



NATIONAL QUALITY FORUM

**National Voluntary
Consensus Standards
for Ambulatory Care:
Specialty Clinician
Performance
Measures**

A
CONSENSUS
REPORT

NATIONAL QUALITY FORUM

Foreword

The growing use of standardized performance measures to gauge the quality of healthcare has contributed mightily to the healthcare quality improvement movement in the United States. The National Quality Forum (NQF) has endorsed consensus standards in a variety of settings, including hospitals, home health, nursing homes, and ambulatory practices, but to date, only limited attention has been focused on quality measurement at the clinician level.

This report seeks to fill this gap by identifying 20 national voluntary consensus standards for specialty clinician care provided in ambulatory settings. The NQF-endorsed™ consensus standards for specialty clinician care will facilitate efforts to improve the quality of care delivered in the ambulatory setting in four areas: bone and joint conditions, eye care, geriatrics, and emergency care.

This project represents a significant contribution to existing nationally standardized performance measures to assess the quality of care provided by clinicians in ambulatory settings.

We thank NQF Members and the members of the Specialty Clinician Performance Measures Steering Committee and Technical Advisory Panels for their thoughtful work and commitment to this project, and the Centers for Medicare & Medicaid Services for its support. Through their collaborative efforts, we look forward to witnessing continued healthcare quality improvement.



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National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

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National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

Executive Summary

The attention to public reporting of healthcare quality information initially focused on acute care hospitals, but most Americans receive care in the ambulatory setting. Thus, in the past few years there has been increased interest in information about the quality of physician performance. To meet that need, the National Quality Forum (NQF) has endorsed more than 100 clinician-level ambulatory care performance measures and 7 patient experience with care measures that are specific to ambulatory care.

Yet not all aspects of care in the ambulatory setting have benefited equally from measure development and use. Specifically, measurement of the performance of specialty care providers has been neglected. To counterbalance this, NQF has undertaken to endorse consensus standards for specialty clinicians (including physicians and other licensed independent practitioners) in both the hospital and outpatient settings.

This report details 20 NQF-endorsed™ national voluntary consensus standards for specialty clinician care in the ambulatory setting. The NQF-endorsed consensus standards for specialty clinician care will facilitate efforts to improve the quality of care delivered in four areas: bone and joint conditions (osteoporosis), eye care, geriatrics, and emergency care. These measures are intended for clinician-level accountability, including public reporting.

Implementation of these consensus standards and public reporting of the results will enhance the roadmap that consumers can use to select high-quality healthcare providers and will drive the improvement

of care across the United States. It will also enhance performance-based quality improvement initiatives and provide a means to catalyze value-based purchasing.

National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures*

PRIORITY AREA	MEASURE
Bone and Joint Conditions (Osteoporosis)	<ul style="list-style-type: none"> ■ Osteoporosis: communication with the physician managing ongoing care postfracture ■ Osteoporosis: screening or therapy for women aged 65 years and older ■ Osteoporosis: management following fracture ■ Osteoporosis: pharmacologic therapy
Eye Care	<ul style="list-style-type: none"> ■ Primary open angle glaucoma (POAG): optic nerve evaluation ■ Age-related macular degeneration: dilated macular examination ■ Diabetic retinopathy: documentation of presence or absence of macular edema and level of severity of retinopathy ■ Diabetic retinopathy: communication with the physician managing ongoing diabetes care
Geriatrics	<ul style="list-style-type: none"> ■ Medication reconciliation ■ Urinary incontinence: assessment of presence or absence of urinary incontinence in women aged 65 years and older ■ Urinary incontinence: characterization of urinary incontinence in women aged 65 years and older ■ Urinary incontinence: plan of care for urinary incontinence in women aged 65 years and older ■ Screening for future fall risk ■ Advance care plan
Emergency Care	<ul style="list-style-type: none"> ■ Electrocardiogram (ECG) performed for non-traumatic chest pain ■ Aspirin at arrival for acute myocardial infarction (AMI) ■ ECG performed for syncope ■ Assessment of oxygen saturation for community-acquired bacterial pneumonia ■ Assessment of mental status for community-acquired bacterial pneumonia ■ Empiric antibiotic for community-acquired bacterial pneumonia

* See appendix A for specifications, risk adjustment (if applicable), additional background, and reference material.

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National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

Introduction

As public reporting of hospital, nursing home, and home health quality has been implemented nationally,¹ many stakeholders have shown great interest in having information about the quality of physician performance, a trend that has prompted greater attention in the area of clinician-level measurement. Toward that end, in 2006 and 2007 the National Quality Forum (NQF) endorsed more than 100 clinician-level ambulatory care performance measures in 10 areas: asthma/respiratory illness; bone and joint conditions; diabetes; heart disease; hypertension; medication management; mental health and substance use disorders; obesity; prenatal care; and prevention, immunization, and screening.²

Ambulatory (outpatient) care has been an especially active area of performance measurement, even though not all aspects of care in that setting have benefited equally from measure development and use—specifically the performance of specialty care providers. Various stakeholders also have recognized a need to fill in the gaps of hospital-based measure sets, particularly in the area of specialty clinician (physician and other licensed independent practitioners) hospital care. NQF has endorsed 26 measures for hospital care in this report's companion report, *National Voluntary Consensus Standards for Hospital Care: Specialty Clinician Performance Measures*.

¹See www.medicare.gov.

²National Quality Forum (NQF), *National Voluntary Consensus Standards for Ambulatory Care: A Consensus Report*, Washington, DC: NQF; in press.

At the request of the Centers for Medicare & Medicaid Services (CMS), NQF has considered clinician-level (including physicians and other licensed independent practitioners) measures applicable to patients cared for by specialists in outpatient and hospital settings. This report identifies 20 consensus standards for clinician-level specialty care in the ambulatory setting, which is where patients in the United States receive most of their healthcare, with more than a billion visits to physician offices and hospital outpatient and emergency departments each year.³

National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

This report presents an initial set of 20 national voluntary consensus standards for specialty clinician care in the ambulatory setting, encompassing evidence-based performance measures in the following 4 areas⁴:

- bone and joint conditions (osteoporosis);
- eye care;
- geriatrics; and
- emergency care.⁵

Relationship to Other NQF-Endorsed Consensus Standards

This report does not represent the entire scope of NQF work relevant to the quality of outpatient or hospital care. NQF has completed or is currently working on separate projects relevant to various healthcare settings, patient safety issues, and patient conditions.

*A National Framework for Healthcare Quality Measurement and Reporting*⁶ provides a standardized framework for identifying

³National Center for Health Statistics, *Health, United States, 2004 with Chartbook on Trends in the Health of Americans*, Hyattsville, Maryland; 2004.

⁴One measure in the area of geriatrics, Advance Care Plan, originally was considered as part of this project, and while it was not recommended at that time (see commentary), a revised measure was subsequently recommended during a project to achieve consensus on ambulatory care measures that was funded by the Robert Wood Johnson Foundation.

⁵Consensus standards in the areas of skin conditions and gastrointestinal conditions were considered, but no measures in those areas were endorsed.

⁶NQF, *A National Framework for Healthcare Quality Measurement and Reporting: A Consensus Report*, Washington, DC: NQF; 2002.

voluntary healthcare quality consensus standards and articulates guiding principles and priorities for healthcare quality improvement. *National Priorities for Healthcare Quality Measurement and Reporting* identifies priorities applicable to ambulatory care, including reducing disparities; care coordination and communication; patient safety (including medication management); and healthcare conditions (asthma, depression, ischemic heart disease, hypertension, obesity, tobacco dependence, and pregnancy, childbirth, and newborn care).

Serious Reportable Events in Healthcare: 2006 Update identifies 28 serious adverse events (e.g., surgery performed on the wrong patient, infant discharged to the wrong person) that NQF believes should be reported by all healthcare facilities.⁷ Similarly, *Safe Practices for Better Healthcare: 2006 Update* describes 30 healthcare safe practices⁸ that should be used universally to reduce the risk of harm resulting from processes, systems, or environments of care.

Hospital-focused performance measures are included in several NQF reports. *National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measure Set*⁹ endorsed an initial set of 39 measures in 8 priority areas that were chosen from existing measures as reasonable indicators of hospital quality that are useful to consumers, purchasers, hospitals, and quality

improvement organizations alike. *National Voluntary Consensus Standards for Cardiac Surgery*¹⁰ endorsed 21 performance measures for cardiac surgery that can be used for external accountability, public disclosure, internal reporting, and quality improvement. *National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism*¹¹ has resulted in the endorsement of a policy statement, key characteristics of preferred practices, and two performance measures.

The full constellation of measures, along with those endorsed in this report, provide a growing number of NQF-endorsed™ voluntary consensus standards that directly and indirectly reflect the importance of measuring and improving the quality of care. Organizations that adopt these consensus standards will promote the development of safer and higher-quality care for patients throughout the nation.

Identifying the Set

The NQF Ambulatory Care Steering Committee (appendix C) established the initial approach to evaluating potential consensus standards. The approach included establishing a scope, identifying selection criteria, and screening candidate consensus standards through the application of NQF-endorsed, standardized

⁷ NQF, *Serious Reportable Events in Healthcare: 2006 Update – A Consensus Report*, Washington, DC: NQF; 2007.

⁸ NQF, *Safe Practices for Better Healthcare: 2006 Update – A Consensus Report*, Washington, DC: NQF; 2007.

⁹ NQF, *National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measure Set – A Consensus Report*, Washington, DC: NQF; 2003.

¹⁰ NQF, *National Voluntary Consensus Standards for Cardiac Surgery – A Consensus Report*, Washington, DC: NQF; 2004.

¹¹ NQF, *National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism: Policy, Preferred Practices, and Initial Performance Measures – A Consensus Report*, Washington, DC: NQF; 2006.

measure evaluation criteria. Additionally, the Steering Committee identified a purpose statement for the ambulatory care setting.

Purpose

The purpose of this set of ambulatory care consensus standards is to improve the quality of ambulatory care—through accountability and public reporting—by standardizing quality measurement that describes specialist-level performance in ambulatory care settings, including physician offices, clinics, emergency rooms, and health centers.

Scope

The NQF-endorsed national voluntary consensus standards for specialty clinician care encompass those that:

- are suitable for clinician-level accountability;
- include the performance of a multi-disciplinary team of healthcare providers for which the clinician is ultimately accountable;
- are derived from all data sources;
- are fully developed and precisely specified; and
- are fully open source.¹²

Selection Criteria

The primary focus of ambulatory care quality and performance in this report is at the clinician level. Accordingly, the proposed

consensus standards in this set do not include measures that are exclusively plan-level, community-level, or population-based. The proposed consensus standards are intended for use at the clinical level, although this does not preclude roll-up analysis at the small and large group levels of analysis. Implementing organizations should determine the rules of attribution, sample size requirements, and statistical significance based on the characteristics and goals of the measurement program.

The following principles guided the selection of consensus standards:

- The focus of the measures is primarily accountability, as a driver of quality improvement.
- The focus should be on the unit of analysis, for example, the clinician practice-level, rather than the data source.
- Measures should be feasible, and scientifically accurate, and should reflect an aspect of care substantially influenced by the clinician practice.

Additionally, the following important measure characteristics also were considered in the selection of potential consensus standards:

- address vulnerable populations;
- address all relevant populations;
- consider possible perverse incentives or unintended consequences;
- have clear and complete specifications;

¹²On January 29, 2003, the NQF Board of Directors adopted a policy that NQF will endorse only fully open source measures. Open source is defined by NQF as being “fully disclosed” (i.e., data elements, measure algorithm, if applicable, and risk adjustment methods/data elements/algorithms are fully described and disclosed; if calculation requires database-dependent coefficients that change frequently, the existence of such coefficients shall be disclosed and the general frequency with which they change, shall be disclosed, but the precise numerical value need not be disclosed).

- have been pilot tested or are already in use; and
- address high variation, including over/underuse.

Identification of Candidate Consensus Standards

Measures were evaluated based on the criteria derived from the work of the NQF Strategic Framework Board and endorsed by NQF (box A).^{13,14,15,16} These criteria were applied to candidate consensus standards identified through several complementary strategies.

Box A – Criteria for Evaluation and Selection

Proposed consensus standards were evaluated for their suitability based on four sets of standardized criteria (e.g., importance, scientific acceptability, usability, and feasibility). Not all acceptable measures will be strong—or equally strong—among each of the four sets of criteria, or strong among each of their related criteria. Rather, a candidate consensus standard is assessed regarding the extent to which it meets any of the desired criteria within each set:

1. **Importance.** This set addresses the extent to which a measure reflects a variation in quality or low levels of overall performance and the extent to which it captures key aspects of the flow of care.
 - a. The measure addresses one or more key leverage points for improving quality.
 - b. Considerable variation in the quality of care exists.
 - c. Performance in the area (e.g., setting, procedure, condition) is suboptimal, suggesting that barriers to improvement or best practice may exist.
2. **Scientific acceptability.** A measure is scientifically sound if it produces consistent and credible results when implemented.
 - a. The measure is well defined and precisely specified. Measures must be specified sufficiently to be distinguishable from other measures, and they must be implemented consistently across institutions. Measure specifications should provide detail about cohort definition, as well as the denominator and numerator for rate-based measures and categories for range-based measures.
 - b. The measure is reliable, producing the same results a high proportion of the time when assessed in the same population.
 - c. The measure is valid, accurately representing the concept being evaluated.
 - d. The measure is precise, adequately discriminating between real differences in provider performance.

continued

¹³The Strategic Framework Board's design for a national quality measurement and reporting system, *Med Care*, 2003;41(1)suppl:I-1–I-89.

¹⁴NQF, *A National Framework for Healthcare Quality Measurement and Reporting: A Consensus Report*, Washington, DC: NQF; 2002.

¹⁵NQF, *A Comprehensive Framework for Hospital Care Performance Evaluation: A Consensus Report*, Washington, DC: NQF; 2003.

¹⁶NQF, *National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set – A Consensus Report*. Washington, DC: NQF; 2004.

Box A – Criteria for Evaluation and Selection (continued)

- e. The measure is adaptable to patient preferences and a variety of contexts of settings. Adaptability depends on the extent to which the measure and its specifications account for the variety of patient choices, including refusal of treatment and clinical exceptions.
 - f. An adequate and specified risk-adjustment strategy exists, where applicable.
 - g. Patient outcomes or consistent evidence is available linking the structure and process measures to patient outcomes.
3. **Usability.** Usability reflects the extent to which intended audiences (e.g., consumers, purchasers) can understand the results of the measure and are likely to find them useful for decisionmaking.
- a. The measure can be used by the stakeholder to make decisions.
 - b. The differences in performance levels are statistically meaningful.
 - c. The differences in performance are practically and clinically meaningful.
 - d. Risk stratification, risk-adjustment, and other forms of recommended analyses can be applied appropriately.
 - e. Effective presentation and dissemination strategies exist (e.g., transparency, ability to draw conclusions, information available when needed to make decisions).
- f. Information produced by the measure can/will be used by at least one healthcare stakeholder audience (e.g., public/consumers, purchasers, clinicians and providers, policymakers, accreditors/regulators) to make a decision or take an action.
 - g. Information about specific conditions for which the measure is appropriate has been given.
 - h. Methods for aggregating the measure with other, related measures (e.g., to create a composite measure) are defined, if those related measures are determined to be more understandable and more useful in decision-making. Risks of such aggregation, including misrepresentation, have been evaluated.
4. **Feasibility.** Feasibility is generally based on the way in which data can be obtained within the normal flow of clinical care and the extent to which an implementation plan can be achieved.
- a. The point of data collection is tied to care delivery, when feasible.
 - b. The timing and frequency of measure collection are specified.
 - c. The benefit of measurement is evaluated against the financial and administrative burden of implementation and maintenance of the measure set.
 - d. An auditing strategy is designed and can be implemented.
 - e. Confidentiality concerns are addressed.

The NQF-Endorsed National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

The NQF-endorsed consensus standards for specialty clinician care encompass 20 measures that will facilitate efforts to improve the quality of care delivered in the ambulatory setting in 4 areas: bone and joint conditions (osteoporosis); eye care; geriatrics; and emergency care. These measures are intended for clinician-level accountability, including public reporting. Table 1 presents brief descriptions of each recommended measure. Because consensus standards must be consistently specified to meet the goal of standardization, detailed specifications are provided in appendix A.

Research Recommendations

In addition to the NQF-endorsed consensus standards, many recommendations for further research and development of measures in general, as well as in the specialty areas, were identified to accompany the set of consensus standards.

