

Care Coordination Endorsement Maintenance 2012: Phases 1 and 2

TECHNICAL REPORT

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Care Coordination Endorsement Maintenance 2012: Phases 1 and 2

TECHNICAL REPORT

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

-National Strategy for Quality Improvement in Health Care, 2011

Background and Context

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

Because poorly coordinated care regularly leads to unnecessary suffering for patients, as well as avoidable readmissions and emergency department visits, increased medical errors, and higher costs, coordination of care is increasingly recognized as critical for improvement of patient outcomes and the success of healthcare systems. For example, individuals with chronic conditions and multiple co-morbidities—and their families and caregivers—often find it difficult to navigate our complex and fragmented healthcare system. As this ever-growing group transitions from one care setting to another, poor outcomes resulting from incomplete or inaccurate transfer of information, poor communication, and a lack of follow-up care become more likely. Yet the sharing of information across settings and between providers through electronic health records (EHRs) could reduce the unnecessary and costly duplication of patient services,¹ while the number of serious medication events could be reduced through patient education and the reconciliation of medication lists.² The Agency for Healthcare Research and Quality estimates that adverse medication events cause more than 770,000 injuries and deaths each year, more than half of which affect those over age 65.³ The cost of treating patients who are harmed by these events is estimated to be as high as \$5 billion annually.⁴ Furthermore, the Institute of Medicine has found that care coordination initiatives such as patient education and the development of new provider payment models could result in an estimated \$240 billion in savings.⁵

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

- Healthcare Home;

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

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

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

In its role as the convener of the National Priorities Partnership (NPP), NQF supports the priorities and goals identified by the Department of Health and Human Services' (HHS) National Quality Strategy.⁸ NPP has long supported care coordination as a national priority. In 2010, NPP convened a Care Coordination workgroup that identified actions to achieve reductions in 30-day readmissions. Workgroup members identified barriers to achieving this goal and discussed opportunities to leverage health information technology and build system capacity. In preparation for this workshop, NQF commissioned a background paper: *Aligning Our Efforts to Achieve Care Coordination*.⁹ This paper offered an overview of the national state of care coordination activities and recommended high-level drivers of change.

Meanwhile, The HIT team at NQF initiated a project to assess the readiness of electronic data and health IT systems to support quality measurement of care planning during transitions of care, as well as provide recommendations for advancing such infrastructure. The expert panel convened for this project completed a review of industry initiatives related to the plan of care use in care coordination, workflow and data components related to the plan of care, and identification of the characteristics of the plan of care. This work informed an environmental scan to develop a baseline understanding of the use of HIT to support transitions of care and quality measurement. NQF worked with Brigham and Women's Hospital to conduct the environmental scan, and the results demonstrate the opportunity to improve data capture and exchange to support patient-centered, longitudinal plans of care. The TEP will make recommendations to advance the capture of essential care plan data elements at the point of care, promote the adoption of interoperability standards, and enhance the use of care plan data in decision support. These recommendations could greatly advance quality improvement and measurement activities of care coordination.

Finally, NQF's Measure Applications Partnership (MAP) recently identified an initial group of measure families, sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the National Quality Strategy (NQS) priorities and high-impact conditions. MAP's Families of Measures report released on October 1, includes a Care Coordination Measure Family with 62 available measures and a number of measure gap areas. The family includes measures addressing avoidable admissions and readmissions, system infrastructure support, care transitions, communication, care planning, and patient surveys related to care coordination.

NQF's Current Care Coordination Project

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

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

- Phase I: Addressing implementation and methodological issues
 - Commissioned paper
 - Environmental scan
 - Development of Pathway Forward for Care Coordination measurement and development of the Call for Measures
- Phase II: Measure evaluation
 - Review of measures through the NQF Consensus Development Process
 - Prioritization of recommendations for Care Coordination measurement as part of continued work on the Pathway Forward

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

Unfortunately, despite targeted outreach and an extended *Call for Measures* period, no new measures were submitted to the second phase of this project, and the Committee therefore evaluated only the 15 previously-endorsed Care Coordination measures that were scheduled for maintenance review. Because of their concern that no new measures were submitted to the project and because they noted significant gaps within the currently endorsed portfolio of measures (most notably, the lack of the cross-cutting components of care coordination within the measures), the Committee also identified and prioritized future areas for Care Coordination measure development in the second phase of the project.

The remainder of this report details the work of both phases of the current project.

Phase One: Addressing implementation and methodological issues

Commissioned Paper: [Health Information Technology to Support Care Coordination and Care Transitions](#)

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

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

The authors of the paper structured their discussion using the seven constructs for measuring integrated patient care proposed by Singer and colleagues.¹⁰ Using this framework, the authors described data needs for care coordination and addressed current capabilities of clinical information systems to fulfill those needs. They outlined both organizational and technical barriers to improving the capabilities of HIT and health information exchange. Finally, they proposed strategies to address each barrier. The authors stressed the importance of the continued development of core care coordination standards, incentivizing those standards industry-wide, and developing tools that can be used to electronically capture all of the elements in these standards.

The Committee noted, however, the importance of questioning whether information collected and transferred across systems actually measures care coordination in a meaningful way. They emphasized a fundamental principle of measure development: that the concept must address meaningful components of care coordination before it ultimately becomes an electronic measure. For example, a measure capturing whether or not a transition record was transmitted to a patient could be strengthened and made more meaningful by adding an element evaluating whether or not that information was understood by the patient. The Committee agreed that all future measures should strive to capture meaningful elements of care coordination—such as patient and family understanding—and not merely transactional elements.

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

Environmental Scan: [Current Measures of Care Coordination & Gap Areas](#)

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

The author reviewed primary literature, including the [AHRQ Care Coordination Measures Atlas](#),¹¹ as well as consulting databases such as the [Quality Measures Clearinghouse](#)¹² and the [National Guideline Clearinghouse](#).¹³ All identified measures were mapped to the domains within the NQF and the AHRQ care coordination frameworks to demonstrate gap areas.

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

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

When mapping these measures to the NQF domains, it became clear that there is a lack of measures that truly evaluate transitions and communication between numerous settings. Also, while many of the measures fell within the Care Planning domain, most were measures of patient experience and did not examine critical care coordination activities such as the establishment of accountability and the communication of critical information. The findings of the scan, though not surprising, highlighted the need for cross-cutting measures as well as measures that incorporate community-level involvement and/or examine coordination for vulnerable populations.

Vision of the Care Coordination Pathway Forward

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

The Committee, understanding that care coordination measurement is a rapidly evolving field, emphasized the need to think of it in terms of “incremental build”,. They also recognized that existing measures may outlive their usefulness as the field evolves. Deliberations, therefore, were not limited to what is only currently possible or supported by HIT infrastructure, but also considered the ideal state of care coordination measurement for the future.

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

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

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

- **Close link to Outcomes**
 - Ideally, quality performance measures are based on evidence regarding the types of interventions and services that will achieve desired outcomes and reflect high-quality care. However, the effects of newer, innovative measures have not always been studied, and thus the Committee acknowledged the need to balance NQF evidence criteria with an openness for new and innovative ways to measure care coordination.
- **Process Measures**
 - As the field of measurement moves towards outcome measures, process measures such as appointment-making continue to remain important indicators of care coordination. For example, a meaningful measure may be one that ensures a follow-up appointment is completed successfully.
 - Process and adherence measures potentially could be rolled into a bundle to indicate the level of coordination of one's care.
- **High-Risk Populations**
 - All patients require some aspect of care coordination; however, there are certain high-risk populations for whom more in-depth and complex coordination is needed. Measures should strive to identify these high-risk populations through stratification by such elements as prior number of emergency-department visits or medication usage.
 - Measures may be solely focused on high-risk populations due to differences in the infrastructure needed to support these groups.
 - Measures that allow for risk-adjustment of outcomes are needed, particularly when reported at a population level or used for comparative purposes. Stratification by number of visits to the emergency department or medication usage could identify high-risk populations and support appropriate, targeted care. However, there is also concern with risk-adjusting too extensively, potentially masking sub-optimal care or hindering the identification of disparities.
- **Shared Plan of Care**
 - An ideal way of standardizing the care coordination process is through the use of a shared Plan of Care, which would be applicable to all patients, including the healthiest and those with chronic conditions.
 - A Plan of Care should be considered one that is updated on an ongoing basis and not owned by any one discipline, but driven by all care team members, including the patient, who would have the ability to access in its current state and upload home health information.
 - Measureable outcomes of goals are essential components of a Plan of Care.
 - The Plan of Care could additionally address issues of accountability, assigning different parties to various components of the Plan. However, it may be difficult to determine who ultimately is accountable for the Plan of Care.
 - The effectiveness of a Plan of Care depends upon the ability of the patient and his or her family to understand its contents. Therefore, health literacy and language barriers should be addressed at the onset of care in order to ensure meaningful patient and family engagement.
- **Cost**
 - Understanding the resource utilization associated with coordinating care will be increasingly relevant as reimbursement strategies are aligned with these functions. There is a need for measures that could begin to identify cost savings potentials of care coordination activities.

Also, as part of the discussion of the Pathway Forward, Committee members shared their knowledge of existing measures that should be considered in the second phase of the project; however, no new measures with adequate testing were identified. To ensure that care coordination measures submitted to NQF are meaningful and appropriate, the Committee agreed that the *Call for Measures* for this and future projects should reflect the high-priority areas discussed above. Also, the Committee agreed that specifications for EHRs should be included in measures submissions to the extent possible.

Phase Two: Measure Evaluation

Table 1: Care Coordination Endorsement Maintenance Summary

	Maintenance	New	Total
Measures under consideration	15	0	15
Withdrawn from consideration	0	0	0
Measures recommended	12*	0	12
Measures not recommended	3	0	1
Reasons for not recommending	Importance - 3		

* Includes two measures that are paired.

The second phase of the project focused on evaluating, through NQF’s Consensus Development Process, 15 measures that were scheduled for maintenance review. As previously noted, despite targeted outreach and an extended *Call for Measures* period, no new measures were submitted to this project.¹⁴

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

The Overarching Issues section outlines the concerns raised by the Committee and the preliminary votes on the four evaluation criteria for each of the fifteen measures evaluated, provided below in Table 2.

Overarching Issues

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

Limited evidence base

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

Reliability and validity

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

Feasibility

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

Terminology and lack of standardized definitions

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

Competing and related measures

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

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

For this project, the Committee addressed a total of 8 measures (seven from the current Care Coordination project and one that was evaluated in another project) that were identified as competing and/or related measures, as follows.

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

<p style="text-align: center;">0553</p> <p style="text-align: center;">Care for Older Adults – Medication Review</p> <p style="text-align: center;">(NCQA)</p>	<p style="text-align: center;">0419</p> <p style="text-align: center;">Documentation of Current Medications</p> <p style="text-align: center;">in the Medical Record</p> <p style="text-align: center;">(CMS)</p>
Includes medication review and documentation of a medication list in the medical record	Includes documenting of medications, including all prescriptions, over-the-counters, herbals, vitamin/mineral/dietary supplements and must contain the name, dosages, frequency, and route
Includes patients age 66 years and older	Includes patients age 18 years and older
Measured at least once in the measurement period—but an outpatient visit is not required	Measured at each outpatient encounter
Can be fulfilled by a provider with proscribing privileges or a clinical pharmacist	Can be fulfilled by an “eligible professional”

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

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

0097 Medication Reconciliation (NCQA)	0554 Medication Reconciliation Post-Discharge (NCQA)	0646 Reconciled Medication List Received by Discharged Patients (AMA-PCPI)
Includes patients age 65 years and older	Includes patients age 65 years and older	Includes all patients
Timeframe is 60 days	Timeframe is 30 days	Timeframe is each discharge
Can be fulfilled by a physician in a physician office	Can be fulfilled by a provider with proscribing privileges, clinical pharmacist, or nurse, and an outpatient visit is not required	Facility-level measure (setting is hospital)
Documented in medical record	Documented in medical record	Provided to patient
Clinician level of analysis	Health plan level of analysis	Facility level of analysis
Data from administrative claims	Data from administrative claims	Data for denominator from administrative claims, data for numerator from medical record

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

- Five transition record measures (#0647, #0648, #0649, #0558, and #0557) were identified as competing and/or related. On a conceptual level, all five of these measures address the provision of transition records for patients discharged from an inpatient setting. Measures #0558 and #0557, which were not evaluated in the current Care Coordination project, are specific to patients discharged from a hospital-based psychiatric setting. In initial discussions, the Committee had few comments regarding these two measures, other than noting that a strength of measure #0648 (as compared to #0558) was the specification of a time frame for when the transition record should be sent. Additional discussion of measures #0557 and #0558 by the Care Coordination Steering Committee was suspended because these measures will be evaluated in a behavioral health project later in the year. An additional measure (#0338) was initially identified as a competing/related measure and discussed by the Committee. Since that discussion, however, this measure was evaluated in an NQF project examining

pulmonary measures, and was not recommended as suitable for endorsement; thus, it was not be considered further in this project.

- The three transition record measures that were evaluated in this project differ in the following ways:

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

In their discussion of these three transition record measures, Committee members noted that transition records should always be shared with the patient, but also cautioned that the information that should be transmitted to the patient (particularly information that aids in self-care management) may be different from what is transmitted to the next provider.

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

Measure developers were granted additional time during the public and member comment period to respond jointly (as appropriate) to questions surrounding the competing and related measures.

Several comments from NQF member organizations noted the need to combine or harmonize the measures in these three sets. After review of these comments and further discussion, the Committee voted on whether or not any measures among the three sets could be considered superior, and/or whether the measures were harmonized sufficiently for final recommendation for endorsement, based on NQF [guidance on related/competing measures](#) for these comparisons. The Committee did not ultimately recommend any of the identified measures as superior. The Committee did, however, urge developers to continue working towards harmonization, favoring endorsement of measures with the broadest possible applicability. In many cases, measure developers agreed to make specific modifications to their measures pending approval of their internal advisory panels.

Recommendations for Future Measure Development

In addition to the recommendations made by the Steering Committee during the first phase of the project to inform the *Call for Measures*, the Committee also made numerous recommendations for future development of care coordination measures during the second phase of the project. These recommendations emerged from their measure evaluation deliberations, as well as from a structured exercise in which they considered how the 25 NQF-endorsed Care Coordination Preferred Practices could be used to help shape measure development

and promote organizational progress toward better care coordination. Not surprisingly, there was substantial overlap in the recommendations from these two efforts; however, results from both are presented below.

Recommendations made as part of the measure evaluation process

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

1. Measure maturity

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

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

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

2. Using measurement to drive practice

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

3. Other recommendations

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

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

Recommendations made as part of a structured exercise

Because no new measures were submitted to the project, the Steering Committee embarked upon a separate, structured exercise in the second phase of the project to identify specific recommendations for future measure development. This work, in addition to the strategic recommendations made by the Steering Committee during the first phase of this project, is indicative of an urgent need to move the field forward to begin addressing significant measurement gaps. This discussion resulted in the identification of several essential care coordination measurement concepts (see table below).

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

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

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

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

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0097 Medication Reconciliation

[Specifications](#) [Submission](#)

Status: Maintenance, Original Endorsement: May 01, 2007 , Most Recent Endorsement: Jan 25, 2012

Description: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.

Numerator Statement: Patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented

The medical record must indicate that the physician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of a inpatient facility discharge medication.

Denominator Statement: All patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Integrated Delivery System, Population : County or City

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Registry, Paper Records

Measure Steward: National Committee for Quality Assurance **Other Organizations:** This measure was developed with the cooperation of the American Geriatrics Society, the National Committee for Quality Assurance and the American Medical Association.

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-19; M-7; L-0; I-0 1b. Performance Gap: H-21; M-4; L-1; I-0 1c. Evidence: Y-17; N-3; I-6

Rationale: Although much of the Steering Committee’s concern with this measure centered around the lack of evidence linking the process of medication reconciliation with improved patient outcomes, members cited professional knowledge and judgment to confirm that medication reconciliation is linked with the reduction of medical errors and polypharmacy, and improved patient outcomes.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-7; M-18; L-1; I-0 2b. Validity: H-3; M-21; L-2; I-0

Rationale: The Committee questioned the 60-day timeframe associated with the measure, noting that patients may be readmitted within 60 days. Developers explained that while a 30-day timeframe had been proposed initially, the sample size of patients with outpatient visits within 30 days of discharge was too small for accurate measurement and therefore the timeframe was expanded to 60 days. Committee members also commented that the measure description should reflect that additional clinical providers (not just physicians) can be included in this measure. One Steering Committee member asked for clarification about whether e-measure specifications are available for this measure, and the developer explained that they are currently working to develop e-measure specifications. Another Committee member noted that HL7 standards do not currently include a “reconciled medication list” element (only a “medication list” element) and that e-measure specifications for this measure will not be possible until additional elements are included in the HL7 standards.

0097 Medication Reconciliation

[Specifications](#) [Submission](#)

3. Usability: H-7; M-17; L-2; I-0

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

Rationale: Although this measure is included in PQRS, relatively few physicians reported on this measure in 2007.

4. Feasibility: H-7; M-16; L-3; I-0

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

Rationale: Steering Committee members were concerned with the burden of data collection and commented on the lack of more recent PQRS data that might indicate an increased rate of reporting of this measure. Developers explained that PQRS data are difficult to obtain from CMS.

5. Related and Competing Measures (5a. Harmonization; 5b. Superior to competing measures)

0554: Medication Reconciliation Post-Discharge

0646: Reconciled Medication List Received by Discharged Patients

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

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

0097 Medication Reconciliation

[Specifications](#) [Submission](#)

Public & Member Comment and Evaluation of Related and Competing Measures

Comments included:

- Comments suggested the use of a 30-day time frame because the majority of rehabilitation patients generally have a follow up appointment with a primary care physician within 30 days of discharge.
- Three supportive comments.

The Committee asked the developer a series of questions about the potential for combining and/or harmonizing measures.

Response: Measure #0097 is jointly maintained by NCQA and AMA-PCPI. Both developers have agreed, pending review and approval by their measure development workgroup, to combine measure #0097 with #0554. Specially, they propose aligning the time-frame. NCQA and AMA/PCPI propose the following changes to #0097 to combine these measures:

- Align time-frame for reconciliation to 30 days post-discharge
- Align text of numerator to define medication reconciliation identically between the two measures
- Align the eligible providers who can perform medication reconciliation
- Add a denominator subset to allow for measurement at the provider level. Currently the denominator for #0097 is more narrowly defined (patients with ambulatory visits) than the denominator for #0554 (all patients).
- Change the eligible population age range to all ages

The developer of #0554 (NCQA) has agreed to harmonize this measure to align with measures #0097 and #0646, pending approval of their advisory panels and subsequent approval by their membership organizations. Specifically, they propose expanding the age range of the eligible population for this measure to include all ages and aligning the language used in the numerator with #0097.

Measure development staff for NCQA and PCPI are in agreement with the Steering Committee comment on the need for an outpatient medication reconciliation measure for patients of all ages (i.e., not limited to the "age 65 and older" limitation of measures #0097 and #0554). Such a measure would unfortunately be beyond the purview of the Geriatrics Work Group, that developed measure #0097, jointly convened by NCQA and PCPI. The proposed measure would, however, be a logical and desirable addition to the earlier work (including measure #0646) of the Care Transitions Work Group convened by PCPI. Given multiple other measure development priorities, AMA currently has no immediate plans to reconvene that group, but would consider adding to our 2012-13 work plan if CMS funding is made available to support the development of additional care coordination measures.

