary Score (PCS) and Mental Summary Score (MCS) | Survey based measure that assesses a Medicare Advantage Organization's ability over time to maintain or improve the physical and mental health of its Medicare members. The HOS evaluates physical and mental health using a set of survey questions known as the Veterans RAND 12 Item Health Survey | National Committee for Quality Assurance |

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		(VR-12),4,5 a multipurpose, short-form health survey with 14 questions. The HOS instrument has used the VR-12 since 2006. The HOS is a part of the HEDIS Effectiveness of Care domain. The eight scales provide the basis for two summary measures, the PCS and the MCS, and form two distinct, higher-ordered clusters (principal components), which are the basis for scoring the PCS and MCS summary measures. A performance measurement data set is created by merging a cohort's baseline and follow up data. Additionally, death information is incorporated into the performance measurement data set for those baseline respondents who died between baseline and follow up. The HOS performance measurement results are computed using a rigorous case mix/risk adjustment model. There are six main categories of actual health outcomes used in the performance measurement analysis: 1. alive and physical health better; 2. alive and physical health the same; 3. dead or physical health worse; 4. mental health better; 5. mental health the same; and 6. mental health worse. Each beneficiary is classified into one of the three physical health categories and one of the three mental health categories. In calculating expected outcomes, separate case mix models are warranted for death and for physical	

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		component summary scores and mental component summary scores. A series of six different death models (formerly eight models), three different physical health models, and three different mental health models are used, since all beneficiaries do not have data for all of the independent variables that could be used to calculate an expected score. In other words, each expected outcome for a beneficiary is derived from the best fit model, which is based on those variables for which the beneficiary has data. One model is used for each beneficiary, and there are no predictions made with missing data. Beneficiary level results are aggregated to derive the MAO, state, and HOS national percent better, same, and worse than expected values. Outliers are those MAOs that performed significantly better (i.e., better than expected) or significantly worse (i.e., worse than expected) when compared to the national average. The national average is based on all plans that participated in performance measurement. MAOs can be outliers on a measure of physical health (which is based on death and the physical component summary score), or on a measure of mental health (which is based on the mental component summary score).	

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OT2-007-09	Care for Older Adults: Advance Care Planning, Functional Status Assessment, Pain Screening	Care for Older Adults: The percentage of adults 65 years and older who received the following during the measurement year: • Advance Care Planning • Functional Status Assessment • Pain Screening	National Committee for Quality Assurance
OT2-008-09	Bariatric surgery and complications during the hospitalization or within 180 days of discharge © Ingenix	This measure identifies patients 12 years and older with bariatric surgery who had a defined complication during hospitalization or within 180 days of discharge.	© Ingenix
OT2-009-09	Gastrointestinal Hemorrhage Mortality Rate	Number of inpatient deaths per 100 discharges with qualifying esophageal hemorrhage (see denominator definition).	Agency for Healthcare Research and Quality
OT2-010-09	Imaging Timeliness of Care - Time Between Diagnostic Mammogram and Needle/Core Biopsy © National Consortium of Breast Centers	The time in business days required between the day of the diagnostic mammogram which identifies a suspicious lesion and the day of the needle/core biopsy of that lesion. Target population are those women who require needle/core biopsy of the breast. Almost all of those women will have had a diagnostic mammogram which was used to define the suspicious lesion. Timeliness (and quality) of care for those women can be identified by the number of days required between the suspcious diagnostic mammogram and the biopsy. This time period has been shown to be especially stressful for all patients, both those who are diagnosed with cancer as well as those who are found to be cancer-free.	© National Consortium of Breast Centers