General Recommendations

Several areas of great interest among stakeholders were identified. These areas were not specific to any particular condition but rather were cross-cutting for these ambulatory care measures. In the future, measure developers should:

- Develop additional measures for clinicians who perform procedures in many specialties.
- Develop specialty-specific consensus-based measures relevant to the needs of children and adolescents and their families.
- Evaluate validity, reliability, and other metrics relating to performance of the measures themselves.
- Evaluate what, if any, relationship exists between the documentation of practices and their delivery, and ideally, the correlation with changes in patient outcomes.

- Evaluate whether development of measures of clinician performance across a large number of characteristics ensures more accurate and meaningful indicators of performance.
- Prioritize future development of measures to reflect impact of the condition on quality of life years (QALYs), and low-cost/high-QALY return.
- Evaluate the burden of measurement if the provider reports on all services that should be provided to a target population.
- Pilot test all measures at different levels of analysis.
- Compare results using electronic health record systems for the population “sample” with traditional sampling methods for non-electronic records.
- Compare existing measures derived from the Medicare Health Outcomes Survey and other sources with new CPT-II coded measures.

Eye Care

The following additional areas for research and development should be pursued. Measure developers need to:

- Develop standardized severity classifications for age-related macular degeneration using Age-Related Eye Disease Study classifications as a model.
- Encourage future development of measures that would benefit children—particularly a pediatric vision screening measure for assessing compliance with recommended pediatric vision screening protocols in the primary care environment.

Gastrointestinal Conditions

The following areas should be pursued for further measure development for GI conditions. Such measures should:

- Ensure that colonoscopy performance measures encompass all procedures whether they involve screening or surveillance.
- Explore public reporting of procedural volume and complications rates at the physician-level for endoscopy and other procedures.

- Include a colonoscopy measure that assesses duration of the withdrawal period.

Geriatrics

The following areas should be investigated for potential research and future measure development. Measure developers should:

- Collect additional data on effective caregiver education techniques for individuals caring for someone with dementia.
- Examine the comprehensiveness of other measurement topic areas included in ambulatory care, including vision, hearing, and immunization measures.
- Conduct further research on the logistics of reconciling ambulatory medications with discharge medications in electronic health records systems.
- Explore the implications of “systems-level” improvements and creating incentives – for example, a communication system for coordinating hospital discharge with community physicians.
- Explore measures related to Alzheimer’s disease as well as multiple comorbid conditions.

Skin Conditions

Measure development for assessing the delivery of care for dermatological conditions is urgently needed; such measures should include:

- those involving coordination and continuity of care, and
- those addressing other dermatologic areas besides melanoma.

Acknowledgment

This project was conducted under a grant from CMS (grant # HHSM-500-2006-000271).

Table 1 – National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

MEASURE NAME	MEASURE DESCRIPTION	IP OWNER ⁱ
Bone and Joint Conditions (Osteoporosis)		
Osteoporosis: communication with the physician managing ongoing care postfracture	Percentage of patients aged 50 years and older treated for a hip, spine, or distal radial fracture with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis	AAFP AAOS AACE ACRheum AMA PCPI* NCQA*
Osteoporosis: screening or therapy for women aged 65 years and older	Percentage of female patients aged 65 years and older who have a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months	AAFP AAOS AACE ACRheum AMA PCPI* NCQA*

(more)

ⁱ Intellectual Property (IP) owner. For the most current specifications and supporting information, please refer to the IP owner.

IP OWNERS

AAACE - American Association of Clinical Endocrinologists (www.aace.com)

AAFP - American Academy of Family Physicians (www.aafp.org)

AAO - American Academy of Ophthalmology (www.aao.org)

AAOS - American Academy of Orthopaedic Surgeons (www.aaos.org)

ACEP - American College of Emergency Physicians (www.acep.org)

ACRheum - American College of Rheumatology (www.rheumatology.org)

AGA - American Gastroenterological Association Institute (www.gastro.org)

AGS - American Geriatrics Society (www.americangeriatrics.org)

AMA PCPI - American Medical Association Physician Consortium for Performance Improvement (www.physicianconsortium.org)

CMS-PQRI - Centers for Medicare & Medicaid Services Physician Quality Reporting Initiative (www.cms.hhs.gov/PQRI/)

NCQA - National Committee for Quality Assurance (www.ncqa.org)

* Physician Performance Measures (Measures) and related data specifications, developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (the Consortium) and the National Committee for Quality Assurance (NCQA) pursuant to government sponsorship under subcontract 6205-05-054 with Mathematica Policy Research, Inc. under contract 500-00-0033 with Centers for Medicare & Medicaid Services.

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**Table 1 – National Voluntary Consensus Standards for Ambulatory Care:
Specialty Clinician Performance Measures**

MEASURE NAME	MEASURE DESCRIPTION	IP OWNER ¹
Bone and Joint Conditions (Osteoporosis) (continued)		
Osteoporosis: management following fracture	Percentage of patients aged 50 years or older with fracture of the hip, spine, or distal radius that had a central DXA measurement ordered or performed or pharmacologic therapy prescribed	AAFP AAOS AAACE ACRheum AMA PCPI* NCQA*
Osteoporosis: pharmacologic therapy	Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months	AAFP AAOS AAACE ACRheum AMA PCPI* NCQA*
Eye Care		
Primary open angle glaucoma (POAG): optic nerve evaluation	Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months	AAO AMA PCPI* NCQA*
Age-related macular degeneration: dilated macular examination	Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration that had a dilated macular examination performed, which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months	AAO AMA PCPI* NCQA*
Diabetic retinopathy: documentation of presence or absence of macular edema and level of severity of retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed, which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months	AAO AMA PCPI* NCQA*
Diabetic retinopathy: communication with the physician managing ongoing diabetes care	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes regarding the findings of the macular or fundus exam at least once within 12 months	AAO AMA PCPI* NCQA*
Geriatrics		
Medication reconciliation	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing ongoing care who had a reconciliation of the discharge medications with the current medication list in the medical record documented	AGS AMA PCPI* NCQA*
Urinary incontinence: assessment of presence or absence of urinary incontinence in women aged 65 years and older	Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months	AGS AMA PCPI* NCQA*
Urinary incontinence: characterization of urinary incontinence in women aged 65 years and older	Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months	AGS AMA PCPI* NCQA*

(more)

**Table 1 – National Voluntary Consensus Standards for Ambulatory Care:
Specialty Clinician Performance Measures**

MEASURE NAME	MEASURE DESCRIPTION	IP OWNER ⁱ
Geriatrics (continued)		
Urinary incontinence: plan of care for urinary incontinence in women aged 65 years and older	Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months	AGS AMA PCPI* NCQA*
Screening for future fall risk	Percentage of patients aged 65 years and older who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months	AGS AMA PCPI* NCQA*
Advance care plan	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decisionmaker 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 decisionmaker or provide an advance care plan	AGS AMA PCPI* NCQA*
Emergency Care		
Electrocardiogram (ECG) performed for non-traumatic chest pain	Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had an ECG performed	ACEP AMA PCPI* NCQA*
Aspirin at arrival for acute myocardial infarction (AMI)	Percentage of patients with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay	ACEP AMA PCPI* NCQA*
ECG performed for syncope	Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had an ECG performed	ACEP AMA PCPI* NCQA*
Assessment of oxygen saturation for community-acquired bacterial pneumonia	Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed	ACEP AMA PCPI* NCQA*
Assessment of mental status for community-acquired bacterial pneumonia	Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with mental status assessed	ACEP AMA PCPI* NCQA*
Empiric antibiotic for community-acquired bacterial pneumonia	Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed	ACEP AMA PCPI* NCQA*

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Appendix A

Specifications of the NQF-Endorsed National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

The following table summarizes the detailed specifications for each of the National Quality Forum (NQF)-endorsed™ national voluntary standards for ambulatory care, part 1. All information presented has been derived directly from measure sources/developers without modification or alteration (except when the measure developer agreed to such modification during the NQF Consensus Development Process) and is current as of November 2007.

All NQF-endorsed voluntary consensus standards are open source, meaning they are fully accessible and disclosed.

Issues regarding any NQF-endorsed consensus standards (e.g., modifications to specifications, emerging evidence) may be submitted to NQF for review and consideration via the “Implementation Feedback Form” found at www.qualityforum.org/implementation_feedback.htm. NQF will transmit this information to the measure developers and/or compile it for consideration in updating the measure set.

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

BONE AND JOINT CONDITIONS (OSTEOPOROSIS)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING CARE POSTFRACTURE	AAFP AAOS AAACE ACRheum AMA PCPI* NCQA*	<p>Patients with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as "administrative data"). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.</p>	<p>All patients aged 50 years and older treated for hip, spine, or distal radial fracture.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as "administrative data"). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator An ICD-9 Diagnosis Code and either a CPT E&M Service Code or a CPT Procedure Code, and patient demographics (age, etc.) are used to determine patients that are included in the measure. ICD-9 Diagnosis Codes: 733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05,</p>	<p>Denominator Documentation of medical reason(s) for not communicating with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.</p> <p>Documentation of patient reason(s) for not communicating with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.</p> <p>Exclude patients for whom postfracture communication was not documented by reason of appropriate denominator exclusion.</p>	<p>Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires</p> <p>(more)</p>

¹ Intellectual Property (IP) owner. For the most current specifications and supporting information please refer to the IP owner.

IP Owners

AAACE - American Association of Clinical Endocrinologists (www.aaace.com)
 AAFP - American Academy of Family Physicians (www.aafp.org)
 AAO - American Academy of Ophthalmology (www.ao.org)
 AAOS - American Academy of Orthopaedic Surgeons (www.aaos.org)
 ACEP - American College of Emergency Physicians (www.acep.org)
 ACRheum - American College of Rheumatology (www.rheumatology.org)
 AGA - American Gastroenterological Association Institute (www.gastro.org)
 AGS - American Geriatrics Society (www.americangeriatrics.org)
 AMA/PCPI - American Medical Association Physician Consortium for Performance Improvement (www.physicianconsortium.org)
 CMS-PQRI - Centers for Medicare & Medicaid Services- Physician Quality Reporting Initiative (www.cms.hhs.gov/pqri/)

*Physician Performance Measures (Measures) and related data specifications, developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (the Consortium) and the National Committee for Quality Assurance (NCQA) pursuant to government sponsorship under subcontract 6205-05-054 with Mathematica Policy Research, Inc. under contract 500-00-0033 with Centers for Medicare & Medicaid Services. These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the Consortium) or NCQA. Neither the AMA, NCQA, Consortium nor its members shall be responsible for any use of the Measures.

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Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

BONE AND JOINT CONDITIONS (OSTEOPOROSIS) (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING CARE POSTFRACTURE <i>continued</i>		<p>Definition: Communication may include: Documentation in the medical record indicating that the physician treating the fracture communicated (e.g., verbally, by letter, DXA report was sent) with the physician managing the patient's ongoing care</p> <p><i>OR</i></p> <p>A copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.</p> <p>Instructions: The communication to the physician managing the ongoing care of the patient should occur within three months of treatment for the fracture.</p> <p>CPT Category II Codes are used to report the numerator of the measure.</p> <p>If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service or Procedure Codes, and the appropriate CPT Category II Code.</p> <p>Identify patients with documentation of postfracture communication:</p> <p>CPT II 5015F: Documentation of communication with physician managing the ongoing care of the patient that a fracture occurred and that patient was or should be tested or treated for osteoporosis.</p> <p>Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p>	<p>805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.13, 820.20, 820.21, 820.22, 820.8, 820.9</p> <p><i>AND</i></p> <p>CPT E&M Service Codes: 99024, 99201-99705, 99212-99215, 99241-99245, 99354-99355</p> <p><i>OR</i></p> <p>CPT Procedure Codes: 22305-22327, 22520, 22521, 22523, 22524, 25600-25609, 27230-27248.</p> <p>Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 50 years and older treated for hip, spine, or distal radial fracture.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p>	<p>If using electronic data, exclude patients using the following codes: Append a modifier (1P or 2P) to the CPT Category II Code to report patients with documented circumstances that meet the denominator exclusion criteria.</p> <ul style="list-style-type: none"> ■ 1P: Documentation of medical reason(s) for not communicating with the physician managing the ongoing care of the patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis. ■ 2P: Documentation of patient reason(s) for not communicating with the physician managing the ongoing care of the patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis. <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p> <ul style="list-style-type: none"> ■ Medical reason(s) for not communicating with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis. ■ Patient reason(s) for not communicating with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis. 	<p>manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.</p> <p>As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p> <p>(more)</p>

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

BONE AND JOINT CONDITIONS (OSTEOPOROSIS) (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING CARE POSTFRACTURE <i>continued</i>		<p>Numerator Documentation in medical record of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients with documentation of postfracture communication.</p>	<p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients aged 50 years and older treated for hip, spine, or distal radial fracture. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 50 years and older treated for hip, spine, or distal radial fracture.</p>	<p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>(more)</p>

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

BONE AND JOINT CONDITIONS (OSTEOPOROSIS) (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: SCREENING OR THERAPY FOR WOMEN AGED 65 YEARS AND OLDER	AAFP AAOS AAACE ACRheum AMA PCPI* NCOA*	<p>Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months.</p> <p>Definitions Pharmacologic Therapy: U.S. Food and Drug Administration–approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone (PTH (1–34), teriparatide), and selective estrogen receptor modulators or SERMs (raloxifene).</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months. CPT Category II codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the listed E&M Service Codes and the appropriate CPT Category II Code.</p>	<p>All female patients aged 65 years and older.</p> <p>Electronic Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All female patients aged 65 years and older. CPT E&M Service Codes and patient demographics (age, gender, etc.) are used to determine patients that are included in the measure. CPT E&M Service Codes: 99201–99205, 99212–99215, 99241–99245, 99354–99355, 99387, 99397, 99401–99404.</p> <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All female patients aged 65 years and older Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p>	<p>Denominator Documentation of medical reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy. Documentation of patient reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy. Documentation of system reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy. Exclude patients for whom central DXA measurement was not ordered or performed and pharmacologic therapy was not prescribed by reason of appropriate denominator exclusion. If using electronic data, exclude patients using the following codes: Append a modifier (1P, 2P, or 3P) to one of the listed CPT Category II Codes to report patients with documented circumstances that meet the denominator exclusion criteria. ■ 1P: Documentation of medical reason(s) for not ordering or performing a central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy (other than minerals/vitamins) for osteoporosis</p>	<p>Data sources used will depend on implementation and approach. The electronic data use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination</p>

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Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

BONE AND JOINT CONDITIONS (OSTEOPOROSIS) (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: SCREENING OR THERAPY FOR WOMEN AGED 65 YEARS AND OLDER <i>continued</i>		<p>Identify patients with central DXA measurement ordered or performed or pharmacologic therapy prescribed</p> <ul style="list-style-type: none"> ■ CPT Codes: 76075-76077 <p>OR</p> <ul style="list-style-type: none"> ■ NDC Codes for prescription of pharmacologic therapy (listed above) <p>OR</p> <ul style="list-style-type: none"> ■ CPT II 3095F: Central Dual-energy X-Ray Absorptiometry (DXA) results documented <p>OR</p> <ul style="list-style-type: none"> ■ CPT II 3096F: Central Dual-energy X-Ray Absorptiometry (DXA) ordered <p>OR</p> <ul style="list-style-type: none"> ■ CPT II 4005F: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months.</p> <p>Documentation in medical record that patient had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months.</p>	<p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All female patients aged 65 years and older. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all female patients aged 65 years and older.</p>	<ul style="list-style-type: none"> ■ 2P: Documentation of patient reason(s) for not ordering or performing central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy (other than minerals/vitamins) for osteoporosis ■ 3P: Documentation of system reason(s) for not ordering or performing central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy (other than minerals/vitamins) for osteoporosis. <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p> <ul style="list-style-type: none"> ■ Medical reason(s) for not ordering or performing a central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy ■ Patient reason(s) for not ordering or performing central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy ■ System reason(s) for not ordering or performing central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy. <p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

BONE AND JOINT CONDITIONS (OSTEOPOROSIS) (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: SCREENING OR THERAPY FOR WOMEN AGED 65 YEARS AND OLDER <i>continued</i>		<p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months.</p> <p>EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients with central DXA measurement ordered or performed or pharmacologic therapy prescribed.</p>			(more)