Steering Committee Recommendation for Endorsement: Yes-17; No-4

Because measures #0097 and #0554 were identified as competing measures, with #0097 considered to be a subset of #0554, the Committee was asked to vote on whether they could recommend either #0097 or #0554 as the superior measure.

Voting results: Recommend #0097 as superior-1; Recommend #0554 as superior-3; Neither #0097 or #0554 is clearly superior-17

Rationale: The majority of the Committee members could not recommend either #0097 or #0554 as the superior measure and acknowledged the commitment from the developers to combine the measures in the near future. Thus, measure #0097 will go forward from the Committee as recommended for endorsement.

The Committee reiterated their desire for greater harmonization between the measures; however, they recognized advantages of both measures (e.g., need for medication reconciliation during an outpatient visit as well as in the absence of an office visit). The Committee also noted a need for alignment with future EHR requirements for medication reconciliation.

CSAC Review (July 12, 2012)

Decision: Approved for continued endorsement

Board Review (August 8, 2012)

0097 Medication Reconciliation

[Specifications](#) [Submission](#)

Decision: Ratified for continued endorsement

0171 Acute care hospitalization (risk-adjusted)

[Specifications](#) [Submission](#)

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

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

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

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

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

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

Risk factors include:

Prior Care Setting –

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

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

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

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

Age and Gender Interactions –

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

0171 Acute care hospitalization (risk-adjusted)

[Specifications](#) [Submission](#)

determined based on the patient's age at Stay_Start_Date.

CMS Hierarchical condition categories (HCCs) –

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

Details of the CMS-HCC model and the code lists for defining the HCCs can be found here:

https://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp

A description of the development of the CMS-HCC model can be found here:

<https://www.cms.gov/HealthCareFinancingReview/Downloads/04Summerpg119.pdf>

ESRD and Disability Status –

Original End Stage Renal Disease (ESRD) and current ESRD status are included as risk factors. Original disabled status and male, and original disabled status and female, are also included. Medicare beneficiaries with ESRD or disabled status represent a fundamentally different health profile.

Interaction Terms –

All interaction terms included in the 2008 and 2012 HCC risk adjustment models that were statistically significant predictors of ED Use and ACH were included. Interaction terms account for the additional effect two risk factors may have when present simultaneously, which is more than the additive effect of each factor separately. N/A - not stratified

Level of Analysis: Facility

Type of Measure: Outcome

Data Source: Administrative claims

Measure Steward: Centers for Medicare & Medicaid Services **Other Organizations:** Abt Associates, Inc.

Case Western Reserve University

University of Colorado at Denver, Division of Health Care Policy and Research

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-14; M-9; L-0; I-0 1b. Performance Gap: H-13; M-9; L-0; I-1 1c. Evidence:

Rationale: The Committee deemed this to be an important measure; however, they acknowledged the difficulty in “parsing” attribution for hospitalization between different providers and settings, especially since this is an “all-cause” measure that does not require the reason for hospitalization to be related to the reason for home health care. Because this is an outcome measure, the Committee was not required to vote on the evidence subcriterion. Developers noted that the measure takes a broad view of the impact that home health care can have on patient outcomes and pointed to the exclusion of planned hospitalizations; they also emphasized that they do not expect a zero-percent hospitalization rate. Because this is an outcome measure, the Committee was not required to vote on the evidence subcriterion.

<p>0171 Acute care hospitalization (risk-adjusted)</p> <p>Specifications Submission</p>
<p>2. Scientific Acceptability of Measure Properties (based on decision logic): Yes</p> <p>(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)</p> <p>2a. Reliability: H-14; M-10; L-0; I-0 2b. Validity: H-11; M-12; L-1; I-0</p> <p><u>Rationale:</u> The Committee expressed support for excluding planned hospitalizations from the numerator and for accounting for previous care settings in the risk model. When asked about the methods of reliability and validity testing and the exclusion of low-utilization payment adjustment (LUPA) episodes from the measure, developers clarified that they used the observed rate for their reliability testing, and acknowledged this testing to be “necessary but maybe not completely sufficient”. Further—to justify use of payment error audits as an appropriate method for validity testing—developers posited that there is no reason to believe that hospitals would be more likely to have erroneous claims for home health patients than for others. They also explained the exclusion of LUPAs as a decision made so as not to unfairly penalize an agency that may have had less time to impact a patient’s condition or that did in fact make a clinically appropriate decision to refer a patient to the hospital. Also, in response to a Committee member’s query, developers verified that “present on admission” information is not used in the measure, nor is the patient’s hospice or palliative care status.</p>
<p>3. Usability: H-11; M-13; L-0; I-0</p> <p><i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i></p> <p><u>Rationale:</u> A previous version of this measure (that is based on OASIS data) is currently reported on Home Health Compare. One Committee member noted that the complexity of the risk adjustment used for this measure may make its implications less understandable to the public.</p>
<p>4. Feasibility: H-17; M-7; L-0; I-0</p> <p><i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)</i></p> <p><u>Rationale:</u> Committee members noted that although the claims data that this measure is based on are routinely gathered, specialized knowledge (e.g., to apply the risk adjustment methodology) is necessary to compute the measure score.</p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement: Y-24; N-0</p> <p>Rationale: Although not perceived as a strong measure of care coordination per se, the Steering Committee agreed that this measure meets NQF criteria and is suitable for endorsement.</p>
<p>Public & Member Comment</p> <p>Comments included:</p> <ul style="list-style-type: none"> • One supportive comment
<p>CSAC Review (July 12, 2012)</p>
<p>Decision: Approved for continued endorsement</p>
<p>Board Review (August 8, 2012)</p>
<p>Decision: Ratified for continued endorsement</p>

0173 Emergency Department Use without Hospitalization

[Specifications](#) [Submission](#)

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

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

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

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

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

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

Risk factors include:

Prior Care Setting –

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

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

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

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

Age and Gender Interactions –

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

CMS Hierarchical condition categories (HCCs) –

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

Details of the CMS-HCC model and the code lists for defining the HCCs can be found here:

0173 Emergency Department Use without Hospitalization

[Specifications](#) [Submission](#)

https://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp

A description of the development of the CMS-HCC model can be found here:

<https://www.cms.gov/HealthCareFinancingReview/Downloads/04Summerpg119.pdf>

ESRD and Disability Status –

Original End Stage Renal Disease (ESRD) and current ESRD status are included as risk factors. Original disabled status and male, and original disabled status and female, are also included. Medicare beneficiaries with ESRD or disabled status represent a fundamentally different health profile.

Interaction Terms –

All interaction terms included in the 2008 and 2012 HCC risk adjustment models that were statistically significant predictors of ED Use and ACH were included. Interaction terms account for the additional effect two risk factors may have when present simultaneously, which is more than the additive effect of each factor separately. Measure is not stratified.

Level of Analysis: Facility

Type of Measure: Outcome

Data Source: Administrative claims

Measure Steward: Centers for Medicare & Medicaid Services **Other Organizations:** Abt Associates, Inc.

Case Western Reserve University

University of Colorado at Denver, Division of Health Care Policy and Research

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-14; M-10; L-0; I-0 1b. Performance Gap: H-12; M-11; L-1; I-0 1c. Evidence:

Rationale: There was some disagreement within the Committee regarding the impact of the measure in light of the fact that only 10 percent of home health patients who utilize the ED are not admitted (this would include approximately 230,000 ED visits, which is a very small percentage of total ED visits in the U.S.). Committee members noted that there are many drivers for ED use (e.g., cultural, legal, etc.) that may be outside of the control of home health agencies. There was also some concern that this measure might be somewhat misconstrued because in many cases, ED utilization is an appropriate response, even if the patient is not admitted. The developer reminded the Committee that variation in performance rates signals the likelihood that home health agencies can impact ED usage rates. Because this is an outcome measure, the Committee was not required to vote on the evidence subcriterion.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-13; M-10; L-1; I-0 2b. Validity: H-8; M-14; L-2; I-0

Rationale: This measure uses the same risk adjustment methodology, reliability/validity testing, and denominator exclusions as measure 0171. One Committee member asked for clarification about whether observation stays are included in this measure and the developer confirmed that they are included. Another Committee member asked if characteristics of the ED or the neighborhood were accounted for in the measure, and the developer stated that neither was included in the measure. Another Committee asked if the measure examined only potentially avoidable ED visits, and the developer clarified that this measure is an all-cause measure.

<p>0173 Emergency Department Use without Hospitalization</p> <p>Specifications Submission</p>
<p>3. Usability: H-5; M-18; L-1; I-0</p> <p><i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)</i></p> <p><u>Rationale:</u> One Committee member noted that, because of the time required for risk-adjustment, the measure may be less useful for internal quality improvement investigations. The developer informed the Committee that some testing has been done by CMS to ensure that the meaning of the measure, as represented on Home Health Compare, is understandable to the public.</p>
<p>4. Feasibility: H-14; M-9; L-1; I-0</p> <p><i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)</i></p> <p><u>Rationale:</u></p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement: Y-23; N-1</p> <p>Rationale: Although the Committee was concerned that clinical, legal, or cultural factors outside of the control of the home health agency also can influence ED use, and that the measure itself might encourage “cherry picking” of patients, they agreed that this measure meets NQF criteria and is suitable for endorsement</p>
<p>Public & Member Comment</p> <p>Comments included:</p> <ul style="list-style-type: none"> • One supportive comment
<p>CSAC Review (July 12, 2012)</p>
<p>Decision: Approved for continued endorsement</p>
<p>Board Review (August 8, 2012)</p>
<p>Decision: Ratified for continued endorsement</p>

0326 Advance Care Plan

[Specifications](#) [Submission](#)

Status: Maintenance, Original Endorsement: Nov 05, 2007 , Most Recent Endorsement: Jan 25, 2012

Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Numerator Statement: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Denominator Statement: All patients aged 65 years and older

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A

Level of Analysis: Clinician : Individual

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

Measure Steward: National Committee for Quality Assurance **Other Organizations:** This measure was developed with the cooperation of the American Geriatrics Society, the National Committee for Quality Assurance and the American Medical Association.

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-23; M-3; L-0; I-0 1b. Performance Gap: H-20; M-4; L-0; I-2 1c. Evidence: Y-15; N-4; I-7

Rationale: The Committee expressed strong support of the importance of advanced care planning for this population. There was overall agreement on both a gap in performance as well as an overall low performance for this measure, although there was a desire by some members of the Committee to see performance statistics for various population subgroups (e.g., underserved groups, cognitively impaired, etc.). Committee members also suggested that while there is strong evidence for the value of advanced care planning overall, there is less evidence linking advanced care planning to desired outcomes such as improved quality of life or potential cost savings.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-6; M-11; L-5; I-4 2b. Validity: H-2; M-11; L-7; I-6

Rationale: There was considerable difference of opinion between Committee members regarding the reliability and validity of the measure (note that there was a tie for validity). Much of the concern with this measure was related to how the measure is specified. Committee members were confused about what is actually being measured (i.e., that a “conversation” occurred, that various components of an advanced care plan, such as an advanced directive, durable power of attorney, etc.—have been documented, or some combination). They were also concerned about the time frame of the measure, since it seems to be measuring, on an annual basis, whether or not an advanced care plan is documented in the medical record—but is not measuring whether the plan has been updated, or at least discussed, at least annually. While the developer clarified that this measure holds the physician accountable for the documentation, Committee members maintained it is often other providers (e.g., nurse, social worker) who often have advanced care conversations with patients. Additionally, Committee members were concerned that advanced care planning conversations are actually occurring, but for some reason, they are not being captured with this measure through the use of CPT-II codes. There was also considerable discussion about the testing of the measure, and although the developer described inter-rater reliability testing done based on manual record abstraction, some Committee members were not convinced that adequate testing had been done to assure that reporting of a CPT-II code does in fact reflect actual documentation of advanced care planning in the medical record.

0326 Advance Care Plan

[Specifications](#) [Submission](#)

3. Usability: H-4; M-14; L-8; I-0

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

Rationale: Developers noted that the reporting rate submitted by the developer was based on all physicians, and that specialists or those with few patients age 65 years or older in their practice likely would not choose to report on this measure.

4. Feasibility: H-2; M-12; L-10; I-2

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

Rationale: There was disagreement among Committee members about the feasibility of this measure due to uncertainties about the specificity of the measure, its reliance on the use of CPT-II codes, the relatively low reporting rate of the measure in the 2008 PQRI, and reservations about capturing appropriate data elements in electronic systems.

Steering Committee Recommendation on Overall Suitability for Endorsement: Y-18; N-8

Rationale: Committee members recommended this measure as suitable for endorsement at this time because of the importance of the topic; however, the Committee strongly expressed their desire for better measures of advanced care planning.

0326 Advance Care Plan

[Specifications](#) [Submission](#)

Public & Member Comment

Comments included:

- Commenters were concerned that this measure is a “check-box” measure and will not have an effect on quality, outcomes, or cost.
- Suggested areas for improvement included specifying required elements for the advance care plan, including a broader array of providers who could be held accountable for, and empowered to, create and document such a plan in the patient record, measuring whether the advance care plan was followed and updated accordingly, and identifying and including patient preferences in the advance care plan
- The measure represents a reasonable starting point but more development is needed in this area

Developer Response:

- NCQA and AMA/PCPI agrees this measure is limited in the information it captures. However, it is important to note that even as a limited measure, performance (50% in 2010) demonstrates an important quality gap that needs to be addressed. There are many tools which are available to physicians to guide the advanced care planning discussion with patients and outline the important elements which should be documented. The measure specification provided by NCQA and AMA/PCPI on the AMA website lists several elements which may be important to include or discuss in the advanced care planning process. However, NCQA and AMA/PCPI believes the specific elements of an advanced care plan are best decided on by the provider and patient.
- We appreciate this comment and wish to clarify that this measure does not limit advanced care planning documentation to a physician.
- Regarding the comment that more development is needed in this area: NCQA appreciates the suggestion and encourages the development of more measures in this area.

Steering Committee Response: In their discussion of these comments, the Committee remained somewhat divided on this measure. One member reiterated concerns about the validity of the measure, and agreed with the commenters that it is a check-the-box measure. However, other members stated that while the measure, as specified, may not go far enough, it is better than nothing. The Committee agreed to re-evaluate the measure after further reviewing the measure specifications, notes from the in-person meeting, and comments. Upon re-evaluation, the Committee again decided to recommend the measure.

Vote Following Consideration of Public and Member Comments:

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

1a. Impact: H-12; M-4; L-2; I-0 **1b. Performance Gap:** H-11; M-7; L-0; I-0 **1c. Evidence:** Y-12; N-1; I-5

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

2a. Reliability: H-0; M-13; L-2; I-3 **2b. Validity:** H-0; M-11; L-4; I-3

Usability: H-5; M-9; L-2; I-2

Feasibility: H-3; M-11; L-2; I-2

Steering Committee Recommendation on Overall Suitability for Endorsement: Y-13; N-5

Rationale: While the Committee acknowledged weaknesses with the measure, they again noted the importance of the topic and encouraged developers to continue to refine the measure.

CSAC Review (July 12, 2012)

0326 Advance Care Plan

[Specifications](#) [Submission](#)

Decision: Approved for continued endorsement

- The CSAC, like the Steering Committee, was divided on the usefulness of this measure. Some members reiterated concerns that the measure, as currently specified, is a “check-the-box” measure that will not impact patient outcomes while others considered the measure “a starting point” that is necessary because currently the creation/discussion of an advance care plan is still far from standard practice. Some CSAC members voiced the idea that *not* recommending the measure might drive other developers to create a better, more meaningful measure; others however, voiced their belief that continued endorsement would at least signal to providers that creation of an advance care plan is an expected component of good quality care. Ultimately, the CSAC voted 9 to 5 (with one abstention), to support the Steering Committee’s recommendation for endorsement, noting that the measure should be considered as one step on the way to a more progressive measure that incorporates such aspects as patient and family understanding.

Board Review (August 8, 2012)

Decision: Ratified for continued endorsement

0494 Medical Home System Survey

[Specifications](#) [Submission](#)

Status: Maintenance, Original Endorsement: Aug 29, 2008 , Most Recent Endorsement: Jan 25, 2012

Description: The following 6 composites are generated from the Medical Home System Survey (MHSS). Each measure is used to assess a particular domain of the patient-centered medical home.

Measure 1: Improved access and communication

Measure 2: Care management using evidence-based guidelines

Measure 3: Patient tracking and registry functions

Measure 4: Support for patient self-management

Measure 5: Test and referral tracking

Measure 6: Practice performance and improvement functions

Numerator Statement: The composite measures do not have a typical numerator. Each composite is composed of elements; each element is made up of individual factors. The composite score is calculated by adding the element scores. The element scores are based on the proportion of individual factors with a satisfactory “yes” response (see Standards documentation for details).

Note: In the calculation algorithm, the measurement domains are termed “composites,” the measures within each domain are referred to as “elements,” and the items within a measure, or measure subcomponents, are referred to as “factors.”

Denominator Statement: N/A

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification None N/A

Level of Analysis: Clinician : Group/Practice

Type of Measure: Structure

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Healthcare Provider Survey, Management Data, Other, Paper Records, Patient Reported Data/Survey

Measure Steward: National Committee for Quality Assurance **Other Organizations:**

0494 Medical Home System Survey

[Specifications](#) [Submission](#)

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-10; M-11; L-1; I-0 1b. Performance Gap: H-6; M-13; L-3; I-0 1c. Evidence: Y-15; N-2; I-5

Rationale: The Committee agreed that the impact of a medical home is substantial, citing its inclusion in health reform regulations and alignment with both meaningful use and the preferred practices for care coordination endorsed by NQF in 2010. The Committee noted that while there is a fairly robust body of evidence that includes good quality studies, early evaluations of the medical home model have not yet shown, for the most part, significant impacts on health outcomes. Developers reminded the Committee that some more recent studies have shown some improved patient outcomes for diabetes care, as well as improvements in patient, physician, and staff satisfaction, and, in North Carolina, reduced hospitalizations and emergency room visits.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-2; M-17; L-3; I-0 2b. Validity: H-1; M-11; L-8; I-2

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

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

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

0494 Medical Home System Survey

[Specifications](#) [Submission](#)

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

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

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

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

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

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

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

Rationale: Although there were concerns about the difficulties in collecting data for this measure and the fit of this measure as a performance metric, the Committee stressed the importance of the medical home model and the role of this measure in advancing this model of healthcare delivery.

Public & Member Comment

Comments included:

- No comments were received for this measure

CSAC Review (July 12, 2012)

Decision: Approved for continued endorsement

Board Review (August 8, 2012)

Decision: Ratified for continued endorsement

0526 Timely Initiation of Care

[Specifications](#) [Submission](#)

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

Description: Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.

Numerator Statement: Number of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.

Denominator Statement: All home health episodes other than those covered by generic denominator exclusions.

Exclusions: No measure-specific exclusions.

Adjustment/Stratification: No risk adjustment or risk stratification N/A - process measure - not risk adjusted. Not stratified.

Level of Analysis: Facility

Type of Measure: Process

Data Source: Electronic Clinical Data

Measure Steward: Centers for Medicare & Medicaid Services **Other Organizations:** Abt Associates, Inc.

