OHIC Measure Alignment Work Group
2022 Annual Review of the Acute Care Hospital Aligned Measure Set
Measure Specifications

28	Severe Obstetric Complications (eCQM)	185
29	Social Needs Screening and Intervention	190
30	Topical Fluoride for Children	201

American College of Surgeons Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI)

NQF Endorsement Status	Endorsed
NQF ID	0753
Measure Type	Outcome
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	Facility adjusted Standardized Infection Ratio (SIR) and Adjusted Ranking Metric (ARM) for deep incisional and organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients aged >= 18 years as reported through the CDC National Health and Safety Network (NHSN).
Numerator	Deep incisional primary (DIP) and organ/space SSIs during the 30-day postoperative period among patients = 18 years of age, who undergo inpatient colon surgeries or abdominal hysterectomies. SSIs will be identified before discharge from the hospital, upon readmission to the same hospital, or during outpatient care or admission to another hospital (post-discharge surveillance). Numerator Exclusion SSI events with PATOS* field = yes.
Denominator	An NHSN Operative Procedure is a procedure: that is included in the ICD-10-PCS or CPT NHSN operative procedure code mapping. And takes place during an operation where at least one incision (including laparoscopic approach and cranial Burr holes) is made through the skin or mucous membrane, or reoperation via an incision that was left open during a prior operative procedure And takes place in an operating room (OR), defined as a patient care area that met the Facilities Guidelines Institute s (FGI) or American Institute of Architects (AIA) criteria for an operating room when it was constructed or renovated. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab.

American College of Surgeons Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI)

	Exclusions: Otherwise eligible procedures that are assigned an ASA score of 6 are not eligible for NHSN SSI surveillance.
Denominator Exclusions	Denominator data are excluded from the SSI measure due to various reasons related to data quality, data outlier and data errors. The complete list of universal exclusion criteria applied to denominator are listed in the SSI section of the SIR guide that is referenced above. These exclusions include but are not limited to procedures associated with SSI events where the PATOS = yes, and those with ASA Class VI (6). The measure specific denominator exclusions for the Complex 30-day SSI, are off plan colon and abdominal hysterectomy procedures, procedures performed on persons under the age of 18, and procedure performed on an outpatient basis. . Note: Under the 2015 baseline, both primarily closed procedures and those that are not closed primarily are included in the denominator data. Persons under the age of 18, those having a procedure performed on an outpatient basis, procedures associated with SSI events where the PATOS = yes, those with ASA Class VI (6) are excluded. Note: Both primarily closed procedures and those that are not closed primarily are included in the denominator data.
Rationale	The use of this measure will promote SSI prevention activities which will lead to improved patient outcomes including reduction of avoidable medical costs, and patient morbidity and mortality.
Evidence	The use of this measure will promote SSI prevention activities which will lead to improved patient outcomes including reduction of avoidable medical costs, and patient morbidity and mortality. When SIRs are compared over time, assessment of performance can be made. In separate analyses, CDC and ACS have demonstrated a significant performance gaps in SIRs across facilities. The data cited above are unpublished, obtained from an internal analysis of ACS NSQIP and CDC NHSN data. These gaps have been repeatedly demonstrated since the inception of the program in published semiannual reports to ACS NSQIP participants

American College of Surgeons Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI)

Developer/Steward

Steward	Centers for Disease Control and Prevention (CDC)
Contact	Not Available
Measure Developer	Centers for Disease Control and Prevention CDC
Development Stage	Fully Developed

Characteristics

Measure Type	Outcome
Meaningful Measure Area	Healthcare-Associated Infections
Healthcare Priority	Make Care Safer by Reducing Harm Caused in the Delivery of Care
eCQM Spec Available	Not Available
NQF Endorsement Status	Endorsed
NQF ID	0753
Last NQF Update	2019-06-10
Target Population Age	18+
Target Population Age (High)	Not Available
Target Population Age (Low)	18
Reporting Level	Facility
Conditions	Infection
Subconditions	Surgical Site Infection

American College of Surgeons Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI)

Care Settings	Hospital Inpatient; Hospital/Acute Care Facility

Groups

Core Measure Set	Not Available

Measure Group	Group Identifier
SSI	
HAI	3
HAI	
HAI	4
Colon and Abdominal Hysterectomy SSI	

Measure Links

Measure Program: Hospital Value-Based Purchasing

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Safety

American College of Surgeons Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI)

Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2016-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

Milestone: Finalized

Effective Date	2013-08-19
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

NQF Endorsement Status	Endorsed
NQF ID	0138
Measure Type	Outcome
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	This measure calculates the total number of healthcare-associated CAUTI among patients in bedded inpatient care locations, from the total number of indwelling urinary catheter days for each location under surveillance for CAUTI during the associated data period. This measure is risk-adjusted.
Numerator	Total number of observed healthcare-associated CAUTI among patients in bedded inpatient care locations (excluding patients in Level II or III neonatal ICUs).
Denominator	Total number of predicted healthcare-associated CAUTI among inpatient care locations under surveillance for CAUTI during the data period, based on the national CAUTI baseline Data is calculated using the facility's number of catheter days and the following significant risk factors: Acute Care Hospitals: CDC Location, Facility bed size, Medical school affiliation, and Facility type Critical Access Hospitals: Medical school affiliation Long-Term Acute Hospitals: Average length of stay, Setting type, and Location type Inpatient Rehabilitation Facilities: Setting type, Proportion of admissions with traumatic and non-traumatic spinal cord dysfunction, Proportion of admissions with stroke
Denominator Exclusions	Denominator Exclusions: The following are not considered indwelling catheters by NHSN definitions:

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

	1. Suprapubic catheters 2. Condom catheters 3. "In and out" catheterizations 4. Nephrostomy tubes Note, that if a patient has either a nephrostomy tube or a suprapubic catheter and also has an indwelling urinary catheter, the indwelling urinary catheter will be included in the CAUTI surveillance.
Rationale	Evidence that this measure promotes CAUTI prevention activities that will lead to improved patient outcomes including reduction of avoidable medical costs, and patient morbidity and mortality through reduced need for antimicrobials and reduced length of stay.
Evidence	In 2017, among the 2,589 hospitals in U.S. with enough CAUTI data to calculate a standardized infection ratio (SIR), 11% had an SIR significantly higher (worse) than 0.88, the value of the national SIR.

Developer/Steward

Steward	Centers for Disease Control and Prevention
Contact	MMSSupport@Battelle.org
Measure Developer	Centers for Disease Control and Prevention
Development Stage	Fully Developed

Characteristics

Measure Type	Outcome
Meaningful Measure Area	Healthcare-Associated Infections
Healthcare Priority	Make Care Safer by Reducing Harm Caused in the Delivery of Care
eCQM Spec Available	Not Available

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

NQF Endorsement Status	Endorsed
NQF ID	0138
Last NQF Update	2019-10-23
Target Population Age	Not Specified
Target Population Age (High)	Not Available
Target Population Age (Low)	Not Available
Reporting Level	Facility
Conditions	Infection
Subconditions	Catheter Associated Urinary Tract Infections (CAUTI)
Care Settings	Behavioral Health/Psychiatric: Inpatient; Dialysis Facility; Home Care; Hospice; Hospital Inpatient; Hospital/Acute Care Facility; IP units within acute care hospitals; Inpatient Rehabilitation Facility; Institution and Community; Long-term Care Hospital; Nursing Home; Other; PPS-Exempt Cancer Hospitals; Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Groups

Core Measure Set	Not Available

Measure Group	Group Identifier
HAI	2
CAUTI	
HAI	

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Measure Links

Measure Program: Long-Term Care Hospital Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2012-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html

Milestones

Milestone: Implemented

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Effective Date	2013-10-01
Comments	Not Available

Milestone: Finalized

Effective Date	2011-08-18
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	http://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf

Measure Program: Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	Not Available

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Data Reporting End Date	2018-10-01

Measure Program Links

Measure Program: Hospital Inpatient Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Not specified
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	2013-01-01
Data Reporting End Date	2020-01-01

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

Milestones

Milestone: Removed

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Effective Date	2021-10-01
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf

Milestone: Implemented

Effective Date	2013-10-01
Comments	Not Available

Measure Program: Inpatient Rehabilitation Facility Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2011-10-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Milestones

Milestone: Implemented

Effective Date	2011-10-01
Comments	Not Available
Milestone Links	https://www.medicare.gov/inpatientrehabilitationfacilitycompare/

Measure Program: Inpatient Rehabilitation Facility Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Making care safe through timeliness and responsiveness of care
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2012-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Milestones

Milestone: Implemented

Effective Date	2014-10-01
Comments	Not Available

Milestone: Finalized

Effective Date	2012-11-15
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2015-08-06/pdf/2015-18973.pdf

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	http://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf

Measure Program: Hospital Acquired Condition Reduction Program

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	Not Available

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Reporting Status	Active
Data Reporting Begin Date	2014-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program

Milestones

Milestone: Implemented

Effective Date	2014-10-01
Comments	Not Available

Milestone: Finalized

Effective Date	2013-08-19
Comments	Not Available

Milestone: Considered

Effective Date	2012-12-01
Comments	Not Available

Other Data	**Name**	**Value**
	MUC ID	1370

Measure Program: Hospital Compare

Info As Of	Not Available

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2013-10-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

Milestones

Milestone: Implemented

Effective Date	2018-04-01
Comments	Not Available
Milestone Links	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

Measure Program: Prospective Payment System-Exempt Cancer Hospital Quality Reporting

Info As Of	Not Available

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2013-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/PCHQR.html

Milestones

Milestone: Considered

Effective Date	2019-12-01
Comments	MUC2019-18: Measure submitted in 2019 with significant revisions and is under consideration
Milestone Links	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/Measures-under-Consideration-List-for-2018.pdf

Other Data	**Name**	**Value**

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Name	Value
MUC ID	MUC2019-18

Milestone: Implemented

Effective Date	2013-10-01
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2012-08-31/pdf/2012-19079.pdf

Milestone: Finalized

Effective Date	2012-08-31
Comments	Not Available

Milestone: Proposed

Effective Date	2012-05-11
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2012-05-11/pdf/2012-9985.pdf

Measure Program: Long-Term Care Hospital Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Reporting Status	Active
Data Reporting Begin Date	2011-10-01
Data Reporting End Date	Not Available

Measure Program Links

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Measures Information | CMS

Milestones

Milestone: Implemented

Effective Date	2011-10-01
Comments	Not Available
Milestone Links	https://www.medicare.gov/longtermcarehospitalcompare/

Measure Program: Hospital Value-Based Purchasing

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Safety
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

Data Reporting Begin Date	2016-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

Milestone: Finalized

Effective Date	2014-08-22
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

Measure Information Form

Measure Set: Perinatal Care (PC)

Set Measure ID: PC-02

Performance Measure Name: Cesarean Birth

Description: Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth

Rationale: The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean birth (CB) rates. Some hospitals now have CB rates over 50%. Hospitals with CB rates at 15-20% have infant outcomes that are just as good and better maternal outcomes (Gould et al., 2004). There are no data that higher rates improve any outcomes, yet the CB rates continue to rise. This measure seeks to focus attention on the most variable portion of the CB epidemic, the term labor CB in nulliparous women. This population segment accounts for the large majority of the variable portion of the CB rate, and is the area most affected by subjectivity.

As compared to other CB measures, what is different about NTSV CB rate (Low-risk Primary CB in first births) is that there are clear cut quality improvement activities that can be done to address the differences. Main et al. (2006) found that over 60% of the variation among hospitals can be attributed to first birth labor induction rates and first birth early labor admission rates. The results showed if labor was forced when the cervix was not ready the outcomes were poorer. Alfirevic et al. (2004) also showed that labor and delivery guidelines can make a difference in labor outcomes. Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al., 1989; Goyert et al., 1989; Luthy et al., 2003). The dramatic variation in NTSV rates seen in all populations studied is striking according to Menacker (2006). Hospitals within a state (Coonrod et al., 2008; California Office of Statewide Hospital Planning and Development [OSHPD], 2007) and physicians within a hospital (Main, 1999) have rates with a 3-5 fold variation.

Type Of Measure: Outcome

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with cesarean births

> **Included Populations:** *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for cesarean birth as defined in Appendix A, Table 11.06
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *ICD-10-PCS Other Procedure Codes*

- *ICD-10-PCS Principal Procedure Code*

Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation

Included Populations:

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1
- Nulliparous patients with *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more of gestation completed

Excluded Populations:

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for multiple gestations and other presentations as defined in Appendix A, Table 11.09
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay >120 days
- *Gestational Age* < 37 weeks or UTD

Data Elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *Gestational Age*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *Previous Live Births*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce cesarean births.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- Agency for Healthcare Research and Quality. (2002). *AHRQ Quality Indicators Guide to Inpatient Quality Indicators: Quality of Care in Hospitals Volume, Mortality, and Utilization*. Revision 4 (December 22, 2004). AHRQ Pub. No. 02-RO204.
- Alfirevic, Z., Edwards, G., & Platt, M.J. (2004). The impact of delivery suite guidelines on intrapartum care in "standard primigravida." *Eur J Obstet Gynecol Reprod Biol*.115:28-31.
- American College of Obstetricians and Gynecologists. (2000). *Task Force on Cesarean Delivery Rates. Evaluation of Cesarean Delivery*. (Developed under the direction of the Task Force on Cesarean Delivery Rates, Roger K. Freeman, MD, Chair, Arnold W. Cohen, MD, Richard Depp III, MD, Fredric D. Frigoletto Jr, MD, Gary D.V. Hankins, MD, Ellice Lieberman, MD, DrPH, M. Kathryn Menard, MD, David A. Nagey, MD, Carol W. Saffold, MD, Lisa Sams, RNC, MSN and ACOG Staff: Stanley Zinberg, MD, MS, Debra A. Hawks, MPH, and Elizabeth Steele).
- Bailit, J.L., Garrett, J.M., Miller, W.C., McMahon, M.J., & Cefalo, R.C. (2002). Hospital primary cesarean delivery rates and the risk of poor neonatal outcomes. *Am J Obstet Gynecol*. 187(3):721-7.
- Bailit, J. & Garrett, J. (2003). Comparison of risk-adjustment methodologies. *Am J Obstet Gynecol*.102:45-51.
- Bailit, J.L., Love, T.E., & Dawson, N.V. (2006). Quality of obstetric care and risk-adjusted primary cesarean delivery rates. *Am J Obstet Gynecol*.194:402.
- Bailit, J.L. (2007). Measuring the quality of inpatient obstetrical care. *Ob Gyn Sur*. 62:207-213.
- Berkowitz, G.S., Fiarman, G.S., Mojica, M.A., et al. (1989). Effect of physician characteristics on the cesarean birth rate. *Am J Obstet Gynecol*. 161:146-9.
- California Office of Statewide Hospital Planning and Development. (2017). Hospital Volume and Utilization Indicators for California, Retrieved from the Internet on February 22, 2018 at: https://www.oshpd.ca.gov/HID/AHRQ-Volume-Utilization.html
- Caughey, A.B., Cahill, A.G., Guise, JM., Rouse, D.J. (2019). Safe prevention of the primary cesarean delivery. American College of Obstetricians and Gynecologists, 123: 693-711. Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery.
- Cleary, R., Beard, R.W., Chapple, J., Coles, J., Griffin, M., & Joffe, M. (1996). The standard primipara as a basis for inter-unit comparisons of maternity care. *Br J Obstet Gynecol*. 103:223-9.
- Coonrod, D.V., Drachman, D., Hobson, P., & Manriquez, M. (2008). Nulliparous term singleton vertex cesarean delivery rates: institutional and individual level predictors. *Am J Obstet Gynecol*. 694-696.
- DiGiuseppe, D.L., Aron, D.C., Payne, S.M., Snow, R.J., Dieker, L., & Rosenthal, G.E. (2001). Risk adjusting cesarean delivery rates: a comparison of hospital profiles based on medical record and birth certificate data. *Health Serv Res*.36:959-77.
- Gould, J., Danielson, B., Korst, L., Phibbs, R., Chance, K.,& Main, E.K., et al. (2004). Cesarean delivery rate and neonatal morbidity in a low-risk population. *Am J Obstet Gynecol*, 104:11-19.
- Goyert, G.L., Bottoms, F.S., Treadwell, M.C., et al. (1989). The physician factor in cesarean birth rates. *N Engl J Med*.320:706-9.
- Le Ray, C., Carayol, M., Zeitlin, J., Berat, G., & Goffinet, F. (2006). Level of perinatal care of the maternity unit and rate of cesarean in low-risk nulliparas. *Am J Obstet Gynecol*. 107:1269-77.
- Luthy, D.A., Malmgren, J.A., Zingheim, R.W., & Leininger, C.J. (2003). Physician contribution to a cesarean delivery risk model. *Am J Obstet Gynecol*.188:1579-85.
- Main, E.K. (1999). Reducing cesarean birth rates with data-driven quality improvement activities. *Peds*. 103: 374-383.