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

BONE AND JOINT CONDITIONS (OSTEOPOROSIS) (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: MANAGEMENT FOLLOWING FRACTURE	AAFP AAOS AAACE ACRheum AMA PCPI* NCQA*	<p>Patients who had a central DXA measurement ordered or performed or pharmacologic therapy prescribed.</p> <p>Definitions Pharmacologic Therapy: U.S. Food and Drug Administration–approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1–34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).</p> <p>Instructions: The management (DXA ordered or performed or pharmacologic therapy prescribed) should occur within three months of notification of the fracture from the physician treating the fracture. Please note prior DXA status or already on treatment pre-fracture would meet this measure.</p> <p>Electronic Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who had a central DXA measurement ordered or performed or pharmacologic therapy prescribed.</p>	<p>All patients aged 50 years and older with a fracture of the hip, spine, or distal radius.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 50 years and older with a fracture of the hip, spine, or distal radius. An ICD-9 Diagnosis Code, CPT E&M Service Codes or CPT Procedure Code, and patient demographics (age, etc.) are used to determine patients that are included in the measure. ICD-9 Diagnosis Codes: 733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.13, 820.20, 820.21, 820.22, 820.8, 820.9 AND CPT E&M Service Codes: 99024, 99201–99205, 99212–99215, 99241–99245, 99354–99355 OR</p>	<p>Denominator Exclusion Documentation of medical reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy. Documentation of patient reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy. Documentation of system reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy. Exclude patients for whom central DXA measurement was not ordered or performed or pharmacologic therapy was not prescribed by reason of appropriate denominator exclusion. If using electronic data, exclude patients using the following codes: Append a modifier (1P, 2P, or 3P) to one of the CPT Category II Codes to report patients with documented circumstances that meet the denominator exclusion criteria. ■ 1P: Documentation of medical reason(s) for not ordering or performing a central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy (other than minerals/vitamins) for osteoporosis</p>	<p>Data sources used will depend on implementation and approach. The electronic data use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination (more)</p>

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BONE AND JOINT CONDITIONS (OSTEOPOROSIS) (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: MANAGEMENT FOLLOWING FRACTURE <i>continued</i>		<p>CPT Category II Codes are used to report the numerator of the measure.</p> <ol style="list-style-type: none"> If reporting CPT Category II Codes, submit the listed ICD-9 Code, CPT E&M Service or Procedure Code, and the appropriate CPT Category II Code. Identify patients who had central DXA measurement ordered or performed or pharmacologic therapy prescribed. <ul style="list-style-type: none"> CPT Codes: 76075-76077 <p><i>OR</i></p> <ul style="list-style-type: none"> NDC Codes or documentation in the medical record of prescription for pharmacologic therapy (listed above) <p><i>OR</i></p> <ul style="list-style-type: none"> CPT II 3095F: Central dual X-ray absorptiometry (DXA) results documented <p><i>OR</i></p> <ul style="list-style-type: none"> CPT II 3096F: Central dual X-ray absorptiometry (DXA) ordered <p><i>OR</i></p> <ul style="list-style-type: none"> CPT II 4005F: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Documentation in medical record that central DXA measurement ordered or performed or pharmacologic therapy prescribed.</p>	<p>CPT Procedure Codes: 22305-22327, 22520, 22521, 22523, 22524, 25600-25609, 27230-27248.</p> <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 50 years and older with a fracture of the hip, spine, or distal radius.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, then supplement where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 50 years and older with a fracture of the hip, spine, or distal radius.</p>	<ul style="list-style-type: none"> 2P: Documentation of patient reason(s) for not ordering or performing a central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy (other than minerals/vitamins) for osteoporosis 3P: Documentation of system reason(s) for not ordering or performing a central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy (other than minerals/vitamins) for osteoporosis. <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p> <ul style="list-style-type: none"> Medical reason(s) for not ordering or performing a central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy Patient reason(s) for not ordering or performing central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy System reason(s) for not ordering or performing central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy. <p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>of the numerator.</p> <p>As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

BONE AND JOINT CONDITIONS (OSTEOPOROSIS) (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: MANAGEMENT FOLLOWING FRACTURE <i>continued</i>		<p>Hybrid Users should follow the requirements of electronic data collection, then supplement where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who had central DXA measurement ordered or performed or pharmacologic therapy prescribed.</p> <p>EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients who had central DXA measurement ordered or performed or pharmacologic therapy prescribed.</p>			(more)

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

BONE AND JOINT CONDITIONS (OSTEOPOROSIS) (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: PHARMACOLOGIC THERAPY	AAFP AAOS AAACE ACRheum AMA PCPI* NCQA*	<p>Patients who were prescribed pharmacologic therapy within 12 months.</p> <p>Definition Pharmacologic Therapy: U.S. Food and Drug Administration-approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who were prescribed pharmacologic therapy within 12 months. CPT Category II Codes are used to report the numerator of the measure. 1. If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Code. Identify patients documented to have pharmacologic therapy prescribed.</p>	<p>All patients aged 50 years and older with a diagnosis of osteoporosis.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 50 years and older with the diagnosis of osteoporosis. ICD-9 Diagnosis Codes, CPT E&M Service Codes, and patient demographics (age, etc.) are used to determine patients that are included in the measure. ■ CPT E&M Service Codes: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99386-99387, 99396-99397, 99401-99404 <i>AND</i> ■ ICD-9-CM Codes: 733.00, 733.01, 733.02, 733.03, 733.09.</p> <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 50 years and older with a diagnosis of osteoporosis.</p>	<p>Denominator Documentation of medical reason(s) for not prescribing pharmacologic therapy.</p> <p>Documentation of patient reason(s) for not prescribing pharmacologic therapy.</p> <p>Documentation of system reason(s) for not prescribing pharmacologic therapy.</p> <p>Exclude patients for whom pharmacologic therapy was not prescribed by reason of appropriate denominator exclusion.</p> <p>If using electronic data, exclude patients using the following codes: Append a modifier (1P, 2P, or 3P) to one of the CPT Category II Codes above to report patients with documented circumstances that meet the denominator exclusion criteria. ■ 1P: Documentation of medical reason(s) for not prescribing pharmacologic therapy (other than minerals/vitamins) for osteoporosis ■ 2P: Documentation of patient reason(s) for not prescribing pharmacologic therapy (other than minerals/vitamins) for osteoporosis ■ 3P: Documentation of system reason(s) for not prescribing pharmacologic therapy (other than minerals/vitamins) for osteoporosis.</p>	<p>Data sources used will depend on implementation and approach. The electronic data use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination (more)</p>

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

BONE AND JOINT CONDITIONS (OSTEOPOROSIS) (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
OSTEOPOROSIS: PHARMACOLOGIC THERAPY <i>continued</i>		<ul style="list-style-type: none"> ■ NDC Codes for pharmacologic therapy for osteoporosis (listed above) <p>OR</p> <ul style="list-style-type: none"> ■ CPT II 4005F: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Documentation in medical record that pharmacologic therapy was prescribed within 12 months.</p> <p>Hybrid Users should follow the requirements of electronic data collection, then supplement where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients aged 50 years and older with a diagnosis of osteoporosis.</p> <p>EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 50 years and older with a diagnosis of osteoporosis.</p> <p>Numerator Patients who had pharmacologic therapy prescribed within 12 months. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients documented to have pharmacologic therapy prescribed.</p>	<p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, then supplement where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients aged 50 years and older with a diagnosis of osteoporosis.</p> <p>EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 50 years and older with a diagnosis of osteoporosis.</p>	<p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p> <ul style="list-style-type: none"> ■ Medical reason(s) for not prescribing pharmacologic therapy for osteoporosis ■ Patient reason(s) for not ordering or performing central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy ■ System reason(s) for not ordering or performing central dual X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy. <p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EYE CARE

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
PRIMARY OPEN ANGLE GLAUCOMA: OPTIC NERVE EVALUATION	AAO AMA PCPI* NCOA*	<p>Patients who had an optic nerve head evaluation during one or more office visits within 12 months.</p> <p>Electronic Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who had an optic nerve head evaluation during one or more office visits within 12 months. CPT Category II Codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Code.</p> <p>Identify patients documented to have received optic nerve head evaluation.</p> <ul style="list-style-type: none"> ■ CPT II 2027F: Optic nerve head evaluation performed. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Documentation in medical record that an optic nerve head evaluation was performed during one or more office visits within 12 months.</p>	<p>All patients aged 18 years and older with a diagnosis of primary open angle glaucoma.</p> <p>Electronic Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 18 years and older with a diagnosis of primary open angle glaucoma. ICD-9 Diagnosis Codes, CPT E&M Codes, and patient demographics (age, etc) are used to determine patients that are included in the measure.</p> <ul style="list-style-type: none"> ■ ICD-9-CM Codes: 365.01, 365.10, 365.11, 365.12, 365.15 <p>AND</p> <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 92002, 92004, 92012, 92014, 99201-99205, 99212-99215, and 99241-99245. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 18 years and older with a diagnosis of primary open angle glaucoma.</p>	<p>Denominator Exclusion Documentation of medical reason(s) for not performing an optic nerve head evaluation.</p> <p>Exclude patients for whom evaluation of optic nerve head was not performed by reason of appropriate denominator exclusion.</p> <p>If using electronic data, exclude patients using the following codes: Append a modifier (1P) to the CPT Category II Code to report patients with documented circumstances that meet the denominator exclusion criteria.</p> <ul style="list-style-type: none"> ■ 1P: Documentation of medical reason(s) for not performing an optic nerve head evaluation. <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p> <ul style="list-style-type: none"> ■ Medical reason(s) for not performing an optic nerve head evaluation. <p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination</p> <p>(more)</p>

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EYE CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
PRIMARY OPEN ANGLE GLAUCOMA: OPTIC NERVE EVALUATION <i>continued</i>		<p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who had an optic nerve head evaluation during one or more office visits within 12 months. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients with documentation of optic nerve head evaluation during one or more office visits within 12 months.</p>	<p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 18 years and older with a diagnosis of primary open angle glaucoma.</p>		<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EYE CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
AGE-RELATED MACULAR DEGENERATION: DILATED MACULAR EXAMINATION	AAO AMA PCPI* NCOA*	<p>Patients who had a dilated macular examination performed, which included documentation of the presence or absence of macular thickening or hemorrhage and the level of macular degeneration severity during one or more office visits within 12 months.</p> <p>Electronic Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who had a dilated macular examination performed, which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months.</p> <p>CPT Category II codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the listed ICD-9 Codes, CPT E&M Service Codes, and the appropriate CPT Category II Code.</p> <p>Identify patients documented to have received macular examination.</p> <ul style="list-style-type: none"> ■ CPT II 2019F: Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity. 	<p>All patients aged 50 years and older with a diagnosis of age-related macular degeneration.</p> <p>Electronic Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 50 years and older with a diagnosis of age-related macular degeneration. ICD-9 Diagnosis Codes, CPT E&M Service Codes, and patient demographics (age, etc) are used to determine patients that are included in the measure.</p> <ul style="list-style-type: none"> ■ ICD-9-CM Codes: 362.50, 362.51, 362.52 <p>AND</p> <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 92002, 92004, 92012, 92014, 99201-99205, 99212-99215, and 99241-99245. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 50 years and older with a diagnosis of age-related macular degeneration.</p>	<p>Denominator Documentation of medical reason(s) for not performing a dilated macular examination.</p> <p>Documentation of patient reason(s) for not performing a dilated macular examination.</p> <p>Exclude patients for whom a dilated macular examination was not performed by reason of appropriate denominator exclusion.</p> <p>If using electronic data, exclude patients using the following codes: Append a modifier (1P or 2P) to the CPT Category II Code to report patients with documented circumstances that meet the denominator exclusion criteria.</p> <ul style="list-style-type: none"> ■ 1P: Documentation of medical reason(s) for not performing a dilated macular examination ■ 2P: Documentation of patient reason(s) for not performing a dilated macular examination. <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p> <ul style="list-style-type: none"> ■ Medical reason(s) for not performing a dilated macular examination ■ Patient reason(s) for not performing a dilated macular examination. 	<p>Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination (more)</p>

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EYE CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
AGE-RELATED MACULAR DEGENERATION: DILATED MACULAR EXAMINATION <i>continued</i>		<p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients who had a dilated macular examination performed, which included documentation of the presence or absence of macular thickening or hemorrhage <i>AND</i> the level of macular degeneration severity during one or more office visits within 12 months.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who had a dilated macular examination performed, which included documentation of the presence or absence of macular thickening or hemorrhage <i>AND</i> the level of macular degeneration severity during one or more office visits within 12 months.</p>	<p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 50 years and older with a diagnosis of age-related macular degeneration.</p>	<p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EYE CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
AGE-RELATED MACULAR DEGENERATION: DILATED MACULAR EXAMINATION <i>continued</i>		EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients with documentation of a dilated macular examination performed, which included documentation of the presence or absence of macular thickening or hemorrhage <i>AND</i> the level of macular degeneration severity during one or more office visits within 12 months.			
DIABETIC RETINOPATHY: DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY	AAO AMA PCPI* NCOA*	<p>Patients who had a dilated macular or fundus exam performed, which included documentation of the level of severity of retinopathy <i>AND</i> the presence or absence of macular edema during one or more office visits within 12 months.</p> <p>Definition: Medical record must include: Documentation of the level of severity of retinopathy (e.g., background diabetic retinopathy, proliferative diabetic retinopathy, non-proliferative diabetic retinopathy) <i>AND</i> documentation of whether macular edema was present or absent.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy <i>AND</i> the</p>	<p>All patients aged 18 years and older with a diagnosis of diabetic retinopathy.</p> <p>Electronic Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 18 years and older with a diagnosis of diabetic retinopathy. ICD-9 diagnosis codes, CPT E&M Service Codes, and patient demographics (age, gender, etc.) are used to determine patients that are included in the measure.</p> <ul style="list-style-type: none"> ■ ICD-9-CM Codes: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06 <p><i>AND</i></p> <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 92002, 92004, 92012, 92014, 99201-99205, 99212-99215, and 99241-99245. 	<p>Denominator Documentation of medical reason(s) for not performing a dilated macular or fundus examination. Documentation of patient reason(s) for not performing a dilated macular or fundus examination not performed by reason of appropriate denominator exclusion. If using electronic data, exclude patients using the following codes: Append a modifier (1P or 2P) to the above CPT Category II Code to report patients with documented circumstances that meet the denominator exclusion criteria.</p> <ul style="list-style-type: none"> ■ 1P: Documentation of medical reason(s) for not performing a dilated macular or fundus examination ■ 2P: Documentation of patient reason(s) for not performing a dilated macular or fundus examination. <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p>	<p>Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access (<i>more</i>)</p>

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EYE CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
DIABETIC RETINOPATHY: DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY <i>continued</i>		<p>presence or absence of macular edema during one or more office visits within 12 months.</p> <p>CPT Category II Codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the appropriate ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Code.</p> <p>Identify patients documented to have received a dilated macular or fundus exam.</p> <ul style="list-style-type: none"> ■ CPT II 2021F: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Documentation in medical record that a dilated macular or fundus examination was performed during one or more office visits within 12 months.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p>	<p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 18 years and older with a diagnosis of diabetic retinopathy.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 18 years and older with a diagnosis of diabetic retinopathy.</p>	<ul style="list-style-type: none"> ■ Medical reason(s) for not performing a dilated macular or fundus examination ■ Patient reason(s) for not performing a dilated macular or fundus examination. <p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.</p> <p>As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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EYE CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
DIABETIC RETINOPATHY: DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY <i>continued</i>		<p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who had a dilated macular or fundus examination performed during one or more office visits within 12 months.</p> <p>EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients with documentation of a dilated macular or fundus examination during one or more office visits within 12 months.</p>			
DIABETIC RETINOPATHY: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING DIABETES CARE	AAO AMA PCPI* NCQA*	<p>Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care.</p> <p>Definition Communication may include: Documentation in the medical record indicating that the results of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the physician managing the patient's diabetic care <i>OR</i> a copy of a letter in the medical record to the physician managing the patient's diabetic care outlining the findings of the macular or fundus exam.</p>	<p>All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed.</p> <p>Electronic Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as "administrative data"). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed.</p>	<p>Denominator Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.</p> <p>Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.</p> <p>Exclude patients for whom dilated macular or fundus exam findings were not communicated by reason of appropriate denominator exclusion.</p>	<p>Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The</p> <p>(more)</p>

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EYE CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
DIABETIC RETINOPATHY: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING DIABETES CARE <i>continued</i>		<p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient’s diabetic care.</p> <p>CPT Category II Codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Code.</p> <p>Identify patients with macular or fundus exam findings communicated.</p> <ul style="list-style-type: none"> ■ CPT II 5010F: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Documentation in medical record, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient’s diabetic care.</p>	<p>ICD-9 Diagnosis Codes, CPT E&M Service Codes, CPT Category II Codes, and patient demographics (age, gender, etc.) are used to determine patients that are included in the measure.</p> <ul style="list-style-type: none"> ■ ICD-9-CM Codes: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06 <p><i>AND</i></p> <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 92002, 92004, 92012, 92014, 99201-99205, 99212-99215, and 99241-99245 <p><i>AND</i></p> <ul style="list-style-type: none"> ■ CPT II 2021F: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema <i>AND</i> level of severity of retinopathy. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p>	<p>If using electronic data, exclude patients using the following codes: Append a modifier (1P or 2P) to the CPT Category II Code (5010F) to report patients with documented circumstances that meet the denominator exclusion criteria.</p> <ul style="list-style-type: none"> ■ 1P: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes ■ 2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes. <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p> <ul style="list-style-type: none"> ■ Medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes ■ Patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes. 	<p>medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator. <i>(more)</i></p>