Case Western Reserve University

University of Colorado at Denver, Division of Health Care Policy and Research

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-13; M-11; L-0; I-0 1b. Performance Gap: H-6; M-14; L-3; I-1 1c. Evidence: Y-24; N-0; I-0

Rationale: On average, approximately 11 percent of home health patients do not receive their first home visit in the timeframe specified by the measure. Although only one article was cited as evidence for this measure, the Committee agreed that it was strong study. However, Committee members agreed to apply the exception for evidence, with unanimous consensus that the potential benefits of timely initiation of care would outweigh any potential harms.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-15; M-8; L-1; I-0 2b. Validity: H-8; M-15; L-0; I-1

Rationale: To test validity of the measure, developers analyzed the relationship between timely initiation of care and two other home health quality measures (acute care hospitalization and improvement in bathing). However, they found that timely initiation of care was associated with a higher likelihood of acute care hospitalization. In a workgroup call prior to the in-person Steering Committee meeting, the developers reported that a CMS-convened expert panel suggested that this unexpected result might be driven by the fact that this measure is collected only for those patients for whom home health care was actually provided (i.e., they wouldn't have hospitalization data for patients who did not get home care). During that call, workgroup members suggested that the denominator statement/exclusions should be modified so as to clarify that the measure is not capturing the complete set of patients for whom home healthcare was recommended.

3. Usability: H-18; M-6; L-0; I-0

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

Rationale: This measure is publicly reported on Home Health Compare. It is also reported in Home Health Outcome Based Quality Improvement (OBQI) reports and used in home health quality initiatives.

<p>0526 Timely Initiation of Care Specifications Submission</p>
<p>4. Feasibility: H-23; M-1; L-0; I-0 <i>(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)</i> Rationale: The Committee expressed no concerns regarding the feasibility of this measure.</p>
<p>Steering Committee Recommendation on Overall Suitability for Endorsement: Y-24; N-0 Rationale: After applying the exception for evidence, the Steering Committee agreed that this measure meets NQF criteria as suitable for endorsement.</p>
<p>Public & Member Comment Comments included:</p> <ul style="list-style-type: none"> • One comment suggested that the developer clarify “two days” to “two calendar days” to ensure that home health services are started in an appropriate timeframe • One supportive comment <p>Developer Response:</p> <ul style="list-style-type: none"> • Thank you for your comment. The method of calculating the acceptable timeframe for the “Timely Initiation of Care” measure involves comparing the relationships between dates collected from multiple items in the OASIS data set. These calculations are described in the “Numerator Statement” and “Numerator Details” sections of the NQF Measure Submission and Evaluation Form. It is the opinion of the measure developers that it would be preferable to have additional details about the time period contained in those sections, rather than adding the word “calendar” in the “Measure Description” section. There are regulatory requirements in the Home Health Conditions of Participation (CFR 484.55) regarding when agencies are required to start services.
<p>CSAC Review (July 12, 2012)</p>
<p>Decision: Approved for continued endorsement</p>
<p>Board Review (August 8, 2012)</p>
<p>Decision: Ratified for continued endorsement</p>

0553 Care for Older Adults – Medication Review

[Specifications](#) [Submission](#)

Status: Maintenance, Original Endorsement: Aug 05, 2009 , Most Recent Endorsement: Jan 25, 2012

Description: Percentage of adults 66 years and older who had a medication review; a review of all a member’s medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.

Numerator Statement: At least one medication review (Table COA-B) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Table COA-C)

Table COA-B Codes to identify medication review: Medication review (CPT 90862, 99605, 99606), (CPT-II 1160F)

Table COA-C Codes to Identify Medication List (CPT-II 1159F)

Denominator Statement: All patients 66 and older as of December 31 of the measurement year

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Paper Records

Measure Steward: National Committee for Quality Assurance **Other Organizations:**

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-19; M-7; L-0; I-0 1b. Performance Gap: H-14; M-12; L-0; I-0 1c. Evidence: Y-18; N-5; I-3

Rationale: The Committee expressed some concern about the mixed results from the body of evidence. Developers explained these mixed results by noting that the cited studies used varying definitions of medication review and examined medication review as only one of a bundle of interventions (with the “bundle” differing across studies). The Committee also commented on the statistics presented by the developer, noting the indication of improvement in performance from 2008 to 2010.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-9; M-14; L-2; I-1 2b. Validity: H-5; M-17; L-2; I-2

Rationale: Committee members noted the lack of specificity in the definition of a medication review and a concern that this might be a “checkbox” measure. Developers clarified that this measure includes both a medication list as well as a discussion about the medications. Committee members also questioned the optional exclusions allowed for health plans; developers noted that this was a mistake in the original submission materials and clarified that there are no exclusions for this measure.

3. Usability: H-7; M-17; L-2; I-0

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

Rationale: This is a HEDIS measure and is publicly reported.

0553 Care for Older Adults – Medication Review

[Specifications](#) [Submission](#)

4. Feasibility: H-3; M-19; L-4; I-0

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

Rationale: Committee members noted that medical record abstraction likely would be necessary to compute this measure. The developer clarified that they have specified this measure at the health plan level, but noted that plans may compute the measure at the clinician level.

5. Related and Competing Measures (5a. Harmonization; 5b. Superior to competing measures)

0419: Documentation of Current Medications in the Medical Record (*NOTE: This measure was not evaluated in the Care Coordination project but was recently reviewed in the Patient Safety Complications project.*)

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

Rationale: Despite concerns about the lack of specificity in the definition of medication review, the Committee found this measure to be suitable for endorsement.

Public & Member Comment and Evaluation of Related and Competing Measures

Comments included:

- Commenters suggested that #0553 and #0419 be further aligned.
- Comments suggested that the measure could require chart audit for most practices unless they had a compatible EHR with the correct data elements and HIE agreement with the health plan. The cost of chart audits could be prohibitively expensive to practices and health plans
- One commenter clarified that this measure includes both a medication list as well as a discussion about the medications
- One commenter noted that #0553 includes age 66 and older, not 65 and older

Steering Committee Response: Regarding the comment on the need for chart audits: Committee members agree that medical record abstraction likely would be necessary for this measure. However, 19 of the 26 Committee members rated this measure as having moderate feasibility.

The Committee asked the developer a series of questions about the potential for combining and/or harmonizing measures.

Developer Response:

NCQA appreciates the overlap between these measures and NCQA sees measure #0419 as a subset of #0553. An individual meeting the numerator for 0419 is necessary but not sufficient to fulfill the numerator for #0553. NCQA proposes modifying #0553 to become a composite measure which includes 0419 in addition to documentation that the medication list was reviewed for appropriateness by a prescribing practitioner. If this change is approved by the NCQA's measurement advisory panels, #0419 would become one factor in a larger composite measure. To facilitate this alignment, NCQA will propose the following changes to #0553.

- Change the age range to all ages. NCQA will continue to report performance and testing data only on the age 65+ population, but agrees this measure can apply to a broader population.
- Use similar language to define "documentation of medication list in medical record." NCQA will propose revising the language for updating the medication list to align with the language from measure #0419 (i.e. "All prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route")
- Use similar codes to define "documentation of medication list in medical record." NCQA will propose revising the codes to include the codes used in the numerator of measure #0419 (G8427). NCQA will continue to report only cases where both elements of the composite (documentation of medication list in medical record and review of medication for appropriateness by a prescribing practitioner) are met.

0553 Care for Older Adults – Medication Review

[Specifications](#) [Submission](#)

- Add a denominator subset to align with the denominator for #0419. Currently the denominator for #0419 is more narrowly defined (patients with ambulatory visits) than the denominator for #0553 (all patients).

NCQA will propose these changes to their measurement advisory panels in the Summer/Fall of 2012. If approved, these changes will go to public comment in February of 2013 and be voted on for final approval in Spring of 2013. If approved, NCQA will update measure #0553 during the NQF annual update with these changes.

Steering Committee Recommendation for Endorsement: Yes-12, No-9

Because measure #0419 was identified as competing measures, the Committee was asked to vote on whether they could recommend either #0553 or #0419 as the superior measure.

Voting results: Recommend #0553 as superior-5; Recommend #0419 as superior-4; Neither #0553 or #0419 is superior-12

Rationale: The majority of the Committee members could not recommend either #0419 or #0553 as the superior measure. They reiterated their desire for greater harmonization between the measures and acknowledged the commitment from the developer to modify #0553 in the near future. Thus, measure #0553 will go forward from the Committee as recommended for endorsement and the CSAC will review measures #0553 and #0419 at the same time.

CSAC Review (July 12, 2012)

Decision: Approved for continued endorsement

- The CSAC discussed this measure as it related to measure #0419, but did not recommend either measure as superior, and agreed to support continued endorsement of both measures, with the stipulation that the developers work toward harmonization by making agreed-upon modifications to their measures within six months.
- Progress on harmonization will be reviewed by the CSAC at its November 2012 in-person meeting. A memo comparing the two measures, summarizing their background, and detailing changes proposed by the developers can be accessed [here](#).

Board Review (August 8, 2012)

Decision: Ratified for continued endorsement

0554 Medication Reconciliation Post-Discharge

[Specifications](#) [Submission](#)

Status: Maintenance, Original Endorsement: Aug 05, 2009 , Most Recent Endorsement: Jan 25, 2012

Description: The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.

Numerator Statement: Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through administrative or medical record review on or within 30 days of discharge.

Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record, on or within 30 days after discharge.

Denominator Statement: All discharges from an in-patient setting for health plan members who are 66 years and older as of December 31 of the measurement year.

Exclusions: Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count the only the readmission discharge or the discharge from the facility to which the member was transferred.

Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records

Measure Steward: National Committee for Quality Assurance **Other Organizations:**

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-20; M-6; L-0; I-0 1b. Performance Gap: H-15; M-11; L-0; I-0 1c. Evidence: Y-20; N-4; I-2

Rationale: The Committee noted the limited evidence base for this measure, but reiterated their support for a medication reconciliation measure. Although the data provided by developers reflects a substantial gap in performance, the developers did not adequately describe how the data were collected and did not provide any data on disparities to illustrate a gap in performance.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-9; M-15; L-2; I-0 2b. Validity: H-6; M-18; L-2; I-0

Rationale: The Committee expressed confusion about why this measure is specified for those ages 66 and older while measure 0097 is specified for patients ages 65 and older. The developer explained that this is done to ensure that the patient was eligible for Medicare during the entire measurement year. The Committee also expressed confusion about the exclusion of discharges from the denominator. The developer clarified that they have specified this measure for the health plan level and explained that, although there was much debate prior to the decision, these exclusions were incorporated so as not to “double ding” health plans. There was also an extended discussion between Committee members and the developers concerning whether additional health plan data reflecting medication reconciliation (but stored external to the medical record) would be counted in the measure. Developers clarified that only reconciliations that are documented in the medical record are counted.

0554 Medication Reconciliation Post-Discharge

[Specifications](#) [Submission](#)

3. Usability: H-9; M-16; L-1; I-0

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

Rationale: This is a HEDIS measure and is publically reported.

4. Feasibility: H-6; M-16; L-3; I-1

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

Rationale: Developers noted that, as a HEDIS measure, this measure is routinely audited. However, Committee members noted that the developers did not provide results from these audits, nor did they discuss the extent and implications of missing data.

5. Related and Competing Measures *(5a. Harmonization; 5b. Superior to competing measures)*

0097: Medication Reconciliation

0646: Reconciled Medication List Received by Discharged Patients

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

Rationale: Despite concerns over the lack of evidence and some confusion over measure specifications, the Committee found this measure to be suitable for endorsement.

Public & Member Comment and Evaluation of Related and Competing Measures

Comments included:

- Comments suggested that #0097, #0554, and #0646 be harmonized to reflect the 30-day discharge timeframe. Additionally, commenters noted harmonization with #0097 is necessary to ensure that time and age elements are consistent
- One commenter suggested that medication reconciliation can be defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record, on or within 30 days after discharge.

The Committee asked the developer a series of questions about the potential of combining and/or harmonizing measures.

Developer Response:

- Although specified differently, the age range for measures #0097 and #0554 is harmonized to include all adults age 65 and older. Measure #0554 uses an age of 66 years or older at the end of measurement year to ensure all adults in the measure were 65 or older during the measurement year.
- In an effort to include the broadest possible eligible population, NCQA will propose expanding the age range of the eligible population for measure #0554 to include all ages and align the language used in the numerator with #0097. NCQA will continue to report performance and testing data for the 65+ population.

NCQA will propose these changes in the Summer/Fall of 2012 and, if approved, they will then go to public comment in February of 2013 and be given final approval in Spring of 2013. If approved, NCQA will update measure #0554 during the NQF annual update with these changes.

0554 Medication Reconciliation Post-Discharge

[Specifications](#) [Submission](#)

Steering Committee Recommendation for Endorsement: Yes-17, No-4

Because measures #0097 and #0554 were identified as competing measures, with #0097 considered to be a subset of #0554, the Committee was asked to vote on whether they could recommend either #0097 or #0554 as the superior measure.

Voting results: Recommend #0097 as superior-1; Recommend #0554 as superior-3; Neither #0097 or #0554 is clearly superior-17

Rationale: The majority of the Committee members could not recommend either as the superior measure and acknowledged the commitment from the developers to modify the measures in the near future. Thus, measure #0554 will go forward from the Committee as recommended for endorsement. The Committee reiterated their desire for greater harmonization between the measures; however, they recognized advantages of both measures (e.g., need for medication reconciliation during an outpatient visit as well as in the absence of an office visit). The Committee also noted a need for alignment with future EHR requirements for medication reconciliation.

CSAC Review (July 12, 2012)

Decision: Approved for continued endorsement

Board Review (August 8, 2012)

Decision: Ratified for continued endorsement

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

[Specifications](#) [Submission](#)

Status: Maintenance, Original Endorsement: May 05, 2010 , Most Recent Endorsement: May 05, 2010

Description: Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories

Numerator Statement: Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories:

Medications to be TAKEN by patient:

- Continued*

Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND

- New*

Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge

* Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed

Medications NOT to be Taken by patient:

- Discontinued

Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND

- Allergies and Adverse Reactions

Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued

Denominator Statement: All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.

Time Window: Each time a patient is discharged from an inpatient facility

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Adjustment/Stratification: No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Facility, Integrated Delivery System

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other**

Organizations: ABIM Foundation

American College of Physicians

Society of Hospital Medicine

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

[Specifications](#) [Submission](#)

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-23; M-1; L-0; I-0 1b. Performance Gap: H-18; M-6; L-0; I-0 1c. Evidence: Y-21; N-3; I-0

Rationale: Committee members strongly supported the clinical importance of medication reconciliation. There was some concern about the adequacy of the evidence because few (if any) studies have focused exclusively on the impact of medication reconciliation. However, several studies cited by the developers have found that medication reconciliation—as one component in a bundle of patient education interventions—can reduce adverse drug events and hospital readmissions; Committee members described these studies as “strong evidence” for medication reconciliation.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-2; M-17; L-4; I-1 2b. Validity: H-1; M-17; L-4; I-2

Rationale: Committee members noted that the sample size used for validity testing was small (n=100), that empirical testing was performed using EHR data from only one site, that validity using chart abstraction from paper records was not tested, and that none of the sampled records included patients discharged from a nursing facility. They also discussed the use of the terms “allergies”, “adverse reactions”, and “adverse events” in the numerator specifications and clarified that an adverse reaction is a subcategory of an adverse event, and that adverse events would not be recorded in an “allergy” field in an EHR. Committee members also expressed concern that the indication(s) for medications was not included as one of the elements in the reconciled medication; one member commented that the lack of indication would be “a big miss.”

3. Usability: H-10; M-13; L-0; I-1

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

Rationale: This measure is used in the Highmark Quality Blue Pay for Performance program (63 participating hospitals in 2011). Aggregate results are publicly reported.

4. Feasibility: H-5; M-16; L-2; I-1

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

Rationale: Developers expressed their belief that inclusion of the indication(s) for the medication in the reconciled medication list would adversely impact the feasibility of the measure by substantially increasing the burden of data collection and scoring of the measure.

5. Related and Competing Measures (5a. Harmonization; 5b. Superior to competing measures)

0097: Medication Reconciliation

0554: Medication Reconciliation Post-Discharge

Steering Committee Recommendation on Overall Suitability for Endorsement (pending decisions on related/competing measures): Y-24; N-0

Rationale: Although there were some concerns about the details of the measure specifications and validity testing, the Committee found this to be a high-impact measure with a strong evidence base.

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

[Specifications](#) [Submission](#)

Public & Member Comment

Comments included:

- Comments suggested that #0097, #0554, and #0646 be harmonized to reflect the 30-day discharge timeframe.
- One commenter noted that medication reconciliation is only a first step in improving health outcomes and also suggested that this measure fails to address the evaluation of actual medications in the home and the pattern of administration. These elements will provide insight into compliance and outcomes
- Three supportive comments

Steering Committee Response:

The Committee agrees that care coordination measures should reflect “the other side of the handshake” and has specifically noted the need for measures to address whether a patient actually understood the information (e.g., via teach-back). The Committee agrees with your suggestions for future measure development; we will update the report to include these suggestions.

The Committee asked the developer a series of questions about the potential of combining and/or harmonizing measures.

Developer Response:

- Thank you for your comment. These measures refer to multiple steps in the process of medication reconciliation. #0646 is medication reconciliation at the time of discharge performed by the inpatient provider and communicated to the patient. #0097 and #0554 are medication reconciliation post discharge performed by the usual care provider and documented in the medical record.

Also, the developer has noted willingness to make changes to measures #0097 and #0554 to better align with #0646, including changing the eligible population age range to all ages.

Steering Committee Recommendation for Endorsement: Yes-21, No-0

Rationale: After additional discussion and consideration of the responses made by the developer to harmonize measures #0097, #0554, and #0646, the Committee noted the importance of providing a medication reconciliation at the time of hospital discharge and unanimously re-affirmed their recommendation for endorsement for this measure.

CSAC Review (July 12, 2012)

Decision: Approved for continued endorsement

Board Review (August 8, 2012)

Decision: Ratified for continued endorsement

0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

*Paired with measure 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) [Specifications](#) [Submission](#)

Status: Maintenance, Original Endorsement: May 05, 2010 , Most Recent Endorsement: May 05, 2010

Description: Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements

Numerator Statement: Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements:

Inpatient Care

- Reason for inpatient admission, AND
- Major procedures and tests performed during inpatient stay and summary of results, AND
- Principal diagnosis at discharge

Post-Discharge/ Patient Self-Management

- Current medication list, AND
- Studies pending at discharge (eg, laboratory, radiological), AND
- Patient instructions

Advance Care Plan

- Advance directives or surrogate decision maker documented OR
- Documented reason for not providing advance care plan

Contact Information/Plan for Follow-up Care

- 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND
- Contact information for obtaining results of studies pending at discharge, AND
- Plan for follow-up care, AND
- Primary physician, other health care professional, or site designated for follow-up care

Denominator Statement: All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.

Exclusions: Patients who died.

Patients who left against medical advice (AMA) or discontinued care.