- Main E.K., Bloomfield, L., & Hunt, G. (2004). Development of a large-scale obstetric quality-improvement program that focused on the nulliparous patient at term. *Am J Obstet Gynecol*.190:1747-58.
- Main, E.K., Moore, D., Farrell, B., Schimmel, L.D., Altman, R.J., Abrahams, C., et al., (2006). Is there a useful cesarean birth measure? Assessment of the nulliparous term singleton vertex cesarean birth rate as a tool for obstetric quality improvement. *Am J Obstet Gynecol*. 194:1644-51.
- Main, E.K, Shen-Chih, C., Cape, V., Sakowski, C., Smith, H., Vasher, J. (2019). Safety assessment scale of a large-scale improvement collaborative to reduce nulliparous cesarean delivery rates. American College of Obstetricians and Gynecologists, 133 (4): 613-623.
- Menacker, F. (2005).Trends in cesarean rates for first births and repeat cesarean rates for low-risk women: United States, 1990-2003. *Nat Vital Stat Rep*. 54(4): 1-5.
- Romano, P.S., Yasmeen, S., Schembri, M.E., Keyzer, J.M., & Gilbert, W.M. (2005). Coding of perineal lacerations and other complications of obstetric care in hospital discharge data. *Am J Obstet Gynecol*.106:717-25.
- U.S. Department of Health and Human Services. (2000). *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office. Measure 16-9.
- Yasmeen, S., Romano, P.S., Schembri, M.E., Keyzer, J.M., & Gilbert, W.M. (2006). Accuracy of obstetric diagnoses and procedures in hospital discharge data. *Am J Obstet Gynecol*. 194:992-1001.

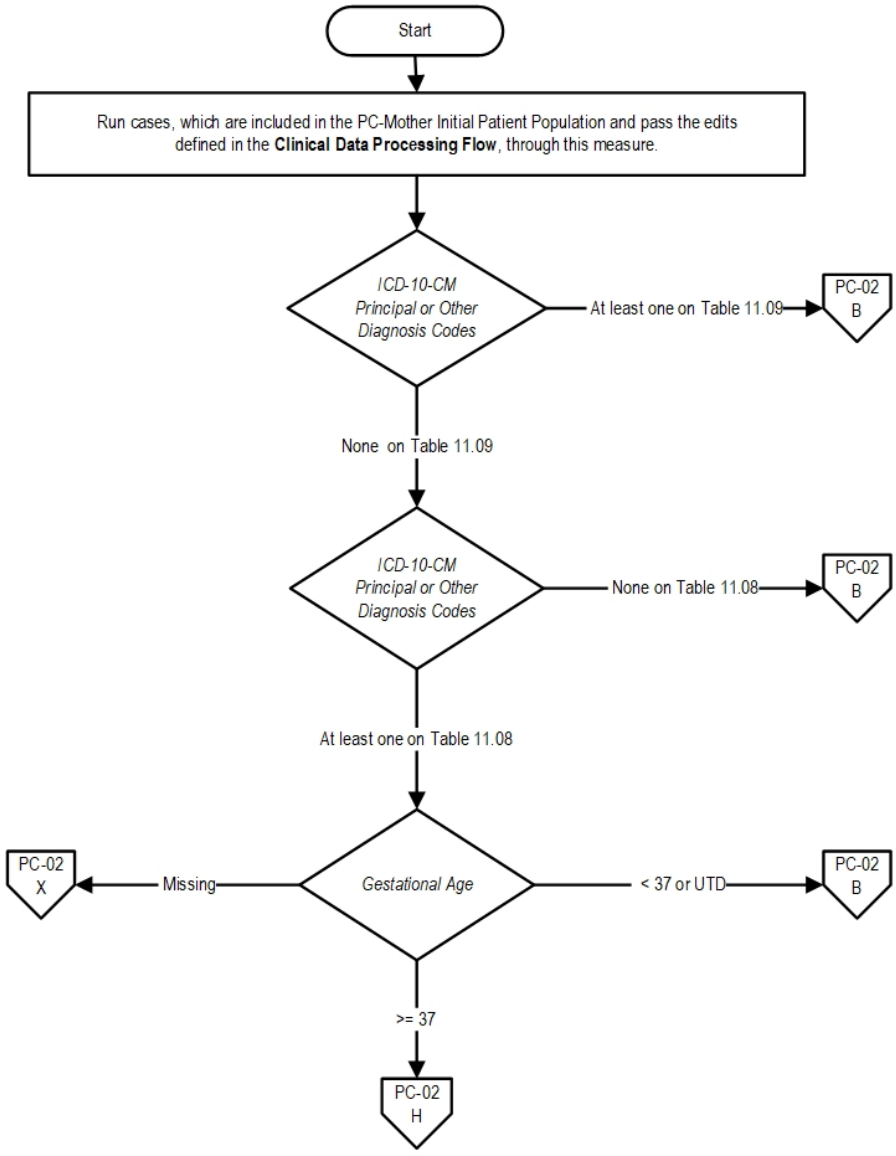
Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

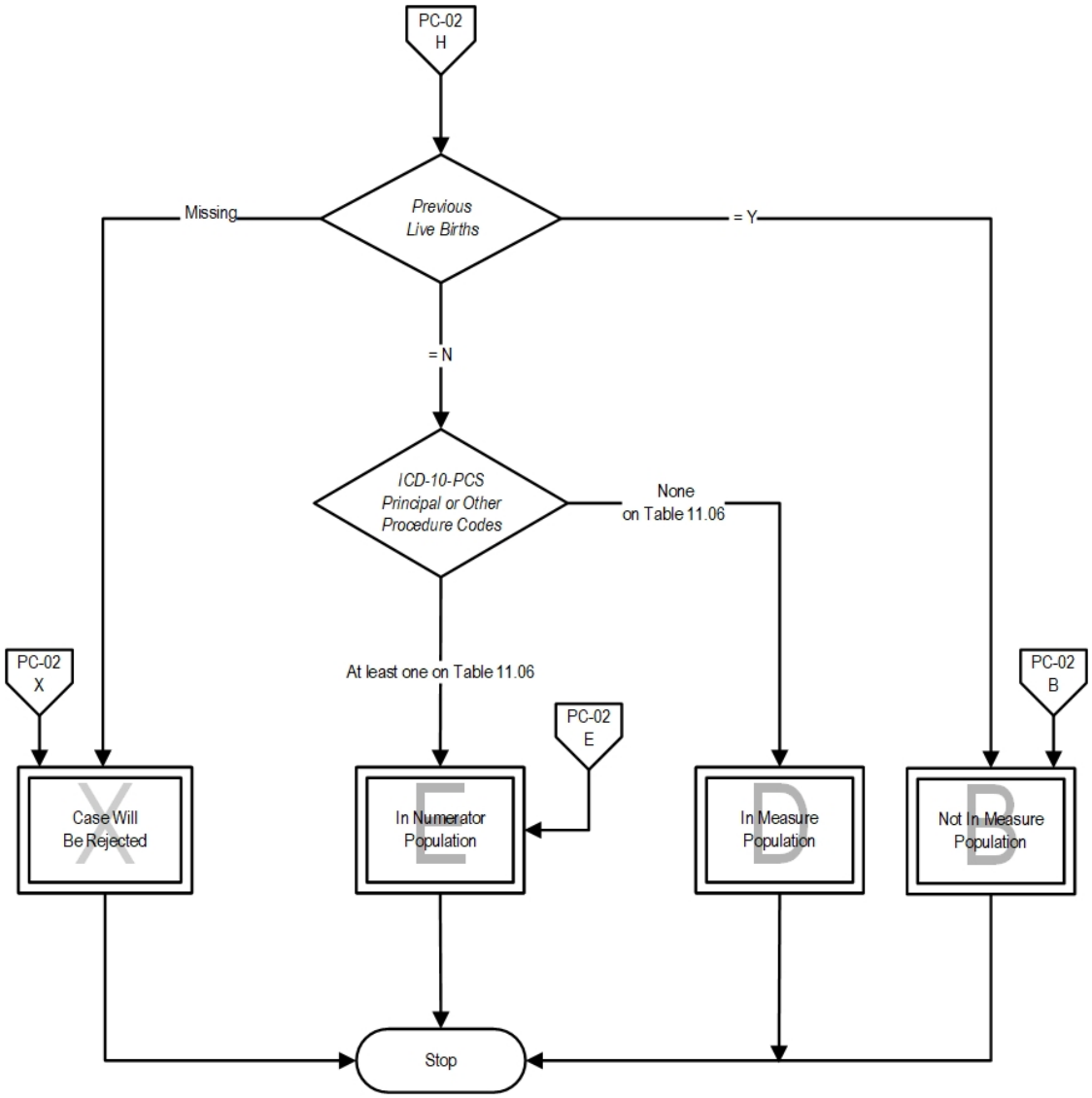
Measure Algorithm:

PC-02: Cesarean Birth

Numerator: Patients with cesarean births

Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation





National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

NQF Endorsement Status	Not Endorsed
NQF ID	9999
Measure Type	Outcome
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	Standardized Infection Ratio (SIR) and Adjusted Ranking Metric (ARM) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in bedded inpatient care locations.
Numerator	Total number of observed healthcare-associated CLABSIs among patients in bedded inpatient care locations.
Denominator	Total number of central line days for each location under surveillance for CLABSI during the data period.
Denominator Exclusions	S.8. Denominator Exclusions: The following devices are excluded as central lines: - Non-lumened pacemaker wires and other non-lumened devices inserted into central blood vessels or the heart - Arterial catheters - Arteriovenous fistula - Arteriovenous graft - Extracorporeal membrane oxygenation (ECMO) - Hemodialysis reliable outflow (HERO) dialysis catheters - Intra-aortic balloon pump (IABP) devices - Atrial catheters (also known as transthoracic intra-cardiac catheters, those catheters inserted directly into the right or left atrium via the heart wall) - Peripheral IV or Midlines - Ventricular Assist Device (VAD)

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Rationale	A substantial body of peer-reviewed studies and reviews document that CLABSI can be minimized through proper management of the central line. Efforts to improve central line insertion and maintenance practices, with early discontinuance of lines are recommended. These efforts result in decreased morbidity and mortality and reduced healthcare costs. Use of this measure to track CLABSIs through a nationalized standard for HAI monitoring, leads to improved patient outcomes and provides a mechanism for identifying improvements and evaluating prevention efforts.
Evidence	Among the 2,337 hospitals in U.S. with enough CLABSI data to calculate an SIR, 9% had an SIR significantly higher (worse) than 0.81, the value of the national

Developer/Steward

Steward	Centers for Disease Control and Prevention (CDC)
Contact	Not Available
Measure Developer	Centers for Disease Control and Prevention (CDC)
Development Stage	Fully Developed

Characteristics

Measure Type	Outcome
Meaningful Measure Area	Healthcare-Associated Infections
Healthcare Priority	Make Care Safer by Reducing Harm Caused in the Delivery of Care
eCQM Spec Available	No
NQF Endorsement Status	Not Endorsed
NQF ID	9999

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Last NQF Update	Not Available
Target Population Age	Not Specified
Target Population Age (High)	Not Available
Target Population Age (Low)	Not Available
Reporting Level	Facility
Conditions	Infection
Subconditions	Central Line-Associated Bloodstream Infections (CLABSI)
Care Settings	Behavioral Health/Psychiatric: Inpatient; Dialysis Facility; Home Care; Hospice; Hospital Inpatient; Hospital/Acute Care Facility; Inpatient Rehabilitation Facility; Institution and Community; Long-term Care Hospital; Nursing Home; Other; PPS-Exempt Cancer Hospitals; Post Acute/Long Term Care Facility: Long Term Acute Care Hospital

Groups

Core Measure Set	Not Available

Measure Group	Group Identifier
HAI	
HAI	1
CLABSI	

Measure Links

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Measure Program: Long-Term Care Hospital Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Electronic Clinical Data (non-EHR); Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2011-10-01
Data Reporting End Date	Not Available

Measure Program Links

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Measures Information | CMS

Milestones

Milestone: Implemented

Effective Date	2011-10-01
Comments	Not Available
Milestone Links	https://www.medicare.gov/longtermcarehospitalcompare/

Measure Program: Hospital Acquired Condition Reduction Program

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Info As Of	Not Available
Program / Model Notes	
Data Sources	Paper Medical Records; Electronic Clinical Data (non-EHR)
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2014-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program

Milestones

Milestone: Implemented

Effective Date	2014-10-01
Comments	Not Available

Milestone: Finalized

Effective Date	2013-08-19
Comments	Not Available

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Measure Program: Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	Not Available
Data Reporting End Date	2018-10-01

Measure Program Links

Measure Program: Prospective Payment System-Exempt Cancer Hospital Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Paper Medical Records; Electronic Clinical Data (non-EHR); Electronic Health Record
Purposes	Not Available
Quality Domain	Not Available

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2013-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/PCHQR.html

Milestones

Milestone: Considered

Effective Date	2019-12-01	
Comments	MUC2019-19: Measure submitted in 2019 with significant revisions and is under consideration	
Milestone Links	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/Measures-under-Consideration-List-for-2018.pdf	
Other Data	**Name**	**Value**
	MUC ID	MUC2019-19

Milestone: Implemented

Effective Date	2013-10-01
Comments	Not Available

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Milestone Links	https://www.govinfo.gov/content/pkg/FR-2012-08-31/pdf/2012-19079.pdf

Milestone: Finalized

Effective Date	2012-08-31
Comments	Not Available

Milestone: Proposed

Effective Date	2012-05-11
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2012-05-11/pdf/2012-9985.pdf

Measure Program: Hospital Inpatient Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Electronic Health Record; Paper Medical Records; Electronic Clinical Data (non-EHR)
Purposes	Not Available
Quality Domain	Not specified
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Inactive
Data Reporting Begin Date	2013-01-01
Data Reporting End Date	2020-01-01

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

Milestones

Milestone: Removed

Effective Date	2021-10-01
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf

Milestone: Implemented

Effective Date	2013-10-01
Comments	Not Available

Measure Program: Long-Term Care Hospital Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Electronic Clinical Data (non-EHR)
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	No

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Reporting Status	Active
Data Reporting Begin Date	2012-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html

Milestones

Milestone: Implemented

Effective Date	2013-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf

Milestone: Finalized

Effective Date	2011-08-18
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	http://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Measure Program: Hospital Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2017-08-14
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

Milestones

Milestone: Implemented

Effective Date	2018-04-01
Comments	Not Available
Milestone Links	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Measure Program: Hospital Value-Based Purchasing

Info As Of	Not Available
Program / Model Notes	
Data Sources	Electronic Health Record; Paper Medical Records; Electronic Clinical Data (non-EHR)
Purposes	Not Available
Quality Domain	Safety
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2016-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

Milestone: Finalized

Effective Date	2014-08-22
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

NQF Endorsement Status	Endorsed
NQF ID	1717
Measure Type	Outcome
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	This measure calculates the total number of observed hospital-onset CDI LabID events among all inpatients in the facility, excluding well baby-nurseries and NICUs, from the total number of expected hospital-onset CDI LabID events, determined through the facility's number of inpatient days, bed size, affiliation with a medical school, microbiological test used to identify C. difficile, and community onset CDI admission prevalence rate.
Numerator	Total number of observed hospital-onset CDI LabID events among all inpatients in the facility, excluding well baby-nurseries and NICUs
Denominator	Total number of predicted hospital-onset CDI LabID events, calculated using the facility's number of inpatient days, facility type, CDI event reporting from Emergency Department and 24 hour observation units, bed size, ICU bed size, affiliation with medical school, microbiological test method used to identify C. difficile, and community-onset CDI admission prevalence rate.
Denominator Exclusions	Data from patients who are not assigned to an inpatient bed are excluded from the denominator counts, including outpatient clinics, 24-hour observation units, and emergency department visits. Inpatient rehab locations and inpatient psychiatric locations that have their own Centers for Medicare and Medicaid Services (CMS) Certification Number (CCN) are excluded. Additionally, data from well-baby nurseries and NICUs are excluded from the denominator count.
Rationale	Clostridium difficile (C. diff) infection can cause fever diarrhea, fever, appetite loss, nausea, and abdominal pain. Most cases of C. diff infection occur in

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

	patients taking antibiotics. C. diff. Infections may be prevented or stopped from spreading to other patients when inpatient rehabilitation facilities use infection control steps recommended by CDC. The measure can then be used to drive prevention practices that will lead to improved outcomes, including the reduction of patient morbidity and mortality
Evidence	Clostridium difficile is responsible for a spectrum of C. difficile infections (CDI), including uncomplicated diarrhea, pseudomembranous colitis, and toxic megacolon which can, in some instances, lead to sepsis and even death. In recent years, a previously unrecognized strain of C. difficile with increased virulence and high levels of antimicrobial resistance has resulted in outbreaks in healthcare facilities in the United States. Additionally, CDI has become more common in the community setting, with increased risk in those with a recent inpatient stay in a healthcare facility. Significant increases in cost of inpatient care and post-hospitalization care have been seen in cases of CDI.