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EYE CARE (continued)					
Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
DIABETIC RETINOPATHY: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING DIABETES CARE <i>continued</i>		<p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients with documentation of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care, at least once within 12 months.</p>	<p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed.</p>	<p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	(more)

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GERIATRICS

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
MEDICATION RECONCILIATION	AGS AMA PCPI* NCOA*	<p>Patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented.</p> <p>The medical record must indicate that the physician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of a inpatient facility discharge medication.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented. CPT Category II Codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the listed CPT E&M Service Codes and the appropriate CPT Category II Code.</p> <p>Identify patients with documentation of reconciliation of the discharge medications with the current medication list in the medical record:</p> <ul style="list-style-type: none"> ■ CPT II 1111F: Discharge medications reconciled with the current medication list in outpatient medical record. 	<p>All patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing ongoing care.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing ongoing care. CPT E&M Service Codes, CPT Category II Code, and patient demographics (age, gender, etc.) are used to determine patients that are included in the measure.</p> <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99387, 99397, 99401, 99402, 99403, 99404 <p>AND</p>	None.	<p>Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator. <i>(more)</i></p>

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
MEDICATION RECONCILIATION <i>continued</i>		<p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented.</p> <p>EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented.</p>	<p>■ CPT II 1110F: Patient discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days.</p> <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing ongoing care.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p>		As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
MEDICATION RECONCILIATION <i>continued</i>			<p>Denominator All patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing ongoing care. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 65 years and older.</p>		
URINARY INCONTINENCE: ASSESSMENT OF PRESENCE OR ABSENCE OF URINARY INCONTINENCE IN WOMEN AGED 65 YEARS AND OLDER	AGS AMA PCPI* NCOA*	<p>Patients who were assessed for the presence or absence of urinary incontinence within 12 months. Definition: Urinary incontinence is defined as any involuntary leakage of urine. Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria. Numerator Patients who were assessed for the presence or absence of urinary incontinence within 12 months. 1. CPT Category II Codes are used to report the numerator of the measure. If reporting CPT Category II Codes, submit the listed CPT E&M Service Codes and the appropriate CPT Category II Code.</p>	<p>All female patients aged 65 years and older. Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria. Denominator All female patients aged 65 years and older. CPT E&M Service Codes and patient demographics (age, gender, etc.) are used to determine patients that are included in the measure. ■ CPT E&M Service Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99387, 99397, 99401, 99402, 99403, 99404.</p>	<p>Denominator Exclusion Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence. Exclude patients for whom patient was not an eligible candidate for an assessment of the presence or absence of urinary incontinence by reason of appropriate exclusion. If using electronic data, exclude patients using the following codes: ■ GXXXX: Clinician documented that patient was not an eligible candidate for an assessment of the presence or absence of urinary incontinence OR ■ Append a modifier (1P) to the following CPT Category II Code to report patients with documented circumstances that meet the denominator exclusion criteria. <i>(more)</i></p>	<p>Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the</p>

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
<p>URINARY INCONTINENCE: ASSESSMENT OF PRESENCE OR ABSENCE OF URINARY INCONTINENCE IN WOMEN AGED 65 YEARS AND OLDER <i>continued</i></p>		<p>Identify patients with documentation of an assessment for the presence or absence of urinary incontinence in the medical record:</p> <ul style="list-style-type: none"> ■ CPT II 1090F: Presence or absence of urinary incontinence assessed. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients who were assessed for the presence or absence of urinary incontinence within 12 months.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who were assessed for the presence or absence of urinary incontinence within 12 months. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients with documentation of assessment for the presence or absence of urinary incontinence within 12 months.</p>	<p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All female patients aged 65 years and older.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All female patients aged 65 years and older. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all female patients aged 65 years and older with a diagnosis of urinary incontinence.</p>	<p>■ 1P: Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence.</p> <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p> <ul style="list-style-type: none"> ■ Medical reason(s) for not assessing for the presence or absence of urinary incontinence. <p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate exclusions.</p>	<p>sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator. As noted in the measure description, those electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p> <p style="text-align: right;"><i>(more)</i></p>

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
URINARY INCONTINENCE: CHARACTERIZATION OF URINARY INCONTINENCE IN WOMEN AGED 65 YEARS AND OLDER	AGS AMA PCPI* NCOA*	<p>Patients whose urinary incontinence was characterized (may include one or more of the following: frequency, volume, timing, type of symptoms and how bothersome to the patient) at least once within 12 months.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients whose urinary incontinence was characterized (may include one or more of the following: frequency, volume, timing, type of symptoms and how bothersome to the patient) at least once within 12 months.</p> <p>1. CPT Category II Codes are used to report the numerator of the measure. If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Code.</p> <p>Identify patients with documentation of characterization of urinary incontinence in the medical record:</p> <ul style="list-style-type: none"> ■ CPT II 1091F: Urinary incontinence characterized (e.g., frequency, volume, timing, type of symptoms, how bothersome). 	<p>All female patients aged 65 years and older with a diagnosis of urinary incontinence.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All female patients aged 65 years and older with a diagnosis of urinary incontinence.</p> <p>ICD-9 Diagnosis Codes, CPT E&M Service Codes, and patient demographics (age, gender, etc.) are used to determine patients that are included in the measure.</p> <ul style="list-style-type: none"> ■ ICD-9-CM Codes: 307.6 (non-organic origin), 625.6 (stress, female), 788.30, 788.31, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 <p>AND</p> <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99387, 99397, 99401, 99402, 99403, 99404. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p>	None.	Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination (more)

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
URINARY INCONTINENCE: CHARACTERIZATION OF URINARY INCONTINENCE IN WOMEN AGED 65 YEARS AND OLDER <i>continued</i>		<p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients whose urinary incontinence was characterized (may include one or more of the following: frequency, volume, timing, type of symptoms and how bothersome to the patient) at least once within 12 months.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients whose urinary incontinence was characterized (may include one or more of the following: frequency, volume, timing, type of symptoms and how bothersome to the patient) at least once within 12 months.</p>	<p>Denominator All female patients aged 65 years and older with a diagnosis of urinary incontinence.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All female patients aged 65 years and older with a diagnosis of urinary incontinence. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all female patients aged 65 years and older with a diagnosis of urinary incontinence.</p>		<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
URINARY INCONTINENCE: PLAN OF CARE FOR URINARY INCONTINENCE IN WOMEN AGED 65 YEARS AND OLDER	AGS AMA PCPI* NCOA*	<p>Patients with a documented plan of care for urinary incontinence at least once within 12 months.</p> <p>Definition: Plan of care may include behavioral interventions (e.g., bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients with a documented plan of care for urinary incontinence at least once within 12 months.</p> <ol style="list-style-type: none"> CPT Category II Codes are used to report the numerator of the measure. If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Code. <p>Identify patients with a plan of care for urinary incontinence documented:</p> <ul style="list-style-type: none"> CPT II 0509F: Urinary incontinence plan of care documented. 	<p>All female patients aged 65 years and older with a diagnosis of urinary incontinence.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All female patients aged 65 years and older with a diagnosis of urinary incontinence. ICD-9 Diagnosis Codes, CPT E&M Service Codes, and patient demographics (age, gender, etc.) are used to determine patients that are included in the measure.</p> <ul style="list-style-type: none"> ICD-9-CM Codes: 307.6 (non-organic origin), 625.6 (stress, female), 788.30, 788.31, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 <p>AND</p> <ul style="list-style-type: none"> CPT E&M Service Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99387, 99397, 99401, 99402, 99403, 99404. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p>	None.	<p>Data sources used will depend on implementation and approach. The electronic data use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination</p> <p>(more)</p>

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
URINARY INCONTINENCE: PLAN OF CARE FOR URINARY INCONTINENCE IN WOMEN AGED 65 YEARS AND OLDER <i>continued</i>		<p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients with a documented plan of care for urinary incontinence at least once within 12 months.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients with a documented plan of care for urinary incontinence at least once within 12 months. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients with a documented plan of care for urinary incontinence at least once within 12 months.</p>	<p>Denominator All female patients aged 65 years and older with a diagnosis of urinary incontinence.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All female patients aged 65 years and older with a diagnosis of urinary incontinence. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all female patients aged 65 years and older with a diagnosis of urinary incontinence.</p>		<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
SCREENING FOR FUTURE FALL RISK	AGS AMA PCPI* NCOA*	<p>Patients who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months.</p> <p>Definition: A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force (Tinetti).</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months.</p> <p>1. If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Code.</p> <p>Identify patients with documentation of screening for future fall risk (2 or more falls in the past year or any fall with injury in the past year).</p>	<p>All patients aged 65 years and older.</p> <p>Electronic Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 65 years and older. CPT E&M Service Codes and patient demographics (age, gender, etc.) are used to determine patients that are included in the measure.</p> <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99387, 99397, 99401, 99402, 99403, 99404. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 65 years and older.</p>	<p>Denominator Exclusion Documentation of medical reason(s) for not screening for future fall risk (e.g., patient is not ambulatory).</p> <p>Exclude patients for whom patient was not an eligible candidate for fall risk screening by reason of medical exclusion.</p> <p>If using electronic data, exclude patients using the following codes: Append a modifier (1P) to the CPT Category II Code (either 1100F or 1101F) to report patients with documented circumstances that meet the denominator exclusion criteria.</p> <ul style="list-style-type: none"> ■ 1P: Medical reason(s) for not screening for future fall risk (e.g., patient is not ambulatory). <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of: <ul style="list-style-type: none"> ■ Medical reason(s) for not screening for future fall risk (e.g., patient is not ambulatory). </p> <p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate exclusions.</p>	<p>Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination (more)</p>

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
SCREENING FOR FUTURE FALL RISK <i>continued</i>		<ul style="list-style-type: none"> ■ CPT II 1100F: Patient screened for future fall risk; documentation of 2 or more falls in the past year or any fall with injury in the past year <p style="text-align: center;"><i>OR</i></p> <ul style="list-style-type: none"> ■ CPT II 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users should collect data on 100% of their denominator population instead of a sample.</p>	<p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients aged 65 years and older. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 65 years and older.</p>		of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
SCREENING FOR FUTURE FALL RISK <i>continued</i>		<p>Numerator Patients who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months.</p> <p>EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months.</p>			
ADVANCE CARE PLAN	AGS AMA PCPI* NCOA*	<p>Patients who have an advance care plan or surrogate decisionmaker documented in the medical record or documentation in the medical record that an advance care plan was discussed but did not wish or was not able to name a surrogate decisionmaker or provide an advance care plan.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who have an advance care plan or surrogate decisionmaker documented in the</p>	<p>All patients aged 65 years and older.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 65 years and older ICD-9 Diagnosis Codes, CPT Procedure Codes, and patient demographics (age, gender, etc.) are used to determine patients who are included in the measure.</p> <p>Evaluation and Management/Office Visit Codes (CPT) are required for denominator inclusion to</p>	None.	Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or (more)

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ADVANCE CARE PLAN <i>continued</i>		<p>medical record or documentation in the medical record that an advance care plan was discussed but did not wish or was not able to name a surrogate decisionmaker or provide an advance care plan.</p> <p>This measure can be reported with CPT Category II Codes.</p> <p>1. If reporting CPT Category II Codes, submit the appropriate CPT Category II Code.</p> <p>Identify patients with documentation of a surrogate decisionmaker or advance care plan in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decisionmaker or provide an advance care plan:</p> <ul style="list-style-type: none"> ■ CPT II 1XXXF: Advance care planning discussed and documented; advance care plan or surrogate documented <p>OR</p> <ul style="list-style-type: none"> ■ CPT II 1XXXF: Advance care planning discussed and documented; neither care plan nor surrogate designated by patient. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients who have an advance care plan or surrogate decisionmaker documented in the medical record or documentation in the medical record that an advance care plan was discussed</p>	<p>identify patients aged 65 years and older who were seen by the physician.</p> <ul style="list-style-type: none"> ■ CPT Procedure Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404. <p>Manual Abstraction Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 65 years and older.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p>		<p>electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.</p> <p>As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p> <p style="text-align: right;"><i>(more)</i></p>

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GERIATRICS (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ADVANCE CARE PLAN <i>continued</i>		<p>but did not wish or was not able to name a surrogate decisionmaker or provide an advance care plan.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who have an advance care plan or surrogate decisionmaker documented in the medical record or documentation in the medical record that an advance care plan was discussed but did not wish or was not able to name a surrogate decisionmaker or provide an advance care plan. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients with documentation of a surrogate decisionmaker or advance care plan in the medical record.</p>	<p>Electronic Health Record Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients aged 65 years and older. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 65 years and older.</p>		(more)

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EMERGENCY CARE					
Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ELECTRO-CARDIOGRAM PERFORMED FOR NON-TRAUMATIC CHEST PAIN	ACEP AMA PCPI* NCOA*	<p>Patients who had an ECG performed.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who had an ECG performed. CPT Category II Codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service Codes, and the appropriate CPT-II Codes.</p> <p>Identify patients who had an ECG performed:</p> <ul style="list-style-type: none"> ■ CPT Codes: 93000, 93010 <p>OR</p> <ul style="list-style-type: none"> ■ CPT II 3120F: 12-Lead ECG performed. <p>Medical record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients who had an ECG performed.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and</p>	<p>All patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain. ICD-9 Diagnosis Codes, CPT E&M Service Codes, and patient demographics (age, etc.) are used to determine patients that are included in the measure.</p> <ul style="list-style-type: none"> ■ ICD-9-CM Codes: 413.0, 413.1, 413.9, 786.50, 786.51, 786.52, 786.59 <p>AND</p> <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 99281, 99282, 99283, 99284, 99285, 99291. <p>Medical record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain.</p>	<p>Denominator Exclusion Documentation of medical reason(s) for not performing an ECG.</p> <p>Documentation of patient reason(s) for not performing an ECG.</p> <p>Exclude patients for whom an ECG was not performed by reason of appropriate denominator exclusion.</p> <p>If using electronic data, exclude patients using the following codes: Append a modifier (1P or 2P) to the CPT Category II Code to report patients with documented circumstances that meet the denominator exclusion criteria.</p> <ul style="list-style-type: none"> ■ 1P: Documentation of medical reason(s) for not performing an ECG ■ 2P: Documentation of patient reason(s) for not performing an ECG. <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p> <ul style="list-style-type: none"> ■ Medical reason(s) for not performing an ECG ■ Patient reason(s) for not performing an ECG. <p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>Data sources used will depend on implementation and approach. The electronic data use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination (more)</p>

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EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ELECTRO-CARDIOGRAM PERFORMED FOR NON-TRAUMATIC CHEST PAIN <i>continued</i>		<p>then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who had an ECG performed.</p> <p>EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients who had ECG performed.</p>	<p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain.</p> <p>EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain.</p>		of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.