Adjustment/Stratification: No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Facility, Integrated Delivery System

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other Organizations:** ABIM Foundation

American College of Physicians

Society of Hospital Medicine

0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

*Paired with measure 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) [Specifications](#) [Submission](#)

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-16; M-6; L-0; I-0 1b. Performance Gap: H-10; M-10; L-1; I-2 1c. Evidence: Y-18; N-4; I-0

Rationale: Because this is a fairly new measure, data on performance gap was demonstrated primarily via references to the literature; however, data from the Highmark Quality Blue Pay for Performance program for 2011 suggests that performance is low (10% in quarter 1, 17% in quarter 2, and 38% in quarter 3). Developers relied mainly on a clinical guideline as the evidence base; however, they also cited references linking provision of discharge information/patient education to improved patient self-management /compliance and reduced hospital readmissions. Committee members questioned, however, whether the right elements have been included in the list of specified elements.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-2; M-14; L-4; I-3 2b. Validity: H-1; M-12; L-5; I-5

Rationale: Developers tested data element validity for 100 patients by comparing data from a report automatically generated from an EHR to a visual inspection of the full EHR. However, they supplied only overall statistics (88% agreement, kappa=.69) rather than statistics for each data element. They also provided results of a systematic assessment of face validity. The committee asked and received clarification that, to be counted in the numerator, the transition record must include all of the specified data elements, and the transition record must be reviewed with the patient and then given to the patient. Voting results on validity was split due to two main concerns. First, the empirical testing of the measure was done using data from only one site's EHR, which was customized to facilitate the review and printing of the transition record (note that e-measure specifications have not been provided because every facility may have a different template for a transition record in their EHR). Second, there was some uncertainty among Committee members as to whether additional testing is needed to illustrate measure validity if data are collected via manual abstraction from paper records. Steering Committee members suggested that developers be cautious about the terminology used in the measure specifications (particularly the term "inpatient", which some may erroneously interpret as hospital inpatient only).

3. Usability: H-14; M-6; L-3; I-0

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

Rationale: This measure is used in the Highmark Quality Blue Pay for Performance program (63 participating hospitals in 2011). Aggregate results are publicly reported.

4. Feasibility: H-8; M-11; L-3; I-1

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

Rationale: Committee members were somewhat divided on how difficult it might be to derive this measure from EHRs. However, there was general agreement that deriving this measure via chart abstraction (for organizations that do not have electronic systems) would be time consuming and expensive.

5. Related and Competing Measures (5a. Harmonization; 5b. Superior to competing measures)

0648: Timely Transmission of Transition Record

0649: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges)

0558: HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge

0557: HBIPS-6 Post discharge continuing care plan created

0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

*Paired with measure 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) [Specifications](#) [Submission](#)

Steering Committee Recommendation on Overall Suitability for Endorsement (*pending decisions on related/competing measures*): **Y-23; N-0**

Rationale: Although there were concerns about the need for additional validity testing and the burden of data collection for paper-based organizations, overall, the Committee found this to be an important measure with a relatively solid evidence base that met NQF evaluation criteria.

Public & Member Comment and Evaluation of Related and Competing Measures

Comments included:

- Comments suggested that the outcome targeted by this process measure is not clear.
- Three supportive comments

Steering Committee Response:

- The Committee reviewed the evidence for this measure and concluded that it meets the NQF subcriterion. While developers relied mainly on a clinical guideline as the evidence base for this measure, they also cited references linking provision of discharge information/patient education to improved patient self-management /compliance and reduced hospital readmissions.

The Committee asked the developer a series of questions about the potential of combining and/or harmonizing measures. *[Note: Additional discussion of measures #0557 and #0558 by the Care Coordination Steering Committee was suspended because these measures will be evaluated in a behavioral health project later in the year.]*

The developer noted that combining these measures in some way would negatively impact feasibility and would make it difficult to determine which component had caused the measure failure. They also argued that Emergency Department (ED) discharges are different than from inpatient hospital stays due to varied presentations and shorter timeframes, necessitating a separate ED measure with less stringent requirements for the transition record.

Steering Committee Recommendation for Endorsement: Yes-15, No-6

Because measures #0647, #0648, and #0649 are competing measures, the Committee was first asked to vote on whether there is a justifiable reason for a different transition record for inpatient facilities (#0647) and EDs (#0649).

Voting results: There is no need for a different ED measure-11; There is a need for a different ED measure-10.

The Committee was also asked to vote on whether there is a need for two separate measures to track provision of a transition record to the patient (#0647) and to the next provider (#0648).

Voting results: There is a need for separate measures-15; There is not a need for separate measures-6

Rationale: The Committee noted a need for different content and presentation (particularly in relation to language and health literacy) in a transition record that is given to the patient compared to one given to the next provider. They also agreed that measures #0647 and #0648 be should be designated as paired measures. Thus, this measure will go forward from the Committee as recommended for endorsement, to be paired with measure #0648.

CSAC Review (July 12, 2012)

Decision: Approved for continued endorsement

Board Review (August 8, 2012)

Decision: Ratified for continued endorsement

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

*Paired with measure 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

[Specifications Submission](#)

Status: Maintenance, Original Endorsement: May 05, 2010 , Most Recent Endorsement: May 05, 2010

Description: Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge

Numerator Statement: Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge

Denominator Statement: All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Facility, Integrated Delivery System

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other**

Organizations: ABIM Foundation

American College of Physicians

Society of Hospital Medicine

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-23; M-0; L-0; I-0 1b. Performance Gap: H-15; M-8; L-0; I-0 1c. Evidence: Y-18; N-5; I-0

Rationale: Data on performance gap was demonstrated primarily via references to the literature. Data from the Highmark Quality Blue Pay for Performance program for 2011 suggest that performance is not optimal (30% in quarter 1, 50% in quarter 2, and 80% in quarter 3); however, developers did not provide distributional statistics to show the extent of variation in the measure.

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

*Paired with measure 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

[Specifications Submission](#)

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-2; M-16; L-3; I-2 2b. Validity: H-2; M-15; L-3; I-2

Rationale: Steering Committee members were concerned that the reliability testing results (kappa=.49, 95% CI: 0.05-0.93) were substantially lower than what was found for measure 0647. Developers suggested that the small sample size (n=100) might contribute to the low reliability statistic; they also explained that the testing site used an automatic fax to transmit the transition record and suggested that the date of the fax may not have been stored long-term in the EHR. Some committee members were concerned that reliability/validity testing did not include testing of manual abstraction from paper records. Developers did clarify that the testing included checking that the transmitted records contained a standardized list of elements (that is, if some of the elements were missing, that record would not be included in the numerator of the measure). Also, because the specifications were unclear, Steering Committee members requested confirmation from the developer that this measure includes the same standardized set of elements as measure 0647.

3. Usability: H-10; M-8; L-2; I-2

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

Rationale: This measure is used in the Highmark Quality Blue Pay for Performance program (63 participating hospitals in 2011), and aggregate results are publicly reported. Developers clarified that this measure requires a written transition record; Steering Committee members noted that verbal hand-offs also may be done in practice and that future measure development should consider broadening the measure to reflect this.

4. Feasibility: H-5; M-15; L-2; I-1

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

Rationale: As with measure 0647, Committee members felt that deriving this measure via chart abstraction (for organizations that do not have electronic systems) might be time consuming and expensive.

5. Related and Competing Measures (5a. Harmonization; 5b. Superior to competing measures)

0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

0649: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges)

0558: HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge

0557: HBIPS-6 Post discharge continuing care plan created

Steering Committee Recommendation on Overall Suitability for Endorsement (pending decisions on related/competing measures): Y-22; N-0

Rationale: Although there were concerns about the need for additional reliability testing and the burden of data collection for paper-based organizations, the Committee found this to be an important measure that met NQF criteria as suitable for endorsement.

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

*Paired with measure 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

[Specifications Submission](#)

Public & Member Comment and Evaluation of Related and Competing Measures

Comments included:

- No comments received for this measure

The Committee asked the developer a series of questions about the potential of combining and/or harmonizing measures. *[Note: Additional discussion of measures #0557 and #0558 by the Care Coordination Steering Committee was suspended because these measures will be evaluated in a behavioral health project later in the year.]*

The developer noted that combining these measures in some way would negatively impact feasibility and would make it difficult to determine which component had caused the measure failure. They also argued that Emergency Department (ED) discharges are different than from inpatient hospital stays due to varied presentations and shorter timeframes, necessitating a separate ED measure with less stringent requirements for the transition record.

Steering Committee Recommendation for Endorsement: Yes-15, No-6

The Committee was asked to vote on whether there is a need for two separate measures to track provision of a transition record to the patient (#0647) and to the next provider (#0648).

Voting results: There is a need for separate measures-15; There is not a need for separate measures-6

Rationale: The Committee noted a need for different content and presentation (particularly in relation to language and health literacy) in a transition record that is given to the patient compared to one given to the next provider. They also agreed that measures #0647 and #0648 should be designated as paired measures. Thus, this measure will go forward from the Committee as recommended for endorsement, to be paired with measure #0647.

CSAC Review (July 12, 2012)

Decision: Approved for continued endorsement

Board Review (August 8, 2012)

Decision: Ratified for continued endorsement

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

[Specifications](#) [Submission](#)

Status: Maintenance, Original Endorsement: May 05, 2010 , Most Recent Endorsement: May 05, 2010

Description: Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements

- **Numerator Statement:** Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements:
- Major procedures and tests performed during ED visit, AND
- Principal diagnosis at discharge OR chief complaint, AND
- Patient instructions, AND
- Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND
- List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each

Denominator Statement: All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health care

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Patients who declined receipt of transition record

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Facility, Integrated Delivery System

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other**

Organizations: ABIM Foundation

American College of Physicians

Society of Hospital Medicine

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

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

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-16; M-6; L-0; I-0 1b. Performance Gap: H-14; M-7; L-1; I-0 1c. Evidence: Y-15; N-7; I-0

Rationale: There was some concern that the evidence presented pertained to transfer of information after an inpatient stay rather than transfer of information after an emergency department visit. Developers responded by noting that there is very little evidence that specifically addresses transfer of information from the ER; this this was confirmed by a Committee member.

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

[Specifications](#) [Submission](#)

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-1; M-14; L-7; I-1 2b. Validity: H-2; M-14; L-6; I-1

Rationale: Some Committee members were concerned that this measure was tested using the same inpatient sample as used in measures 0647 and 0648, and were unsure if the testing results would be similar for ED. Committee members also noted that it may be difficult to define an “emergency department”; however, developers clarified that urgent care and observational care is not included in this measure.

3. Usability: H-11; M-9; L-3; I-0

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

Rationale: This measure is used in the Highmark Quality Blue Pay for Performance program (63 participating hospitals in 2011). Aggregate results are publicly reported.

4. Feasibility: H-12; M-8; L-3; I-0

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

Rationale: There was some discussion among the members about the appropriateness of having fewer standard data elements in this measure compared to what was required for measure 0647; however, the general consensus was that the specified elements are obtainable, achievable, and transmissible in an ED setting. Also, as with measures 0647 and 0648, Committee members felt that deriving this measure via chart abstraction would be time consuming and expensive.

5. Related and Competing Measures (5a. Harmonization; 5b. Superior to competing measures)

0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

0648: Timely Transmission of Transition Record

0558: HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge

0557: HBIPS-6 Post discharge continuing care plan created

Steering Committee Recommendation on Overall Suitability for Endorsement (pending decisions on related/competing measures): Y-23; N-0

Rationale: Although the evidence base was more limited for this measure than for the other transition record measures, the Committee found this to be a useful measure for improving care coordination.

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

[Specifications](#) [Submission](#)

Public & Member Comment and Evaluation of Related and Competing Measures

Comments included:

- Concerns around possible legal issues related to this measure arose after its inclusion in the CMS Hospital Outpatient Quality Reporting program. Hospitals were concerned that requiring a transition record for all patients discharged from the Emergency Department could potentially be a violation of state laws protecting privacy, especially when minors or domestic violence were concerned.
- Other concerns raised by hospitals regarding the current specifications included the need to clearly define the population of patients targeted for the denominator, and more guidance regarding the term “major tests and procedures” which is used in the current specifications.

Developer Response:

- Since CMS made us aware of the implementation challenges involved with this measure, the AMA-PCPI has been in regular communication with CMS to address the issues. We've recently added a measure exception to #0649, which reads "Patients for whom providing the information contained in the transition record violates state or federal laws governing the release of protected health information." We believe that the sensitive privacy issues identified by users of the measure arise more often in the acute E.D. setting; however, we plan on revisiting the issue upon further implementation of the measure and formal update and maintenance of the PCPI Care Transitions measure set. We expect this exception to be used at low frequency.
- In regards to clearly defining the denominator population, CMS included settings in their data collection tool that weren't specified in the measure (ie, observation and internal transfers). We've since explained the measure intent and are hopeful that future implementation of the measure will adhere to the specifications outlined in our measure. The data element “major tests & procedures” was discussed at length by the Care Transitions Work Group; the term was left intentionally vague so that hospitals can interpret what may be appropriate for their particular institution. The Work Group didn't want to provide a definition of or extra guidance about "major tests and procedures" because it would be limiting. The term is meant to be broad and inclusive.

Committee Response: After an explanation of the privacy concerns by the developer, the Committee did not express any additional concerns about the usability or feasibility of this measure.

The Committee asked the developer a series of questions about the potential of combining and/or harmonizing measures.

The developer stated that combining these measures in some way would negatively impact feasibility and would make it difficult to determine which component had caused the measure failure. They also argued that Emergency Department (ED) discharges are different than from inpatient hospital stays due to varied presentations and shorter timeframes, necessitating a separate ED measure with less stringent requirements for the transition record.

Steering Committee Recommendation for Endorsement: Consensus Not Reached

Because measures #0647, #0648, and #0649 are competing measures, the Committee was first asked to vote on whether there is a justifiable reason for a different transition record for inpatient facilities (#0647) and EDs (#0649).

Voting results: There is no need for a different ED measure-11; There is a need for a different ED measure-10.

Committee members who voted in favor of needing two separate measures cited the differences between ED visits and inpatient stays, the infeasibility of collecting some of the elements in the ED environment, and the differences in state privacy laws. Committee members who opposed having two separate measures noted that the information that should be conveyed is very similar, if not identical; they also noted the need for alignment with future EHR requirements for transition records, a concern that a different standard may adversely impact ED patients, and a preference for fewer measures.

Because consensus was not reached, NQF is releasing this measure for member vote.

CSAC Review (July 12, 2012)

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

[Specifications](#) [Submission](#)

Decision: Approved for continued endorsement

Board Review (August 8, 2012)

Decision: Ratified for continued endorsement

0511 Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy

Submission

Status: Maintenance, Original Endorsement: Oct 28, 2008 , Most Recent Endorsement: Oct 28, 2008

Description: Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT) that were performed

Numerator Statement: Final reports that include physician documentation of correlation with existing relevant* imaging studies (eg, x-ray, MRI, CT)

Definition:

*Relevant imaging studies are defined as studies that correspond to the same anatomical region in question.

Denominator Statement: All final reports for patients, regardless of age, undergoing bone scintigraphy

Note: Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material) from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report.

Exclusions: System reason for not documenting correlation with existing relevant imaging studies in final report (eg, no existing relevant imaging study available, patient did not have a previous relevant imaging study)

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other Organizations:** Society of Nuclear Medicine

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

1. Importance to Measure and Report (based on decision logic): No

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-1; M-9; L-7; I-6 1b. Performance Gap: H-4; M-9; L-1; I-9 1c. Evidence: Y-5; N-18; I-0

Rationale: While the Committee acknowledged the need to correlate bone scintigraphy results with results from other (relevant) imaging studies, they considered the focus of the measure as too narrow (i.e., targeted to bone scintigraphy rather than any radiology study). The Committee was also concerned that there seemed to be little or no evidence to support the assumption that correlation with relevant studies would improve patient outcomes and/or reduce unnecessary treatment.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: 2b. Validity:

Rationale:

3. Usability:

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

Rationale:

0511 Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy

[Submission](#)

4. Feasibility:

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

Rationale:

Steering Committee Recommendation on Overall Suitability for Endorsement: No

Rationale: The measure did not pass the criterion of Importance to Measure and Report.

Public & Member Comment

Comments included:

- No comments were received for this measure

0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care
[Submission](#)

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

Description: Percentage of short term home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems.

Numerator Statement: Number of home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems.

Denominator Statement: Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.

Exclusions: - Episodes in which the patient was not on any medications since the last OASIS assessment.

- Episodes ending in patient death. Note: The information needed to calculate this measure is not collected if the home health episode ends in death. The measure cannot be calculated in excluded cases due to data limitations.

- Long-term episodes (as indicated by the presence of a follow-up assessment between admission and transfer or discharge). Note: This exclusion was added at the request of NQF reviewers during initial consideration of the measure in 2008. To avoid excessive burden to agencies related to reviewing records longer than 60 days, this implementation measure reports on care provided since the last OASIS assessment. However, restricting the measure to care since the most recent OASIS assessment raised concerns among NQF Steering Committee members that measures might not accurately reflect care for longer-stay patients, as some interventions may have been implemented prior to the most recent OASIS assessment. In response, measure specifications were changed so that home care episodes that require a recertification are not included in publicly-reported measures on implementation of evidence-based practices. The reports that CMS provides for agency use in quality improvement activities include separate break-outs for short-term episodes and long-term episodes, as well as a combined "all episodes" measure.

Adjustment/Stratification: No risk adjustment or risk stratification N/A - process measure - not risk adjusted N/A - measure not stratified.

Level of Analysis: Facility

Type of Measure: Process

Data Source: Electronic Clinical Data

Measure Steward: Centers for Medicare & Medicaid Services **Other Organizations:** Abt Associates, Inc.

Case Western Reserve University

University of Colorado at Denver, Division of Health Care Policy and Research

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

1. Importance to Measure and Report (*based on decision logic*): **No**

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-5; M-13; L-5; I-1 1b. Performance Gap: H-6; M-9; L-8; I-1 1c. Evidence: Y-7; N-16; I-0

Rationale: Committee members were concerned that this measure is too distal to the desired outcome, especially given that it does not include a "teach-back" component to assure patient understanding. One Committee member noted that some of the studies cited as evidence pertained to nurse pharmacist teams, which would not be typical in the home setting. Another member argued that the predictive analysis done to demonstrate measure validity (which in fact did not demonstrate the expected relationship between the measure and two other outcome measures) actually established the unimportance of the measure.

0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care
[Submission](#)

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: 2b. Validity:

Rationale:

3. Usability:

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

Rationale:

4. Feasibility:

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

Rationale:

Steering Committee Recommendation on Overall Suitability for Endorsement: No

Rationale: The measure did not pass the criterion of Importance to Measure and Report.

Public & Member Comment

Comments included:

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

Steering Committee Response: While the Committee reaffirmed their recognition and support of the importance of medication education, they repeated their concerns about the lack of proximity of this measure with desired outcomes. They declined to re-evaluate the measure.

0645 Biopsy Follow-up

[Submission](#)

Status: Maintenance, Original Endorsement: May 05, 2010 , Most Recent Endorsement: May 05, 2010

Description: Percentage of patients who are undergoing a biopsy whose biopsy results have been reviewed by the biopsying physician and communicated to the primary care/referring physician and the patient.

Numerator Statement: Patients who are undergoing a biopsy whose biopsy results have been reviewed by the biopsying physician and communicated to the primary care/referring physician and the patient, denoted by entering said physician's initials into a log, as well as by documentation in the patient's medical record.