Developer/Steward

Steward	Centers for Disease Control and Prevention (CDC)
Contact	MMSSupport@Battelle.org
Measure Developer	Centers for Disease Control and Prevention NHSN
Development Stage	Fully Developed

Characteristics

Measure Type	Outcome
Meaningful Measure Area	Healthcare-Associated Infections
Healthcare Priority	Make Care Safer by Reducing Harm Caused in the Delivery of Care
eCQM Spec Available	Not Available

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

NQF Endorsement Status	Endorsed
NQF ID	1717
Last NQF Update	2019-06-11
Target Population Age	Not specified
Target Population Age (High)	Not Available
Target Population Age (Low)	Not Available
Reporting Level	Facility
Conditions	Infection
Subconditions	Clostridium Difficile Infection (CDI)
Care Settings	Behavioral Health/Psychiatric: Inpatient; Dialysis Facility; Emergency Department; Emergency Department and Services; Home Care; Hospice; Hospital Inpatient; Hospital/Acute Care Facility; Inpatient Rehabilitation Facility; Long-term Care Hospital; Nursing Home; Other; Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Groups

Core Measure Set	Not Available

Measure Group	Group Identifier
HAI	
HAI	6
CDI	

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Measure Links

Measure Program: Inpatient Rehabilitation Facility Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Making care safe through timeliness and responsiveness of care
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2015-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/MAP-2013-2014.zip

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html,
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/MAP-2013-2014.zip

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html,

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html,
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/MAP-2013-2014.zip,
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/MAP-2013-2014.zip

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18447.pdf

Milestone: Finalized

Effective Date	2014-08-06
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2015-08-06/pdf/2015-18973.pdf

Milestone: Considered

Effective Date	2013-12-01	
Comments	Not Available	
Other Data	**Name**	**Value**
	MUC ID	E1717

Milestone: Reference

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	http://www.qualityforum.org/QPS/QPSTool.aspx?tID=9:690&Exact=False&Keyword=inpatient+rehabilitation+facilities#qpsPageState=%7B%22TabType%22%3A1,%22TabContentType%22%3A2,%22SearchCriteriaForStandard%22%3A%7B%22TaxonomyIDs%22%3A%5B%5D,%22SelectedTypeAheadFilterOption%22%3A%7B%22FilterOptionLabel%22%3A%22inpatient+rehabilitation+facilities%22,%22SearchType%22%3A0,%22TaxonomyId%22%3A0,%22SortWeight%22%3A0,%22TypeOfTypeAheadFilterOption%22%3A1,%22ID%22%3A21603,%22IsNew%22%3Afalse,%22IsActive%22%3Afalse,%22IsDeleted%22%3Afalse,%22IsLocked%22%3Afalse,%22IsLoading%22%3Afalse%7D,%22Keyword%22%3A%22inpatient+rehabilitation+facilities%22,%22PageSize%22%3A%2225%22,%22OrderType%22%3A%2210%22,%22OrderBy%22%3A%22ASC%22,%22PageNo%22%3A2,%22IsExactMatch%22%3Atrue,%22QueryStringType%22%3A%22%22,%22ProjectActivityId%22%3A%220%22,%22FederalProgramYear%22%3A%220%22,%22FederalFiscalYear%22%3A%220%22,%22FilterTypes%22%3A2%7D,%22SearchCriteriaForForPortfolio%22%3A%7B%22Tags%22%3A%5B%5D,%22FilterTypes%22%3A0,%22PageStartIndex%22%3A1,%22PageEndIndex%22%3A25,%22PageNumber%22%3Anull,%22PageSize%22%3A%2225%22,%22SortBy%22%3A%22Title%22,%22SortOrder%22%3A%22ASC%22,%22SearchTerm%22%3A%22%22%7D,%22ItemsToCompare%22%3A%5B%5D,%22SelectedStandardIdList%22%3A%5B%5D,%22StandardID%22%3A1717,%22EntityTypeID%22%3A1%7D

Measure Program: Inpatient Rehabilitation Facility Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2014-10-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-

Milestones

Milestone: Implemented

Effective Date	2014-10-01
Comments	Not Available
Milestone Links	https://www.medicare.gov/inpatientrehabilitationfacilitycompare/

Measure Program: Hospital Inpatient Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Quality Domain	Not specified
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	2014-01-01
Data Reporting End Date	2020-01-01

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

Milestones

Milestone: Removed

Effective Date	2021-10-01
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf

Milestone: Implemented

Effective Date	2014-10-01
Comments	Not Available

Measure Program: Long-Term Care Hospital Compare

Info As Of	Not Available

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2013-10-01
Data Reporting End Date	Not Available

Measure Program Links

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Measures Information | CMS

Milestones

Milestone: Implemented

Effective Date	2013-10-01
Comments	Not Available
Milestone Links	https://www.medicare.gov/longtermcarehospitalcompare/

Measure Program: Long-Term Care Hospital Quality Reporting

Info As Of	Not Available
Program / Model Notes	

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Data Sources	Not Available
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2015-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

Milestone: Finalized

Effective Date	2013-08-19
Comments	Not Available

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

Measure Program: Prospective Payment System-Exempt Cancer Hospital Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2016-01-01
Data Reporting End Date	2022-01-01

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/PCHQR.html

Milestones

Milestone: Implemented

Effective Date	2017-10-01
Comments	Not Available

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Milestone: Finalized

Effective Date	2015-08-17
Comments	Not Available

Milestone: Proposed

Effective Date	2015-04-30
Comments	Not Available

Measure Program: Hospital Acquired Condition Reduction Program

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2016-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	https://www.federalregister.gov/articles/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the#p-2676

Milestone: Finalized

Effective Date	2013-08-19
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

Milestone: Considered

Effective Date	2012-12-01
Comments	Not Available

Other Data	**Name**	**Value**
	MUC ID	474

Measure Program: Hospital Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2014-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18447.pdf

Milestone: Finalized

Effective Date	2014-08-06
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2015-08-06/pdf/2015-18973.pdf

Milestone: Reference

Effective Date	1900-01-01

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Comments	Not Available
Milestone Links	http://www.qualityforum.org/QPS/QPSTool.aspx?tID=9:690&Exact=False&Keyword=inpatient+rehabilitation+facilities#qpsPageState=%7B%22TabType%22%3A1,%22TabContentType%22%3A2,%22SearchCriteriaForStandard%22%3A%7B%22TaxonomyIDs%22%3A%5B%5D,%22SelectedTypeAheadFilterOption%22%3A%7B%22FilterOptionLabel%22%3A%22inpatient+rehabilitation+facilities%22,%22SearchType%22%3A0,%22TaxonomyId%22%3A0,%22SortWeight%22%3A0,%22TypeOfTypeAheadFilterOption%22%3A1,%22ID%22%3A21603,%22IsNew%22%3Afalse,%22IsActive%22%3Afalse,%22IsDeleted%22%3Afalse,%22IsLocked%22%3Afalse,%22IsLoading%22%3Afalse%7D,%22Keyword%22%3A%22inpatient+rehabilitation+facilities%22,%22PageSize%22%3A%2225%22,%22OrderType%22%3A%2210%22,%22OrderBy%22%3A%22ASC%22,%22PageNo%22%3A2,%22IsExactMatch%22%3Atrue,%22QueryStringType%22%3A%22%22,%22ProjectActivityId%22%3A%220%22,%22FederalProgramYear%22%3A%220%22,%22FederalFiscalYear%22%3A%220%22,%22FilterTypes%22%3A2%7D,%22SearchCriteriaForForPortfolio%22%3A%7B%22Tags%22%3A%5B%5D,%22FilterTypes%22%3A0,%22PageStartIndex%22%3A1,%22PageEndIndex%22%3A25,%22PageNumber%22%3Anull,%22PageSize%22%3A%2225%22,%22SortBy%22%3A%22Title%22,%22SortOrder%22%3A%22ASC%22,%22SearchTerm%22%3A%22%22%7D,%22ItemsToCompare%22%3A%5B%5D,%22SelectedStandardIdList%22%3A%5B%5D,%22StandardID%22%3A1717,%22EntityTypeID%22%3A1%7D https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalcompare.html

Measure Program: Hospital Value-Based Purchasing

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Purposes	Not Available
Quality Domain	Safety
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2016-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf

Milestone: Finalized

Effective Date	2014-08-22
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-12-18-2.html

****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

Measure Information Form

Measure Set: Perinatal Care (PC)

Set Measure ID: PC-01

Performance Measure Name: Elective Delivery

Description: Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed

Rationale: For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative (ACOG, 1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) (Clark et al., 2009).

According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean births and longer maternal length of stay. The American Academy of Family Physicians (2000) also notes that elective induction doubles the cesarean delivery rate. Repeat elective cesarean births before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009).

Type Of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with elective deliveries

> **Included Populations:** *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for one or more of the following:
>
> - Medical induction of labor as defined in Appendix A, Table 11.05 while not in *Labor* prior to the procedure
> - Cesarean birth as defined in Appendix A, Table 11.06 and all of the following:
>   - not in *Labor*
>   - no history of a *Prior Uterine Surgery*
>
> **Excluded Populations:** None
>
> **Data Elements:**

- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*
- *Labor*
- *Prior Uterine Surgery*

Denominator Statement: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed

Included Populations:

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1

Excluded Populations:

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07
- History of prior stillbirth
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay > 120 days
- *Gestational Age* < 37 or >= 39 weeks or UTD

Data Elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *Gestational Age*
- *History of Stillbirth*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could be analyzed further to determine specific patterns or trends to help reduce elective deliveries.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4.Retrieved December 29, 2008 at: http://www.aafp.org/afp/20000215/tips/39.html.
- American College of Obstetricians and Gynecologists. (November 1996). ACOG Educational Bulletin.
- Borders, E.B., Birsner, M.L., Gyanmfi-Bannerbaum, C. (2019). Avoidance of nonmedically indicated early-term deliveries and associated neonatal morbidities. American College of Obstetricians and Gynecologists Committee Opinion, 133:2, e156-163.
- Clark, S., Miller, D., Belfort, M., Dildy, G., Frye, D., & Meyers, J. (2009). Neonatal and maternal outcomes associated with elective delivery. [Electronic Version]. *Am J Obstet Gynecol*. 200:156.e1-156.e4.
- Glantz, J. (Apr.2005). Elective induction vs. spontaneous labor associations and outcomes. [Electronic Version]. *J Reprod Med*. 50(4):235-40.
- Tita, A., Landon, M., Spong, C., Lai, Y., Leveno, K., Varner, M, et al. (2009). Timing of elective repeat cesarean delivery at term and neonatal outcomes. [Electronic Version]. *NEJM*. 360:2, 111-120.

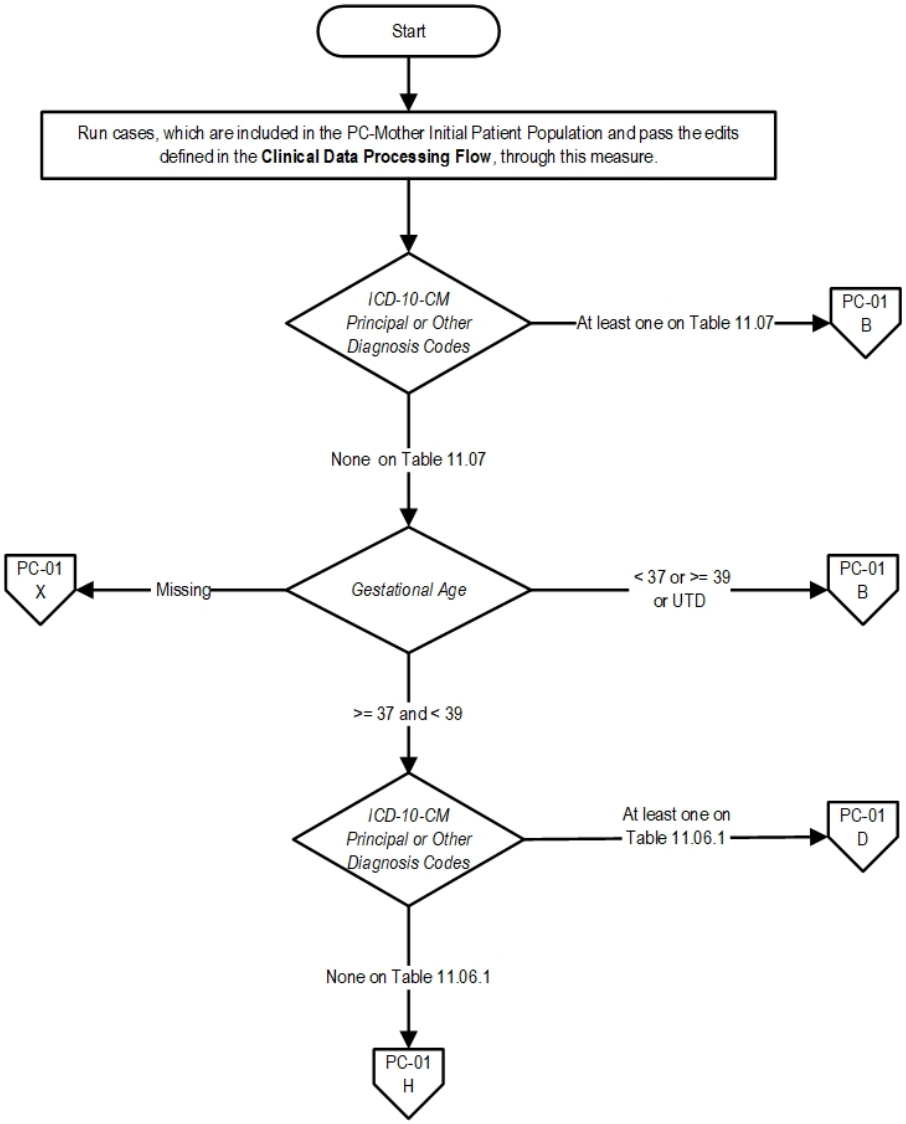
Original Performance Measure Source / Developer:
Hospital Corporation of America-Women's and Children's Clinical Services

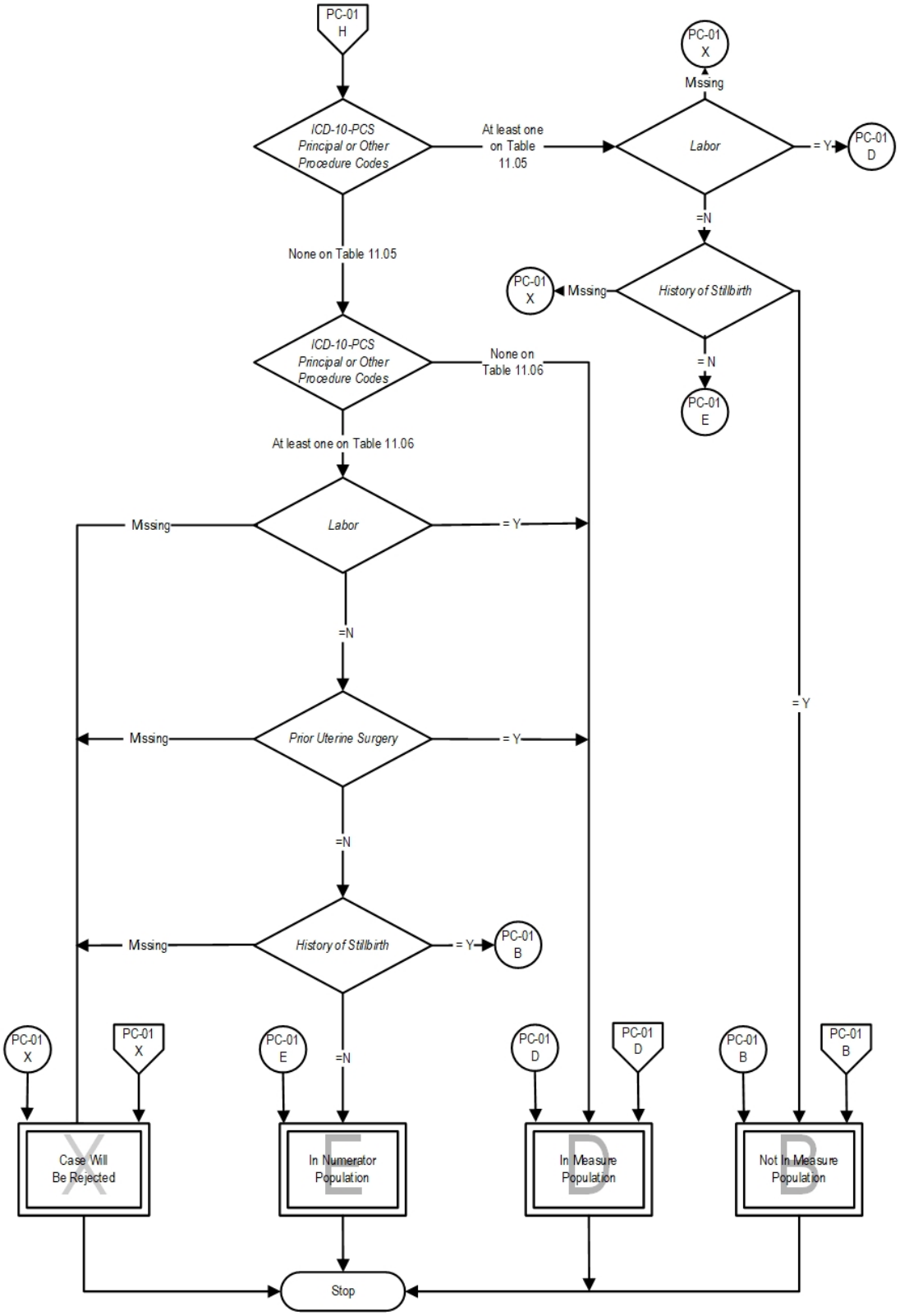
Measure Algorithm:

PC-01: Elective Delivery

Numerator: Patients with elective deliveries

Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed





*Follow-Up After Emergency Department Visit for Mental Illness (FUM)**

***Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of the ED visit. Report three age stratifications and total rate: • 6–17 years. • 18–64 years. • 65 years and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	None.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

Multiple visits in a 31-day period If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

ED visits followed by inpatient admission Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusion Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUM-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Mental Illness

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	6-17	Benefit	Metadata
FollowUp7Day	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Follow-Up After Emergency Department Visit for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	Age determination dates may be changed (i.e., age 6 as of the date of the ED visit). Changing the denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

*Follow-Up After Emergency Department Visit for Substance Use (FUA)**

***Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Revised the measure name from *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* to *Follow-Up After Emergency Department Visit for Substance Use.*
- Revised terminology from "alcohol or other drug abuse or dependence (AOD)" to "substance use" or substance use disorder (SUD)."
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added a pharmacy benefit requirement.
- Added ED visits with a diagnosis of unintentional and undetermined drug overdose to the denominator.
- Revised and restructured the numerator logic and value sets.
- Added required exclusions in the Rules for Allowable Adjustments.