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EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ASPIRIN AT ARRIVAL FOR ACUTE MYOCARDIAL INFARCTION (AMI)	ACEP AMA PCPI* NCOA*	<p>Patients who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients with AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay. CPT Category II Codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Codes. Identify patients who received or took aspirin 24 hours before emergency department arrival or during emergency department stay: <ul style="list-style-type: none"> ■ CPT II 4084F: Aspirin received within 24 hours before emergency department arrival or during emergency department stay. Medical Record Manual abstraction of data elements from patient record data collection.</p>	<p>All patients with an emergency department discharge diagnosis of acute myocardial infarction.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients with an emergency department discharge diagnosis of acute myocardial infarction. ICD-9 Diagnosis Codes, CPT E&M Service Codes, and patient demographics (age, etc.) are used to determine patients that are included in the measure. <ul style="list-style-type: none"> ■ ICD-9 Codes: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91 AND <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 99281, 99282, 99283, 99284, 99285, 99291. Medical Record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients with an emergency department discharge diagnosis of acute myocardial infarction.</p>	<p>Denominator Exclude patients for whom aspirin was not received or taken within 24 hours before emergency department arrival or during emergency department stay by reason of appropriate denominator exclusion. If using electronic data, exclude patients using the following codes: Append a modifier (1P or 2P) to the CPT Category II Codes to report patients with documented circumstances that meet the denominator exclusion criteria. <ul style="list-style-type: none"> ■ 1P: Documentation of medical reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay ■ 2P: Documentation of patient reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay. If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of: <ul style="list-style-type: none"> ■ Medical reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay </p>	<p>Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination (more)</p>

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EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ASPIRIN AT ARRIVAL FOR ACUTE MYOCARDIAL INFARCTION (AMI) <i>continued</i>		<p>Numerator Patients who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients with AMI who received aspirin within 24 hours before emergency department arrival or during emergency department stay.</p>	<p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients with an emergency department discharge diagnosis of acute myocardial infarction. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients with an emergency department discharge diagnosis of acute myocardial infarction.</p>	<ul style="list-style-type: none"> ■ Patient reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay. <p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ELECTRO-CARDIOGRAM PERFORMED FOR SYSCOPE	ACEP AMA PCPI* NCOA*	<p>Patients who had an ECG performed.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients who had an ECG performed. CPT Category II Codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Codes. Identify patients who had an ECG performed: <ul style="list-style-type: none"> ■ CPT Codes: 93000, 93010 <i>OR</i> <ul style="list-style-type: none"> ■ CPT II 3120F: 12-Lead ECG performed. </p> <p>Medical Record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients who had an ECG performed.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and</p>	<p>All patients aged 60 years and older with an emergency department discharge diagnosis of syncope.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 60 years and older with an emergency department discharge diagnosis of syncope. ICD-9 Diagnosis Codes, CPT E&M Service Codes, and patient demographics (age, etc.) are used to determine patients that are included in the measure. <ul style="list-style-type: none"> ■ ICD-9-CM Codes: 780.2 <i>AND</i> <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 99281, 99282, 99283, 99284, 99285, 99291. </p> <p>Medical Record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 60 years and older with an emergency department discharge diagnosis of syncope.</p>	<p>Denominator Exclude patients for whom an ECG was not performed by reason of appropriate denominator exclusion. If using electronic data, exclude patients using the following codes: Append a modifier (1P or 2P) to the CPT Category II Codes to report patients with documented circumstances that meet the denominator exclusion criteria. <ul style="list-style-type: none"> ■ 1P: Documentation of medical reason(s) for not performing an ECG ■ 2P: Documentation of patient reason(s) for not performing an ECG. If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of: <ul style="list-style-type: none"> ■ Medical reason(s) for not performing an ECG ■ Patient reason(s) for not performing an ECG. If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions. </p>	<p>Data sources used will depend on implementation and approach. The electronic data use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination <i>(more)</i></p>

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EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ELECTRO-CARDIOGRAM PERFORMED FOR SYNCOPÉ <i>continued</i>		<p>then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients who had an ECG performed. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients who had an ECG performed.</p>	<p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients aged 60 years and older with an emergency department discharge diagnosis of syncope. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 60 years and older with an emergency department discharge diagnosis of syncope.</p>		<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ASSESSMENT OF OXYGEN SATURATION FOR COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA	ACEP AMA PCPI* NCOA*	<p>Patients with oxygen saturation documented and reviewed.</p> <p>Medical record may include one of the following: physician documentation that oxygen saturation was reviewed, dictation by the physician including oxygen saturation, physician initials in the chart that oxygen saturation was reviewed, or other indication that oxygen saturation had been acknowledged by the physician.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients with oxygen saturation documented and reviewed.</p> <p>CPT Category II codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes submit the listed ICD-9, E&M Service Codes, and the appropriate CPT Category II Codes.</p> <p>Identify patients who had their oxygen saturation documented and reviewed.</p> <ul style="list-style-type: none"> ■ CPT II 3028F: Oxygen saturation results documented and reviewed. 	<p>All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.</p> <p>For purposes of measurement in the emergency department, this measure is intended to include only those patients with an emergency department discharge diagnosis of community-acquired bacterial pneumonia.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.</p> <p>ICD-9 Diagnosis Codes, CPT E&M Service Codes, and patient demographics (age, etc.) are used to determine patients that are included in the measure.</p> <ul style="list-style-type: none"> ■ ICD-9 Codes: 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 <p>AND</p> <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 99281, 99282, 99283, 99284, 99285, 99291. 	<p>Denominator Exclude patients for whom oxygen saturation was not assessed by reason of appropriate denominator exclusion.</p> <p>If using electronic data, exclude patients using the following codes:</p> <p>Append a modifier (1P, 2P, or 3P) to one of the CPT Category II Codes to report patients with documented circumstances that meet the denominator exclusion criteria.</p> <ul style="list-style-type: none"> ■ 1P: Documentation of medical reason(s) for not documenting and reviewing oxygen saturation ■ 2P: Documentation of patient reason(s) for not documenting and reviewing oxygen saturation ■ 3P: Documentation of system reason(s) for not documenting and reviewing oxygen saturation. <p>If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of:</p> <ul style="list-style-type: none"> ■ Medical reason(s) for not documenting and reviewing oxygen saturation ■ Patient reason(s) for not documenting and reviewing oxygen saturation ■ System reason(s) for not documenting and reviewing oxygen saturation. 	<p>Data sources used will depend on implementation and approach.</p> <p>The electronic data source requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination</p> <p>(more)</p>

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ASSESSMENT OF OXYGEN SATURATION FOR COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA <i>continued</i>		<p>Medical Record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients with oxygen saturation documented and reviewed.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients with oxygen saturation documented and reviewed.</p> <p>EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients who had oxygen saturation documented and reviewed.</p>	<p>Medical Record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.</p>	<p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ASSESSMENT OF MENTAL STATUS FOR COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA	ACEP AMA PCPI* NCOA*	<p>Patients with mental status assessed. Medical record may include documentation by physician that patient's mental status was noted (e.g., patient is oriented or disoriented).</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as "administrative data"). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients with mental status assessed. CPT Category II Codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Codes. Identify patients who had their mental status assessed: <ul style="list-style-type: none"> ■ CPT II 2014F: Mental status assessed. </p> <p>Medical Record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients with mental status assessed.</p>	<p>All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia. For purposes of measurement in the emergency department, this measure is intended to include only those patients with an emergency department discharge diagnosis of community-acquired bacterial pneumonia.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as "administrative data"). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia. ICD-9 Diagnosis Codes, CPT E&M Service Codes, and patient demographics (age, etc.) are used to determine patients that are included in the measure. <ul style="list-style-type: none"> ■ ICD-9-CM Codes: 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 </p> <p>AND <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 99281, 99282, 99283, 99284, 99285, 99291. </p>	None.	Data sources used will depend on implementation and approach. The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination <i>(more)</i>

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
ASSESSMENT OF MENTAL STATUS FOR COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA <i>continued</i>		<p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients with mental status assessed. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients who had mental status assessed.</p>	<p>Medical Record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.</p>		<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
EMPIRIC ANTIBIOTIC FOR COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA	ACEP AMA PCPI* NCOA*	<p>Patients with an appropriate empiric antibiotic prescribed.</p> <p>Appropriate empiric antibiotic for treatment of community-acquired bacterial pneumonia (CAP) should include any medication from one of the following four drug classes: Fluoroquinolones, Macrolides, Doxycycline, Beta Lactam with Macrolide or Doxycycline (as defined by current ATS/IDSA guidelines).</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Numerator Patients with appropriate empiric antibiotic prescribed. CPT Category II Codes are used to report the numerator of the measure.</p> <p>1. If reporting CPT Category II Codes, submit the listed ICD-9, CPT E&M Service Codes, and the appropriate CPT Category II Codes. Identify patients with appropriate empiric antibiotic prescribed: <ul style="list-style-type: none"> ■ CPT II 4045F: Appropriate empiric antibiotic prescribed. </p>	<p>All patients 18 years and older with the diagnosis of community-acquired bacterial pneumonia.</p> <p>For purposes of measurement in the emergency department, this measure is intended to include only those patients with an emergency department discharge diagnosis of community-acquired bacterial pneumonia.</p> <p>Electronic Data Collection Electronic data collection requires users to identify the eligible population (denominator) and numerator using electronic data (also referred to as “administrative data”). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</p> <p>Denominator All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia. ICD-9 Diagnosis Codes, CPT E&M Service Codes, and patient demographics (age, etc.) are used to determine patients that are included in the measure. <ul style="list-style-type: none"> ■ ICD-9-CM Codes: 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 AND <ul style="list-style-type: none"> ■ CPT E&M Service Codes: 99281, 99282, 99283, 99284, 99285, 99291. </p>	<p>Denominator Exclude patients for whom appropriate empiric antibiotic was not prescribed by reason of appropriate denominator exclusion. If using electronic data, exclude patients using the following codes: Append a modifier (1P, 2P, or 3P) to the CPT Category II Codes to report patients with documented circumstances that meet the denominator exclusion criteria. <ul style="list-style-type: none"> ■ 1P: Documentation of medical reason(s) for not prescribing appropriate empiric antibiotic ■ 2P: Documentation of patient reason(s) for not prescribing appropriate empiric antibiotic ■ 3P: Documentation of system reason(s) for not prescribing appropriate empiric antibiotic. If using the medical record or hybrid methodologies, exclude patients who have documentation in the medical record of: <ul style="list-style-type: none"> ■ Medical reason(s) for not prescribing appropriate empiric antibiotic. ■ Patient reason(s) for not prescribing appropriate empiric antibiotic. ■ Documentation of system reason(s) for not prescribing appropriate empiric antibiotic. </p>	<p>Data sources used will depend on implementation and approach. The electronic data use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination</p>

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Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures

EMERGENCY CARE (continued)

Measure	IP Owner ¹	Numerator	Denominator	Exclusions	Data Source
EMPIRIC ANTIBIOTIC FOR COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA <i>continued</i>		<p>Medical Record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Numerator Patients with appropriate empiric antibiotic prescribed.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Numerator Patients with appropriate empiric antibiotic prescribed. EHR users may opt to use the codes listed in the electronic data collection methodology to identify patients who had an appropriate antibiotic prescribed.</p>	<p>Medical Record Manual abstraction of data elements from patient records (hard-copy charts) constitutes medical record data collection.</p> <p>Denominator All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. Sample sizes may be defined by different implementers.</p> <p>Hybrid Users should follow the requirements of electronic data collection, select a sample of patients, and then supplement the electronic data where needed with medical record abstraction of data elements to fulfill measure reporting requirements.</p> <p>Electronic Health Record (EHR) EHR users may opt to use this methodology or the electronic data collection methodology described previously. EHR users should collect data on 100% of their denominator population instead of a sample.</p> <p>Denominator All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia. EHR users may opt to use the codes listed in the electronic data collection methodology to identify all patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.</p>	<p>If using the EHR methodology, exclude patients using the codes listed in the electronic data collection methodology or who have documentation in the medical record of the appropriate denominator exclusions.</p>	<p>of the numerator. As noted in the measure description, those practices that have electronic health records systems can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

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NATIONAL QUALITY FORUM

Appendix B

Members and Board of Directors

Members*

CONSUMER COUNCIL

AARP
 AFL-CIO
 Alliance for Retired Americans
 American Federation of Teachers
 Healthcare
 American Hospice Foundation
 Childbirth Connection
 Consumer Coalition for Quality Health
 Care
 Consumers Advancing Patient Safety
 Consumers' Checkbook
 Coordinating Center
 Health Care for All
 International Association of Machinists
 March of Dimes
 National Breast Cancer Coalition
 National Citizen's Coalition for
 Nursing Home Reform
 National Coalition for Cancer
 Survivorship
 National Consumers League
 National Partnership for Women &
 Families
 Service Employees Industrial Union

HEALTH PROFESSIONAL, PROVIDER, AND HEALTH PLAN COUNCIL

Academy of Managed Care Pharmacy
 Administrators for the Professions
 Adventist HealthCare
 Advocate Health Partners
 Aetna
 Alegent Health
 American Academy of Family
 Physicians
 American Academy of Hospice and
 Palliative Medicine

American Academy of Ophthalmology
 American Academy of Orthopaedic
 Surgeons
 American Academy of Pediatrics
 American Association of Ambulatory
 Surgery Centers
 American Association of Nurse
 Anesthetists
 American Chiropractic Association
 American College of Cardiology
 American College of Chest Physicians
 American College of Gastroenterology
 American College of Obstetricians and
 Gynecologists
 American College of Physicians
 American College of Radiology
 American College of Rheumatology
 American College of Surgeons
 American Geriatrics Society
 American Heart Association
 American Hospital Association
 American Medical Association
 American Medical Group Association
 American Nurses Association
 American Optometric Association
 American Organization of Nurse
 Executives
 American Osteopathic Association
 American Society for Gastrointestinal
 Endoscopy
 American Society for Therapeutic
 Radiology and Oncology
 American Society of Anesthesiologists
 American Society of Breast Surgeons
 American Society of Clinical Oncology
 American Society of Colon and Rectal
 Surgeons
 American Society of Health-System
 Pharmacists

*When voting under the NQF Consensus Development Process occurred for this report.

American Society of Hematology
American Society of Interventional Pain Physicians
American Society of Plastic Surgeons
American Thoracic Society
America's Health Insurance Plans
AmSurg Corporation
Aramark Healthcare
Ascension Health
Association for Behavioral Health and Wellness
Atlantic Health
Aurora Health Care
Baptist Memorial Health Care Corporation
Bayhealth Medical Center
Baylor Health Care System
BJC HealthCare
Blue Cross Blue Shield Association
Boca Raton Community Hospital
Bon Secours Health System
Bronson Healthcare Group
Calgary Health Region - Quality Improvement and Health Information
Carolinas Medical Center
Catholic Health Association of the United States
Catholic Health Initiatives
Catholic Healthcare Partners
Cedars-Sinai Medical Center
Central Baptist Hospital
Chesapeake Bay ENT
Child Health Corporation of America
Children's Hospitals and Clinics of Minnesota
CHRISTUS Health
CIGNA Healthcare
Clark Consulting
College of American Pathologists
Community Health Accreditation Program
Community Health Plan of Washington
Condell Health Network
Connecticut Hospital Association
Council of Medical Specialty Societies
DaVita
Detroit Medical Center
Duke University Health System
Emergency Department Practice Management Association
Evanston Northwestern Healthcare
Exeter Health Resources
Federation of American Hospitals
Florida Hospital Medical Center
Gentiva Health Services
Good Samaritan Hospital
Greater New York Hospital Association
Hackensack University Medical Center
HCA, Inc.
Health Management Associates
Healthcare Leadership Council
HealthHelp
HealthPartners
HealthSouth Corporation
Henry Ford Health System
Highmark, Inc.
HIP Health Plans
Hoag Hospital
Horizon Blue Cross Blue Shield of New Jersey
Hospice and Palliative Nurses Association
Hospital for Special Surgery
HRDIA
Hudson Health Plan
Illinois Hospital Association
Infusion Nurses Society
INTEGRIS Health
Intermountain Healthcare
John Muir Health
Johns Hopkins Health System
Kaiser Permanente
KU Med at the University of Kansas Medical Center
Lake Forest Hospital
Los Angeles County - Department of Health Services
Mayo Foundation
MedQuest Associates
MedStar Health
Memorial Health University Medical Center
Memorial Hermann Healthcare System
Memorial-Sloan Kettering Cancer Center
Mercy Medical Center
Meridian Health System
Milliman Care Guidelines
Munson Medical Center
National Association for Home Care and Hospice
National Association of Chain Drug Stores
National Association of Children's Hospitals and Related Institutions
National Association of Public Hospitals and Health Systems
National Consensus Project for Quality Palliative Care
National Consortium of Breast Centers
National Hospice and Palliative Care Organization
National Rural Health Association
Nebraska Heart Hospital
Nemours Foundation
New York-Presbyterian Hospital and Health System
North Carolina Baptist Hospital
North Mississippi Medical Center
North Shore - Long Island Jewish Health System
North Texas Specialty Physicians
Northwestern Memorial Healthcare
Norton Healthcare, Inc.
Oakwood Healthcare System
Palmetto Health Alliance
Park Nicollet Health Services
Partners HealthCare System, Inc.
Pharmacy Quality Alliance
Planetree
Premier, Inc.