Denominator Statement: All patients undergoing a biopsy.

Exclusions: Patients not undergoing a biopsy.

Adjustment/Stratification: No risk adjustment or risk stratification N/A N/A

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Type of Measure: Process

Data Source: Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Academy of Dermatology **Other Organizations:**

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

1. Importance to Measure and Report (*based on decision logic*): **No**

(1a. High Impact: 1b. Performance Gap 1c. Evidence)

1a. Impact: H-9; M-10; L-4; I-2 1b. Performance Gap: H-2; M-10; L-4; I-9 1c. Evidence: Y-10; N-14; I-0

Rationale: Only three articles were cited as evidence for this measure by the developer, but the Committee did not choose to invoke the exception to the evidence criterion. However, developers did not provide information about the methods used in the articles or the consistency of the findings. Further, although the measure was backed by a clinical practice guideline, one Committee member noted that it was unclear if the guideline was based on research or on expert opinion. Some Committee members, however, noted that even without empirical evidence, it is intuitive that reporting of biopsy results is appropriate and beneficial.

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

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: 2b. Validity:

Rationale:

3. Usability:

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

Rationale:

4. Feasibility:

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

Rationale:

Steering Committee Recommendation on Overall Suitability for Endorsement: No

Rationale: The measure did not pass the criterion of Importance to Measure and Report.

0645 Biopsy Follow-up

[Submission](#)

Public & Member Comment

Comments included:

- No comments were received for this measure

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

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

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

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

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

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

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

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

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

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

¹¹ “Care Coordination Measures Atlas,” 2011, The Agency for Healthcare Research and Quality, January 2011 <http://www.ahrq.gov/qual/careatlas/>

¹² National Quality Measures Clearinghouse,” Agency for Healthcare Research and Quality, September 2012. <http://www.qualitymeasures.ahrq.gov/>

¹³ McDonald KM, Schultz E, Albin L, Pineda N, Lonhard J, Sundaram V, Smith-Spangler C, Burstrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Standord University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.

¹⁴ In an effort to gain insight as to why no new measures were submitted to the project and to identify barriers and challenges to developing care coordination measures, NQF staff subsequently circulated a short information-gathering survey to measure developers. Several developers noted that the idea of accountability—and the extent to which a provider can realistically affect the processes or outcomes being measured—makes the development of care coordination measures difficult. Developers also noted the challenges—including the high costs associated with fully specifying and testing a measure—associated with integrating data from multiple settings and/or providers.

Appendix A: Measure Specifications

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

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

0097 Medication Reconciliation	
Exclusion Details	N/A
Risk Adjustment	N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>Calculation for Performance</p> <p>For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator and Denominator.</p> <p>Step 1: Determine the eligible population. The eligible population is all the patients aged 65 years and older.</p> <p>Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above.</p> <p>Step 3: Determine the number of patients who meet the numerator criteria as specified in section 2a1.3 above. The numerator includes all patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented</p> <p>Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2 Attachment PCPI Sample Calculation Algorithm.pdf</p>
Copyright/Disclaimer	<p>Physician Performance Measures (Measures) and related data specifications, developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (the Consortium) and the National Committee for Quality Assurance (NCQA) pursuant to government sponsorship under subcontract 6205-05-054 with Mathematica Policy Research, Inc. under contract 500-00-0033 with Centers for Medicare & Medicaid Services.</p> <p>These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.</p> <p>The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the Consortium) or NCQA. Neither the AMA, NCQA, Consortium nor its members shall be responsible for any use of the Measures.</p> <p>THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.</p> <p>© 2004-6 American Medical Association and National Committee for Quality Assurance. All Rights Reserved.</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>CPT® contained in the Measures specifications is copyright 2005 American Medical Association G codes and associated descriptions included in these Measure specifications are in the public domain.</p> <p>These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.</p> <p>THE MEASURES AND SEPCIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.</p>

0171 Acute care hospitalization (risk-adjusted)																			
Status	Maintenance, Original Endorsement: Mar 31, 2009, Most Recent Endorsement: Jan 31, 2012 Time-limited																		
Steward	Centers for Medicare & Medicaid Services Other organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research																		
Description	Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.																		
Type	Outcome																		
Data Source	Administrative claims Denominator: Medicare Home Health Claims Numerator: Medicare Inpatient Claims Exclusions: Medicare Home Health Claims, Medicare Enrollment Data Risk Factors: Medicare Enrollment Data, Medicare Part A & B Claims URL Identification of Short Term Hospitals: https://www.cms.gov/transmittals/downloads/R29SOMA.pdf General Medicare Data Documentation: http://www.resdac.org/ddvh/index.asp URL Claims: http://www.resdac.org/ddvh/dd_via2.asp Enrollment: http://www.resdac.org/ddde/dd_de.asp																		
Level	Facility																		
Setting	Home Health																		
Numerator Statement	Number of home health stays for patients who have a Medicare claim for an unplanned admission to an acute care hospital in the 60 days following the start of the home health stay.																		
Numerator Details	<p>Time Window: 60 days following the start of the home health stay.</p> <p>The 60 day time window is calculated by adding 60 days to the “from” date in the first home health claim in the series of home health claims that comprise the home health stay. Acute care hospitalization occurs (and the home health stay is included in the numerator) if the patient has at least one Medicare inpatient claim from short term or critical access hospitals (identified by CMS Certification Number ending in 0001-0879, 0800-0899, or 1300-1399) during the 60 day window.</p> <p>Inpatient claims for planned hospitalizations are excluded from the measure numerator. Planned hospitalizations are defined using the same criteria as the Yale Hospital-Wide All-Cause Unplanned Readmission Measure. Specifically, admissions are categorized as “planned” based on AHRQ Procedure and Condition CCS as well as other sets of ICD-9-CM procedure codes. These admissions are excluded unless they have a discharge condition category considered “acute or complication of care,” which is defined using AHRQ Condition CCS. The definitions of AHRQ CCS can be found here:</p> <p>http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp#download</p> <p>The AHRQ CCS that define planned hospitalizations are found below and are AHRQ Procedure CCS unless otherwise noted.</p> <table border="1"> <thead> <tr> <th>AHRQ CCS</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>45</td> <td>PTCA</td> </tr> <tr> <td>254</td> <td>Rehabilitation (Condition CCS)</td> </tr> <tr> <td>84</td> <td>Cholecystectomy and common duct exploration</td> </tr> <tr> <td>157</td> <td>Amputation of lower extremity</td> </tr> <tr> <td>44</td> <td>CABG</td> </tr> <tr> <td>78</td> <td>Colorectal resection</td> </tr> <tr> <td>51</td> <td>Endarterectomy; vessel of head and neck</td> </tr> <tr> <td>113</td> <td>Transurethral resection of prostate</td> </tr> </tbody> </table>	AHRQ CCS	Description	45	PTCA	254	Rehabilitation (Condition CCS)	84	Cholecystectomy and common duct exploration	157	Amputation of lower extremity	44	CABG	78	Colorectal resection	51	Endarterectomy; vessel of head and neck	113	Transurethral resection of prostate
AHRQ CCS	Description																		
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113	Transurethral resection of prostate																		

0171 Acute care hospitalization (risk-adjusted)

- 99 Other OR Gastrointestinal therapeutic procedures
- 48 Insertion; revision; replacement; removal of cardiac pacemaker or cardioverter/defibrillator
- 45 Maintenance chemotherapy (Condition CCS)
- 211 Therapeutic radiology for cancer treatment
- 3 Laminectomy; excision intervertebral disc
- 43 Heart valve procedures
- 152 Arthroplasty knee
- 158 Spinal fusion
- 55 Peripheral vascular bypass
- 52 Aortic resection; replacement or anastomosis
- 36 Lobectomy or pneumonectomy
- 153 Hip replacement; total and partial
- 60 Embolectomy and endarterectomy of lower limbs
- 85 Inguinal and femoral hernia repair
- 104 Nephrectomy; partial or complete
- 1 Incision and excision of CNS
- 124 Hysterectomy; abdominal and vaginal
- 167 Mastectomy
- 10 Thyroidectomy; partial or complete
- 114 Open prostatectomy
- 74 Gastrectomy; partial and total
- 119 Ooporectomy; unilateral and bilateral
- 154 Arthroplasty other than hip or knee
- ICD-9-CM procedure codes 30.5, 31.74, 34.6 Radial laryngectomy, revision of tracheostomy, scarification of pleura
- 166 Lumpectomy; quadrantectomy of breast
- 64 Bone marrow transplant
- 105 Kidney transplant
- 176 Other organ transplantation
- ICD-9-CM procedure codes 94.26, 94.27 Electroshock therapy
- Discharge AHRQ Condition CCS considered “acute or complication of care” are listed below.
- AHRQ CCS Description
- 237 Complications of device; implant or graft
- 106 Cardiac dysrhythmias
- Condition CCS 207, 225, 226, 227, 229, 230, 231, 232 Fracture
- 100 Acute myocardial infarction
- 238 Complications of surgical procedures or medical care
- 108 Congestive heart failure; nonhypertensive
- 2 Septicemia (except in labor)
- 146 Diverticulosis and diverticulitis
- 105 Conduction disorders
- 109 Acute cerebrovascular disease
- 145 Intestinal obstruction without hernia
- 233 Intracranial injury
- 116 Aortic and peripheral arterial embolism or thrombosis
- 122 Pneumonia (except that caused by TB or sexually transmitted disease)
- 131 Respiratory failure; insufficiency; arrest (adult)
- 157 Acute and unspecified renal failure
- 201 Infective arthritis and osteomyelitis (except that caused by TB or sexually transmitted disease)
- 153 Gastrointestinal hemorrhage
- 130 Pleurisy; pneumothorax; pulmonary collapse
- 97 Peri-; endo-; and myocarditis; cardiomyopathy
- 127 Chronic obstructive pulmonary disease and bronchiectasis
- 55 Fluid and electrolyte disorders
- 159 Urinary tract infection

0171 Acute care hospitalization (risk-adjusted)	
	245 Syncope 139 Gastroduodenal ulcer (except hemorrhage) 160 Calculus of urinary tract 112 Transient cerebral ischemia
Denominator Statement	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
Denominator Details	<p>Time Window: 12-month observation period, updated quarterly.</p> <p>A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days. Each home health payment episode is associated with a Medicare home health (HH) claim, so home health stays are constructed from claims data using the following procedure.</p> <ol style="list-style-type: none"> 1. First, retrieve HH claims with a “from” date (FROM_DT) during the 12-month observation period or the 120 days prior to the beginning of the observation period and sequence these claims by “from” date for each beneficiary. 2. Second, drop claims with the same “from” date and “through” date (THROUGH_DT) and claims listing no visits and no payment. Additionally, if multiple claims have the same “from” date, keep only the claim with the most recent process date. 3. Third, set Stay_Start_Date(1) equal to the “from” date on the beneficiary’s first claim. Step through the claims sequentially to determine which claims begin new home health stays. If the claim “from” date is more than 60 days after the “through” date on the previous claim, then the claim begins a new stay. If the claim “from” date is within 60 days of the “through” date on the previous claim, then the claim continues the stay associated with the previous claim. 4. Fourth, for each stay, set Stay_Start_Date(n) equal to the “from” date of the first claim in the sequence of claims defining that stay. Set Stay_End_Date(n) equal to the “through” date on the last claim in that stay. Confirm that Stay_Start_Date(n+1) – Stay_End_Date(n) > 60 days for all adjacent stays. 5. Finally, drop stays that begin before the 12-month observation window. <p>Note the examining claims from the 120 days before the beginning of the 12-month observation period is necessary to ensure that stays beginning during the observation period are in fact separated from previous home health claims by at least 60 days.</p>
Exclusions	The following are excluded: home health stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window (60 days following the start of the home health stay) or until death; home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim; home health stays in which the patient receives service from multiple agencies during the first 60 days; and home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the start of the home health stay.
Exclusion Details	<ol style="list-style-type: none"> 1. Home health stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window (60 days following the start of the home health stay) or until death. <ul style="list-style-type: none"> • Both enrollment status and beneficiary death date are identified using the Medicare Enrollment Database (EDB). 2. Home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim. <ul style="list-style-type: none"> • Exclude the stay if LUPAIND = L for the first claim in the home health stay. 3. Home health stays in which the patient receives service from multiple agencies during the first 60 days. <ul style="list-style-type: none"> • Define Initial_Provider = PROVIDER on the first claim in the home health stay. • If Initial_Provider does not equal PROVIDER for a subsequent claim in the home health stay AND if the “from” date of the subsequent claim is within 60 days of Stay_Start_Date, then exclude the stay. 4. Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the start of the home health stay. <ul style="list-style-type: none"> • Enrollment status is identified using the Medicare Enrollment Database (EDB).

	0171 Acute care hospitalization (risk-adjusted)
Risk Adjustment	<p>Statistical risk model</p> <p>Multinomial logit with outcomes of “No acute event”, “Emergency Department without Hospitalization”, and “Acute Care Hospitalization”.</p> <p>Risk factors include:</p> <p>Prior Care Setting –</p> <p>The main categories are community (i.e., no prior care setting), outpatient emergency room, inpatient-acute (IP-acute), inpatient rehabilitation facility (IRF), psychiatric facility, long-term care facility (LTC), and skilled nursing facility (SNF). The hierarchy of setting is SNF, most recent inpatient stay, and outpatient ER. Acumen used the five cohorts from the Yale Hospital-Wide All-Cause Unplanned Readmission Measure to segregate the IP-acute category. The five cohorts are:</p> <ol style="list-style-type: none"> 1. Surgery/Gynecology: admissions likely cared for by surgical or gynecological teams, based on AHRQ procedure categories; 2. Cardiorespiratory: admissions treated by the same care teams with very high readmission rates, such as for pneumonia, chronic obstructive pulmonary disease, and heart failure; 3. Cardiovascular: admissions treated by separate cardiac or cardiovascular team in large hospitals, such as for acute myocardial infarctions; 4. Neurology: admissions for neurological conditions, such as stroke, that may be treated by a separate neurology team in large hospitals; and 5. Medicine: admissions for all other non-surgical patients. <p>These cohorts were designed to account for differences in readmission risk for surgical and non-surgical patients.</p> <p>Finally, the IP-acute categories and the SNF category were further refined by length of stay. Each of the five IP-acute categories are separated into stays of length 0 to 3 days, 4 to 8 days, and 9 or more days, while the SNF categories are split into stays of length 0 to 13, 14 to 41, and 42 and more days. A patient cared for in both a skilled nursing facility and an inpatient hospital during the 30 days prior to starting home health care is included in the skilled nursing categories and not the inpatient categories. The length of stay is determined from the last inpatient or skilled nursing stay prior to beginning home health care.</p> <p>Age and Gender Interactions –</p> <p>Age is subdivided into 12 bins for each gender: aged 0-34, 35-44, 45-54, five-year age bins from 55 to 95, and a 95+ category. Using a categorical age variable allows the model to account for the differing effects of age and gender. Age is determined based on the patient’s age at Stay_Start_Date.</p> <p>CMS Hierarchical condition categories (HCCs) –</p> <p>HCCs were developed for the risk adjustment model used in determining capitation payments to Medicare Advantage plans and are calculated using Part A and B Medicare claims. While the CMS-HHC model uses a full year of claims data to calculate HCCs, for these measures, we use only 6 months of data to limit the number of home health stays excluded due to missing HCC data. All 2008 HCCs and CCs that are not hierarchically ranked that were statistically significant predictors of ACH and ED use are included in the model.</p> <p>Details of the CMS-HCC model and the code lists for defining the HCCs can be found here: https://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp</p> <p>A description of the development of the CMS-HCC model can be found here: https://www.cms.gov/HealthCareFinancingReview/Downloads/04Summerpg119.pdf</p> <p>ESRD and Disability Status –</p> <p>Original End Stage Renal Disease (ESRD) and current ESRD status are included as risk factors. Original disabled status and male, and original disabled status and female, are also included. Medicare beneficiaries with ESRD or disabled status represent a fundamentally different health profile.</p> <p>Interaction Terms –</p>

	0171 Acute care hospitalization (risk-adjusted)
	All interaction terms included in the 2008 and 2012 HCC risk adjustment models that were statistically significant predictors of ED Use and ACH were included. Interaction terms account for the additional effect two risk factors may have when present simultaneously, which is more than the additive effect of each factor separately. Attachment NQF_CBM_RiskAdjustment_24Feb2012.pdf
Stratification	N/A - not stratified
Type Score	Rate/proportion better quality = lower score
Algorithm	<ol style="list-style-type: none"> 1. Construct Home Health Stays from HH Claims (see 2a1.7 for details) 2. Identify numerator window (60 days following Stay_Start_Date) for each stay and exclude stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window or until patient death. 3. Exclude stays that begin with a LUPA or that involve a provider change during the numerator window 4. Link stays to enrollment data by beneficiary. 5. Exclude stays for patients who are not continuously enrolled in fee-for-service Medicare during the 6 months prior to Stay_Start_Date. 6. Calculate demographic risk factors for each stay (age, gender, etc.) using enrollment data. 7. Link to Part A and Part B claims for 6 months prior to Stay_Start_Date for each beneficiary 8. Calculate prior care setting indicators, HCCs, and HCC interactions. 9. Link to Inpatient (IP) claims from Short Stay and Critical Access hospitals (excluding planned hospitalizations - see 2a1.3 for details) for numerator window (60 days following Stay_Start_Date) 10. Set Hospital Admission indicator (Hosp_Admit = 1) if any IP claims are linked to the stay in step 9. 11. Using coefficients from the multinomial logit risk model and risk factors calculated in steps 6 and 8, calculate the predicted probability of being included in the measure numerator for each stay (Pred_Hosp). Additionally calculate the average of Pred_Hosp across all stays that are included in the measure denominator (not excluded in steps 3 or 5) and call this value National_pred_Hosp. 12. Calculate observed and risk adjusted rates for each home health agency (Initial_Provider): <ol style="list-style-type: none"> a. Calculate the observed rate of Acute Care Hospitalization as the fraction all (non-excluded) HH Stays with that agency as Initial_Provider that are also included in the measure numerator (Hosp_Admit = 1). Call the value Agency_obs_Hosp. b. Calculate the agency predicated rate of Acute Care Hospitalization by taking the average of Pred_Hosp across all (non-excluded) stays with that agency as Initial_Provider. Call this value Agency_pred_Hosp. c. Calculate the risk adjusted rate of Acute Care Hospitalization using the following formula: $\text{Agency_riskadj_Hosp} = \text{National_pred_Hosp} + (\text{Agency_obs_Hosp} - \text{Agency_pred_Hosp})$ If an agency's calculated risk adjusted rate is negative, that agency will have a publicly reported rate of 0% Attachment PlannedHospitalizationExclusion_Acumen_10Feb2012.pdf
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	0173 Emergency Department Use without Hospitalization
Status	Maintenance, Original Endorsement: Mar 31, 2009, Most Recent Endorsement: Jan 31, 2012 Time-limited
Steward	Centers for Medicare & Medicaid Services Other organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research
Description	Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.
Type	Outcome
Data Source	Administrative claims Denominator: Medicare Home Health Claims Numerator: Medicare Inpatient and Outpatient Claims Exclusions: Medicare Home Health Claims, Medicare Enrollment Data Risk Factors: Medicare Enrollment Data, Medicare Part A & B Claims URLS: Identification of ED visits: http://www.resdac.org/Tools/TBs/TN-003_EmergencyRoominClaims_508.pdf Identification of Short Term Hospitals: https://www.cms.gov/transmittals/downloads/R29SOMA.pdf General Medicare Data Documentation: http://www.resdac.org/ddvh/index.asp URL SEE URLs IN 2a1.26. URL Claims: http://www.resdac.org/ddvh/dd_via2.asp Enrollment: http://www.resdac.org/ddde/dd_de.asp
Level	Facility
Setting	Home Health
Numerator Statement	Number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay.
Numerator Details	Time Window: 60 days following the start of the home health stay. The 60 day time window is calculated by adding 60 days to the “from” date in the first home health claim in the series of home health claims that comprise the home health stay. If the patient has any Medicare outpatient claims with any ER revenue center codes (0450-0459, 0981) during the 60 day window AND if the patient has no Medicare inpatient claims for an unplanned admission to an acute care hospital (identified by the CMS Certification Number on the IP claim ending in 0001-0879, 0800-0899, or 1300-1399) during the 60 day window, then the stay is included in the measure numerator.
Denominator Statement	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.