Description

The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	13 years and older as of the ED visit. Report two age stratifications and a total rate: • 13–17 years. • 18 and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	None.
Anchor date	None.

Benefit

Medical, chemical dependency and pharmacy.

Note: *Members with detoxification-only chemical dependency benefits do not meet these criteria.*

Event/diagnosis

An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) ***or*** any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year, where the member was 13 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.

Multiple visits in a 31-day period

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

ED visits followed by inpatient admission

Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusion

Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a mental health provider.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** a mental health provider.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

- An observation visit (Observation Value Set) ***with*** a mental health provider.
- A peer support service (Peer Support Services Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- A telephone visit (Telephone Visits Value Set), ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telephone visit (Telephone Visits Value Set), ***with*** a mental health provider.
- An e-visit or virtual check-in (Online Assessments Value Set), ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set), ***with*** a mental health provider.
- A substance use disorder service (Substance Use Disorder Services Value Set).
- A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set).
- A substance use service (Substance Use Services Value Set).
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).*
- *Refer to Appendix 3 for the definition of "mental health provider." Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUA-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	13-17	Benefit	Metadata
FollowUp7Day	18+	EligiblePopulation	For each Stratification, repeat per Metric
	Total	ExclusionAdminRequired	For each Stratification, repeat per Metric
		NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Follow-Up After Emergency Department Visit for Substance Use

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination date(s) may be changed (i.e., age 13 as of ED visit). Changing denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events and diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of SUD or any diagnosis of unintentional drug overdose, who had a follow-up visit).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Updated the steps for identifying acute readmission or direct transfer in the event/diagnosis.
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added psychiatric collaborative care management to the numerator.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of discharge. Report three age stratifications and total rate: • 6–17 years. • 18–64 years. • 65 years and older. • Total.
Continuous enrollment	The total is the sum of the age stratifications. Date of discharge through 30 days after discharge.
Allowable gap	None.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute readmission or direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).
4. Identify the discharge date for the stay.

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

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

Required exclusion

Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up

A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) ***with*** (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), ***with*** a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a mental health provider.
- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*
- *Refer to Appendix 3 for the definition of "mental health provider." Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUH-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	6-17	Benefit	Metadata
FollowUp7Day	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Follow-Up After Hospitalization for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify inpatient stays and diagnoses. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses who had a follow-up visit with a mental health practitioner).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

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NQF Endorsement Status	Endorsed
NQF ID	0166
Measure Type	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description

HCAHPS is a 32-item survey instrument that produces 11 publicly reported measures:

7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and care transition); and

4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital).

Please note: The FY 2020 Final Rule finalized the removal of the three Pain Management questions beginning with 10/1/19 discharges.

Numerator

The HCAHPS Survey asks recently discharged patients about aspects of their hospital experience that they are uniquely suited to address. The core of the survey contains 21 items that ask how often or whether patients experienced a critical aspect of hospital care, rather than whether they were satisfied with their care. Also included in the survey are four screener items that direct patients to relevant questions, five items to adjust for the mix of patients across hospitals, and two items that support Congressionally-mandated reports. Hospitals may include additional questions after the core HCAHPS items.

HCAHPS is administered to a random sample of adult inpatients between 48 hours and six weeks after discharge. Patients admitted in the medical, surgical

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and maternity care service lines are eligible for the survey; HCAHPS is not restricted to Medicare beneficiaries. Hospitals may use an approved survey vendor or collect their own HCAHPS data if approved by CMS to do so. HCAHPS can be implemented in four survey modes: mail, telephone, mail with telephone follow-up, or active interactive voice recognition (IVR), each of which requires multiple attempts to contact patients. Hospitals must survey patients throughout each month of the year. IPPS hospitals must achieve at least 300 completed surveys over four calendar quarters.

For full details, see the current HCAHPS Quality Assurance Guidelines, V.13.0, pp. 55-63,
under the Quality Assurance button on the official HCAHPS On-Line Web site at

http://www.hcahpsonline.org/globalassets/hcahps/quality-assurance/2018_qag_v13.0.pdf

Denominator

Eligibility for the HCAHPS Survey.
The HCAHPS Survey is broadly intended for patients of all payer types who meet the following criteria:

Eighteen (18) years or older at the time of admission

Admission includes at least one overnight stay in the hospital

An overnight stay is defined as an inpatient admission in which the patient's admission date is different from the patient's discharge date. The admission need not be 24 hours in length. For example, a patient had an overnight stay if he or she was admitted at 11:00 PM on Day 1, and discharged at 10:00 AM on Day 2. Patients who did not have an overnight stay should not be included in the sample frame (e.g., patients who were admitted for a short period of time solely for observation; patients admitted for same day diagnostic tests as part of outpatient care).

Non-psychiatric MS-DRG/principal diagnosis at discharge

Note: Patients whose principal diagnosis falls within the Maternity Care, Medical, or Surgical service lines and who also have a secondary psychiatric diagnosis are still eligible for the survey.

Alive at the time of discharge

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Note: Pediatric patients (under 18 years old at admission) and patients with a primary psychiatric diagnosis are ineligible because the current HCAHPS instrument is not designed to address the unique situation of pediatric patients and their families, or the behavioral health issues pertinent to psychiatric patients.

Exclusions from the HCAHPS Survey
There is a two-stage process for determining whether a discharged patient can be included in the HCAHPS Sample Frame. The first stage is to determine whether the discharged patient meets the HCAHPS eligibility criteria, listed above. If the patient meets the eligibility criteria, then a second set of criteria is applied: Exclusions from the HCAHPS Survey.

Patients who meet the eligible population criteria outlined above are to be included in the HCAHPS Sample Frame. However, there are a few categories of otherwise eligible patients who are excluded from the sample frame. These are:

No-Publicity patients who request that they not be contacted (see below)

Court/Law enforcement patients (i.e., prisoners); this does not include patients residing in halfway houses

Patients with a foreign home address (the U.S. territories Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses and therefore, are not excluded)

Patients discharged to hospice care (Hospice-home or Hospice-medical facility)

Patients who are excluded because of state regulations

Patients discharged to nursing homes and skilled nursing facilities

No-Publicity patients are defined as those who voluntarily sign a no-publicity request while hospitalized or who directly request a survey vendor or hospital not to contact them (Do Not Call List). These patients should be excluded from the HCAHPS Survey. However, documentation of patients no-publicity status must be retained for a minimum of three years.

Court/Law enforcement patients (i.e., prisoners) are excluded from HCAHPS

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	because of both the logistical difficulties in administering the survey to them in a timely manner, and regulations governing surveys of this population. These individuals can be identified by the admission source (UB-04 field location 15) 8 Court/Law enforcement, patient discharge status code (UB-04 field location 17) 21 Discharged/transferred to court/law enforcement, or patient discharge status code 87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission. This does not include patients residing in halfway houses. Patients with a foreign home address are excluded from HCAHPS because of the logistical difficulty and added expense of calling or mailing outside of the United States (the U.S. territories - Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign address
Denominator Exclusions	There is a two-stage process for determining whether a discharged patient can be included in the HCAHPS Sample Frame. The first stage is to determine whether the discharged patient meets the HCAHPS eligibility criteria, listed above. If the patient meets the eligibility criteria, then a second set of criteria is applied: Exclusions from the HCAHPS Survey. Patients who meet the eligible population criteria outlined above are to be included in the HCAHPS Sample Frame. However, there are a few categories of otherwise eligible patients who are excluded from the sample frame. These are: No-Publicity patients Patients who request that they not be contacted (see below) Court/Law enforcement patients (i.e., prisoners); this does not include patients residing in halfway houses Patients with a foreign home address (the U.S. territories Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses and therefore, are not excluded) Patients discharged to hospice care (Hospice-home or Hospice-medical facility) Patients who are excluded because of state regulations Patients discharged to nursing homes and skilled nursing facilities

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No-Publicity patients are defined as those who voluntarily sign a no-publicity request while hospitalized or who directly request a survey vendor or hospital not to contact them (Do Not Call List). These patients should be excluded from the HCAHPS Survey. However, documentation of patients no-publicity status must be retained for a minimum of three years.

Court/Law enforcement patients (i.e., prisoners) are excluded from HCAHPS because of both the logistical difficulties in administering the survey to them in a timely manner, and regulations governing surveys of this population. These individuals can be identified by the admission source (UB-04 field location 15) 8 Court/Law enforcement, patient discharge status code (UB-04 field location 17) 21 Discharged/transferred to court/law enforcement, or patient discharge status code 87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission. This does not include patients residing in halfway houses.

Patients with a foreign home address are excluded from HCAHPS because of the logistical difficulty and added expense of calling or mailing outside of the United States (the U.S. territories - Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses and therefore, are not excluded).

Patients discharged to hospice care are excluded from HCAHPS because of the heightened likelihood that they will expire before the survey process can be completed. Patients with a Discharge Status of 50 Hospice home or 51 Hospice medical facility would not be included in the sample frame. Discharge Status is the same as the UB-04 field location 17.

Some state regulations place further restrictions on patients who may be contacted after discharge. It is the responsibility of the hospital/survey vendor to identify any applicable regulations and to exclude those patients as required by law or regulation in the state in which the hospital operates.

Patients discharged to nursing homes and skilled nursing facilities are excluded from HCAHPS. This applies to patients with a Discharge Status (UB-04 field location 17) of:

03 Skilled nursing facility

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	61 SNF Swing bed within hospital 64 Certified Medicaid nursing facility 83 Skilled nursing facility with a planned acute care hospital inpatient readmission 92 Certified Medicaid nursing facility with a planned acute care hospital inpatient readmission Hospitals/Survey vendors must retain documentation that verifies all exclusions and ineligible patients. This documentation is subject to review. Note: Patients must be included in the HCAHPS Survey sample frame unless the hospital/ survey vendor has positive evidence that a patient is ineligible or fits
Rationale	The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS (pronounced H-caps), also known as the CAHPS Hospital Survey*, is a 32-item survey instrument and data collection methodology for measuring patients perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there were no common metrics and no national standards for collecting and publicly reporting information about patient experience of care. Since 2008, HCAHPS has allowed valid comparisons to be made across hospitals locally, regionally and nationally. Three broad goals have shaped HCAHPS. First, the standardized survey and implementation protocol produce data that allow objective and meaningful comparisons of hospitals on topics that are important to consumers. Second, public reporting of HCAHPS results creates new incentives for hospitals to improve quality of care. Third, public reporting enhances accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the Centers for Medicare & Medicaid Services (CMS) and the HCAHPS Project Team have taken substantial steps to assure that the survey is credible, practical and actionable.
Evidence	Not Available

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Developer/Steward

Steward	Centers for Medicare & Medicaid Services (CMS)
Contact	Not Available
Measure Developer	Not Available
Development Stage	Fully Developed

Characteristics

Measure Type	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
Meaningful Measure Area	Patient's Experience of Care
Healthcare Priority	Strengthen Person & Family Engagement as Partners in their Care
eCQM Spec Available	No
NQF Endorsement Status	Endorsed
NQF ID	0166
Last NQF Update	2019-10-25
Target Population Age	18+
Target Population Age (High)	Not Available
Target Population Age (Low)	18
Reporting Level	Facility
Conditions	Not Available
Subconditions	Not Available
Care Settings	Hospital Inpatient; Hospital/Acute Care Facility

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Groups

Core Measure Set	Not Available

Measure Group	**Group Identifier**
HCAHPS	

Measure Links

Measure Program: Prospective Payment System-Exempt Cancer Hospital Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2016-01-01
Data Reporting End Date	2022-01-01

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Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/PCHQR.html

Milestones

Milestone: Implemented

Effective Date	2015-10-01
Comments	Not Available
Milestone Links	https://www.federalregister.gov/articles/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Milestone: Finalized

Effective Date	2013-08-19
Comments	Not Available
Milestone Links	https://www.federalregister.gov/articles/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Milestone: Proposed

Effective Date	2013-05-10
Comments	Not Available

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available

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Milestone Links	https://qualitynet.org/dcs/ContentServer?cid=1228772864217&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page

Measure Program: Hospital Inpatient Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Not specified
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2011-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

Milestones

Milestone: Implemented

Effective Date	2010-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/search/pagedetails.action?browsePath=2010%

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	2F08%2F08-16%5C%2F2%2FHealth+and+Human+Services+Department&granuleId=2010-19092&packageId=FR-2010-08-16&fromBrowse=true

Milestone: Finalized

Effective Date	2010-08-16
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/search/pagedetails.action?browsePath=2010%2F08%2F08-16%5C%2F2%2FHealth+and+Human+Services+Department&granuleId=2010-19092&packageId=FR-2010-08-16&fromBrowse=true

Measure Program: Hospital Value-Based Purchasing

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Person and Community Engagement Domain
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2012-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-

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Programs/HVBP/Hospital-Value-Based-Purchasing

Milestones

Milestone: Implemented

Effective Date	2012-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf

Milestone: Finalized

Effective Date	2011-05-06
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf

Measure Program: Hospital Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified; Patient Reported Data and Surveys
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2020-01-01
Data Reporting End Date	Not Available

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Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

Milestones

Milestone: Implemented

Effective Date	2015-10-01
Comments	Not Available
Milestone Links	https://www.federalregister.gov/articles/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Milestone: Finalized

Effective Date	2013-08-19
Comments	Not Available
Milestone Links	https://www.federalregister.gov/articles/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Milestone: Proposed

Effective Date	2013-05-10
Comments	Not Available

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available

Hospital Consumer Assessment of Healthcare Providers and Systems

Milestone Links	https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalcompare.html https://qualitynet.org/dcs/ContentServer?cid=1228772864217&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

NQF Endorsement Status	Not Endorsed
NQF ID	9999
Measure Type	Outcome
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	This measure is a re-specified version of the measure, “Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any condition” (NQF 1789), which was developed for patients 65 years and older using Medicare claims. This re-specified measure attributes outcomes to MIPS participating clinician groups and assesses each group’s readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): medicine, surgery/gynecology, cardio-respiratory, cardiovascular, and neurology.
Numerator	The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as a subsequent inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. Any readmission is eligible to be counted as an outcome, except those that are considered planned. To align with data years used, the planned readmission algorithm version 4.0 was used to classify readmissions as planned or unplanned
Denominator	Patients eligible for inclusion in the measure have an index admission hospitalization to which the readmission outcome is attributed and includes admissions for patients: Enrolled in Medicare Fee-For-Service (FFS) Part A for the 12 months prior to the date of admission; Aged 65 or over; Discharged alive from a non-federal short-

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

	term acute care hospital; and, Not transferred to another acute care facility.
Denominator Exclusions	1. Patients discharged against medical advice (AMA) are excluded. 2. Admissions for patients to a PPS-exempt cancer hospital are excluded. 3. Admissions primarily for medical treatment of cancer are excluded. 4. Admissions primarily for psychiatric disease are excluded. 5. Admissions for “rehabilitation care; fitting of prostheses and adjustment devices” (CCS 254) are excluded. 6. Admissions where patient cannot be attributed to a clinician group.
Rationale	This risk-adjusted administrative claims measure was proposed to address unplanned readmissions at the physician group level of Medicare aged > 65 patients. This measure is a re-specified version of the hospital-level measure, “Hospital-Wide All-Cause, Unplanned Readmission Measure” (NQF #1789), which has been in the MIPS program since 2017. In the event we did not finalize this measure, we would have maintained the current measure Q458: All-Cause Hospital Readmission. The respecification of this measure promotes a systems-level approach by clinicians and focus on high-risk conditions, such as COPD and heart failure. The measure was evaluated by the MAP and was conditionally supported pending NQF endorsement. While we agreed with the MAP that NQF endorsement of measures is preferred, NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus as required in section 1848(q)(2)(D)(v) of the Act. A riskadjusted readmission rate of 15.3 percent at the physician group level was provided by the measure developer. The readmission rate indicates a substantial need to reduce the expected rate and variation of rates across eligible physician groups. Physician groups have the capability to influence unplanned readmission outcomes by appropriate medication reconciliation at discharge, reduction of infection risk, and ensuring proper outpatient follow-up. As an administrative claims measure, there is no separate reporting burden. To maintain continuity with the existing measure Q458: All-