Presbyterian Healthcare Services
 Providence Health System
 Robert Wood Johnson Health Network
 Robert Wood Johnson Hospital - Hamilton
 Robert Wood Johnson University Hospital - New Brunswick
 Rockford Health System
 Sentara Norfolk General Hospital
 Sisters of Mercy Health System
 Society of Critical Care Medicine
 Society of Thoracic Surgeons
 Sodexo Healthcare Services
 St. Mary's Hospital
 Stamford Health System
 State Associations of Addiction Services
 State University of New York - College of Optometry
 Sutter Health
 Tampa General Hospital
 Tenet Healthcare
 Texas Health Resources
 The Methodist Hospital
 Thomas Jefferson University Hospital
 Triad Hospitals
 Trinity Health
 UAB Health Systems
 UnitedHealth Group
 University Health Systems of Eastern Carolina
 University Hospitals of Cleveland
 University of California-Davis Medical Group
 University of Michigan Hospitals and Health Centers
 University of Pennsylvania Health System
 University of Texas-MD Anderson Cancer Center
 US Department of Defense - Health Affairs
 UW Health
 Vail Valley Medical Center
 Vanguard Health Management
 Veterans Health Administration
 VHA, Inc.
 Virtua Health
 Washington State Hospital Association
 Waukesha Elmbrook Health Care
 WellPoint
 WellStar Health System
 Yale New Haven Health System

PURCHASER COUNCIL

BoozAllenHamilton
 Buyers Health Care Action Group
 Centers for Medicare & Medicaid Services
 District of Columbia Department of Health
 Employer Health Care Alliance Cooperative
 Employers' Coalition on Health
 Florida Health Care Coalition
 General Motors

Greater Detroit Area Health Council
 HealthCare 21
 KPMG LLP
 Leapfrog Group
 Lehigh Valley Business Conference on Health
 Maine Health Management Coalition
 National Association of Health Data Organizations
 National Association of State Medicaid Directors
 National Business Coalition on Health
 National Business Group on Health
 New Jersey Health Care Quality Institute
 Pacific Business Group on Health
 Schaller Anderson
 St. Louis Business Health Coalition
 Washington State Health Care Authority

RESEARCH AND QUALITY IMPROVEMENT COUNCIL

Abbott Laboratories
 ABIM Foundation
 Abiomed
 ACC/AHA Task Force on Performance Measures
 Accreditation Association for Ambulatory Health Care - Institute for Quality Improvement
 ACS/MIDAS+
 Advanced Medical Technology Association
 AGA Institute
 Agency for Healthcare Research and Quality
 American Academy of Nursing
 American Association of Colleges of Nursing
 American Board of Medical Specialties
 American College of Emergency Physicians
 American College of Medical Quality
 American Data Network
 American Health Quality Association
 American Medical Association - Physician Consortium for Performance Improvement
 American Medical Informatics Association
 American Pharmacists Association Foundation
 American Psychiatric Association for Research and Education
 American Society for Quality - Health Care Division
 Amgen, Inc.
 Association for the Advancement of Wound Care
 Association for Professionals in Infection Control and Epidemiology
 Association of American Medical Colleges
 AstraZeneca
 AYR Consulting Group
 Battelle Memorial Institute
 Baxter
 Bristol-Myers Squibb Company
 C.R. Bard
 California HealthCare Foundation
 Cancer Care Ontario

Cardinal Health, Inc.
CareScience
Center to Advance Palliative Care
Centers for Disease Control and Prevention
Cerner Corporation
City of New York Department of Health and Hygiene
Cleveland Clinic Foundation
CNA Corporation
Cook Group Incorporated
Coral Initiative, LLC
CRG Medical
Delmarva Foundation
Dialog Medical
Disease Management Association of America
ECRI Institute
eHealth Initiative
Eli Lilly and Company
excelleRx
Florida Initiative for Children's Healthcare Quality
Forum of End Stage Renal Disease Networks
GlaxoSmithKline
Health Alliance of Mid-America
Health Care Compliance Strategies
Health Grades
Health Resources and Services Administration
Health Services Advisory Group
Healthcare Association of New York State
Hospira
Illinois Department of Public Health
Infectious Diseases Society of America
Institute for Clinical Systems Improvement
Institute for Safe Medication Practices
Integrated Healthcare Association
Integrated Resources for the Middlesex Area
Iowa Foundation for Medical Care
Iowa Healthcare Collaborative
IPRO
Jefferson Health System, Office of Health Policy and Clinical Outcomes
Johnson & Johnson Health Care Systems
Kidney Care Partners
Long Term Care Institute
Loyola University Health System - Center for Clinical Effectiveness
Lumetra
Maine Quality Forum
McKesson Corporation
MedAssets
MedMined
MEDRAD, Inc.
MHA Keystone Center for Patient Safety and Quality
Minnesota Community Measurement
National Academy for State Health Policy
National Association for Healthcare Quality
National Committee for Quality Assurance
National Institutes of Health
National Minority Quality Forum
National Patient Safety Foundation
National Research Corporation
Neocure
New Jersey Hospital Association
New York University College of Nursing
North Carolina Center for Hospital Quality and Patient Safety
Northeast Health Care Quality Foundation
Ohio KePRO
Online Users for Computer-assisted Healthcare
Onmicare, Inc.
Partnership for Prevention
Pennsylvania Health Care Cost Containment Council
Pennsylvania Patient Safety Authority
Pfizer
PhRMA
Press, Ganey Associates
Professional Research Consultants, Inc.
Renal Physicians Association
Research!America
Rhode Island Department of Health
Roswell Park Cancer Institute
sanofi-aventis
Schering-Plough
Society for Healthcare Epidemiology of America
Society of Hospital Medicine
Solucient
State of New Jersey Department of Health and Senior Services
Substance Abuse and Mental Health Services Administration
Texas Medical Institute of Technology
The Joint Commission
The Lewin Group
Thomson Healthcare
Uniform Data System for Medical Rehabilitation
United Hospital Fund
United Surgical Partners International
University of North Carolina - Program on Health Outcomes
URAC
US Pharmacopeia
Virginia Cardiac Surgeon Quality Initiative
Vitas Healthcare Corporation
West Virginia Medical Institute
Wisconsin Collaborative for Healthcare Quality

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Washington, DC

Nancy H. Nielsen, MD, PhD

Speaker, House of Delegates
AMA for Physician Consortium for Performance
Improvement
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NATIONAL QUALITY FORUM

Appendix C

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NATIONAL QUALITY FORUM

Appendix D

Commentary

Introduction

In October 2006, the National Quality Forum (NQF) initiated a project to achieve consensus on a set of specialty clinician performance measures at the request of the Centers for Medicare & Medicaid Services (CMS). NQF's work in ambulatory care began in 2005 under the direction of the Ambulatory Care Steering Committee. The Ambulatory Care Steering Committee (appendix C) representing key healthcare constituencies – including consumers, providers, purchasers, and research and quality improvement organizations – was again convened to evaluate the outpatient specialty clinician measures. Technical Advisory Panels (TAPs) (appendix C) in each area were formed to assist NQF staff on measure evaluations, advise the Steering Committee on the technical aspects of the measures, and make recommendations to the Steering Committee. This appendix summarizes the deliberations of the Steering Committee and the TAPs.

Approach to Measure Evaluation

CMS asked NQF to consider measures in six specialty areas: emergency care, eye care, gastrointestinal conditions, geriatrics, osteoporosis, and skin conditions (melanoma).

Identifying Candidate Consensus Standards

The process for identifying the universe of candidate consensus standards, evaluating measures, and review by the TAPs was the same as used in previous ambulatory care project activities.¹ NQF staff used

¹National Quality Forum (NQF), *National Voluntary Consensus Standards for Ambulatory Care: Part 1*, Washington, DC: NQF; in press.

several strategies to identify candidate consensus standards:

- open solicitation of measures through NQF’s “Call for Measures.” From October 10, 2006, through November 8, 2006, the “Call” was distributed through the following avenues:
 - posted on NQF’s web site,
 - e-mailed to NQF Members,
 - e-mailed to all Ambulatory Care project Steering Committee and TAP members, and
 - e-mailed to more than 1,300 individuals requesting to be kept apprised of NQF activities;
- review of NQF-endorsed™ measures and other related, ongoing NQF consensus work to identify ambulatory care measures within other efforts; and
- active search of additional candidate consensus standards in the Agency for Healthcare Research and Quality’s National Quality Measures Clearinghouse.

Measures were excluded if an organization would not sign an intellectual property agreement or submit the information necessary for evaluation.

Purpose

NQF had previously endorsed the following purpose statement for ambulatory care measures and decided it also should apply to the specialty measures under consideration:

The purpose of this set of ambulatory care consensus standards is to improve the quality of ambulatory care – via accountability and public reporting – by standardizing quality measurement in ambulatory care settings, including physician offices, clinics, emergency rooms, and health centers.

Scope

The Steering Committee identified several criteria to define the scope of the measure set. The set of ambulatory care measures includes measures that are:

- suitable for physician/clinician practice level accountability;
- derived from all data sources;
- fully developed and precisely specified; and
- fully open source.²

Evaluation of Candidate Consensus Standards

NQF staff prepared detailed measure evaluations using standardized criteria established in NQF’s *A National Framework for Healthcare Quality Measurement and Reporting*.³ Information for the measure evaluations was obtained from the measure developers, literature review, and independent research. The TAP for each priority area provided preliminary review of the measure evaluations prepared by

²On January 29, 2003, the National Quality Forum (NQF) Board of Directors adopted a policy that NQF will endorse only fully open source measures. Open source is defined by NQF as being “fully disclosed” (i.e., data elements, measure algorithm, if applicable, and risk-adjustment methods/data elements/algorithms are fully described and disclosed; if calculation requires database-dependent coefficients that change frequently, the existence of such coefficients shall be disclosed and the general frequency with which they change shall be disclosed, but the precise numerical value need not be disclosed).

³NQF, *National Framework for Healthcare Quality Measurement and Reporting: A Consensus Report*, Washington, DC: NQF; 2002.

NQF staff and made recommendations to the Steering Committee based on the perceived strengths and weaknesses of each measure and technical reasons regarding whether or not the measure should be recommended.

Additionally, the Steering Committee provided guidance to the TAPs requesting recommendations regarding:

- the clarity and completeness of specifications, including definitions and coding;
- possible perverse incentives/unintended consequences;
- level of analysis;
- accountability/ability to influence process or outcome;
- some inference about data burden;
- consideration of all data sources; and
- when testing data are not provided by the developer, need for assessment of the “face validity” and feasibility of the data source.

The TAPs met in person or by conference calls to review the candidate consensus standards in each area. The TAP comments and recommendations⁴ were included in each measure evaluation. Summary tables were prepared to facilitate the Steering Committee’s consideration of the TAP comments and recommendations.

Harmonization of Similar Measures

Because some of the recommended clinician-level consensus standards are similar to the hospital-level measures, the TAPs and the Steering Committee discussed alignment

with hospital-level measures where needed, and they were advised of other harmonization efforts.

Specifically, in 2006 NQF led discussions with measure developers to review clinician- and hospital-level measures in use or under development for use by the Alliances and to facilitate aligning the measure specifications where alignment is desirable and critical. The Harmonization Work Group of the Quality Alliance Steering Committee strove to identify and take advantage of immediate opportunities to harmonize measures. Where harmonization was not possible in the near term, the Work Group identified next steps, including the establishment of a timeframe and the identification of responsible organizations to work toward further measures.

Recommendation of the Measures

The Steering Committee considered the measures in each area by conference call and in a meeting in Washington, D.C. Comments and recommendations from the TAPs formed the basis of the initial deliberations. The chairs or representatives of the TAPs attended the meeting to present their recommendations.

Criteria for Recommending Measures

The Steering Committee established several potential inclusion criteria in addition to the standardized measure evaluation criteria (importance, scientific acceptability,

⁴In addition, research recommendations made for the various measure categories can be found in the body of this report.

usability, and feasibility). The Steering Committee determined that the interest in quality and performance of ambulatory care is at the physician/clinician practice level and did not recommend exclusively community-level or health plan-level measures for this set.

The Steering Committee also identified priorities to select the set of consensus standards:

- clinician practice-level measures;
- measures that address vulnerable populations;
- measures that address all relevant populations;
- consideration of possible perverse incentives or unintended consequences;
- clarity and completeness of specifications;
- measures that have been pilot tested or that already are in use; and
- measures that address high variation, including over/underuse.

The Steering Committee determined that the following principles should also guide the selection of measures:

- The driving force of the measures is primarily accountability as well as quality improvement.
- The focus should be on who collects the data, rather than the data source per se.
- Measures should be feasible, controllable, and scientifically accurate.

General Issues

During the Steering Committee's deliberations about the measures, several themes recurred regardless of the specialty area.

CMS Plans for Implementation in the Physician's Quality Reporting Initiative

Discussion frequently focused on CMS's planned use of the measures in the Physician Quality Reporting Initiative (PQRI). Representatives from CMS advised that even though the agency had contracted for the development of the measures and would be using them in the PQRI, the measures are specified for broad use—that is, for use by many different potential implementers.

CPT-II and G Codes

The proposed measures are specified for many different data sources, including self-reporting by physicians using new codes on billing forms. TAP and Steering Committee members raised the concern that because the new CPT II and G-Codes have not been widely used, the clinician uptake, understanding and consistency of use, and therefore data reliability are unknown. The Steering Committee strongly recommended that the CPT II Codes be pilot tested and closely evaluated before widespread implementation, because there are no data from cognitive or field testing, and the effect of measurement on administrative burden, cost, and clinical care is unknown.

Exclusions

TAP discussions revealed concerns regarding the broad exclusions common to all of the measures, namely the exclusions for “medical reasons,” “patient reasons,” and “system reasons.” The Steering Committee acknowledged that it has recommended measures developed by the American Medical Association Physician Consortium for Performance Improvement (AMA PCPI) with the same exclusion specifications; however, specific concerns were raised by the TAPs, including the following:

- lack of definition for what is acceptable to include under each type of reason for exclusion;
- difficulty in determining whether the exclusions are appropriate without medical record review by a knowledgeable clinician;
- difficulties involved in auditing;
- the fact that broad categories of exclusions defined as “medical-,” “patient-” or “system-” related are likely to introduce a great deal of variability in the way the measures are reported, because physicians are likely to derive different interpretations regarding what should be excluded. The use of exclusions should be tracked and reported by physician groups if the current process for exclusions is implemented;
- issues involving the overall methodology of removing excluded patients from the denominator (patients for whom the service was measured). The denominator is affected by exclusions (as opposed to simply having the denominator be the true population and indicating what percent received the service). The TAP

recommended that the excluded patients be included in the denominator, but also recommended that a reason code should be provided to indicate why a service was not performed;

- certain reasons should not be acceptable exclusions, such as “patient did not feel like it”;
- the exclusions too easily let the clinician off the hook and may encourage “gaming”; and
- more narrowly defined exclusions could provide more meaningful information on reasons for excluding patients, such as lack of insurance coverage for a test or drug or religious reasons.

The Steering Committee requested additional information from the AMA PCPI/National Committee for Quality Assurance (NCQA) measure developers about the exclusions included in many of the measures. The measure developers provided guidelines for use of the three categories of exclusions in more detail and noted that the data would identify outliers that could be further evaluated.

The Steering Committee deliberations identified the following issues:

- Measure development is still imperfect; therefore, the current measures are what are available for use.
- These measures will be used prospectively by physicians, which will require them to decide whether a patient is excluded at the time of treatment. This leads to a deliberative thought process.
- Some physicians will overuse these exclusions; thus, further analysis will be needed to determine the reasons.

- The shared decisionmaking roles of physicians and patients regarding the right course of action are marked by tension.

“Low-Threshold” Performance

The Steering Committee noted that several of the measures address very basic clinical care processes, such as the examination of the eye or skin. Even though the measures address important conditions such as cataracts and melanoma, sufficient evidence was not presented to demonstrate a lack of performance or opportunity for quality improvement. Steering Committee members noted that, in the absence of evidence of an opportunity to improve performance, these “low-threshold” measures do not provide sufficient information about the quality of care to offset the burden of data collection and reporting. Additionally, Steering Committee members noted that the minimal nature of the measures does not have credibility with some stakeholder groups, particularly consumers and purchasers.

Measures for Specific Providers (Specialists)

The Steering Committee members strongly emphasized that they do not support the designation of measures designated for specific types of providers and that the measures should always be “patient centered.”

Bone and Joint Conditions (Osteoporosis)

NQF has previously endorsed five measures for bone and joint conditions, including one measure for osteoporosis. The Bone and Joint TAP was reconvened to review five newly developed measures from NCQA and AMA PCPI addressing osteoporosis management. The TAP noted that the proposed consensus standards address individual aspects of care in an important clinical area, but the TAP was concerned about the specifications rather than the processes of care being measured—particularly the new CPT II and G Codes and the use of broad exclusions.

Recommended Measures

Osteoporosis: communication with the physician managing ongoing care postfracture (AAFP/AAOS/AACE/AC Rheum/AMA PCPI/NCQA⁵)

The Bone and Joint TAP recommended this measure, with the only reservations being the lack of any previous use or testing and the broad exclusions. The TAP noted that although coordination of care for osteoporosis management is important, the evidence is limited that communication alone has an impact on improved coordination of care and outcomes. The Steering Committee accepted the Bone and Joint TAP recommendation.