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

0173 Emergency Department Use without Hospitalization	
	<p>acute), inpatient rehabilitation facility (IRF), psychiatric facility, long-term care facility (LTC), and skilled nursing facility (SNF). The hierarchy of setting is SNF, most recent inpatient stay, and outpatient ER. Acumen used the five cohorts from the Yale Hospital-Wide All-Cause Risk Standardization Readmission Measure to segregate the IP-acute category. The five cohorts are:</p> <ol style="list-style-type: none"> 1. Surgery/Gynecology: admissions likely cared for by surgical or gynecological teams, based on AHRQ procedure categories; 2. Cardiorespiratory: admissions treated by the same care teams with very high readmission rates, such as for pneumonia, chronic obstructive pulmonary disease, and heart failure; 3. Cardiovascular: admissions treated by separate cardiac or cardiovascular team in large hospitals, such as for acute myocardial infarctions; 4. Neurology: admissions for neurological conditions, such as stroke, that may be treated by a separate neurology team in large hospitals; and 5. Medicine: admissions for all other non-surgical patients. <p>These cohorts were designed to account for differences in readmission risk for surgical and non-surgical patients.</p> <p>Finally, the IP-acute categories and the SNF category were further refined by length of stay. Each of the five IP-acute categories are separated into stays of length 0 to 3 days, 4 to 8 days, and 9 or more days, while the SNF categories are split into stays of length 0 to 13, 14 to 41, and 42 and more days. A patient cared for in both a skilled nursing facility and an inpatient hospital during the 30 days prior to starting home health care is included in the skilled nursing categories and not the inpatient categories. The length of stay is determined from the last inpatient or skilled nursing stay prior to beginning home health care.</p> <p>Age and Gender Interactions –</p> <p>Age is subdivided into 12 bins for each gender: aged 0-34, 35-44, 45-54, five-year age bins from 55 to 95, and a 95+ category. Using a categorical age variable allows the model to account for the differing effects of age and gender. Age is determined based on the patient’s age at Stay_Start_Date.</p> <p>CMS Hierarchical condition categories (HCCs) –</p> <p>HCCs were developed for the risk adjustment model used in determining capitation payments to Medicare Advantage plans and are calculated using Part A and B Medicare claims. While the CMS-HHC model uses a full year of claims data to calculate HCCs, for these measures, we use only 6 months of data to limit the number of home health stays excluded due to missing HCC data. All 2008 HCCs and CCs that are not hierarchically ranked that were statistically significant predictors of ACH and ED use are included in the model.</p> <p>Details of the CMS-HCC model and the code lists for defining the HCCs can be found here: https://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp</p> <p>A description of the development of the CMS-HCC model can be found here: https://www.cms.gov/HealthCareFinancingReview/Downloads/04Summerpg119.pdf</p> <p>ESRD and Disability Status –</p> <p>Original End Stage Renal Disease (ESRD) and current ESRD status are included as risk factors. Original disabled status and male, and original disabled status and female, are also included. Medicare beneficiaries with ESRD or disabled status represent a fundamentally different health profile.</p> <p>Interaction Terms –</p> <p>All interaction terms included in the 2008 and 2012 HCC risk adjustment models that were statistically significant predictors of ED Use and ACH were included. Interaction terms account for the additional effect two risk factors may have when present simultaneously, which is more than the additive effect of each factor separately.</p> <p>Attachment NQF_CBM_RiskAdjustment_24Feb2012-634656974096796183.pdf</p>
Stratification	Measure is not stratified.
Type Score	Rate/proportion better quality = lower score

0173 Emergency Department Use without Hospitalization	
Algorithm	<ol style="list-style-type: none"> 1. Construct Home Health Stays from HH Claims (see 2a1.7 for details) 2. Identify numerator window (60 days following Stay_Start_Date) for each stay and exclude stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window or until patient death. 3. Exclude stays that begin with a LUPA or that involve a provider change during the numerator window 4. Link stays to enrollment data by beneficiary. 5. Exclude stays for patients who are not continuously enrolled in fee-for-service Medicare during the 6 months prior to Stay_Start_Date. 6. Calculate demographic risk factors for each stay (age, gender, etc.) using enrollment data. 7. Link to Part A and Part B claims for 6 months prior to Stay_Start_Date for each beneficiary 8. Calculate prior care setting indicators, HCCs, and HCC interactions. 9. Link to Inpatient (IP) claims from Short Stay and Critical Access hospitals(excluding planned hospitalizations) for the numerator window (60 days following Stay_Start_Date) – see specifications for the home health Acute Care Hospitalization (NQF 0171) measure for details. 10. Set Hospital Admission indicator (Hosp_Admit = 1) if any IP claims are linked to the stay in step 9. These stays are not included in the ED Use without Hospitalization measure numerator. 11. Link to Outpatient claims with revenue center codes indicating Emergency Department use for the numerator window (60 days following Stay_Start_Date). 12. Set Outpatient ED Use indicator (OP_ED = 1) if any outpatient claims are linked to the stay in step 11. 13. Flag stays for inclusion in the measure numerator (ED_noHosp = 1) if OP_ED =1 and NOT Hosp_Admit = 1. 14. Using coefficients from the multinomial logit risk model and risk factors calculated in steps 6 and 8, calculate the predicted probability of being included in the measure numerator for each stay (Pred_ED_noHosp). Additionally calculate the average of Pred_ED_noHosp across all stays that are included in the measure denominator (not excluded in steps 3 or 5) and call this value National_pred_ED. 15. Calculate observed and risk adjusted rates for each home health agency (Initial_Provider): <ol style="list-style-type: none"> a. Calculate the observed rate of Emergency Department Use without Hospitalization as the fraction all (non-excluded) HH Stays with that agency as Initial_Provider that are also included in the measure numerator (ED_noHosp = 1). Call the value Agency_obs_ED. b. Calculate the agency predicated rate of Emergency Department use without Hospitalization by taking the average of Pred_ED_noHosp across all (non-excluded) stays with that agency as Initial_Provider. Call this value Agency_pred_ED. c. Calculate the risk adjusted rate of Emergency Department use without Hospitalization using the following formula: $Agency_riskadj_ED = National_pred_ED + (Agency_obs_ED - Agency_pred_ED)$. If an agency's calculated risk adjusted rate is negative, that agency will have a publicly reported rate of 0% URL ALGORITHM IS INCLUDED IN 2a1.20
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0326 Advance Care Plan	
Status	Maintenance, Original Endorsement: Nov 05, 2007, Most Recent Endorsement: Jan 25, 2012 Time-limited
Steward	National Committee for Quality Assurance Other organizations: This measure was developed with the cooperation of the American Geriatrics Society, the National Committee for Quality Assurance and the American Medical Association.
Description	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry None URL http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/geriatrics-ws.pdf
Level	Clinician : Individual
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Home Health, Hospice, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
Numerator Details	Time Window: A twelve month measurement year Report the CPT Category II codes designated for this numerator: 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan Documentation that patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan may also include, as appropriate, the following: That the patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient’s beliefs and thus harmful to the physician-patient relationship.
Denominator Statement	All patients aged 65 years and older
Denominator Details	Time Window: A twelve month measurement year Denominator Criteria (Eligible Cases): Patients aged = 65 years on date of encounter Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404 *Clinicians indicating the place of service as the emergency department will not be included in this measure.
Exclusions	N/A
Exclusion Details	N/A

0326 Advance Care Plan	
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>Step 1: Determine the eligible population. The eligible population is all the patients aged 65 years and older.</p> <p>Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above.</p> <p>Step 3: Determine the number of patients who meet the numerator criteria as specified in section 2a1.3 above. The numerator includes all patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.</p> <p>Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2 Attachment PCPI Sample Calculation Algorithm-634613645501283368.pdf</p>
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0494 Medical Home System Survey	
Status	Maintenance, Original Endorsement: Aug 29, 2008, Most Recent Endorsement: Jan 25, 2012 Time-limited
Steward	National Committee for Quality Assurance
Description	<p>The following 6 composites are generated from the Medical Home System Survey (MHSS). Each measure is used to assess a particular domain of the patient-centered medical home.</p> <p>Measure 1: Improved access and communication</p> <p>Measure 2: Care management using evidence-based guidelines</p> <p>Measure 3: Patient tracking and registry functions</p> <p>Measure 4: Support for patient self-management</p> <p>Measure 5: Test and referral tracking</p> <p>Measure 6: Practice performance and improvement functions</p>
Type	Structure
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Healthcare Provider Survey, Management Data, Other, Paper Records, Patient Reported Data/Survey The Medical Home System Survey asks for physician or practice self-report of processes and structures with accompanying documentation. The documentation required for each factor varies. Examples of documentation include: written evidence of documented process within a practice, record of response times for phone calls and electronic messages, examples of patient records, patient education materials, reports from electronic system for patient health information, and screen shots of electronic resources. A complete list of documentation can be found in the attached Standards documentation.
Level	Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office
Numerator Statement	<p>The composite measures do not have a typical numerator. Each composite is composed of elements; each element is made up of individual factors. The composite score is calculated by adding the element scores. The element scores are based on the proportion of individual factors with a satisfactory “yes” response (see Standards documentation for details).</p> <p>Note: In the calculation algorithm, the measurement domains are termed “composites,” the measures within each domain are referred to as “elements,” and the items within a measure, or measure subcomponents, are referred to as “factors.”</p>

0494 Medical Home System Survey	
Numerator Details	<p>Time Window: The numerator time window is 3 months. Practices must show that measured factors have been in place for at least 3 months. Data should be no more than 12 months old.</p> <p>The MHSS is comprised of 6 composites which contain 27 elements. Each element is made up of individual factors (or measurement items) which can be answered yes/no. The number of factors in an element varies.</p> <p>To calculate the composite score, determine the proportion of factors met in each element (0%, 25%, 50%, 75%, 100%). The proportion of factors met is multiplied by the points allotted for each element. The composite score is the sum of points for all the elements in the composite</p> <p>(See Standards documentation for further detail.)</p> <p>Composite 1) Enhance access and continuity – Total Possible Points 20 Element 1A) Access during office hours (4 factors – 4 points) Element 1B) After-hours access (5 factors – 4 points) Element 1C) Electronic access (6 factors – 2 points) Element 1D) Continuity (3 factors – 2 points) Element 1E) Medical home responsibilities (4 factors – 2 points) Element 1F) Culturally and linguistically appropriate services (4 factors – 2 points) Element 1G) The practice team (8 factors – 4 points)</p> <p>Composite 2) Identify and manage patient populations – Total Possible Points 16 Element 2A) Patient information (12 factors – 3 points) Element 2B) Clinical data (9 factors – 4 points) Element 2C) Comprehensive health assessment (9 factors – 4 points) Element 2D) Use data for population management (4 factors – 5 points)</p> <p>Composite 3) Plan and manage care – Total Possible Points 17 Element 3A) Implement evidence-based guidelines (3 factors – 4 points) Element 3B) Identify high-risk patients (2 factors – 3 points) Element 3C) Care management (7 factors – 4 points) Element 3D) Medication management (6 factors – 3 points) Element 3E) Use of electronic prescribing (6 factors – 3 points)</p> <p>Composite 4) Provide self-care support and community resources – Total Possible Points 9 Element 4A) Support self-care process (6 factors – 6 points) Element 4B) Provide referrals to community resources (4 factors – 3 points)</p> <p>Composite 5) Track and coordinate care – Total Possible Points 18 Element 5A) Test tracking and follow-up (10 factors – 6 points) Element 5B) Referral tracking and follow-up (7 factors – 6 points) Element 5C) Coordinate with facilities and manage care transitions (8 factors – 6 points)</p> <p>Composite 6) Measure and improve performance – Total Possible Points 20 Element 6A) Measure performance (4 factors – 4 points) Element 6B) Measure Patient/Family Experience (4 factors – 4 points) Element 6C) Demonstrate continuous quality improvement (4 factors – 4 points) Element 6D) Tracking results over time (3 factors – 3 points) Element 6E) Report performance (3 factors – 3 points) Element 6F) Report data externally (4 factors – 2 points)</p>
Denominator Statement	N/A

0494 Medical Home System Survey	
Denominator Details	<p>Time Window: The target population is eligible outpatient primary care practices.</p> <p>The practice must provide primary care for all of the patients in its practice, not just selected patients. A practice is one or more clinicians who practice together and provide patient care at a single geographic location. Practicing together means that, for all the clinicians in a practice:</p> <ul style="list-style-type: none"> • The practice care team follows the same procedures and protocols • Medical records for all patients treated at the practice site, whether paper or electronic, are available to and shared by all clinicians, as appropriate • The same systems—electronic and paper-based—and procedures support both clinical and administrative functions, for example: scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up
Exclusions	None
Exclusion Details	N/A
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>None</p>
Stratification	N/A
Type Score	Weighted score/composite/scale better quality = higher score

0494 Medical Home System Survey

Algorithm

Step 1: The score for each element is calculated separately. The score for each element is based on the proportion of factors the practice meets; 0%,25%,50%,75%,100% multiplied by the points allotted to the element. Within each element the number of factors varies and the importance of individual factors varies. Some factors are considered “must-pass” in order to achieve a score of 50% or higher on a particular element.

For example:

Element D: Medication Management – 3 points

The practice manages medication in the following ways.

Factor 1: Review and reconciles medications with patients/families for more than 50 percent of care transitions. Yes/No

Factor 2: Reviews and reconciles medications with patients/families for more than 80 percent of care transitions. Yes/No

Factor 3: Provides information about new prescriptions to more than 80 percent of patients/families. Yes/No

Factor 4: Assesses patient/family understanding of medications for more than 50 percent of patients with date of assessment. Yes/No

Factor 5: Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment. Yes/No

Factor 6: Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates. Yes/No

Element Scoring:

A practice meeting 5-6 of the factors, including factor 1, receives 100% of the points = 3

A practice meeting 3-4 of the factors, including factor 1, receives 75% of the points = 2.25

A practice meeting 2 factors, including factor 1, receives a score 50% of the points = 1.5

A practice meeting only factor 1 receives 25% of the points = 0.75

A practice meeting no factors or does not meet factor 1 receives 0% of the points = 0

Step 2: The composite score is calculated by summing the points award to each element.

For example:

Composite 3: Plan and Manage Care

Element 3A) Implement evidence-based guidelines – 4 points * proportion of factors met

Element 3B) Identify high-risk patients – 3 points * proportion of factors met

Element 3C) Care management – 4 points * proportion of factors met

Element 3D) Medication management – 3 points * proportion of factors met

Element 3E) Use of electronic prescribing - 3 points* proportion of factors met

A practice meeting 50% of 3A factors, 100% of 3B factors, 75% of 3C factors, 100% of 3D factors, and 25% of 3E factors would have the following composite score:

$2 + 3 + 3 + 3 + 0.75 = 11.75$ out of 17 possible points.

The detailed score for each element can be found in the attached Standards documentation.

0494 Medical Home System Survey	
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0526 Timely Initiation of Care	
Status	Maintenance, Original Endorsement: Mar 31, 2009, Most Recent Endorsement: Mar 31, 2009 Time-limited
Steward	Centers for Medicare & Medicaid Services Other organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research
Description	Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.
Type	Process
Data Source	Electronic Clinical Data OASIS-C URL https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQIOASISCAITimePoint.pdf URL https://www.cms.gov/OASIS/Downloads/oasisp200.zip
Level	Facility
Setting	Home Health
Numerator Statement	Number of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.
Numerator Details	<p>Time Window: Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly.</p> <p>Number of home health patient episodes of care where at start of episode:</p> <ul style="list-style-type: none"> • (M0100) Reason for Assessment = 1 (Start of care) AND • (M0030) Start of care date equals (M0102) Physician-ordered Start of Care Date, or • (M0030) Start of care date minus (M0104) Date of Referral is less than 3 days, or • (M0030) Start of care date minus (M1005) Inpatient Discharge Date is less than 3 days <p>PLUS</p> <p>Number of home health patient episodes of care where at start of episode:</p> <ul style="list-style-type: none"> • (M0100) Reason for Assessment = 3 (Resumption of care) AND • (M0032) Resumption of care date equals (M0102) Physician-ordered Resumption of Care Date, or • (M0032) Resumption of care date minus (M0104) Date of Referral is less than 3 days, or • (M0032) Resumption of care date minus (M1005) Inpatient Discharge Date is less than 3 days
Denominator Statement	All home health episodes other than those covered by generic denominator exclusions.
Denominator Details	<p>Time Window: Time Window: Current CMS systems report data on episodes that end within a rolling 12 month period, updated quarterly.</p> <p>Number of home health patient episodes of care, defined as:</p> <p>A start/resumption of care assessment OASIS-C((M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care)) paired with a corresponding discharge/transfer assessment ((M0100) Reason for Assessment = 6 (Transfer to inpatient facility – not discharged), 7 (Transfer to inpatient facility – discharged), 8 (Death at home), or 9 (Discharge from agency)), other than those covered by generic denominator exclusions.</p>
Exclusions	No measure-specific exclusions.