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

	Cause Hospital Readmission, the case minimum will remain at 200 cases for consistency in implementation. For 2023 payment determination, the performance period will include administrative claims from January 1, 2021 to December 31, 2021. For further information regarding the implementation of this measure, please see section IV.A.3.c.(1)(e)(i) of this final rule.
Evidence	Not Available

Developer/Steward

Steward	Centers for Medicare & Medicaid Services (CMS)
Contact	Not Available
Measure Developer	Not Available
Development Stage	Fully Developed

Characteristics

Measure Type	Outcome
Meaningful Measure Area	Admissions and Readmissions to Hospitals
Healthcare Priority	Promote Effective Communication & Coordination of Care
eCQM Spec Available	No
NQF Endorsement Status	Not Endorsed
NQF ID	9999
Last NQF Update	Not Available
Target Population Age	65+
Target Population Age (High)	Not Available

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

Target Population Age (Low)	65
Reporting Level	Accountable Care Organization
Conditions	Not Available
Subconditions	Not Available
Care Settings	Hospital/Acute Care Facility

Groups

Core Measure Set	Not Available

Measure Group	Group Identifier
qpp quality id	479
ACO	8

Measure Links

Measure Program: Medicare Shared Savings Program

Info As Of	Not Available
Program / Model Notes	
Data Sources	Claims Data
Purposes	Not Available
Quality Domain	Communication and Care Coordination
Reporting Frequency	Not Available

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2021-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about

Milestones

Milestone: Implemented

Effective Date	2012-04-01
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2011-11-02/pdf/2011-27461.pdf

Milestone: Finalized

Effective Date	2011-11-02
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2011-11-02/pdf/2011-27461.pdf

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

NQF Endorsement Status	Endorsed
NQF ID	1716
Measure Type	Outcome
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	Standardized infection ratio (SIR) and Adjusted Ranking Metric (ARM) of hospital-onset unique blood source MRSA Laboratory-identified events (LabID events) among all inpatients in the facility
Numerator	Total number of observed hospital-onset unique blood source MRSA LabID events among all inpatients in the facility.
Denominator	The expected number of hospital-onset unique blood source MRSA LabID events, calculated using the facility s number of inpatient days, bed size, affiliation with medical school, and community-onset MRSA bloodstream infection admission prevalence rate.
Denominator Exclusions	Data from patients who are not assigned to an inpatient bed in an applicable location are excluded from the denominator counts. Denominator counts exclude data from inpatient rehabilitation units and inpatient psychiatric units with unique CMS Certification Numbers (CCN) than the acute care facility.
Rationale	The SIR compares a healthcare facility's performance compared to a national baseline. Facilities are able to see whether the number of hospital-onset C. difficile LabID events that they have reported compares to the number that would be expected, given national data. The measure can then be used to drive prevention practices that will lead to improved outcomes, including the reduction of patient morbidity and mortality.
Evidence	Clostridium difficile is responsible for a spectrum of C. difficile infections (CDI),

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

including uncomplicated diarrhea, pseudomembranous colitis, and toxic megacolon which can, in some instances, lead to sepsis and even death. In recent years, a previously unrecognized strain of C. difficile with increased virulence and high levels of antimicrobial resistance has resulted in outbreaks in healthcare facilities in the United States. Additionally, CDI has become more common in the community setting, with increased risk in those with a recent inpatient stay in a healthcare facility. Significant increases in cost of inpatient care and post-hospitalization care have been seen in cases of CDI.

Developer/Steward

Steward	Centers for Disease Control and Prevention (CDC)
Contact	MMSSupport@Battelle.org
Measure Developer	Centers for Disease Control and Prevention (CDC)
Development Stage	Fully Developed

Characteristics

Measure Type	Outcome
Meaningful Measure Area	Healthcare-Associated Infections
Healthcare Priority	Make Care Safer by Reducing Harm Caused in the Delivery of Care
eCQM Spec Available	Not Available
NQF Endorsement Status	Endorsed
NQF ID	1716
Last NQF Update	2019-06-11
Target Population Age	0+

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Target Population Age (High)	Not Available
Target Population Age (Low)	0
Reporting Level	Facility
Conditions	Infection
Subconditions	Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia
Care Settings	Behavioral Health/Psychiatric: Inpatient; Dialysis Facility; Emergency Department and Services; Hospital Inpatient; Hospital/Acute Care Facility; Inpatient Rehabilitation Facility; Long-term Care Hospital; Nursing Home; Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Groups

Core Measure Set	Not Available

Measure Group	Group Identifier
HAI	
MRSA Bacteremia	
HAI	5

Measure Links

Measure Program: Hospital Value-Based Purchasing

Info As Of	Not Available

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Safety
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2016-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf

Milestone: Finalized

Effective Date	2014-08-22

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-12-18-2.html

Measure Program: Long-Term Care Hospital Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	Not Available
Data Reporting End Date	2018-10-01

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Milestones

Milestone: Removed

Effective Date	2018-10-01
Comments	Not Available

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

Milestone: Finalized

Effective Date	2013-08-19
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf http://www.cdc.gov/nhsn/pdfs/pscmanual/12pscmdro_cdadcurrent.pdf

Measure Program: Hospital Compare

Info As Of	Not Available
Program / Model Notes	

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2018-04-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

Milestone: Finalized

Effective Date	2013-08-19
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	http://www.cdc.gov/nhsn/pdfs/pscmanual/12pscmdro_cdadcurrent.pdf https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalcompare.html

Measure Program: Prospective Payment System-Exempt Cancer Hospital Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2018-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/PCHQR.html

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Milestones

Milestone: Implemented

Effective Date	2017-10-01
Comments	Not Available

Milestone: Finalized

Effective Date	2015-08-17
Comments	Not Available

Milestone: Proposed

Effective Date	2015-04-30
Comments	Not Available

Measure Program: Inpatient Rehabilitation Facility Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Making care safe through timeliness and responsiveness of care
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	Not Available

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Data Reporting End Date	2019-10-01

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/MAP-2013-2014.zip

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/MAP-2013-2014.zip

Milestones

Milestone: Removed

Effective Date	2019-10-01
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2018-08-06/pdf/2018-16517.pdf

Milestone: Proposed

Effective Date	2018-05-08
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2018-05-08/pdf/2018-08961.pdf

Other Data	**Name**	**Value**
	MUC ID	E1716

Milestone: Implemented

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18447.pdf

Milestone: Finalized

Effective Date	2014-08-06
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2015-08-06/pdf/2015-18973.pdf

Milestone: Considered

Effective Date	2013-12-01
Comments	Not Available

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	http://www.qualityforum.org/QPS/QPSTool.aspx?tID=9:690&Exact=False&Keyword=inpatient+rehabilitation+facilities#qpsPageState=%7B%22TabType%22%3A1,%22TabContentType%22%3A2,%22SearchCriteriaForStandard%22%3A%7B%22TaxonomyIDs%22%3A%5B%5D,%22SelectedTypeAheadFilterOption%22%3A%7B%22FilterOptionLabel%22%3A%22inpatient+rehabilitation+facilities%22,%22SearchType%22%3A0,%22TaxonomyId%22%3A0,%22SortWeight%22%3A0,%22TypeOfTypeAheadFilterOption%22%3A1,%22ID%22%3A21603,%22IsNew%22%3Afalse,%22IsActive%22%3Afalse,%22IsDeleted%22%3Afalse,%22IsLocked%22%3Afalse,%22IsLoading%22%3Afalse%7D,%22Keyword%22%3A%22inpatient+rehabilitation+facilities%22,%22PageSize%22%3A%2225%22,%22OrderType%22%3A%2210%22,%22OrderBy%22%3A%22ASC%22,%22PageNo%22%3A2,%22IsExactMatch%22%3Atrue,%

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

22QueryStringType%22%3A%22%22,%22ProjectActivityId%22%3A%220%22,%22FederalProgramYear%22%3A%220%22,%22FederalFiscalYear%22%3A%220%22,%22FilterTypes%22%3A2%7D,%22SearchCriteriaForForPortfolio%22%3A%7B%22Tags%22%3A%5B%5D,%22FilterTypes%22%3A0,%22PageStartIndex%22%3A1,%22PageEndIndex%22%3A25,%22PageNumber%22%3Anull,%22PageSize%22%3A%2225%22,%22SortBy%22%3A%22Title%22,%22SortOrder%22%3A%22ASC%22,%22SearchTerm%22%3A%22%22%7D,%22ItemsToCompare%22%3A%5B%5D,%22SelectedStandardIdList%22%3A%5B%5D,%22StandardID%22%3A1716,%22EntityTypeID%22%3A1%7D

Measure Program: Long-Term Care Hospital Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	2013-10-01
Data Reporting End Date	2018-10-01

Measure Program Links

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Measures Information | CMS

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Milestones

Milestone: Implemented

Effective Date	2013-10-01
Comments	Not Available
Milestone Links	https://www.medicare.gov/longtermcarehospitalcompare/

Measure Program: Hospital Acquired Condition Reduction Program

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2016-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	https://www.federalregister.gov/articles/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the#p-2676

Milestone: Finalized

Effective Date	2013-08-19
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

Milestone: Considered

Effective Date	2012-12-01
Comments	Not Available

Other Data	**Name**	**Value**
	MUC ID	582

Measure Program: Inpatient Rehabilitation Facility Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	Not Available
Data Reporting End Date	2019-12-01

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-

Milestones

Milestone: Implemented

Effective Date	2020-01-01
Comments	Not Available
Milestone Links	https://www.medicare.gov/inpatientrehabilitationfacilitycompare/

Measure Program: Hospital Inpatient Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome

Quality Domain	Not specified
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	2014-01-01
Data Reporting End Date	2020-01-01

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

Milestones

Milestone: Removed

Effective Date	2021-10-01
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf

Milestone: Implemented

Effective Date	2014-10-01
Comments	Not Available

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

NQF Endorsement Status	Endorsed
NQF ID	0500
Measure Type	Composite
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	This measure focuses on adults 18 years and older with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis Campaign guidelines, the measure contains several elements, including measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement. As reflected in the data elements and their definitions, these elements should be performed in the early management of severe sepsis and septic shock.
Numerator	The number of patients in the denominator who received ALL of the following components (if applicable) for the early management of severe sepsis and septic shock: initial lactate levels, blood cultures, antibiotics, fluid resuscitation, repeat lactate level, vasopressors, and volume status and tissue perfusion reassessment.
Denominator	Inpatients age 18 and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis, or Septic Shock.
Denominator Exclusions	The following patients are excluded from the denominator: Severe sepsis is not present Patients Transferred in from another acute care facility Patients receiving IV antibiotics for more than 24 hours prior to presentation of severe sepsis. Patients with a Directive for Comfort Care or Palliative Care within 3 hours of presentation of severe sepsis Patients with an Administrative Contraindication to Care within 6

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

hours of presentation of severe sepsis

Patients with an Administrative Contraindication to Care within 6 hours of presentation of septic shock

Patients with a Directive for Comfort Care or Palliative Care within 6 hours of presentation of septic shock

Patients with septic shock who are discharged within 6 hours of presentation

Patients with severe sepsis who are discharged within 6 hours of presentation

Patients with a Length of Stay >120 days

Patients included in a Clinical Trial

Rationale

The evidence cited for all components of this measure is directly related to decreases in organ failure, overall reductions in hospital mortality, length of stay, and costs of care.

A principle of sepsis care is that clinicians must rapidly treat patients with an unknown causative organism and unknown antibiotic susceptibility. Since patients with severe sepsis have little margin for error regarding antimicrobial therapy, initial treatment should be broad spectrum to cover all likely pathogens. As soon as the causative organism is identified, based on subsequent culture and susceptibility testing, de-escalation is encouraged by selecting the most appropriate antimicrobial therapy to cover the identified pathogen, safely and cost effectively (Dellinger, 2012).

Multicenter efforts to promote bundles of care for severe sepsis and septic shock were associated with improved guideline compliance and lower hospital mortality (Ferrer, 2008 and Rhodes, 2015). Even with compliance rates of less than 30%, absolute reductions in mortality of 4-6% have been noted (Levy, 2010 and Ferrer, 2008). Absolute reductions in mortality of over 20% have been seen with compliance rates of 52% (Levy, 2010). Coba et al. has shown that when all bundle elements are completed and compared to patients who do not have bundle completion, the mortality difference is 14% (2011). Thus, there is a direct association between bundle compliance and improved mortality. Without a continuous quality initiative (CQI), even these compliance rates will not improve and will decrease over time (Ferrer, 2008). Multiple studies have shown that, for patients with severe sepsis, standardized order sets, enhanced

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

	bedside monitor display, telemedicine, and comprehensive CQI feedback is feasible, modifies clinician behavior, and is associated with decreased hospital mortality (Thiel, 2009; Micek, 2006; Winterbottom, 2011; Schramm, 2011; Nguyen, 2007; Loyola, 2011).
Evidence	Not Available

Developer/Steward

Steward	Centers for Medicare & Medicaid Services (CMS)
Contact	MMSSupport@Battelle.org
Measure Developer	Not specified
Development Stage	Fully Developed

Characteristics

Measure Type	Composite
Meaningful Measure Area	Preventable Healthcare Harm
Healthcare Priority	Make Care Safer by Reducing Harm Caused in the Delivery of Care
eCQM Spec Available	No
NQF Endorsement Status	Endorsed
NQF ID	0500
Last NQF Update	2017-07-13
Target Population Age	18+
Target Population Age (High)	Not Available
Target Population Age (Low)	18

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

Reporting Level	Facility
Conditions	Infection
Subconditions	Sepsis
Care Settings	Hospital Inpatient; Hospital/Acute Care Facility

Groups

Core Measure Set	Not Available

Measure Group	Group Identifier
SEP	
SEP	1
SEP	01

Measure Links

Measure Program: Hospital Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	2016-10-01
Data Reporting End Date	2017-10-01

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf

Milestone: Finalized

Effective Date	2014-08-22
Comments	Not Available
Milestone Links	http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	https://www.medicare.gov/hospitalcompare/search.html http://www.qualitynet.org/dcs/ContentServer?

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

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Measure Program: Hospital Inpatient Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Available
Purposes	Not Available
Quality Domain	Patient Safety
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2016-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

Milestones

Milestone: Implemented

Effective Date	2016-10-01
Comments	Not Available

Milestone: Finalized

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

Effective Date	2014-08-22
Comments	Not Available

SDOH Screening Measure Specifications

Social Determinants of Health (SDOH) Screening
Steward: Rhode Island Executive Office of Health and Human Services
As of April 8, 2021

SUMMARY OF CHANGES FOR 2021 (PERFORMANCE YEAR 4)

- Updated to include guidance on how to attribute patients and providers to AEs.
- Updated to include an example of ICD-10 Z codes in use by at least one AE to capture SDOH screening results electronically.
- Updated to include information about patient and provider attribution to AEs.

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[1]

The percentage of attributed patients who were screened for Social Determinants of Health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results. Please note that for organizations participating in the Medicaid Accountable Entity (AE) program, the screening tool must be approved by EOHHS to count as meeting numerator requirements.

Eligible Population

Note: *Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.*

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Allowable gap	No break in coverage lasting more than 30 days.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Benefit	Medical
Event/diagnosis	• The patient has been seen by an AE/ACO-affiliated primary care clinician anytime within the last 12 months • For the purpose of this measure "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel. • Follow the below to determine a primary care visit: ○ The following are the eligible CPT/HCPCS office visit

[1] Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 3/18/19.

	codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490; 99495-99496 ○ The following are the eligible telephone visit, e-visit or virtual check-in codes for determining a primary care visit: ▪ CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following POS codes: 02 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following modifiers: 95, GT
Exclusions	• Patients in hospice care (see Code List below) • Refused to participate

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE provider rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[2]

Electronic Data Specifications

The percentage of attributed patients who were screened for Social Determinants of Health using an EOHHS-approved screening tool, where the primary care practice has documentation of the completion of the screening, the date of the screen, and the results.

[2] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment%20M%20-%20PY4%20Attribution%20Guidance.pdf.

Denominator	The eligible population
Numerator	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's EHR. Notes: • Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. • Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria. AEs can, but not required to, use ICD-10 Z codes to track performance for this measure electronically. An example of two Z codes in use by at least one AE is provided below: • Z04 ○ Definition: Encounter for examination and observation for other reasons ○ Meaning: SDOH screening completed • Z53 ○ Definition: Persons encountering health services for specific procedure and treatment, not carried out ○ Meaning: SDOH screening offered, but patient refused/declined to complete screen
Unit of measurement	Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record.
Documentation requirements	All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer or a community partner. The screening results must either be embedded in the EHR or a PDF of the screening results must be accessible in the EHR, i.e., the primary care clinician must not be required to leave the EHR to access a portal or other electronic location to view the screening results. Results for at least one question per required domain must be included for a screen to be considered numerator complaint.
Approved screening tools	For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure.