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OT2-011-09	Surgical Timeliness of Care – Time Between Needle Biopsy and Initial Breast Cancer Surgery © National Consortium of Breast Centers	The time in business days required between the day of the needle biopsy which identifies the presence of a breast cancer and the day of the initial cancer surgery of that lesion. Target population is those women who have had a needle/core biopsy of the breast which shows breast cancer. Timeliness (and quality) of care for those women can be identified by the number of days required between the biopsy and the initial cancer surgery. This time period has been shown to be especially stressful for all patients. The length of time identifies the effectiveness of the interdisciplinary care of the breast cancer patient.	© National Consortium of Breast Centers
OT2-012-09	Bariatric surgery and complications during the hospitalization or within 30 days of discharge © Ingenix	This measure identifies patients 12 years and older with bariatric surgery who had a defined complication during hospitalization or within 30 days of discharge.	© Ingenix
OT2-013-09	Proportion of Pneumonia Patients that have a Potentially Avoidable Complication (during the Index Stay or in the 30-Day Post-Discharge Period) © Bridges to Excellence	Percent of adult population aged 18-65 years who were admitted to a hospital with pneumonia, were followed for one-month after discharge, and had one or more potentially avoidable complications (PACs). PACs may occur during the index stay or during the 30-day post discharge period.	© Bridges to Excellence
OT2-014-09	Opioid-Related Symptom Distress Scale © Pfizer	No description provided.	© Pfizer

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OT2-015-09	Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F) © FACIT.org	The Functional Assessment of Chronic Illness Therapy-Fatigue Scale (FACIT-F Scale) is a 13-item questionnaire that assesses self-reported fatigue and its impact upon daily activities and function. It was developed in 1994-1995 to meet a growing demand for the precise evaluation of fatigue associated with anemia in cancer patients. Subsequent to its development, it has been employed in over 70 published studies including over 20,000 people. Since 1995, studied groups have included cancer patients receiving chemotherapy, cancer patients not receiving chemotherapy, long term cancer survivors, childhood cancer survivors and several other clinical samples including people with rheumatoid arthritis, multiple sclerosis, psoriasis, paroxysmal nocturnal hemoglobinuria, and Parkinson's disease, as well as the general United States population. In all cases, the FACIT-F Scale has been found to be reliable and valid. It has been validated for use in adults with chronic health conditions. There is also a validated modified version suitable with pediatric populations. It has been translated into over 60 non-English languages.	© FACIT.org
OT2-016-09	Functional Assessment of Cancer Therapy-Lung (FACT-L) © FACIT.org	The Functional Assessment of Cancer Therapy-Lung (FACT-L) Scale is a 36-item self-report instrument which measures multidimensional quality of life. It was developed from 1987-1993 and was first published in 1995. The FACT-L meets a growing need for disease-specific health-	© FACIT.org

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		related quality of life (HRQOL) questionnaires that address the general and unique concerns of patients diagnosed with lung cancer. Subsequent to its development, it has been employed in over 20 papers from 15 unique data sets including over 2,500 people with lung cancer. Since 1995, studied groups have included cancer patients receiving chemotherapy, cancer patients receiving radiotherapy, terminally-ill patients and disease-free survivors. In all cases, the FACT-L scale has been found to be reliable and valid. It has been validated with adult lung cancer patients and disease-free survivors.	
OT2-017-09	Functional Assessment of Breast Therapy-Breast (FACT-B) © FACIT.org	Adult breast cancer patients	© FACIT.org
OT2-018-09	Functional Assessment of Cancer Therapy-Colorectal (FACT-C) © FACIT.org	Adult colorectal cancer patients	© FACIT.org
OT2-019-09	Functional Assessment of Cancer Therapy-General Version (FACT-G) © FACIT.org	Adult cancer patients	© FACIT.org

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OT2-020-09	Functional Assessment of Cancer Therapy-Prostate (FACT-P) © FACIT.org	Adult prostate cancer patients	© FACIT.org
OT2-021-09	Functional Assessment of Cancer Therapy-Endometrial (FACT-En) © FACIT.org	Adult endometrial cancer patients	© FACIT.org
OT2-022-09	Proportion of Patients with a Chronic Condition that have a Potentially Avoidable Complication during the Calendar Year © Bridges to Excellence	Percent of adult population aged 18-65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs).	© Bridges to Excellence