0526 Timely Initiation of Care	
Exclusion Details	<p>Measure-Specific Exclusions: None</p> <p>Generic Exclusions: Medicare-certified home health agencies are currently required to collect and submit OASIS data only for adult (aged 18 and over) non-maternity Medicare and Medicaid patients who are receiving skilled home health care. Therefore, maternity patients, patients less than 18 years of age, non-Medicare/Medicaid patients, and patients who are not receiving skilled home services are all excluded from the measure calculation. However, the OASIS items and related measures could potentially be used for other adult patients receiving services in a community setting, ideally with further testing. The publicly-reported data on CMS' Home Health Compare web site also repress cells with fewer than 20 observations, and reports for home health agencies in operation less than six months.</p>
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>N/A - process measure - not risk adjusted.</p>
Stratification	Not stratified.
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>Calculation algorithm available in the Technical Specifications at:</p> <p>https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQITechnicalDocOfMeasures.pdf URL</p> <p>https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQITechnicalDocOfMeasures.pdf</p>
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0553 Care for Older Adults – Medication Review	
Status	Maintenance, Original Endorsement: Aug 05, 2009, Most Recent Endorsement: Jan 25, 2012 Time-limited
Steward	National Committee for Quality Assurance
Description	Percentage of adults 66 years and older who had a medication review; a review of all a member’s medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Paper Records NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). URL http://www.ncqa.org/tabid/370/default.aspx
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State
Setting	Ambulatory Care : Clinician Office, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	At least one medication review (Table COA-B) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Table COA-C) Table COA-B Codes to identify medication review: Medication review (CPT 90862, 99605, 99606), (CPT-II 1160F) Table COA-C Codes to Identify Medication List (CPT-II 1159F)
Numerator Details	Time Window: The measurement year 1) Administrative Specification (if available): At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record, as documented through administrative data. The claim/encounter for a member’s medication review and medication list must be on the same date of service. Codes to identify medication review: Medication review (CPT 90862, 99605, 99606), (CPT-II 1160F) Codes to Identify Medication List (CPT-II 1159F) 2) Medical Record Specification (if necessary): Documentation must come from the same medical record and must include the following. <ul style="list-style-type: none"> • A medication list in the medical record, and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed • Notation that the member is not taking any medication and the date when it was noted A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Prescribing practitioner is defined as a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.
Denominator Statement	All patients 66 and older as of December 31 of the measurement year
Denominator Details	Time Window: The measurement year Use administrative data and medical records for of members 66 years and older as of December 31 of the measurement year.

0553 Care for Older Adults – Medication Review	
Exclusions	N/A
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement.</p> <p>Step 2. Search administrative systems to identify numerator events for all members in the eligible population.</p> <p>Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.</p> <p>Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being measured.</p> <p>Step 5. Calculate the rate.</p>
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0554 Medication Reconciliation Post-Discharge	
Status	Maintenance, Original Endorsement: Aug 05, 2009, Most Recent Endorsement: Jan 25, 2012 Time-limited
Steward	National Committee for Quality Assurance
Description	The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). URL http://www.ncqa.org/tabid/370/default.aspx
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional
Setting	Ambulatory Care : Clinician Office
Numerator Statement	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through administrative or medical record review on or within 30 days of discharge. Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record, on or within 30 days after discharge.
Numerator Details	Time Window: The measurement year 1) Administrative (when available): Medication reconciliation (Table MRP-A) conducted by prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. A member had a medication reconciliation if a claim/encounter contains a code in Table MRP-A. Table MRP-A: Codes to Identify Medication Reconciliation Medication Reconciliation: CPT Category II: 1111F 2) Medical Record (as necessary): Documentation in the medical record must include evidence of medication reconciliation, and the date on which it was performed. The following evidence meets criteria: <ul style="list-style-type: none"> • Notation that medications prescribed or ordered upon discharge were reconciled with the current medications (in outpatient record) by the appropriate practitioner type, or • A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type or • Notation that no medications were prescribed or ordered upon discharge Only documentation in the outpatient record chart meets the intent of the measure, but an in-person, outpatient visit is not required
Denominator Statement	All discharges from an in-patient setting for health plan members who are 66 years and older as of December 31 of the measurement year.

0554 Medication Reconciliation Post-Discharge	
Denominator Details	<p>Time Window: The measurement year (one calendar year)</p> <p>1) Administrative (when available): An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator is based on episodes, not members. Members may appear more than once in the sample. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.</p> <p>2) Medical Record (as necessary): The denominator is based on episodes, not members. Members may appear more than once in the sample. The denominator is based on the discharge date found in the administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.</p>
Exclusions	<p>Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.</p> <p>If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count the only the readmission discharge or the discharge from the facility to which the member was transferred.</p>
Exclusion Details	N/A
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>N/A</p>
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement.</p> <p>Step 2. Search administrative systems to identify numerator events for all members in the eligible population.</p> <p>Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.</p> <p>Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being measured.</p> <p>Step 5. Calculate the rate.</p>
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	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement Other organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine
Description	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0646_AMA PCPI_MEDRECONCILIATION_DataCollectionTool.pdf
Level	Facility, Integrated Delivery System
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	<p>Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories:</p> <p>Medications to be TAKEN by patient:</p> <ul style="list-style-type: none"> - Continued* <p>Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND</p> <ul style="list-style-type: none"> - New* <p>Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge</p> <p>* Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed</p> <p>Medications NOT to be Taken by patient:</p> <ul style="list-style-type: none"> - Discontinued <p>Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND</p> <ul style="list-style-type: none"> - Allergies and Adverse Reactions <p>Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued</p>

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	
Numerator Details	<p>Time Window: At each discharge during measurement period</p> <p>Numerator Definitions:</p> <ul style="list-style-type: none"> • For the purposes of this measure, “medications” includes prescription, over-the-counter, and herbal products. Generic and proprietary names should be provided for each medication, when available. • Given the complexity of the medication reconciliation process and variability across inpatient facilities in documentation of that process, this measure does not require that the medication list be organized under the “taken/NOT taken” headings OR the specified sub-categories, provided that the status of each medication (continued, new, or discontinued) is specified within the list AND any allergic reactions are identified. <p>For EHR:</p> <p>This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for medication reconciliation and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>Producing the Reconciled Medication List</p> <p>Facilities that have implemented an EHR system should utilize their system to develop a standardized template for the Reconciled Medication List. A standardized template will ensure that all required data elements specified in the measure are included whenever a Reconciled Medication List is generated from the EHR. Each facility has the autonomy to customize the format of the</p> <p>Reconciled Medication List, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution.</p> <p>Systematic External Reporting that the Reconciled Medication List was provided to patient</p> <p>In order to report, at the facility level, which of the discharged patients have received a Reconciled Medication List, a discrete data field and code indicating the patient received a reconciled medication list at discharge may be needed in the EHR. Each facility should determine the most effective way to identify whether or not the patient received the reconciled medication list.</p> <p>Transmitting the Reconciled Medication List</p> <p>This performance measure does not require that the Reconciled Medication List be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum. RxNorm has been named as the recommended vocabulary for medications and can be used to identify the medications to which the allergies exist. Allergies (non-substance) and Adverse Events to medications should be expressed using SNOMED-CT. The use of industry standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR.</p> <p>For Claims/Administrative:</p> <p>Numerator Action to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>
Denominator Statement	<p>All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.</p> <p>Time Window: Each time a patient is discharged from an inpatient facility</p>
Denominator Details	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR:</p> <p>Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p>

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

For Claims/Administrative:

Identify patients discharged from inpatient facility using the following:

UB-04 (Form Locator 04 - Type of Bill):

- 0111 (Hospital, Inpatient, Admit through Discharge Claim)
- 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim)
- 0114 (Hospital, Inpatient, Last Claim)
- 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim)
- 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim)
- 0214 (Skilled Nursing-Inpatient, Interim, Last Claim)
- 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim)
- 0224 (Skilled Nursing- Interim, Last Claim)
- 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)
- 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim)

AND

Discharge Status (Form Locator 17)

- 01 (Discharged to home care or self care (routine discharge))
- 02 (Discharged/transferred to a short term general hospital for inpatient care)
- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to an intermediate care facility)
- 05 Discharged/transferred to a designated cancer center or children's hospital
- 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)

OR

UB-04 (Form Locator 04 - Type of Bill):

- 0131 (Hospital Outpatient, Admit through Discharge Claim)
- 0134 (Hospital Outpatient, Interim, Last Claim)

AND

UB-04 (Form Locator 42 - Revenue Code):

- 0762 (Hospital Observation)
- 0490 (Ambulatory Surgery)
- 0499 (Other Ambulatory Surgery)

AND

Discharge Status (Form Locator 17)

- 01 (Discharged to home care or self care (routine discharge))

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	
	<ul style="list-style-type: none"> • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
Exclusions	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p>
Exclusion Details	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>No risk adjustment or risk stratification.</p>
Stratification	<p>We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p>
Type Score	<p>Rate/proportion better quality = higher score</p>

	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Algorithm	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>
Copyright/Disclaimer	<p>Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.</p> <p>These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.</p> <p>Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.</p> <p>THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND</p> <p>© 2009 American Medical Association. All Rights Reserved</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>CPT® contained in the Measures specifications is copyright 2008 American Medical Association.</p>

	<p>0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p>*Paired with measure 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement Other organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine
Description	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0647_AMA PCPI_CARETRANS TransitionRecordINPT_DataCollectionTool.pdf
Level	Facility, Integrated Delivery System
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	<p>Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements:</p> <p>Inpatient Care</p> <ul style="list-style-type: none"> • Reason for inpatient admission, AND • Major procedures and tests performed during inpatient stay and summary of results, AND • Principal diagnosis at discharge <p>Post-Discharge/ Patient Self-Management</p> <ul style="list-style-type: none"> • Current medication list, AND • Studies pending at discharge (eg, laboratory, radiological), AND • Patient instructions <p>Advance Care Plan</p> <ul style="list-style-type: none"> • Advance directives or surrogate decision maker documented OR • Documented reason for not providing advance care plan <p>Contact Information/Plan for Follow-up Care</p> <ul style="list-style-type: none"> • 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND • Contact information for obtaining results of studies pending at discharge, AND • Plan for follow-up care, AND • Primary physician, other health care professional, or site designated for follow-up care

	<p>0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p>*Paired with measure 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
<p>Numerator Details</p>	<p>Time Window: At each discharge during measurement period</p> <p>Numerator Definitions:</p> <p>Numerator Element Definitions:</p> <p>a. Transition record: a core, standardized set of data elements related to patient’s diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.</p> <p>b. Current medication list: all medications to be taken by patient after discharge, including all continued and new medications</p> <p>c. Advance directives: eg, written statement of patient wishes regarding future use of life-sustaining medical treatment</p> <p>d. Documented reason for not providing advance care plan: documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient’s beliefs and thus harmful to the physician-patient relationship</p> <p>e. Contact information/ plan for follow-up care: For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the “receiving” facilities.</p> <p>f. Plan for follow-up care: may include any post-discharge therapy needed (eg, oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc.</p> <p>g. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional</p> <p>For EHR:</p> <p>This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>As the quality measures arena moves forward with EHR reporting, the Care Transitions measures will be aligned with the ONC Health IT Standards Committee (HITSC) recommendations that certain vocabulary standards be used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum.</p> <p>Producing the Transition Record with Specified Elements</p> <p>Facilities that have implemented an EHR should utilize their system to produce a standardized template that providers will complete to generate the Transition Record. A standardized template will ensure that all data elements specified in the performance measure are included each time a Transition Record is prepared. Each facility has the autonomy to customize the format of the Transition Record, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution.</p> <p>Systematic External Reporting of the Transition Record</p> <p>In order to report, at the facility level, which of the discharged patients have received a Transition Record, a discrete data field and code indicating the patient received a Transition Record at discharge may be needed in the EHR.</p> <p>For Claims/Administrative:</p> <p>Numerator Action to be identified through medical record abstraction:</p> <p>See Sample Data Collection Tool attached.</p>

	<p>0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p>*Paired with measure 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
<p>Denominator Statement</p>	<p>All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.</p>
<p>Denominator Details</p>	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR:</p> <p>Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p> <p>For Claims/Administrative:</p> <p>Identify patients discharged from inpatient facility using the following:</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim)

	<p>0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p>*Paired with measure 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
	<p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
Exclusions	<p>Patients who died.</p> <p>Patients who left against medical advice (AMA) or discontinued care.</p>
Exclusion Details	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 - Expired-place unknown
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>No risk adjustment or risk stratification.</p>
Stratification	<p>We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p>
Type Score	<p>Rate/proportion better quality = higher score</p>

	<p>0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p>*Paired with measure 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
<p>Algorithm</p>	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care.]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>
<p>Copyright/Disclaimer</p>	<p>Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.</p> <p>These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.</p> <p>Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium.</p> <p>Neither the Consortium nor its members shall be responsible for any use of these Measures.</p> <p>THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND</p> <p>© 2009 American Medical Association. All Rights Reserved</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>CPT® contained in the Measures specifications is copyright 2008 American Medical Association.</p>

	<p>0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p>*Paired with measure 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010 Time-limited
Steward	<p>American Medical Association - Physician Consortium for Performance Improvement Other organizations: ABIM Foundation</p> <p>American College of Physicians</p> <p>Society of Hospital Medicine</p>
Description	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge
Type	Process
Data Source	<p>Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool.</p> <p>Attachment 0648_AMA PCPI_CARETRANS TimelyTransmissionTransitionRecord_DataCollectionTool.pdf</p>
Level	Facility, Integrated Delivery System
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge

	<p>0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p>*Paired with measure 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
<p>Numerator Details</p>	<p>Time Window: Within 24 hours of each discharge during measurement period</p> <p>Numerator Definitions:</p> <p>a. Transition record: a core, standardized set of data elements related to patient’s diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.</p> <p>b. Transmitted: transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR)</p> <p>c. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional</p> <p>For EHR:</p> <p>This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>Transmitting the Transition Record with Specified Elements</p> <p>The Transition Record should be transmitted to the next provider(s) of care in accordance with current recommended standards for interoperability as determined by the Meaningful Use (CMS EHR Incentive) requirements. The use of industry standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR.</p> <p>Systematic External Reporting that the Transition Record was transmitted within 24 hours of discharge</p> <p>To systematically identify the transition records that were transmitted within 24 hours of discharge, a discrete data field and code may be needed in the EHR. This discrete data field will facilitate external reporting of the information.</p> <p>For Claims/Administrative:</p> <p>Numerator Elements to be identified through medical record abstraction:</p> <p>See Sample Data Collection Tool attached.</p>
<p>Denominator Statement</p>	<p>All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care</p>
<p>Denominator Details</p>	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR:</p> <p>Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p> <p>For Claims/Administrative:</p> <p>Identify patients discharged from inpatient facility using the following:</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim)

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

*Paired with measure 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

- 0214 (Skilled Nursing-Inpatient, Interim, Last Claim)
- 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim)
- 0224 (Skilled Nursing- Interim, Last Claim)
- 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)
- 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim)

AND

Discharge Status (Form Locator 17)

- 01 (Discharged to home care or self care (routine discharge))
- 02 (Discharged/transferred to a short term general hospital for inpatient care)
- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to an intermediate care facility)
- 05 Discharged/transferred to a designated cancer center or children’s hospital
- 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)

OR

UB-04 (Form Locator 04 - Type of Bill):

- 0131 (Hospital Outpatient, Admit through Discharge Claim)
- 0134 (Hospital Outpatient, Interim, Last Claim)

AND

UB-04 (Form Locator 42 - Revenue Code):

- 0762 (Hospital Observation)
- 0490 (Ambulatory Surgery)
- 0499 (Other Ambulatory Surgery)

AND

Discharge Status (Form Locator 17)

- 01 (Discharged to home care or self care (routine discharge))
- 02 (Discharged/transferred to a short term general hospital for inpatient care)
- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to an intermediate care facility)
- 05 Discharged/transferred to a designated cancer center or children’s hospital
- 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)
- 43 (Discharged/transferred to a federal health care facility)

	<p>0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p>*Paired with measure 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
	<ul style="list-style-type: none"> • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
Exclusions	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p>
Exclusion Details	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>No risk adjustment or risk stratification.</p>
Stratification	<p>We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p>
Type Score	<p>Rate/proportion better quality = higher score</p>

	<p>0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p> <p>*Paired with measure 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</p>
<p>Algorithm</p>	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>
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0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement Other organizations: ABIM Foundation American College of Physicians Society of Hospital Medicine
Description	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0649_AMA PCPI_CARETRANS TransitionRecordEDDisch_DataCollectionTool.pdf
Level	Facility, Integrated Delivery System
Setting	Ambulatory Care : Clinic/Urgent Care, Hospital/Acute Care Facility
Numerator Statement	<p>Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements:</p> <ul style="list-style-type: none"> • Major procedures and tests performed during ED visit, AND • Principal diagnosis at discharge OR chief complaint, AND • Patient instructions, AND • Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND • List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	
Numerator Details	<p>Time Window: At each emergency department discharge during measurement period</p> <p>Numerator Definitions:</p> <p>a. Transition record (for ED discharges): a core, standardized set of data elements related to patient’s diagnosis, treatment, and care plan that is discussed with and provided to patient in written, printed, or electronic format. Electronic format may be provided only if acceptable to patient.</p> <p>b. Primary physician or other health care professional designated for follow-up care: may be primary care physician (PCP), medical specialist, or other physician or health care professional. If no physician, other health care professional, or site designated or available, patient may be provided with information on alternatives for obtaining follow-up care needed, which may include a list of community health services/other resources.</p> <p>For EHR:</p> <p>This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, emergency department episode). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>Producing the Transition Record with Specified Elements</p> <p>Emergency departments that have implemented an EHR should establish a standardized template within their system that providers will use to generate the Transition Record. A standardized template will ensure that all data elements specified in the performance measure are included each time a Transition Record is prepared. Each facility has the autonomy to customize the format of the Transition Record, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution.</p> <p>Systematic External Reporting of the Transition Record</p> <p>In order to report, at the facility level, which of the patients discharged from the emergency department have received a Transition Record, a discrete data field and code indicating the patient received a Transition Record at discharge may be needed in the EHR.</p> <p>Transmitting the Transition Record with Specified Elements</p> <p>This performance measure does not require that the Transition Record be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum. The use of industry standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR.</p> <p>For Claims/Administrative:</p> <p>Numerator Elements to be identified through medical record abstraction:</p> <p>See Sample Data Collection Tool attached.</p>
Denominator Statement	All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health care

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	
Denominator Details	<p>Time Window: Each emergency department visit during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p> <p>For Claims/Administrative: Identify patients discharged from emergency department using the following:</p> <p>UB-04 (Form Locator 4 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital, Outpatient, Admit through Discharge Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0450 - Emergency Room <p>AND</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 01 - Discharged to home care or self care (routine discharge) • 06 - Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care
Exclusions	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p> <p>Patients who declined receipt of transition record</p>
Exclusion Details	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care* • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown <p>Exception Definition:</p> <p>*Note: For this measure only, it is anticipated that patients who declined receipt of transition record will also be coded with the 07 Discharge Status code.</p>
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>No risk adjustment or risk stratification.</p>
Stratification	<p>We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</p>
Type Score	<p>Rate/proportion better quality = higher score</p>

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	
Algorithm	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care OR Patients who declined receipt of transition record]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>
Copyright/ Disclaimer	<p>Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.</p> <p>These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.</p> <p>Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.</p> <p>THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND</p> <p>© 2009 American Medical Association. All Rights Reserved</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>CPT® contained in the Measures specifications is copyright 2008 American Medical Association.</p>

Appendix B: Project Steering Committee and NQF Staff

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Appendix C: Related and Competing Measures Comparison Tables

NOTE: Specifications for measures #0557 and #0558 were removed from the comparison tables because they were not evaluated in this project and the Committee had few comments regarding the measures. These two measures will be evaluated in a behavioral health project later in the year.