Required domains	1. Housing insecurity; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance. Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

Code List

The following codes should be utilized to identify patients in hospice care:

Code System	Code
UBREV	0115
UBREV	0125
UBREV	0135
UBREV	0145
UBREV	0155
UBREV	0235
UBREV	0650
UBREV	0651
UBREV	0652
UBREV	0655
UBREV	0656
UBREV	0657
UBREV	0658
UBREV	0659
SNOMED CT US EDITION	170935008
SNOMED CT US EDITION	170936009
SNOMED CT US EDITION	183919006
SNOMED CT US EDITION	183920000
SNOMED CT US EDITION	183921001
SNOMED CT US EDITION	305336008
SNOMED CT US EDITION	305911006
SNOMED CT US EDITION	385763009

Code System	Code
CPT	99377
CPT	99378
HCPCS	G0182
HCPCS	G9473
HCPCS	G9474
HCPCS	G9475
HCPCS	G9476
HCPCS	G9477
HCPCS	G9478
HCPCS	G9479
HCPCS	Q5003
HCPCS	Q5004
HCPCS	Q5005
HCPCS	Q5006
HCPCS	Q5007
HCPCS	Q5008
HCPCS	Q5010
HCPCS	S9126
HCPCS	T2042
HCPCS	T2043
HCPCS	T2044
HCPCS	T2045
HCPCS	T2046

Cardiac Rehabilitation (CRE)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.

Description

The percentage of members 18 years and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. Four rates are reported:

- *Initiation*. The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
- *Engagement 1*. The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.
- *Engagement 2*. The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
- *Achievement*. The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.

Definitions

Intake Period — A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

Episode Date — The most recent cardiac event during the Intake Period, including myocardial infarction (MI), coronary artery bypass graft (CABG), percutaneous coronary intervention (PCI), heart or heart/lung transplant, or heart valve repair/replacement.

For MI, CABG, heart or heart/lung transplant or heart valve repair/replacement, the Episode Date is the *date of discharge.*

For PCI, the Episode Date is the *date of service*.

For inpatient claims, the Episode Date is the *date of discharge*.

For direct transfers, the Episode Date is the discharge *date from the last admission.*

Eligible Population

Product lines — Commercial, Medicaid, Medicare (report each product line separately).

Ages — 18 years and older as of the Episode Date. Report the following age stratifications and total rate:

- 18–64 years.
- 65 and older.

- Total.

The total is the sum of the age stratifications for each product line.

Continuous enrollment Episode Date through the following 180 days.

Allowable gap None.

Anchor date Episode Date.

Benefits Medical.

Event/diagnosis Follow the steps below to identify the eligible population.

Step 1 Identify all members who had any of the following cardiac events during the Intake Period:

- Discharged from an inpatient setting with any of the following on the discharge claim:
  - MI (MI Value Set).
  - CABG (CABG Value Set; Percutaneous CABG Value Set).
  - Heart or heart/lung transplant (Heart Transplant Value Set).
  - Heart valve repair or replacement (Heart Valve Repair or Replacement Value Set).

  To identify discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- PCI. Members who had PCI (PCI Value Set; Other PCI Value Set) in any setting.

Step 2 For each member identified in step 1, the Episode Date is the date of the most recent cardiac event. If a member has more than one cardiac event that meets the event/diagnosis criteria, include only the most recent during the Intake Period.

Step 3 Test for direct transfers. For episodes with a direct transfer to an acute or nonacute setting for any diagnosis, the Episode Date is the discharge date from the last admission.

A *direct transfer* is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.

Exclude both the initial discharge and the direct transfer discharge if the last discharge occurs after June 30 of the measurement year.

Note: *The direct transfer does not require a cardiac event diagnosis.*

Step 4: Required exclusions

Exclude members who meet any of the following criteria:

- Discharged from an inpatient setting with any of the following on the discharge claim during the 180 days after the Episode Date:
  - MI (MI Value Set).
  - CABG (CABG Value Set; Percutaneous CABG Value Set).
  - Heart or heart/lung transplant (Heart Transplant Value Set).
  - Heart valve repair or replacement (Heart Valve Repair or Replacement Value Set).

  To identify discharges:

  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- PCI. Members who had PCI (PCI Value Set; Other PCI Value Set), in any setting, during the 180 days after the Episode Date.
- Members in hospice or using hospice services anytime during the measurement period. Refer to *General Guideline 17: Members in Hospice*.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the intake period through the end of the measurement year.

Step 5: Exclusions

Exclude members who meet any of the following criteria:

Note: *Supplemental and medical record data may not be used for these exclusions*

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year.
  - Living long-term in an institution any time during the intake period through the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the end of the measurement year.
- Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded:

1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the intake period through the end of the measurement year.
2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
   - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
     1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
     2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
     3. Identify the discharge date for the stay.
   - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
   - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
     1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
     2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
     3. Identify the discharge date for the stay.
   - A dispensed dementia medication (Dementia Medications List).

- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) any time during the intake period through the end of the measurement year.

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Administrative Specification

Denominator The eligible population.

Numerators

Initiation At least 2 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 30 days after the Episode Date (31 total days) (on the same or different dates of service).

Engagement 1 At least 12 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 90 days after the Episode Date (91 total days) (on the same or different dates of service).

Engagement 2 At least 24 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 180 days after the Episode Date (181 total days) (on the same or different dates of service).

Achievement At least 36 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 180 days after the Episode Date (181 total days) (on the same or different dates of service).

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CRE-1/2/3: Data Elements for Cardiac Rehabilitation

Metric	Age	Data Element	Reporting Instructions
Initiation	18-64	EligiblePopulation	For each Stratification, repeat per Metric
Engagement1	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
Engagement2	Total	NumeratorByAdmin	For each Metric and Stratification
Achievement		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Cardiac Rehabilitation

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Using product line criteria is not required. Including any product line, combining product lines, or not including product line criteria is allowed.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (i.e., ages 18–30 years).
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events that contain (or map to) codes in the value sets may be used to identify cardiac events. Value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes, with limits	Apply required exclusions according to specified value sets and medication lists. The hospice and palliative care exclusions are not required. Refer to Exclusions in the *Guidelines for the Rules for Allowable Adjustments.*
Exclusions: I-SNP, LTI, Frailty or Advanced Illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Initiation • Engagement 1 • Engagement 2 • Achievement	No	Value sets and logic may not be changed.

Find an eCQM

Cesarean Birth

Receive updates on this topic (/user/login)

Measure Information(/quicktabs/nojs/tabs_pre_rule_measure/0)

Specifications and Data Elements(/quicktabs/nojs/tabs_pre_rule_measure/1)

Measure Information

CMS Measure ID	CMS334v4
Short Name	ePC-02
NQF #	Not Applicable
Measure Description	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth
Initial Population	Inpatient hospitalizations for patients age >= 8 years and < 65 admitted to the hospital for inpatient acute care who undergo a delivery procedure that ends during the measurement period

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Measure Information	
Denominator Statement	Inpatient hospitalizations for nulliparous patients delivered of a live term singleton newborn >= 37 weeks' gestation Note: The eCQM and chart-based measure slightly digress in the denominator logic. eCQM: The measure description states "Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth". ACOG defines nulliparous as a woman with a parity of zero. The eCQM logic concludes that a patient is nulliparous when ONE of the following is true: 1. Parity equals zero 2. Gravidity equals one 3. Preterm and Term births both equal zero. See Definition Section for more details. Chart Based: The chart based measure evaluates the data element "Previous Live Births". If the answer is "yes" the patient will be excluded from the denominator. If a patient had a previous stillbirth or fetal demise, the abstractor is instructed to answer "no" and the patient will remain in the denominator.
Denominator Exclusions	Inpatient hospitalizations for patients with abnormal presentation or placenta previa during the encounter. Note that the chart-based measure excludes single stillbirth and patients with multiple gestations from the denominator. These concepts are mutually exclusive of the denominator requirement of live singleton newborn and therefore the logic does not address single stillbirth nor multiple gestation.
Numerator Statement	Inpatient hospitalizations for patients who deliver by cesarean section.
Numerator Exclusions	None

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Measure Information

Denominator Exceptions	None
Measure Steward	The Joint Commission (/measure-stewards/joint-commission)
Measure Scoring	Proportion measure (/mcw/list/ecqm-measure-score/proportion-measure)
Measure Type	Outcome measure (/mcw/list/ecqm-score-type/outcome-measure)
Improvement Notation	Within Optimal Range. The Joint Commission does not want to encourage inappropriately low Cesarean rates that may be unsafe to patients. Acceptable PC-02 rates are 30% or lower, however there is not an established threshold for what rate may be too low. PC-06 serves as a balancing measure for PC-02 to guard against any unanticipated or unintended consequences and to identify unforeseen complications that might arise as a result of quality improvement activities and efforts for this measure. In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce cesarean births.
Guidance	Vertex position is modeled implicitly, as the measure excludes deliveries with abnormal presentations. Patients who do not receive prenatal care and have no documented gestational age or estimated due date are implicitly excluded from the measure, as gestational age is required to meet denominator criteria. This measure allows for 2 approaches to determine estimated gestational age (EGA) in the following order of precedence: 1. The EGA is calculated using the American College of Obstetricians and Gynecologists ReVITALize guidelines.*

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Measure Information	
	2. The EGA is obtained from a discrete field in the electronic health record. This option is only used when the calculated EGA is not available. Wherever gestational age is mentioned, relative to the delivery, the intent is to capture the last estimated gestational age prior to or at the time of delivery. *ACOG ReVITALize Guidelines for Calculating Gestational Age: Gestational Age = (280-(EDD minus Reference Date))/7 --Estimated Due Date (EDD): The best obstetrical Estimated Due Date is determined by last menstrual period if confirmed by early ultrasound or no ultrasound performed, or early ultrasound if no known lastmenstrual period or the ultrasound is not consistent with last menstrual period, or known date of fertilization (eg, assisted reproductive technology) --Reference Date is the date on which you are trying to determine gestational age. For purposes of this eCQM, Reference Date would be the Date of Delivery. Note however the calculation may yield a non-whole number and gestational age should be rounded off to the nearest completed week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks. The timing relationship of relevantDatetime 42 weeks or less before TimeOfDelivery is applied to the data elements of parity, gravida, preterm/term live births for which prenatal records may include relevant information. The denominator includes logic to determine if the patient is nulliparous. The patient is considered nulliparous when one of the following is true: Parity equals zero Gravida equals one

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Measure Information	
	Preterm and Term births both equal zero Parity, preterm and term live births may be updated by the electronic health record software or by clinicians during a delivery encounter. To capture the pre-delivery value, organizations may need to create a rule or calculation to capture the number prior to the delivery start time. This eCQM is an episode-based measure. An episode is defined as each inpatient hospitalization or encounter that ends during the measurement period. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm (https://ecqi.healthit.gov/qdm)) for more information on the QDM
Meaningful Measure	Safety (/mcw/list/meaningful-measure/safety)

Last Updated: May 04, 2022

Meaningful Measures (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy)

Measures Management System (https://mmshub.cms.gov/)

Quality Payment Program (https://qpp.cms.gov/)

QualityNet (http://qualitynet.cms.gov)

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Fluoride Varnish

Rhode Island Department of Health

A. DESCRIPTION

The percentage of children who received a fluoride varnish application in primary care in the 12 months preceding their first, second, or third birthday.

Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened by their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.

B. ELIGIBLE POPULATION

Age	Children who turn 1, 2, or 3 years of age between January 1 and December 31 of the measurement year.
Continuous Enrollment	Children who are enrolled continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday
Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months or 60 days is not considered continuously enrolled).
Benefit	Medical
Event/Diagnosis	None

C. DATA SOURCE

C.1 – Administrative Specifications

Denominator

Denominator 1: The children in the eligible population who turned 1 during the measurement year.

Denominator 2: The children in the eligible population who turned 2 during the measurement year.

Denominator 3: The children in the eligible population who turned 3 during the measurement year.

Denominator 4: All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3.

Numerators

The numerators identify children who received a fluoride varnish application by a medical practice. National recommendations call for application among young children. The measure is based on three, age-specific indicators.

Numerator 1: Children in Denominator 1 who had a claim with CPT code 99188 or CDT code D1206 billed by a medical practice by their first birthday.

Numerator 2: Children in Denominator 2 who had a claim with CPT code 99188 or CDT code D1206 billed by a medical practice after their first and before or on their second birthdays.

Numerator 3: Children in Denominator 3 who had a claim with CPT code 99188 or CDT code D1206 billed by a medical practice after their second and before or on their third birthdays.

Numerator 4: Children in the entire eligible population who had claim with CPT code 99188 or CDT code D1206 billed by a medical practice in the 12 months preceding their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

Claims data: CPT code 99188 (application of topical fluoride varnish by a physician or other qualified health care professional) or CDT code D1206 (topical application of fluoride varnish) when billed by a medical practice.

C.2 – Medical Record Specifications

Denominator

A systematic sample of 411 drawn from the eligible population stratified by age.

Denominator 1: 137 children from the sample who turned 1 during the measurement year.

Denominator 2: 137 children from the sample who turned 2 during the measurement year.

Denominator 3: 137 children from the sample who turned 3 during the measurement year.

Denominator 4: The entire sample of 411 children.

Numerators

Numerator 1: Children in Denominator 1 who had received a fluoride varnish application that was documented by their first birthday

Numerator 2: Children in Denominator 2 who had received a fluoride varnish application that was documented after their first and before or on their second birthday

Numerator 3: Children in Denominator 3 who received a fluoride varnish application that was documented after their second and before or on their third birthday

Numerator 4: Children in Denominator 4 who had received a fluoride varnish application that was documented in the 12 months preceding their first, second or third birthday (the sum of numerators 1, 2 and 3).

Documentation in the medical record must include all of the following:

- A note indicating the date on which the test was performed, and
- Evidence of a fluoride varnish application

D. EXCLUSIONS

None.

E. CALCULATION ALGORITHM

Step 1:

Determine the denominators.

From the total denominator, sort into three age cohorts: children who turned one, two or three years of age between January 1 and December 31 of the measurement year.

Step 2:

Determine the numerators.

For each age cohort, and for the total, identify children who had received a fluoride varnish application by their birthday as found through claims data or documented in the medical chart.

Claims Data:

Children for whom a claim of 99188 or D1206 billed by a medical practice was submitted for services in the 12 months preceding their birthday.

Medical Record:

Children who had documentation in the medical record of receiving a fluoride varnish application, validated tool in the 12 months preceding their birthday.

Documentation must include the date of screening and evidence that the fluoride varnish application was completed.

Step 3:

Calculate the age-specific indicators (ages 1 to 3) by dividing the age-specific numerator by the age-specific denominator and multiplying by 100 to get a percentage.

Step 4: Create the overall measure of screening based on the age-specific numerators and denominators.

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

If administrative data are used, the entire eligible population is used for the denominator. If using the hybrid method (administrative plus medical record data sources), a systematic sample can be drawn of 411, with 137 in each age group.

F. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

A sample of 411 will provide sufficient statistical power for states reporting a state-wide developmental screening rate for children ages 1 to 3. With the smaller age-specific samples, the confidence intervals around the age-specific rates will be larger. Because states will want to use this measure to improve screening rates, age-specific rates may help states to target their efforts. Some states may wish to augment the sample in order to monitor screening rates for a particular age group; compare screening rates for a particular age group with that in other states; or look within an age group at subgroups, defined by race/ethnicity, geographic region, or language. For these applications, the age-specific sample of 137 maybe insufficient, and the state may need a larger sample to obtain statistically meaningful results. The size of the sample required depends on the use of the data, so consultation with a statistician is recommended. The following instructions guide the development of an oversample.

The eligible population, from which the original sample was drawn, should be stratified by age, and the age-specific sample drawn from within each stratum. To oversample for any age group, the state should return to the original listing of eligible children in that age group, and continue adding children to the sample until the larger sample is complete. However, in order to maintain consistency of reporting and avoid having to weight the age groups to calculate the total, the state should only include the first 137 children sampled in the age-specific and total rates.

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Restructured the numerator logic and value sets.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:

1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.
2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

Definitions

Episode Date

The date of service for any acute inpatient discharge, residential treatment discharge or detoxification visit with a principal diagnosis of substance use disorder.

For an acute inpatient discharge or residential treatment discharge or for detoxification that occurred during an acute inpatient stay or residential treatment stay, the Episode Date is the date of discharge.

For direct transfers, the Episode Date is the discharge date from the transfer admission.

For detoxification (other than detoxification that occurred during an acute inpatient stay or residential treatment stay), the Episode Date is the date of service.

Eligible Population

Product lines

Commercial, Medicaid, Medicare (report each product line separately).

Ages

13 years and older as of the date of discharge, stay or event. Report three age stratifications and total rate:

- 13-17 years.
- 18-64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

Date of episode through 30 days after episode (31 total days).

Allowable gap None.

Anchor date None.

Benefits Medical, chemical dependency and pharmacy.

Event/diagnosis An acute inpatient discharge, residential treatment or detoxification event for a principal diagnosis of substance use disorder on or between January 1 and December 1 of the measurement year. Any of the following code combinations meet criteria:

- An acute inpatient discharge or a residential behavioral health stay ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set) on the discharge claim. To identify acute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays other than behavioral health (Nonacute Inpatient Stay Other Than Behavioral Health Accommodations Value Set).
  3. Identify the discharge date for the stay.
- A detoxification visit (Detoxification Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).