Osteoporosis: screening or therapy for women aged 65 years and older (AAFP/AAOS/AACE/AC Rheum/AMA PCPI/NCQA)

The Bone and Joint TAP felt that the measure is consistent with the evidence, but had concerns about obtaining the

⁵See table 1 in the report or appendix A for the full names of the organizations, intellectual property owners, and measure developers.

information or auditing the five-year look-back period, which may lead to unnecessary repeat bone scans if reports are not available. The Steering Committee, while acknowledging the Bone and Joint TAP reservations, generally agreed that the measure addresses an important screening process for osteoporosis.

Osteoporosis: management following fracture (AAFP/AAOS/AACE/AC Rheum/AMA PCPI/NCQA)

TAP members observed that the measure gives equal credit for ordering or performing services, which in clinical terms are very different actions. The TAP also noted that the measure is triggered by “notification” of the fracture (rather than date of the fracture), which may not be an auditable element. Steering Committee members agreed with the Bone and Joint TAP recommendation to support the measure, but questioned the difference between this measure and the previously endorsed measure, Osteoporosis Management in Women Who Had a Fracture,⁶ noting only differences in age inclusions, exclusions, and data source. The measure developer advised that both were necessary because they will be used in different ways depending on the data source. Some Steering Committee members noted that redundancy has been a concern raised by NQF Members and used as a selection criterion by the Committee in the past. Nevertheless, the Steering Committee ultimately recommended the measure.

Osteoporosis: pharmacologic therapy (AAFP/AAOS/AACE/AC Rheum/AMA PCPI/NCQA)

The Bone and Joint TAP believed that the evidence base for the measure is strong, although it had issues with the specified time window. The Steering Committee

confirmed that the measure asserts that all patients with osteoporosis should be on Food and Drug Administration-approved pharmacologic therapy, which does not include vitamin D and calcium. The Steering Committee recommended the measure.

Measure Not Recommended

Osteoporosis counseling for vitamin D and calcium intake and exercise (AAFP/AAOS/AACE/AC Rheum/AMA PCPI/NCQA)

The Steering Committee discussed the value of the information obtained from this measure compared to the burden of data collection and reporting for patients of all ages. Although patients with osteoporosis should be counseled regarding osteoporosis prevention, the TAP felt that the important aspects were captured in the Osteoporosis Pharmacologic Therapy measure.

Eye Care

The Eye Care TAP reviewed eight proposed consensus standards developed by AMA PCPI and NCQA. The Eye Care TAP strongly recommended these measures as appropriate for all eye care professionals, including optometrists as well as ophthalmologists. The TAP also recommended that a set of measures to evaluate eye care specialists should include several areas of care.

Recommended Measures

Primary open angle glaucoma: optic nerve evaluation (AAO/AMA PCPI/NCQA)

The Eye Care TAP noted that this is a clinically important area and that while

⁶This voluntary consensus standard was endorsed in December 2006 in *National Voluntary Consensus Standards for Ambulatory Care: Part 1*.

the examination should always be done, this may not always happen. The Steering Committee requested clarification regarding whether there is any evidence that clinicians are not performing these examinations, and the measure developer noted that there have been at least two studies identifying gaps in care. The Steering Committee agreed to accept the Eye Care TAP recommendation of the measure.

Age-related macular degeneration (AMD): dilated macular examination (AAO/AMA PCPI/NCQA)

The Eye Care TAP noted that AMD is one of the primary reasons for vision loss in the United States. The TAP recommended this measure after the measure developer included additional codes for evaluation and management services. The Steering Committee agreed with the TAP recommendation in favor of the measure.

Diabetic retinopathy: documentation of presence or absence of macular edema and level of severity of retinopathy (AAO/AMA PCPI/NCQA)

The TAP recommended the measure after the measure developer added some missing evaluation and management codes. The TAP noted that this measure is important because timely intervention is important for patient outcomes. The Steering Committee agreed with the TAP recommendation.

Diabetic retinopathy: communication with physician managing ongoing diabetes care (AAO/AMA PCPI/NCQA)

The Steering Committee agreed with the TAP to recommend this important measure of care coordination.

Measures Not Recommended

Age-related macular degeneration (AMD): antioxidant supplement (AAO/AMA PCPI/NCQA)

The Eye Care TAP did not recommend this measure as initially specified because it appeared to be inconsistent with the evidence, and it ran the risk of resulting in unintended adverse consequences. It was noted there is Level I evidence to support use of a specific formulation of antioxidants for moderate to severe AMD; however, the TAP was concerned that the specifications of the measure do not include antioxidant therapy and that they do not specify therapeutic dosages for levels of severity for macular degeneration. The TAP also noted that the measure did not specifically include smokers as an exclusion group, which incurs the potential for harm. It also was noted that the TAP felt the Age-Related Eye Disease Study demonstrated the benefit of antioxidants only for those with moderate to severe macular degeneration and not for all patients with mild macular degeneration. The TAP was concerned about encouraging inappropriate use of the antioxidant, which has been shown to have side effects, particularly in smokers. The measure developers made changes to the specifications to address the TAP's concerns. The Steering Committee recommended the revised measure.

During the comment period, the Eye Care TAP Chair and the American Optometric Association advised the Steering Committee that a meta-analysis published in the February 28, 2007, issue of the *Journal of the American Medical Association*,⁷ raised patient safety concerns regarding the use of antioxidant supplements for primary and secondary prevention. Because the article has raised

⁷Bjelakovic G, Nikolova D, Gluud LL, et al., Mortality in randomized trials of antioxidant supplements for primary and secondary prevention, *JAMA*, 2007;297:842-857.

controversy regarding use of antioxidants for patients with age-related macular degeneration, the Steering Committee decided that recommending the measure would be premature.

Cataracts: assessment of visual functional status (AAO/AMA PCPI/NCQA)

The Eye Care TAP recommended this measure because of the high volume of cataract surgery performed in the United States and alignment of this measure with the evidence base. There are some data showing gaps in documented visual function status, although the relationship of actual gaps in care is not known. During its discussions, the Steering Committee asked for any evidence that the assessment of visual functional status was not being conducted and was not persuaded by the additional documentation provided. In the absence of any evidence of a gap in care, the Steering Committee did not recommend the measure.

Cataract(s): documentation of pre-surgical axial length, corneal power measurement, and method of intraocular lens power calculation (AAO/AMA PCPI/NCQA)

The TAP did not recommend this measure because of concerns with the “within a 6-month period” specification. The TAP noted that many adults have a cataract operation on each eye several months apart and that because adult eyes do not change within these parameters, the measure should not force additional, unnecessary examinations. The Steering Committee agreed with the TAP to not recommend the measure as currently specified.

Cataracts: pre-surgical dilated fundus evaluation (AAO/AMA PCPI/NCQA)

The TAP recommended this measure because of the high volume of cataract

surgery and some evidence that examination is not always documented. The Steering Committee was not persuaded that evidence of gaps in documentation relate to gaps in actual examination or implications for outcomes. The Steering Committee was reluctant to recommend a measure that would appear to establish a very low threshold for performance. The Steering Committee did not recommend the measure.

Gastrointestinal (GI) Conditions

The GI TAP evaluated 16 measures in 2 areas: 5 measures for gastroesophageal reflux disease (GERD) and 11 measures for polyp surveillance with colonoscopy. GI TAP members discussed the significant problem of GERD, which affects one in four Americans and carries risks of complications, including a very small risk of cancer. The GI TAP looked at the measures as specified, considered the evidence base for the processes of care being measured and any potential unintended consequences, and used the standardized grading schema.

Measures Not Recommended—GERD

Assessment for alarm symptoms (AGAI/AMA PCPI/NCQA)

GI TAP members noted that the measures’ denominators focus on patients with GERD, but the alarm symptoms listed address symptoms for other conditions that may be suspicious for malignancy. The GI TAP members agreed that the evidence shows that listing appropriate alarm symptoms for patients with GERD, such as dysphagia, bleeding, and weight loss, could confuse GERD with other conditions. The GI TAP recommended the measure should be changed so that the specifications

would include dysphagia as the only symptom specified, which is more consistent with the evidence in the GERD population. The measure developer declined to change the measure specifications and responded to a Steering Committee query; despite the lack of evidence, the developer still considered the measure to be good care. No evidence was available regarding opportunity for improvement, although the Steering Committee speculated that there could be an overuse issue embedded in the measure. Given its concerns, the Steering Committee decided not to recommend the measure as specified but encouraged further discussion between the measure developer and the GI TAP to address the concerns.

Upper endoscopy for patients with alarm symptoms (AGAI/AMA PCPI/NCQA)

GI TAP members were concerned that the specified alarm symptoms are inappropriate for patients with GERD, but acknowledged that this measure is important to ensure that patients receive further investigation when symptoms of GERD complications are identified. Additionally, TAP members felt that this measure is more directed to primary care decisionmaking on whether to refer a patient for endoscopy than to the gastroenterologist who will perform the procedure when a patient is referred. Steering Committee members noted a need for more specific exclusions, such as recent endoscopy or patient refusal. The Steering Committee generally felt that this was not a measure of specialty care.

Biopsy for Barrett's esophagus (AGAI/AMA PCPI/NCQA)

GI TAP members agreed that patients diagnosed with Barrett's esophagus should have a biopsy confirmation and noted that this is a measure specifically for endoscopists. The GI TAP pointed out

the lack of current codes for "suspected Barrett's," although there is an ICD-9 Code for "Barrett's esophagus" that is not included in the measure specifications. The GI TAP also voiced concern with putting "suspected Barrett's" in a patient's medical record – that diagnosis may be carried forward even if not confirmed – which may impact a patient's insurability and subsequent treatment. The Steering Committee suggested that the measure be reworked to meet the goal of evaluating whether patients who are diagnosed with Barrett's esophagus have a biopsy confirmation in the medical record.

Barium swallow (AGAI/AMA PCPI/NCQA)

The GI TAP members emphasized that this is a negative measure, noting that it is unlikely physicians will code for something they did not do. The GI TAP added that this measure may encourage physicians to perform endoscopies even though they are not indicated because they want to "do something," and this measure eliminates the barium swallow option. The Steering Committee agreed with the GI TAP and did not recommend the measure.

RDQ (Reflux Disease Questionnaire) (AstraZeneca)

The GI TAP discussed this patient survey measure to ascertain symptoms of GERD and acknowledged its good intent, but noted that there are multiple validated survey instruments for GERD symptoms, and there is no evidence of any relationship to outcome; additionally, the goal of the measure is unclear. TAP members also voiced concerns with language and the educational level required to use the instrument and noted that the survey tool has not been validated for all ages and populations. The Steering Committee accepted the GI TAP's recommendation against the measure.

Polyp Surveillance with Colonoscopy

Several Steering Committee members raised the concern that there may be patient safety concerns with colonoscopy, particularly regarding experience, volume of procedures and relationship to complication rates, and completion of the examination. The Committee suggested that measures should be developed that address these issues.

A group of 11 measures was submitted by the American Gastroenterological Association (AGA) Institute. The measure developers stated that these measures were originally designed for internal quality improvement and that they were aware that they would be judged for accountability and public reporting. The GI TAP determined that the measure Appropriateness of Follow-up Interval Recommended was the target measure and that several other measures in the group only assisted in providing preliminary definition of the denominator population.

Measures Not Recommended— Polyp Surveillance

Colonoscopy for polyp surveillance: description of polyp characteristics (AGA)

GI TAP members noted that describing polyps is included in the American Society of Gastrointestinal Endoscopy guidelines. GI TAP members questioned the use of the size categories “small, medium, large” and noted that there is evidence of underestimation of polyp size by 50 percent. The TAP suggested that it would be more appropriate to document an approximate polyp size in millimeters. The measure developer agreed to remove the “small, medium, large” designation. Although the

measure was recommended, some Steering Committee members opposed it because of the lack of codes but believed that the data would be easy to collect for this measure. Ultimately, the measure was not approved for endorsement by NQF membership because a single GI measure was not perceived to be useful by many stakeholders.

Colonoscopy for polyp surveillance: appropriateness of follow-up interval recommended (AGA)

GI TAP members agreed that this measure addresses an important patient management issue and an overuse problem. TAP members also noted that even though the follow-up recommendations may not be based on the most rigorous evidence, they reflect a broad consensus. It was noted, however, that the measure diverges somewhat from the guidelines of the various professional societies. The GI TAP members suggested that the measure could be improved using the exclusion codes, which would allow for more frequent screening when the colonoscopy is sub-optimal, such as lack of cecal intubation or poor preparation, and that this would be better than having a series of five distinct measures to achieve the same goal. The measure developers agreed to the recommended changes, and the GI TAP recommended the measure.

The Steering Committee, however, noted the complexity of the numerator statements and questioned how the data could be collected and audited without a registry or codes; the Committee noted that a flowsheet would be needed to identify the numerator. The Steering Committee decided that outside of using an electronic health record, the data collection would be burdensome, even though it also found the measure to be interesting at the system or plan level. The Steering Committee initially decided against advancing the measure.

The measure developer advised the Steering Committee that it would be willing to act swiftly to apply for the necessary CPT Category II Codes and address any other specification concerns. The Steering Committee then recommended the measure, which will be included in an addendum to this report.

Colonoscopy for polyp surveillance: cecal intubation rate (AGA)

Colonoscopy for polyp surveillance: cecal intubation documentation (AGA)

Colonoscopy for polyp surveillance: preparation adequacy documentation (AGA)

Colonoscopy for polyp surveillance: rate of preparation adequacy (AGA)

The GI TAP noted that these measures assist in providing preliminary definition of the denominator population that could better be served with exclusions for the Appropriateness of Follow-up Interval Recommended measure, rather than as separate measures. GI TAP members recommended that the processes in these four measures be included in a procedural report measure for all colonoscopies. The Steering Committee agreed that including measures for all colonoscopies (screening and surveillance), rather than just the subset that is biased to more senior, experienced specialists, would have more utility and face validity with other stakeholders.

Colonoscopy for polyp surveillance: assessment of polyp removal (AGA)

GI TAP members suggested that there are two parts to this measure: 1) description of removal and technique used and 2) description of completeness of the removal. The TAP believed that this measure needed exclusions codes. The Steering Committee discussed the referral bias in which larger polyps are referred to more skilled specialists and noted that

there are alternative therapies such as ablation. Some Committee members suggested that rather than risk an incomplete removal of a polyp, some colonoscopists might refer a patient for an inappropriate surgery.

Colonoscopy for polyp surveillance: pathology results present and reviewed (AGA)

GI TAP members agreed with the measure developer's goal of having a tracking method to ensure that pathology reports are not lost or overlooked. GI TAP members were concerned, however, with the technicalities of retrospectively obtaining the information to report the measures and suggested that this should be a facility measure to ensure that a reliable tracking mechanism for pathology reports exists for all procedures in all specialties. The Steering Committee agreed this is an important patient safety issue but noted that it would be better to create an overall pathology measure.

Colonoscopy for polyp surveillance: communication of results and follow-up interval to the patient (AGA)

Colonoscopy for polyp surveillance: communication of results and follow-up interval to the primary care physician (PCP) (AGA)

Colonoscopy for polyp surveillance: communication of results and follow-up interval to the referral source (AGA)

The GI TAP strongly supported the need for appropriate communications with all parties and realized that communication issues are important to a variety of stakeholders; however, GI TAP members pointed out that the timeframes of "within 7 days of pathology report" for reporting to patients and "within 14 days of examination date" for the primary care physician and referral source are arbitrary and questioned the evidence for or source of the timeframes. GI TAP members noted that the timeframe is based on the timing of the

pathology report and that this measure also is evaluating the performance of the pathology services. They noted that additional standardized, global measures of pathology performance are needed to address some of the delayed communication performance concerns that these measures attempt to evaluate. The Steering Committee agreed with the TAP but suggested that the implementation of these measures would be onerous.

Geriatrics

The Geriatrics TAP reviewed 14 measures.

Recommended Measures

Medication reconciliation (AGS/AMA PCPI/NCQA)

The Geriatrics TAP noted that it would strongly support this measure if all patients were included, and commented that excluding patients for the reason of unavailable information was not acceptable. They noted that the measure allows for 60 days in which to perform medication reconciliation, and thus the provider could obtain information during that period. The TAP advised that because of the importance of this measure, the denominator should include all patients. The results of measure reporting should enable the user to determine how many patients actually received medication reconciliation. The Steering Committee strongly agreed with the Geriatrics TAP that the measure should apply to all patients and would only recommend the measure if the specifications were changed to remove the exclusions. The measure developer agreed to revise the specifications.