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

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office	Ambulatory Care : Clinician Office	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	<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>Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through administrative or medical record review on or within 30 days of discharge.</p> <p>Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record, on or within 30 days after discharge.</p>	<p>Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories:</p> <p>Medications to be TAKEN by patient:</p> <ul style="list-style-type: none"> - Continued* <p>Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND</p> <ul style="list-style-type: none"> - New* <p>Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge</p> <p>* Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed</p> <p>Medications NOT to be Taken by patient:</p> <ul style="list-style-type: none"> - Discontinued <p>Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND</p> <ul style="list-style-type: none"> - Allergies and Adverse Reactions <p>Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued</p>
Numerator	Time Window: Ambulatory visits within 60	Time Window: The measurement year	Time Window: At each discharge during

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Details	<p>days of a discharge from an inpatient facility</p> <p>CPT II Category II code 1111F: Discharge medications reconciled with the current medication list in the outpatient medical record</p> <p>Level 1 EHR specifications in development</p>	<p>1) Administrative (when available): Medication reconciliation (Table MRP-A) conducted by prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. A member had a medication reconciliation if a claim/encounter contains a code in Table MRP-A.</p> <p>Table MRP-A: Codes to Identify Medication Reconciliation</p> <p>Medication Reconciliation: CPT Category II: 1111F</p> <p>2) Medical Record (as necessary): Documentation in the medical record must include evidence of medication reconciliation, and the date on which it was performed. The following evidence meets criteria:</p> <ul style="list-style-type: none"> • Notation that medications prescribed or ordered upon discharge were reconciled with the current medications (in outpatient record) by the appropriate practitioner type, or • A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type or • Notation that no medications were prescribed or ordered upon discharge <p>Only documentation in the outpatient record chart meets the intent of the measure, but an in-person, outpatient visit is not required</p>	<p>measurement period</p> <p>Numerator Definitions:</p> <ul style="list-style-type: none"> • For the purposes of this measure, “medications” includes prescription, over-the-counter, and herbal products. Generic and proprietary names should be provided for each medication, when available. • Given the complexity of the medication reconciliation process and variability across inpatient facilities in documentation of that process, this measure does not require that the medication list be organized under the “taken/NOT taken” headings OR the specified sub-categories, provided that the status of each medication (continued, new, or discontinued) is specified within the list AND any allergic reactions are identified. <p>For EHR:</p> <p>This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for medication reconciliation and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>Producing the Reconciled Medication List</p> <p>Facilities that have implemented an EHR system should utilize their system to develop a standardized template for the Reconciled</p>

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
			<p>Medication List. A standardized template will ensure that all required data elements specified in the measure are included whenever a Reconciled Medication List is generated from the EHR. Each facility has the autonomy to customize the format of the Reconciled Medication List, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution.</p> <p>Systematic External Reporting that the Reconciled Medication List was provided to patient</p> <p>In order to report, at the facility level, which of the discharged patients have received a Reconciled Medication List, a discrete data field and code indicating the patient received a reconciled medication list at discharge may be needed in the EHR. Each facility should determine the most effective way to identify whether or not the patient received the reconciled medication list.</p> <p>Transmitting the Reconciled Medication List</p> <p>This performance measure does not require that the Reconciled Medication List be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum. RxNorm has been named as the recommended</p>

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
			vocabulary for medications and can be used to identify the medications to which the allergies exist. Allergies (non-substance) and Adverse Events to medications should be expressed using SNOMED-CT. The use of industry standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR. For Claims/Administrative: Numerator Action to be identified through medical record abstraction: See Sample Data Collection Tool attached.
Denominator Statement	All patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care	All discharges from an in-patient setting for health plan members who are 66 years and older as of December 31 of the measurement year.	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care. Time Window: Each time a patient is discharged from an inpatient facility
Denominator Details	Time Window: Discharges from an inpatient facility within the last 60 days (eg, hospital, skilled nursing facility, or rehabilitation facility) CPT service codes 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404 AND CPT Category II code 1110F: Patient	Time Window: The measurement year (one calendar year) 1) Administrative (when available): An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator is based on episodes, not members. Members may appear more than once in the sample. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. 2) Medical Record (as necessary): The denominator is based on episodes, not	Time Window: Each discharge during 12 consecutive month measurement period For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored. For Claims/Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital, Inpatient, Admit through Discharge Claim)

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	<p>discharged from an inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days</p> <p>OR</p> <p>Documentation in the medical record of a discharge from an inpatient facility within the last 60 days</p> <p>Note: only patients who were discharged from an inpatient facility within the last 60 days will be included in the denominator of this measure.</p>	<p>members. Members may appear more than once in the sample.</p> <p>The denominator is based on the discharge date found in the administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.</p>	<ul style="list-style-type: none"> • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
			<ul style="list-style-type: none"> • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery)

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
			<ul style="list-style-type: none"> • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
			<ul style="list-style-type: none"> • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
Exclusions	N/A	<p>Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.</p> <p>If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count the only the readmission discharge or the discharge from the facility to which the member was transferred.</p>	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p>
Exclusion Details	N/A	N/A	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown
Risk Adjustment	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	N/A	N/A	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	<p>Calculation for Performance</p> <p>For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator and Denominator.</p> <p>Step 1: Determine the eligible population. The eligible population is all the patients aged 65 years and older.</p> <p>Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above.</p> <p>Step 3: Determine the number of patients who meet the numerator criteria as specified in section 2a1.3 above. The numerator includes all patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented</p> <p>Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2 Attachment PCPI Sample Calculation Algorithm.pdf</p>	<p>Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement.</p> <p>Step 2. Search administrative systems to identify numerator events for all members in the eligible population.</p> <p>Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.</p> <p>Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being measured.</p> <p>Step 5. Calculate the rate.</p>	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. <p>--Although the exception cases are removed from</p>

	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
			<p>the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>

	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
Steward	National Committee for Quality Assurance	Centers for Medicare & Medicaid Services
Description	Percentage of adults 66 years and older who had a medication review; a review of all a member’s medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route
Type	Process	Process
Data Source	Administrative claims, Electronic Clinical Data, Paper Records NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). URL http://www.ncqa.org/tabid/370/default.aspx	Administrative claims, Electronic Clinical Data : Registry Medicare Part B claims data URL NQF 0419 Endorsement Summary 012312 zip file of supporting documentation sent to H. Bossley & A. Lyzenga via email on 01/23/12 due to path submission error Attachment m130_attachment_partb_detail_line_item_format.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State	Clinician : Individual, Population : National
Setting	Ambulatory Care : Clinician Office, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Ambulatory Care : Clinician Office, Behavioral Health/Psychiatric : Outpatient, Dialysis Facility, Home Health, Other, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation Clinic, Hospital outpatient
Numerator Statement	At least one medication review (Table COA-B)conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Table COA-C) Table COA-B Codes to identify medication review: Medication review (CPT 90862, 99605, 99606), (CPT-II 1160F) Table COA-C Codes to Identify Medication List (CPT-II 1159F)	ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION. Eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosages, frequency and route NUMERATOR NOTE: By reporting G8427, the eligible professional is attesting the documented current medication information is accurate and complete to the best of his/her knowledge and ability at the time of the patient encounter. This code may also be reported if there is documentation that no medications are currently being taken.
Numerator	Time Window: The measurement year	Time Window: This measure is to be reported at each visit during the 12

	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
Details	<p>1) Administrative Specification (if available): At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record, as documented through administrative data. The claim/encounter for a member’s medication review and medication list must be on the same date of service. Codes to identify medication review: Medication review (CPT 90862, 99605, 99606), (CPT-II 1160F) Codes to Identify Medication List (CPT-II 1159F)</p> <p>2) Medical Record Specification (if necessary): Documentation must come from the same medical record and must include the following.</p> <ul style="list-style-type: none"> • A medication list in the medical record, and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed • Notation that the member is not taking any medication and the date when it was noted <p>A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Prescribing practitioner is defined as a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.</p>	<p>month reporting period. Eligible professionals meet the intent of this measure by making a best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. For the purposes of calculating performance, the Numerator(A) is defined by providers reporting the clinical quality action was performed. For this measure, performing the clinical quality action is numerator HCPCS G8427. Current Medications with Name, Dosage, Frequency and Route Documented G8427: List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route</p>
Denominator Statement	All patients 66 and older as of December 31 of the measurement year	<p>ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION. All visits occurring during the 12 month reporting period for patients aged 18 years and older at the time of the encounter where one or more denominator CPT or HCPCS codes AND any of the 3 numerator HCPCS codes are reported on the claims submission for the encounter. All discussed coding is listed in "2a1.7. Denominator Details" section below.</p>
Denominator Details	<p>Time Window: The measurement year Use administrative data and medical records for of members 66 years and older as of December 31 of the measurement year.</p>	<p>Time Window: All visits occurring during the 12 month reporting period for patients aged 18 years and older at the time of the encounter. For the purposes of defining the denominator, the Performance Denominator(PD) is defined by the patient’s age, encounter date,</p>

	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
		<p>denominator CPT or HCPCS codes and the provider reported numerator HCPCS codes described below (G8427, G8430 & G8428).</p> <p>Patients aged greater than or equal to 18 years on date of encounter AND Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90816, 90817, 90818, 90819, 90821, 90822, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0270, G0402, G0438, G0439</p> <p>AND Patient encounters with the following numerator HCPCS Code G8427, G8430, G8428.</p> <p>Current Medications with Name, Dosage, Frequency and Route Documented G8427: List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route Current Medications with Dosage not Documented, Patient not Eligible G8430: Provider documentation that patient is not eligible for medication assessment Current Medications with Name, Dosage, Frequency, Route not Documented, Reason not Specified G8428: Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) with drug name, dosage, frequency and route not documented by the provider, reason not specified</p>
Exclusions	N/A	ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION. A patient is not eligible or excluded (B) from the performance denominator (PD) if one or more of the following reason(s) exist: 1. Patient refuses to participate

	0553 Care for Older Adults – Medication Review	0419 Documentation of Current Medications in the Medical Record
		<p>2. Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status</p> <p>3. Patient cognitively impaired and no authorized representative(s), caregiver(s), and or other healthcare resources are available</p>
Exclusion Details	N/A	<p>For the purposes of identifying performance exclusions, Denominator Exclusions (B) are defined by providers reporting the exclusion clinical quality action. For this measure, the clinical exclusion code is numerator HCPCS G8430.</p> <p>Current Medications with Dosages not Documented, Patient not Eligible G8430: Provider documentation that patient is not eligible for medication assessment</p>
Risk Adjustment	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification N/A
Stratification	N/A	This measure is not stratified. All eligible patients are subject to the same numerator criteria.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	<p>Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement.</p> <p>Step 2. Search administrative systems to identify numerator events for all members in the eligible population.</p> <p>Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.</p> <p>Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being measured.</p> <p>Step 5. Calculate the rate.</p>	<p>This section provides details and formulas to calculate Performance and Denominator Exclusions.</p> <p>PERFORMANCE CALCULATION</p> <p>To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD) and Denominator Exclusions (B).</p> <p>Numerator (A): Number of patients meeting numerator criteria</p> <p>Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion</p> <p>Denominator Exclusions (B): Number of patients with valid exclusions</p> <p>The method of performance calculation is determined by the following:</p> <ol style="list-style-type: none"> 1) identify the patients who meet the eligibility criteria for the denominator (PD) which includes patients who are 18 years and older with encounters during the reporting period with any of denominator CPT or HCPCS codes and numerator HCPCS codes as listed in "2a1.7. Denominator Details". 2) identify which of those patients meet the numerator criteria (G8427) (A) 3) for those patients who do not meet the numerator criteria, determine

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

	0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
Steward	American Medical Association - Physician Consortium for Performance Improvement	American Medical Association - Physician Consortium for Performance Improvement	American Medical Association - Physician Consortium for Performance Improvement
Description	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements
Type	Process	Process	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0647_AMA PCPI_CARETRANS TransitionRecordINPT_DataCollectionTool.pdf	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0648_AMA PCPI_CARETRANS TimelyTransmissionTransitionRecord_DataCollectionTool.pdf	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records See attached data collection tool. Attachment 0649_AMA PCPI_CARETRANS TransitionRecordEDDisch_DataCollectionTool.pdf
Level	Facility, Integrated Delivery System	Facility, Integrated Delivery System	Facility, Integrated Delivery System
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation	Ambulatory Care : Clinic/Urgent Care, Hospital/Acute Care Facility
Numerator Statement	Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements: Inpatient Care <ul style="list-style-type: none"> Reason for inpatient admission, AND 	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: <ul style="list-style-type: none"> Major procedures and tests performed during ED visit, AND Principal diagnosis at discharge OR chief

	0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	<ul style="list-style-type: none"> • Major procedures and tests performed during inpatient stay and summary of results, AND • Principal diagnosis at discharge Post-Discharge/ Patient Self-Management <ul style="list-style-type: none"> • Current medication list, AND • Studies pending at discharge (eg, laboratory, radiological), AND • Patient instructions Advance Care Plan <ul style="list-style-type: none"> • Advance directives or surrogate decision maker documented OR • Documented reason for not providing advance care plan Contact Information/Plan for Follow-up Care <ul style="list-style-type: none"> • 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND • Contact information for obtaining results of studies pending at discharge, AND • Plan for follow-up care, AND • Primary physician, other health care professional, or site designated for follow-up care 		<p>complaint, AND</p> <ul style="list-style-type: none"> • Patient instructions, AND • Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND • List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each
Numerator Details	<p>Time Window: At each discharge during measurement period</p> <p>Numerator Definitions:</p> <p>Numerator Element Definitions:</p> <p>a. Transition record: a core, standardized set of data elements related to patient’s diagnosis, treatment, and care plan that is discussed with and provided to patient in</p>	<p>Time Window: Within 24 hours of each discharge during measurement period</p> <p>Numerator Definitions:</p> <p>a. Transition record: a core, standardized set of data elements related to patient’s diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the</p>	<p>Time Window: At each emergency department discharge during measurement period</p> <p>Numerator Definitions:</p> <p>a. Transition record (for ED discharges): a core, standardized set of data elements related to patient’s diagnosis, treatment, and care plan that is discussed with and provided to patient</p>

	0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	<p>printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.</p> <p>b. Current medication list: all medications to be taken by patient after discharge, including all continued and new medications</p> <p>c. Advance directives: eg, written statement of patient wishes regarding future use of life-sustaining medical treatment</p> <p>d. Documented reason for not providing advance care plan: documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient’s beliefs and thus harmful to the physician-patient relationship</p> <p>e. Contact information/ plan for follow-up care: For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the “receiving” facilities.</p> <p>f. Plan for follow-up care: may include any post-discharge therapy needed (eg, oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources</p>	<p>facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.</p> <p>b. Transmitted: transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR)</p> <p>c. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional</p> <p>For EHR: This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>Transmitting the Transition Record with Specified Elements</p> <p>The Transition Record should be transmitted to the next provider(s) of care in accordance with current recommended standards for interoperability as determined by the Meaningful Use (CMS EHR Incentive) requirements. The use of industry standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR.</p>	<p>in written, printed, or electronic format. Electronic format may be provided only if acceptable to patient.</p> <p>b. Primary physician or other health care professional designated for follow-up care: may be primary care physician (PCP), medical specialist, or other physician or health care professional. If no physician, other health care professional, or site designated or available, patient may be provided with information on alternatives for obtaining follow-up care needed, which may include a list of community health services/other resources.</p> <p>For EHR: This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, emergency department episode). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>Producing the Transition Record with Specified Elements</p> <p>Emergency departments that have implemented an EHR should establish a standardized template within their system that providers will use to generate the Transition Record. A standardized template</p>

	0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	<p>available for patient support, etc.</p> <p>g. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional</p> <p>For EHR: This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>As the quality measures arena moves forward with EHR reporting, the Care Transitions measures will be aligned with the ONC Health IT Standards Committee (HITSC) recommendations that certain vocabulary standards be used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum.</p> <p>Producing the Transition Record with Specified Elements</p> <p>Facilities that have implemented an EHR should utilize their system to produce a standardized template that providers will</p>	<p>Systematic External Reporting that the Transition Record was transmitted within 24 hours of discharge</p> <p>To systematically identify the transition records that were transmitted within 24 hours of discharge, a discrete data field and code may be needed in the EHR. This discrete data field will facilitate external reporting of the information.</p> <p>For Claims/Administrative: Numerator Elements to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>	<p>will ensure that all data elements specified in the performance measure are included each time a Transition Record is prepared. Each facility has the autonomy to customize the format of the Transition Record, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution.</p> <p>Systematic External Reporting of the Transition Record</p> <p>In order to report, at the facility level, which of the patients discharged from the emergency department have received a Transition Record, a discrete data field and code indicating the patient received a Transition Record at discharge may be needed in the EHR.</p> <p>Transmitting the Transition Record with Specified Elements</p> <p>This performance measure does not require that the Transition Record be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum. The use of industry standards for the transmission of the Reconciled Medication List information will ensure that the information can be received</p>

	0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	<p>complete to generate the Transition Record. A standardized template will ensure that all data elements specified in the performance measure are included each time a Transition Record is prepared. Each facility has the autonomy to customize the format of the Transition Record, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution.</p> <p>Systematic External Reporting of the Transition Record</p> <p>In order to report, at the facility level, which of the discharged patients have received a Transition Record, a discrete data field and code indicating the patient received a Transition Record at discharge may be needed in the EHR.</p> <p>For Claims/Administrative: Numerator Action to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>		<p>into the destination EHR.</p> <p>For Claims/Administrative: Numerator Elements to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>
Denominator Statement	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care	All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health care
Denominator Details	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from</p>	<p>Time Window: Each discharge during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system</p>	<p>Time Window: Each emergency department visit during 12 consecutive month measurement period</p> <p>For EHR: Eligible discharges for the denominator should be identified through the Admission,</p>

	0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	<p>another electronic system where this information is stored.</p> <p>For Claims/Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare 	<p>where this information is stored.</p> <p>For Claims/Administrative: Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) 	<p>Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.</p> <p>For Claims/Administrative: Identify patients discharged from emergency department using the following: UB-04 (Form Locator 4 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital, Outpatient, Admit through Discharge Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0450 - Emergency Room <p>AND</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 01 - Discharged to home care or self care (routine discharge) • 06 - Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care

	0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	<p>certification in anticipation of skilled care)</p> <ul style="list-style-type: none"> • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p>	<ul style="list-style-type: none"> • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) 	

	0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	<p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) 	<ul style="list-style-type: none"> • 0134 (Hospital Outpatient, Interim, Last Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a designated cancer center or children’s hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient 	

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	<ul style="list-style-type: none"> • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) 	<ul style="list-style-type: none"> rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) 	
Exclusions	<p>Patients who died.</p> <p>Patients who left against medical advice (AMA) or discontinued care.</p>	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p>	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p> <p>Patients who declined receipt of transition record</p>
Exclusion Details	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 - Expired-place unknown 	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown 	<p>For Claims/Administrative Data:</p> <p>UB-04 (Form Locator 17 - Discharge Status):</p> <ul style="list-style-type: none"> • 07 – Left against medical advice or discontinued care* • 20 – Expired • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired-place unknown

	0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
			Exception Definition: *Note: For this measure only, it is anticipated that patients who declined receipt of transition record will also be coded with the 07 Discharge Status code.
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification.	No risk adjustment or risk stratification No risk adjustment or risk stratification.	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. For the purpose of this measure, a patient can qualify for the measure multiple times during the measurement period if they have multiple inpatient discharges. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the

	0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	<p>denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator</p> <p>4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care.]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation.</p> <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>	<p>4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care.]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation.</p> <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>	<p>denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator</p> <p>4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: Patients who died OR Patients who left against medical advice (AMA) or discontinued care OR Patients who declined receipt of transition record]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation.</p> <p>--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.</p>

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