The denominator for this measure is based on episodes, not on members. If members have more than episode, include all that fall on or between January 1 and December 1 of the measurement year.

Direct transfers Identify direct transfers to an acute inpatient care or residential setting. If the direct transfer to the acute inpatient or residential care setting was for a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set), use the date of last discharge.

A **direct transfer** is when the discharge date from the first acute inpatient or residential care setting precedes the admission date to a second acute inpatient or residential care setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify direct transfers:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays other than behavioral health (Nonacute Inpatient Stay Other Than Behavioral Health Accommodations Value Set).
3. Identify the admission date for the stay.

Exclude both the initial discharge and the direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the direct transfer to the acute inpatient or residential behavioral health care setting was for any other principal diagnosis, exclude both the original and the direct transfer discharge.

Multiple discharges, visits or events in a 31-day period

After evaluating for direct transfers, if a member has more than one episode in a 31-day period, include only the first eligible episode. For example, if a member is discharged from a residential treatment stay on January 1, include the January 1 discharge and do not include subsequent episodes that occur on or between January 2 and January 31; then, if applicable, include the next episode that occurs on or after February 1. Identify episodes chronologically, including only the first episode per 31-day period.

Note: *Removal of multiple episodes in a 31-day period is based on eligibility. Assess each episode for eligibility before removing multiple episodes in a 31-day period.*

Required exclusion

Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 30 days after an episode for substance use disorder. Do not include visits that occur on the date of the denominator episode.

7-Day Follow-Up

A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 7 days after an episode for substance use disorder. Do not include visits that occur on the date of the denominator episode.

For both indicators, any of the following meet criteria for a follow-up visit.

- An acute or nonacute inpatient admission or residential behavioral health stay ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set) on the discharge claim. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An intensive outpatient encounter or partial hospitalization Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A substance use disorder service (Substance Use Disorder Services Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- Residential behavioral health treatment (Residential Behavioral Health Treatment Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).

Note: *Follow-up does not include detoxification. Exclude all detoxification events (Detoxification Value Set) when identifying follow-up care for numerator compliance.*

Opioid Use Disorder Treatment Medications

Description	Prescription
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant)[1] • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

[1] Buprenorphine administered via transdermal patch or buccal film are not included because they are FDA-approved for the treatment of pain, not for opioid use disorder.

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral and delayed-release tablet)

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*
- *Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than for an opioid use disorder; therefore, is not included on medication lists. The AOD Medication Treatment Value Set and OUD Weekly Drug Treatment Service Value Set include codes that identify methadone treatment for opioid use disorder because these codes are used on medical claims, not on pharmacy claims.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUI-1/2/3: Data Elements for Follow-Up After High Intensity Care for Substance Use Disorder

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	13-17	Benefit	Metadata
FollowUp7Day	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Follow-Up After High Intensity Care for Substance Use Disorder

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination date(s) may be changed (i.e., age 13 as of discharge date). Changing denominator age range is allowed.
Continuous enrollment, Allowable gap	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events and diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder that result in a follow-up visit or service for substance use disorder).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Medication lists, value sets and logic may not be changed.

Hospital Commitment to Health Equity Structural Measure Specifications

In the FY 2023 IPPS/LTCH PPS proposed rule, CMS proposed that hospitals participating in the Hospital Inpatient Quality Reporting Program be required annually to complete the Hospital Commitment to Health Equity questions. Data entry would be through the QualityNet Secure Portal available to authorized users.

Performance Measure Name: Hospital Commitment to Health Equity

Description: This structural measure assesses hospital commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, rural populations, religious minorities, and people living near or below poverty level. If finalized as proposed, hospitals would receive one point each for attesting to five different domains of commitment to advancing health equity for a total of five points.

If finalized, hospitals participating in the Hospital Inpatient Quality Reporting Program must answer the questions during the CMS specified time period. The five domains for hospital attestation and key questions for each domain are the following:

- **Domain 1: Equity is a Strategic Priority**
  Hospital commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. Please attest that your hospital has a strategic plan for advancing healthcare equity and that it includes all of the following elements. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):
  A. Our hospital strategic plan identifies priority populations who currently experience health disparities.
  B. Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals.
  C. Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.
  D. Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

- **Domain 2: Data Collection**
  Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):
  A. Our hospital collects demographic information, including self-reported race and ethnicity, and/or social determinant of health information on the majority of our patients.
  B. Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.
  C. Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified

EHR technology.

- **Domain 3: Data Analysis**
  Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):
  A. Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.

- **Domain 4: Quality Improvement**
  Health disparities are evidence that high quality care has not been delivered equally to all patients. Engagement in quality improvement activities can improve quality of care for all patients. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):
    A. Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.

- **Domain 5: Leadership Engagement**
  Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):
    A. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.
    B. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

Clarifying Information: This measure includes five attestation-based questions, each representing a separate domain of commitment. Hospitals receive one point for each domain to which they attest "yes," stating they are meeting the required competencies. For each domain there are between one and four associated yes/no sub-questions for related structures or activities within the hospital. Hospitals will only receive a point for each domain if they attest "yes" to all related sub-questions. A hospital's score can be a total of zero to five points. There is no "partial credit" for sub-questions. For example, in Domain 1, hospitals must attest "yes" to sub-questions A-D in order to earn the point.

Additional Resources: This measure is supported by evidence and guidance from the following:

- The CMS Meaningful Measures Framework identifies equity as a priority. [1]
- The Office of Minority Health (OMH) framework provides information on building an organizational response to health disparities.[2]

[1] Meaningful Measures 2.0: Moving from Measure Reduction to Modernization | CMS
[2] Health Disparities Guide (cms.gov)

- The National Academy of Medicine (NAM) convened health care quality leaders on strategies to address equity.[3]
- The Institute for Healthcare Improvement (IHI) studied 23 health systems to better understand organizational efforts to improve equity and concluded equity must be a strategic priority.[4] IHI also issued a framework for health care organizations on achieving health equity.[5]
- The Joint Commission (TJC) published a roadmap for hospitals to improve communication, cultural competence, and patient- and family-centered care.[6]

[3] National Academy of Medicine, An Equity Agenda for the Field of Health Care Quality Improvement, 2021(nam.edu)
[4] Health Equity Must Be a Strategic Priority (nejm.org)
[5] Achieving Health Equity: A Guide for Health Care Organizations | IHI - Institute for Healthcare Improvement
[6] aroadmapforhospitalsfinalversion727pdf.pdf (jointcommission.org)

Maternal Morbidity Structural Measure

Hospitals participating in the Hospital Inpatient Quality Reporting Program are required annually to complete the Maternal Morbidity Structural Measure question. Data entry is achieved through the QualityNet Secure Portal available to authorized users.

Performance Measure Name: Maternal Morbidity Structural Measure

Description: Assesses whether or not a hospital participates in a Statewide or National Perinatal Quality Improvement (QI) Collaborative initiative, and implements patient safety practices and/or bundles related to maternal morbidity from that QI Collaborative. If the hospital provides inpatient labor, delivery, and post-partum care, the hospital will be required to respond to the following question:

- **Question:** Does your hospital or health system participate in a Statewide and/or National Perinatal Quality Improvement Collaborative Program aimed at improving maternal outcomes during inpatient labor, delivery and post-partum care, and has implemented patient safety practices or bundles related to maternal morbidity to address complications, including, but not limited to, hemorrhage, severe hypertension/preeclampsia or sepsis?
- **Answer Choices:** (A) Yes, (B) No, or (C) N/A (our hospital does not provide inpatient labor/delivery care)

Clarifying Information: Examples of Statewide or National Perinatal QI collaboratives include the California Maternal Quality Care Collaborative and the Alliance for Innovation on Maternal Health (AIM). When answering the Maternal Morbidity Structural measure, please note that there are two parts to this measure's question. Both parts of the measure's question have to be considered by hospitals when determining which answer choice is appropriate. For example, part one of the question assesses a hospital's participation in a Statewide and/or National Perinatal QI collaborative. Part two of the question assesses a hospital's implementation of patient safety practices and/or bundles related to maternal morbidity from the QI collaboratives. In order to select "(A) Yes", a hospital must be able to answer yes to both parts of the question. If a hospital deems a response of no to either part of the question, then their attestation for the entire question must be "(B) No". Hospitals that do not provide inpatient labor and delivery care services, would select "(C) N/A (our hospital does not provide inpatient labor/delivery care)."

Hospitals participating in the Hospital Inpatient Quality Reporting Program must answer the questions during the CMS specified time period.

Oral Evaluation, Dental Services (OED)

SUMMARY OF CHANGES TO HEDIS MY 2023

- First-year measure.

Description

The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Eligible Population

Product line	Medicaid.
Ages	Under 21 years as of December 31 of the measurement year. Report four age stratifications and a total rate: • 0–2 years • 3–5 years. • 6–14 years. • 15–20 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	180 days during the measurement year.
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	None.
Required exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator	The eligible population.
Numerator[1]	A comprehensive or periodic oral evaluation with a dental provider during the measurement year (Oral Evaluation Value Set ***with*** NUCC Provider Taxonomy Value Set).

[1] The NCQA Value Set Directory includes Current Dental Terminology (CDT) codes, © 2022 American Dental Association. All rights reserved.
Use of the CDT codes by NCQA, including inclusion in HEDIS, is contingent on NCQA and the ADA/DQA entering into an appropriate license agreement.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table OED-1: Data Elements for Oral Evaluation, Dental Services

Metric	Age Stratification	Data Element	Reporting Instructions
OralEvaluationDentalServices	0-2	Benefit	Metadata
	3-5	EligiblePopulation	For each Stratification
	6-14	ExclusionAdminRequired	For each Stratification
	15-20	NumeratorByAdmin	For each Stratification
	Total	Rate	(Percent)

Patient Safety Indicator 90 (PSI 90)
Patient Safety and Adverse Events Composite
July 2021
Hospital-Level Indicator
Type of Score: Ratio

Prepared by:

Agency for Healthcare Research and Quality

U.S. Department of Health and Human Services

www.qualityindicators.ahrq.gov

DESCRIPTION

The weighted average of the observed-to-expected ratios for the following component indicators:

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall With Hip Fracture Rate
- PSI 09 Postoperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity ratios (observed/expected ratios) from selected AHRQ Patient Safety Indicators (PSIs). The weights of the individual component indicators are based on two concepts: the volume of the adverse event and the harm associated with the adverse event. The volume weights were calculated based on the number of safety-related events for the component indicators in the all-payer reference population. The harm weights were calculated by multiplying empirical estimates of the probability of excess harms associated with each patient safety event by the corresponding utility weights (1–disutility). Disutility is the measure of the severity of the adverse events associated with each of the harms (i.e., outcome severity, or least preferred states from the patient perspective). The harm weights were calculated using linked claims data for two years of Medicare Fee for Service beneficiaries.

Table 1. Composite Weights for PSI 90 v2021

INDICATOR	HARM WEIGHT	VOLUME WEIGHT	COMPONENT WEIGHT
PSI 3 Pressure Ulcer Rate	0.3080	0.1048	0.1641
PSI 6 Iatrogenic Pneumothorax Rate	0.1381	0.0457	0.0321
PSI 8 In Hospital Fall With Hip Fracture Rate	0.1440	0.0194	0.0142
PSI 9 Postoperative Hemorrhage or Hematoma Rate	0.0570	0.1526	0.0442
PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate	0.3584	0.0310	0.0564
PSI 11 Postoperative Respiratory Failure Rate	0.2219	0.2125	0.2397
PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	0.1557	0.2318	0.1835
PSI 13 Postoperative Sepsis Rate	0.3102	0.1384	0.2182
PSI 14 Postoperative Wound Dehiscence Rate	0.1441	0.0170	0.0125
PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate	0.1474	0.0468	0.0351

Source: 2018 State Inpatient Databases, Healthcare Cost and Utilization Program, Agency for Healthcare Research and Quality. 2013-2014 Medicare Fee-for-Service claims data.

For more information, see Quality Indicator Empirical Methods and Composite User Guide.

*Pharmacotherapy for Opioid Use Disorder (POD)**

***Adapted with permission by NCQA from the "Continuity of Pharmacotherapy for Opioid Use Disorder" measure owned by The RAND Corporation.**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Clarified in step 4 of the event/diagnosis to count overlapping direct transfer days only once and added an example.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members 16 years of age and older with a diagnosis of OUD.

Definitions

Intake period
A 12-month period that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

OUD dispensing event
OUD pharmacotherapy identified using pharmacy data (medication lists).

OUD medication administration event
OUD pharmacotherapy identified using medical claims data (value sets).

Treatment period start date
The date of an OUD dispensing event or OUD medication administration event with a negative medication history during the Intake Period.

Negative medication history
To qualify for Negative Medication History, the following criteria must be met:

- A period of 31 days prior to the OUD dispensing event or OUD medication administration event when the member had no OUD dispensing events or OUD medication administration events.
- A period of 31 days prior to the OUD dispensing event or OUD medication administration event when the member was not already receiving OUD pharmacotherapy. For example, if an OUD dispensing event has a date of service of January 1, the 31 days prior includes December 1–31. If the member had received a buprenorphine implant (180 days supply) any time during the 179 days prior to December 1, the member is already receiving OUD pharmacotherapy on December 1 and does not have a negative medication history.

Treatment period
A period of 180 calendar days, beginning on the Treatment Period Start Date through 179 days after the Treatment Period Start Date.

Note: *Members can have multiple Treatment Period Start Dates and Treatment Periods during the measurement year. Treatment Periods can overlap.*

Determining same or different medications	Medication lists and value sets that are in the same row of the Opioid Use Disorder Treatment Medications table are the "same medication." For example, if a member has a dispensing event from the Buprenorphine Oral Medications List and an encounter with a code from the Buprenorphine Oral Value Set, this is considered two dispensing events for the same medication. Medication lists and value sets that are in different rows of the Opioid Use Disorder Treatment Medications table are "different medications." For example, if a member has a dispensing event from the Buprenorphine Oral Medications List and a dispensing event from the Buprenorphine Injection Medications List, this is considered two dispensing events for different medications.
Direct transfer	A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	16 years and older as of December 31 of the measurement year. Report two age stratifications and total rate: • 16–64 years. • 65 years and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	31 days prior to the Treatment Period Start Date through 179 days after the Treatment Period Start Date (211 total days).
Allowable gap	None.
Anchor date	None.
Benefits	Medical and pharmacy.

Event/diagnosis Follow the steps below to identify eligible events.

Step 1 Identify members with any diagnosis of OUD (Opioid Abuse and Dependence Value Set) during the Intake Period.

Step 2 For each member identified in step 1, identify all OUD dispensing events or OUD medication administration events during the Intake Period. Use all medication lists and value sets in the Opioid Use Disorder Treatment Medications table below to identify OUD dispensing events and OUD administration events.

Step 3 Test for Negative Medication History. For each OUD dispensing event or OUD medication administration event in step 2, test for a Negative Medication History. Exclude events that do not have a negative medication history. All remaining events with a negative medication history are considered Treatment Period Start Dates.

Step 4 Exclude any Treatment Period Start Dates where the member had an acute or nonacute inpatient stay of eight or more days during the Treatment Period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.
3. Calculate length of stay (LOS) as the admission date through and including the discharge date. If there are direct transfers between stays, add the LOS from any subsequent direct transfers to the initial LOS to calculate a total LOS. If direct transfer days overlap, count each day only once.

For example:

- Exclude a July 1 Treatment Period Start Date where a member was admitted for an inpatient hospital stay on August 1 and discharged on August 8 (LOS = 8 days).
- Exclude a July 1 Treatment Period Start Date where a member had an acute inpatient stay (admission date August 1; discharge date August 4; LOS = 4 days), followed by a direct transfer to a nonacute inpatient facility (admission date August 5; discharge date August 8; LOS = 4 days). Total LOS = 8 days.
- Do not exclude a July 1 Treatment Period Start Date where a member had an acute inpatient stay (admission date August 1; discharge date August 4; LOS = 4 days), followed by a direct transfer to a nonacute inpatient facility (admission date August 4; discharge date August 7, LOS = 4 days). Total LOS = 7 days (do not double count August 4).

Step 5 Calculate continuous enrollment. Members must be continuously enrolled from 31 days prior to the Treatment Period Start Date through 179 days after the Treatment Period Start Date (211 total days).

Note: *All Treatment Period Start Dates (OUD dispensing events or OUD medication administration events) that were not excluded remain in the denominator. The denominator for this measure is based on events, not members.*

Required exclusion Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator New OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days without a gap in treatment of 8 or more consecutive days. Use the steps below to identify the numerator.

Step 1 Identify the Treatment Period for each Treatment Period Start Date in the denominator. Follow the steps below for each Treatment Period in the denominator.

Step 2 Identify all OUD dispensing events and OUD medication administration events during the Treatment Period. Use all the medication lists and value sets in the Opioid Use Disorder Treatment Medications table to identify OUD dispensing events and OUD medication administration events.

Step 3 Identify start and end dates for OUD dispensing events and OUD medication administration events. The start date is the event date and the end date is the start date plus the days supply minus one.