Urinary incontinence (UI): assessment of presence or absence of UI in women aged 65 years and older (AGS/AMA PCPI/NCQA)

The Geriatrics TAP noted that the problem of urinary incontinence is underdiagnosed and under treated. The Steering Committee agreed with the Geriatrics TAP recommendation to advance the measure.

Urinary incontinence: characterization of UI in women aged 65 years and older (AGS/AMA PCPI/NCQA)

The Geriatrics TAP recommended the measure because appropriate characterization of UI addresses the problem of inappropriate use of incontinence medications – that is, use for the wrong indications. The Steering Committee agreed with the Geriatrics TAP recommendation.

Urinary incontinence: plan of care for UI in women aged 65 years and older (AGS/AMA PCPI/NCQA)

Geriatrics TAP members supported this measure and noted that UI care is often inappropriate because of lack of proper evaluation of contributory causes, such as medication for another condition that triggers the UI. The TAP noted that patients often undergo inappropriate testing and treatment resulting from insufficient evaluation and planning. The TAP supported this measure with changes to its specifications to allow other medication changes – not just a new prescription – as an intervention, because UI can be triggered by certain medications. The measure developers made the suggested changes to clarify what is included in a plan of care, and the Steering Committee recommended the measure.

Screening for future fall risk (AGS/AMA PCPI/NCQA)

The Geriatrics TAP stressed the importance of fall risk assessment but noted that the measure as initially specified was simply a fall history applied to all patients over

age 65. The measure also defined risk within the body of the measure as a way to create a denominator for individuals to be further assessed. However, the TAP recommended that the measure should be consistent with American Geriatrics Society guidelines, which recommend a brief assessment after one fall (not two as indicated in the AGS/AMA PCPI/NCQA measure). The measure developers adjusted wording of the measure to more appropriately characterize it as a screening tool for future fall risk, but maintained the definition of risk as being two or more falls or any fall with injury. Steering Committee members noted that the measure would be less sensitive to risk, but more specific to high-risk patients. Geriatrics TAP and Steering Committee members disputed the measure's exclusion example "e.g., patient is not ambulatory" because bedridden and wheelchair patients may fall also, and they questioned why exclusions were needed for the measure. Nevertheless, the Steering Committee recommended that this measure of risk-assessment for future falls go forward.

Advance care plan (AGS/AMA PCPI/NCQA)

The geriatrics measure—advance care planning—originally was evaluated as part of the ambulatory care specialty clinician performance measures, but although the concept was strongly supported by the TAP and Steering Committee members, the original measure specifications were not recommended. The Geriatrics TAP and the Steering Committee would have supported the measure if a denominator change was made that would not permit routine exclusions (exclude only non-competent individuals), as well as a change in the numerator that would allow for meaningful discussion along with medical record documentation (narrative). Steering Committee members were concerned that even though

some patients are not ready to make decisions, the discussion should be broached to encourage planning. Ultimately, during a later phase of the ambulatory project, a revised measure that addressed all of the TAP and Steering Committee concerns was submitted for consideration, and the advance care plan measure was recommended.

Measures Not Recommended

Follow-up after hospitalization (AGS/RAND)

The Geriatrics TAP believed that this is an intuitively important measure, but that it is difficult to identify the evidence base for follow-up given the range of options allowed in the measure. The options allowed include visits and telephone calls, which may not provide the clinical impact needed to influence outcomes. TAP members suggested this should be a system-level measure and pointed out that because a telephone call is not a billable event, data collection is uncertain through CPT-II Codes. The Steering Committee agreed and also agreed with the Geriatrics TAP that the age specification of 75+ years is too limited and did not recommend the measure.

Evaluate function for older patients at new primary care outpatient appointment and hospital admission (AGS/RAND)

The Steering Committee agreed with the Geriatrics TAP that this measure would be more useful as two separate measures because the need for and process of functional assessment would be different in the hospital and outpatient settings. The measure developer noted that the measure was intended for the hospital, group, or plan level. The Steering Committee did not recommend that the measure go forward as a clinician-level measure.

Evaluate cognition for older patients at new primary care outpatient appointment and hospital admission (AGS/RAND)

The Steering Committee agreed with the Geriatrics TAP that this measure would be more useful as two separate measures, one for the inpatient setting and one for the outpatient setting. Cognitive assessment would be different in different settings. The measure developer noted that the measure was intended for the hospital, group, or plan level. The Steering Committee did not recommend that the measure go forward as a clinician-level measure.

Caregiver education for persons with dementia (AGS/RAND)

The Geriatrics TAP noted high variability regarding what constitutes caregiver education. The TAP suggested that the evidence base on the need for caregiver support is strong, but that the evidence base on what constitutes effective interventions is not clear. In addition, the measure would allow for a range of interventions, many of which could be implemented in a manner that is not clinically meaningful. The measure developer explained that caregiver education is defined as “information about dementia diagnosis and prognosis, behavioral issues, and patient safety” and that referral to a social worker is considered to cover all three areas. The Steering Committee and the Geriatrics TAP did not recommend the measure.

Check thyroid and vitamin B12 for new dementia diagnosis (AGS/RAND)

The Geriatrics TAP did not find this measure to be consistent with current evidence or guidelines. The guidelines do not recommend B12, and the methymalonic acid, or MMA, test is more precise than the test for B12. The measure developer agreed to withdraw the measure.

Evaluate for reversible causes of weight loss or malnutrition (AGS/RAND)

The Geriatrics TAP noted that this is a reportable measure for long-term care, but in outpatient settings there is a lack of definition regarding what should be done and when. The Steering Committee and the Geriatrics TAP did not recommend the measure.

Emergency Care

The Emergency Care TAP reviewed nine proposed consensus standards, including seven new measures from AMA PCPI and NCQA, one from the CMS Physician Voluntary Reporting Program (PVRP) starter set, and one submitted as a geriatrics measure. The TAP and Steering Committee identified many general issues that recurred throughout the deliberations on these measures:

- Individual physician measurement, rather than collective department performance, has not been validated in the emergency department setting, with respect to either the validity of the data (i.e., ability to gather and correctly attribute the relevant data points) or the ability of individual clinician measurement to positively influence patient outcomes.
- The attribution of emergency care patients may be confounded by special characteristics of the emergency department such as shift change and hand-offs; inaccurate “physician of record” who is arbitrarily assigned on admission; and other clinicians participating in care such as specialists, residents, and nurse practitioners. The burden of identifying and attributing proper physician accountability was believed to be enormous.

- Emergency department physician billing may be distinct from facility/hospital billing mechanisms and may be done by an off-site billing company. An automated approach will therefore require merging the disparate databases. The diagnosis codes on the two billing forms may not match. The real-time collection of CPT-II or G Codes during the delivery of care to the patient is unrealistic in a busy emergency department, and retrospective chart review will be required to identify the proper coding.
- The patient population captured by these measures and the meaning of “emergency department discharge diagnosis” might be problematic. The AMA PCPI and NCQA measure developers stated the intent of the measures are intended to apply to all patients discharged from the emergency department, including those admitted to the hospital or intensive care unit, transferred to another healthcare facility, or sent home. For patients who are hospitalized, the “emergency department discharge diagnosis” at the time of admission to the hospital may be quite different from the final hospital discharge diagnosis at the time of discharge from the hospital stay. The emergency department discharge diagnosis, for example, may be undifferentiated chest pain, but the hospital discharge diagnosis may be acute myocardial infarction (AMI).

Recommended Measures

Electrocardiogram (ECG) performed for non-traumatic chest pain (ACEP/AMA PCPI/NCQA)

The Emergency Care TAP recommended the measure to the Steering Committee because it has strong face validity and has been in widespread use. Also, the current variation in care is significant. However, the Emergency Care TAP warned that medical documentation generally supports the clinical decisionmaking process regarding why certain tests were ordered rather than why specific tests are not ordered. To require a clinician to document why an ECG was not performed may potentially lead to the unintended consequence of overutilization of clinically unnecessary ECGs. The Steering Committee accepted the TAP recommendation of the measure.

Aspirin at arrival for AMI (ACEP/AMA PCPI/NCQA)

The Emergency Care TAP advised the Steering Committee that there is strong evidence of the relationship to outcomes and that this measure has been tested at the institution level looking at hospital discharge data. The Emergency Care TAP noted, however, that the emergency department discharge diagnosis on admission to the hospital (e.g., “undifferentiated chest pain” or “weakness”) might be different from the hospital discharge diagnosis based on later developments (e.g., “AMI”). The Steering Committee agreed with the TAP and recommended the measure.

Electrocardiogram performed for syncope (ACEP/AMA PCPI/NCQA)

The Emergency Care TAP supported a revised measure with a revised age inclusion of >60 years. The Emergency Care TAP noted that the original denominator of patients >18 years included many young

patients with vaso-vagal syncope for which an ECG would not be indicated. The Steering Committee supported the Emergency Care TAP's recommendation of the measure.

Assessment of oxygen saturation for community-acquired bacterial pneumonia (ACEP/AMA PCPI/NCQA)

The Emergency Care TAP supported the measure with revised numerator wording consistent with the specifications and CPT-II Codes. The measure developer specified that the medical record may include one of following: clinician documentation that oxygen saturation was reviewed, dictation by the clinician including oxygen saturation, clinician initials in the chart that oxygen was reviewed, or other indication that oxygen saturation had been acknowledged by the clinician. With this clarification, the TAP noted that the measure is supported by good scientific evidence and reliability and recommended the measure. The Steering Committee also recommended the measure.

Assessment of mental status for community-acquired bacterial pneumonia (ACEP/AMA PCPI/NCQA)

The Emergency Care TAP agreed to recommend the measure after the measure developer provided clarifying language regarding what is meant by mental status assessment (documentation by physician that patient's mental status was noted, e.g., patient is oriented or disoriented). The Steering Committee accepted the TAP recommendation.

Empiric antibiotic for community-acquired bacterial pneumonia (ACEP/AMA PCPI/NCQA)

The Emergency Care TAP noted that this measure is consistent with strong national guidelines. The Steering Committee accepted the TAP recommendation.

Measures Not Recommended

Vital signs recorded and reviewed for community-acquired bacterial pneumonia (ACEP/AMA PCPI/NCQA)

Although the Emergency Care TAP supported the measure with revised specifications, including a definition of "documented and reviewed," the Steering Committee did not recommend this measure because it was believed that recording vital signs is likely universal and that review of vital signs likely has a high level of adoption. The Committee also noted that "gaming" might be an unintended consequence of reporting this measure.

Acute myocardial infarction patients who received beta blocker within 24 hours before or after hospital arrival (CMS PVRP 2006)

The Emergency Care TAP members did not recommend this measure because the evidence does not support a specific, "within 24 hours" timeframe for use (unlike aspirin use), and there is recent evidence that beta blocker use may be problematic or harmful in patients who have unstable vital signs in the emergency department. Additionally, the Emergency Care TAP noted that the diagnosis of "AMI" is rarely made in the emergency department, but rather during a hospital admission in a majority of cases. Even when the diagnosis is made in the emergency department, the admitting physician assumes the ongoing care for most of the initial 24-hour period. Both factors put this requirement as specified beyond the control of the emergency physician in most cases. The Steering Committee agreed that the evidence does not support this measure as specified. The Committee noted that without appropriate exclusions this measure might be harmful in any setting and did not recommend this measure.

Contact continuity provider from emergency room (AGS/RAND)

The Emergency Care TAP did not recommend this measure because although communication is important, experience shows that communication systems are variable, complex, and often system based, and there is no evidence that this process affects outcomes. The Emergency Care TAP believed that the measure would not be productive, would be a burden that could affect ability to deliver care, and would disrupt relationships with community physicians. The Geriatrics TAP did not recommend the measure unless the specifications were changed to indicate chart review only or automated hospital system review with verification of effectiveness. Steering Committee members, however, decided that the measure addressed an important issue concerning care coordination and communication among providers and recommended the measure go forward, but agreed that clarification was needed regarding the term contact to ensure that physicians consistently interpret this measure. The Steering Committee also identified several technical questions about the measure specifications that should be addressed before the measure is ready to move forward.

Skin Conditions (Melanoma)

The Dermatology TAP did not recommend any of the three measures evaluated:

Melanoma: patient medical history (American Academy of Dermatology (AAD)/AMA PCPI/NCQA)

Melanoma: complete physical skin examination (AAD/AMA PCPI/NCQA)

Melanoma: counseling on self-examination (AAD/AMA PCPI/NCQA)

The Dermatology TAP noted that the specifications would apply to any provider seeing a patient with a history of melanoma, including primary care providers and surgeons, as well as dermatologists. The Dermatology TAP was concerned that generalists may not feel comfortable doing a “complete skin exam” as it is understood by dermatologists and that the option to refer the patient is not included in the specifications. The Dermatology TAP also noted that the visit level for primary care providers and dermatologists might be different.

Steering Committee members asked whether there is any evidence that examinations are not being performed by dermatologists or other clinicians and noted that these measures are very low thresholds of performance. The Committee noted that ambulatory care measures previously endorsed for primary care are more rigorous. Several Committee members strongly emphasized that they do not support measures being designated for specific types of providers and that the measures should always be “patient centered.” The Steering Committee did not recommend any of the measures because of the lack of evidence for any opportunity for improvement; because measuring basic competency rather than performance raises credibility with stakeholders; and because they believed that quality performance measures should be more rigorous.

NATIONAL QUALITY FORUM

Appendix E

Selected References

The following list of references summarizes the evidence considered and reviewed during the screening, evaluation, and selection of measures for the National Quality Forum-endorsed™ voluntary consensus standards. Evidence includes literature that supports a measure's responsiveness to the evaluation criteria (importance, scientific acceptability, usability, and feasibility).

Bone and Joint Conditions (Osteoporosis)

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NATIONAL QUALITY FORUM

Appendix F

Consensus Development Process: Summary

The National Quality Forum (NQF), a voluntary consensus standards-setting organization, brings together diverse healthcare stakeholders to endorse performance measures and other standards to improve healthcare quality. Because of its broad stakeholder representation and formal Consensus Development Process (CDP), NQF-endorsed™ products have special legal standing as voluntary consensus standards. The primary participants in the NQF CDP are NQF member organizations, which include:

- consumer and patient groups;
- healthcare purchasers;
- healthcare providers, professionals, and health plans; and
- research and quality improvement organizations.

Any organization interested in healthcare quality measurement and improvement may apply to be a member of NQF. Membership information is available on the NQF web site, www.qualityforum.org.

Members of the public with particular expertise in a given topic also may be invited to participate in the early identification of draft consensus standards, either as technical advisors or as Steering Committee members. In addition, the NQF process explicitly recognizes a role for the general public to comment on proposed consensus standards and to appeal healthcare quality consensus standards endorsed by NQF. Information on NQF projects, including information on NQF meetings open to the public, is posted at www.qualityforum.org.

Each project NQF undertakes is guided by a Steering Committee (or Review Committee) composed of individuals from each of the four critical stakeholder perspectives. With the assistance of NQF staff and

technical advisory panels and with the ongoing input of NQF Members, a Steering Committee conducts an overall assessment of the state of the field in the particular topic area and recommends a set of draft measures, indicators, or practices for review, along with the rationale for proposing them. The proposed consensus standards are distributed for review and comment by NQF Members and non-members.

Following the comment period, a revised product is distributed to NQF Members for voting. The vote need not be unanimous, either within or across all Member Councils, for consensus to be achieved. If a majority of Members within each Council do not vote approval, staff attempts to reconcile differences among Members to maximize agreement, and a second round of voting is conducted. Proposed consensus standards that have undergone this process and that have been

approved by all four Member Councils on the first ballot or by at least two Member Councils after the second round of voting are forwarded to the Board of Directors for consideration. All products must be endorsed by a vote of the NQF Board of Directors.

Affected parties may appeal voluntary consensus standards endorsed by the NQF Board of Directors. Once a set of voluntary consensus standards has been approved, the federal government may utilize it for standardization purposes in accordance with the provisions of the National Technology Transfer and Advancement Act of 1995 (P.L. 104-113) and the Office of Management and Budget Circular A-119. Consensus standards are updated as warranted.

For this report, the NQF CDP, version 1.7, was in effect. The complete process can be found at www.qualityforum.org.

THE NATIONAL QUALITY FORUM (NQF) is a private, nonprofit, open membership, public benefit corporation whose mission is to improve the American healthcare system so that it can be counted on to provide safe, timely, compassionate, and accountable care using the best current knowledge. Established in 1999, NQF is a unique public-private partnership having broad participation from all parts of the healthcare industry. As a voluntary consensus standards setting organization, NQF seeks to develop a common vision for healthcare quality improvement, create a foundation for standardized healthcare performance data collection and reporting, and identify a national strategy for healthcare quality improvement. NQF provides an equitable mechanism for addressing the disparate priorities of healthcare's many stakeholders.

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