For OUD dispensing events and OUD medication administration events with overlapping days supply, apply the following rules:

- For multiple OUD dispensing events or OUD medication administration events for different medications on the same or different dates of service with overlapping days supply, calculate the start and end dates for each medication individually. For example, if there is a 7-days supply of Oral Buprenorphine on January 1 and a 31-days supply of Buprenorphine Injection on January 5:
  - The Oral Buprenorphine start date is January 1 and the end date is January 7.
  - The Buprenorphine Injection start date is January 5 and the end date is February 4.
- For multiple OUD dispensing events or OUD medication administration events for the same medication on the same date of service or on different dates of service with overlapping days supply, sum the days supply and then calculate start and end dates. For example:
  - If a 7-days supply and a 14-days supply of buprenorphine are dispensed on January 1, the start date is January 1 and the end date is January 21.
  - If a 7-days supply of buprenorphine is dispensed on January 1 and January 5, the start date is January 1 and the end date is January 14.
  - If a member has three codes (or one code billed as three units) from the Buprenorphine Oral Weekly Value Set on January 1, the start date is January 1 and the end date is January 21.
  - If a member has four codes (or one code billed as four units) from the Methadone Oral Weekly Value Set on January 1, the start date is January 1 and the end date is January 28.

For OUD medication administration events identified using a value set, use the days supply listed in the Opioid Use Disorder Treatment Medications table. For OUD dispensing events identified using a medication list, use days supply in the pharmacy data. If days supply is not available in the pharmacy data then

use the days supply listed for the corresponding value set. If the pharmacy data for a buprenorphine oral medication does not contain days supply, count as a 7-days supply.

Step 4 For each Treatment Period, using the start and end dates identified in step 3, determine calendar days covered by an OUD dispensing event or OUD medication administration event. These covered days are referred to as treatment days.

Step 5 Identify gaps in treatment days of 8 or more consecutive days.

Step 6 Determine numerator compliance.

If the Treatment Period does not contain any gaps in treatment of 8 or more consecutive calendar days, the event is numerator compliant.

If the Treatment Period contains at least one gap in treatment of 8 or more consecutive calendar days, the event is not numerator compliant.

Opioid Use Disorder Treatment Medications

Description	Prescription	Medication Lists	Value Sets and Days Supply
Antagonist	• Naltrexone (oral)	• Naltrexone Oral Medications List	• NA—Codes do not exist
Antagonist	• Naltrexone (injectable)	• Naltrexone Injection Medications List	• Naltrexone Injection Value Set (31 days supply)
Partial agonist	• Buprenorphine (sublingual tablet)	• Buprenorphine Oral Medications List	• Buprenorphine Oral Value Set (1 day supply) • Buprenorphine Oral Weekly Value Set (7 days supply)
Partial agonist	• Buprenorphine (injection)	• Buprenorphine Injection Medications List	• Buprenorphine Injection Value Set (31 days supply)
Partial agonist	• Buprenorphine (implant)	• Buprenorphine Implant Medications List	• Buprenorphine Implant Value Set (180 days supply)
Partial agonist	• Buprenorphine/ naloxone (sublingual tablet, buccal film, sublingual film)	• Buprenorphine Naloxone Medications List	• Buprenorphine Naloxone Value Set (1 day supply)
Agonist	• Methadone (oral)	• NA (refer to *Note* below)	• Methadone Oral Value Set (1 day supply) • Methadone Oral Weekly Value Set (7 days supply)

Note

- *Methadone is not included on the medication lists for this measure. Methadone for OUD administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.*

- *The allowable gaps in the measure numerator of 7 or fewer consecutive days are used to account for weekly billing and other variations in billing practices and do not necessarily indicate that OUD pharmacotherapy ended. For example, members receiving daily methadone treatment over their 180-day Treatment Period meet numerator criteria if their treatment is billed weekly.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table POD-1/2/3: Data Elements for Pharmacotherapy for Opioid Use

Metric	Age	Data Element	Reporting Instructions
PharmacotherapyOpioidUseDisorder	16-64	Benefit	Metadata
	65+	EligiblePopulation	For each Stratification
	Total	ExclusionAdminRequired	For each Stratification
		NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Pharmacotherapy for Opioid Use Disorder

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range. The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events and diagnoses that contain (or map to) codes in the value sets and medication lists may be used to identify visits with a diagnosis. Value sets, medication lists and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of pharmacotherapy events with OUD pharmacotherapy for 180 or more days with a diagnosis of OUD).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Pharmacotherapy events	No	Medication lists, value sets and logic may not be changed.

*Postpartum Depression Screening and Follow-Up (PDS-E)**

***Developed with support from the California HealthCare Foundation (CHCF). CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit www.chcf.org to learn more. Also supported by the Zoma Foundation.**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the *Technical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

Description	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. • *Depression Screening.* The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. • *Follow-Up on Positive Screen.* The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women. (B recommendation) The American College of Obstetricians and Gynecologists (ACOG) recommends multiple postpartum visits no later than 12 weeks after birth that include a full assessment of psychological well-being, including screening for postpartum depression and anxiety with a validated instrument. The American Academy of Pediatrics recommends that pediatricians screen mothers for postpartum depression at the infant's one-, two-, four- and six-month visits. The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)
Citations	American Academy of Pediatrics. Earls, M.F. 2010. "Committee on Psychosocial Aspects of Child and Family Health. Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice." *Pediatrics* 126(5):1032– 9. American College of Obstetricians and Gynecologists. 2018. "Screening for Perinatal Depression. ACOG Committee Opinion No. 757." *Obstetrics & Gynecology* 132(5):e208-12.

<table>
<tr><td></td><td>U.S. Preventive Services Task Force. 2016. “Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement.” Annals of Internal Medicine 164:360–6.

U.S. Preventive Services Task Force. 2016. “Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement.” Journal of the American Medical Association 315(4):380–7.</td></tr>
<tr><td colspan="2">Characteristics</td></tr>
<tr><td>Scoring</td><td>Proportion.</td></tr>
<tr><td>Type</td><td>Process.</td></tr>
<tr><td>Stratification</td><td>1. Commercial.
2. Medicaid.</td></tr>
<tr><td>Risk adjustment</td><td>None.</td></tr>
<tr><td>Improvement notation</td><td>A higher rate indicates better performance.</td></tr>
<tr><td colspan="2">Definitions</td></tr>
<tr><td>Participation</td><td>The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.</td></tr>
<tr><td>Participation Period</td><td>The delivery date through 60 days following the date of delivery.</td></tr>
<tr><td>Depression Screening Instrument</td><td>A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Instruments for Adolescents (≤17 years)</th><th>Positive Finding</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire Modified for Teens (PHQ-9M)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>Total Score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]</td><td>Total Score ≥8</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</td><td>Total Score ≥17</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>Total Score ≥10</td></tr>
<tr><td>PROMIS Depression</td><td>Total Score (T Score) ≥60</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.</td></tr>
</table>

<table>
<tr><td></td><td>
<table>
<tr><th colspan="2">Instruments for Adults (18+ years)</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>Total Score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]</td><td>Total Score ≥8</td></tr>
<tr><td>Beck Depression Inventory (BDI-II)</td><td>Total Score ≥20</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</td><td>Total Score ≥17</td></tr>
<tr><td>Duke Anxiety-Depression Scale (DUKE-AD)®[2]</td><td>Total Score ≥30</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>Total Score ≥10</td></tr>
<tr><td>My Mood Monitor (M-3)®</td><td>Total Score ≥5</td></tr>
<tr><td>PROMIS Depression</td><td>Total Score (T Score) ≥60</td></tr>
<tr><td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>Total Score ≥31</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.
</td></tr>
<tr><td>Initial Population</td><td>Deliveries during September 8 of the year prior to the Measurement Period through September 7 of the Measurement Period where the member also meets the criteria for Participation.</td></tr>
<tr><td>Exclusions</td><td>Deliveries in which members were in hospice or using hospice services any time during the Measurement Period.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The Initial Population, minus Exclusions.

Denominator 2
All deliveries from Numerator 1 with a positive finding for depression during the 7–84 days following the date of delivery.</td></tr>
<tr><td>Numerator</td><td>Numerator 1—Depression Screening
Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7–84 days following the date of delivery.

Numerator 2—Follow-Up on Positive Screen
Deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).

Any of the following on or up to 30 days after the first positive screen:
An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.</td></tr>
</table>

	• A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. • A behavioral health encounter, including assessment, therapy, collaborative care or medication management. • A dispensed antidepressant medication. ***OR*** • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. ***Note:*** *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*

Data criteria (element level)

Value Sets:

- **NCQA_Hospice-1.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **PDSE_HEDIS_MY2022-1.0.0**
  - Antidepressant Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1503)
  - Behavioral Health Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1383)
  - Deliveries (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1072)
  - Depression Case Management Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1389)
  - Depression or Other Behavioral Health Condition (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1501)
  - Follow Up Visit (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1385)

Direct Reference Codes and Codesystems:

- **NCQA_Terminology-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

- **PDSE_HEDIS_MY2022-1.0.0**
  - codesystem "ICD-10": 'http://hl7.org/fhir/sid/icd-10-cm'
  - codesystem "LOINC": 'http://loinc.org'
  - codesystem "SNOMEDCT": 'http://snomed.info/sct'
  - code "Beck Depression Inventory Fast Screen total score [BDI]": '89208-3' from "LOINC" display 'Beck Depression Inventory Fast Screen total score [BDI]'
  - code "Beck Depression Inventory II total score [BDI]": '89209-1' from "LOINC" display 'Beck Depression Inventory II total score [BDI]'
  - code "Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]": '89205- 9' from "LOINC" display 'Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]'
  - code "Edinburgh Postnatal Depression Scale [EPDS]": '71354-5' from "LOINC" display 'Edinburgh Postnatal Depression Scale [EPDS]'
  - code "Exercise counseling": 'Z71.82' from "ICD-10" display 'Exercise counseling'
  - code "Final score [DUKE-AD]": '90853-3' from "LOINC" display 'Final score [DUKE-AD]'
  - code "Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]": '55758-7' from "LOINC" display 'Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]'
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
  - code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
  - code "PROMIS-29 Depression score T-score": '71965-8' from "LOINC" display 'PROMIS-29 Depression score T-score'
  - code "Symptoms of depression (finding)": '394924000' from "SNOMEDCT" display 'Symptoms of depression (finding)'
  - code "Total score [CUDOS]": '90221-3' from "LOINC" display 'Total score [CUDOS]'
  - code "Total score [M3]": '71777-7' from "LOINC" display 'Total score [M3]'

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table PDS-E-1/2: Data Elements for Postpartum Depression Screening and Follow-Up

Metric	Data Element	Reporting Instructions
Screening	InitialPopulationByEHR	Repeat per Metric
FollowUp	InitialPopulationByCaseManagement	Repeat per Metric
	InitialPopulationByHIERegistry	Repeat per Metric
	InitialPopulationByAdmin	Repeat per Metric
	InitialPopulation	(Sum over SSoRs)
	ExclusionsByEHR	Repeat per Metric
	ExclusionsByCaseManagement	Repeat per Metric
	ExclusionsByHIERegistry	Repeat per Metric
	ExclusionsByAdmin	Repeat per Metric
	Exclusions	(Sum over SSoRs)
	Denominator	For each Metric
	NumeratorByEHR	For each Metric
	NumeratorByCaseManagement	For each Metric
	NumeratorByHIERegistry	For each Metric
	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Postpartum Depression Screening and Follow-Up

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	NA	There is no age criteria for this measure.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events or diagnoses that contain (or map to) codes in the VSDs may be used to identify visits with a diagnosis. The VSDs and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusion: Hospice	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Depression Screening • Follow-Up on Positive Screen	No	Value sets, Direct Reference Codes and logic may not be changed.

*Prenatal Depression Screening and Follow-Up (PND-E)**

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SUMMARY OF CHANGES TO HEDIS MY 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the *Technical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

Description	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. • *Depression Screening.* The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. • *Follow-Up on Positive Screen.* The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women. (B recommendation) The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at least once during pregnancy or the postpartum period for depression and anxiety symptoms using a standardized, validated tool. The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)
Citations	American College of Obstetricians and Gynecologists. 2018. "Screening for Perinatal Depression. ACOG Committee Opinion No. 757." *Obstetrics & Gynecology* 132(5):e208–12. U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 164:360–6. U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7.

<table>
<tr><th colspan="2">Characteristics</th></tr>
<tr><td>Scoring</td><td>Proportion.</td></tr>
<tr><td>Type</td><td>Process.</td></tr>
<tr><td>Stratification</td><td>1. Commercial.
2. Medicaid.</td></tr>
<tr><td>Risk adjustment</td><td>None.</td></tr>
<tr><td>Improvement notation</td><td>A higher rate indicates better performance.</td></tr>
<tr><th colspan="2">Definitions</th></tr>
<tr><td>Participation</td><td>The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.</td></tr>
<tr><td>Participation Period</td><td>28 days prior to the delivery date through the delivery date.</td></tr>
<tr><td>Pregnancy Episode</td><td>A pregnancy episode in which the delivery date occurs during the Measurement Period.</td></tr>
<tr><td>Depression Screening Instrument</td><td>A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Instruments for Adolescents (≤17 years)</th><th>Positive Finding</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire Modified for Teens (PHQ-9M)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>Total Score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]</td><td>Total Score ≥8</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</td><td>Total Score ≥17</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>Total Score ≥10</td></tr>
<tr><td>PROMIS Depression</td><td>Total Score (T Score) ≥60</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.</td></tr>
</table>

	Instruments for Adults (18+ years) / **Positive Finding** Patient Health Questionnaire (PHQ-9)® — Total Score ≥10 Patient Health Questionnaire-2 (PHQ-2)®[1] — Total Score ≥3 Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2] — Total Score ≥8 Beck Depression Inventory (BDI-II) — Total Score ≥20 Center for Epidemiologic Studies Depression Scale-Revised (CESD-R) — Total Score ≥17 Duke Anxiety-Depression Scale (DUKE-AD)®[2] — Total Score ≥30 Edinburgh Postnatal Depression Scale (EPDS) — Total Score ≥10 My Mood Monitor (M-3)® — Total Score ≥5 PROMIS Depression — Total Score (T Score) ≥60 Clinically Useful Depression Outcome Scale (CUDOS) — Total Score ≥31 [1]Brief screening instrument. All other instruments are full-length. [2]Proprietary; may be cost or licensing requirement associated with use.
Initial Population	Deliveries during the Measurement Period where the member also meets the criteria for Participation.
Exclusions	• Deliveries that occurred at less than 37 weeks gestation. • Deliveries in which members were in hospice or using hospice services any time during the Measurement Period.
Denominator	**Denominator 1** The Initial Population, minus Exclusions. **Denominator 2** All deliveries from Numerator 1 with a positive finding for depression during pregnancy.
Numerator	**Numerator 1—Depression Screening** Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized screening instrument, performed during pregnancy. • *Deliveries between January 1 and December 1 of the Measurement Period:* Screening should be performed between the pregnancy start date and the delivery date (including on the delivery date). • *Deliveries between December 2 and December 31 of the Measurement Period:* Screening should be performed between the pregnancy start date and December 1 of the Measurement Period.

Numerator 2—Follow-Up on Positive Screen
Deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).

Any of the following on or up to 30 days after the first positive screen:

- An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
- A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
- A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
- A dispensed antidepressant medication.

OR

- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Note: *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*

Data criteria (element level)

Value Sets:

- **NCQA_Hospice-1.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **PNDE_HEDIS_MY2022-1.0.0**
  - 37 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1509)
  - 38 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1510)
  - 39 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1511)
  - 40 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1512)
  - 41 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1513)
  - 42 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1514)
  - 43 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1515)
  - Antidepressant Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1503)
  - Behavioral Health Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1383)
  - Deliveries (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1072)
  - Depression Case Management Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1389)
  - Depression or Other Behavioral Health Condition (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1501)

- Follow Up Visit (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1385)
- Weeks of Gestation Less Than 37 (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1479)

Direct Reference Codes and Codesystems:

- **NCQA_Terminology-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"
- **PNDE_HEDIS_MY2022-1.0.0**
  - codesystem "ICD-10": 'http://hl7.org/fhir/sid/icd-10-cm'
  - codesystem "LOINC": 'http://loinc.org'
  - codesystem "SNOMEDCT": 'http://snomed.info/sct/731000124108'
  - code "Beck Depression Inventory Fast Screen total score [BDI]": '89208-3' from "LOINC" display 'Beck Depression Inventory Fast Screen total score [BDI]'
  - code "Beck Depression Inventory II total score [BDI]": '89209-1' from "LOINC" display 'Beck Depression Inventory II total score [BDI]'
  - code "Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]": '89205- 9' from "LOINC" display 'Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]'
  - code "Edinburgh Postnatal Depression Scale [EPDS]": '71354-5' from "LOINC" display 'Edinburgh Postnatal Depression Scale [EPDS]'
  - code "Exercise counseling": 'Z71.82' from "ICD-10" display 'Exercise counseling'
  - code "Final score [DUKE-AD]": '90853-3' from "LOINC" display 'Final score [DUKE-AD]'
  - code "Length of gestation at birth (observable entity)": '412726003' from "SNOMEDCT" display 'Length of gestation at birth (observable entity)'
  - code "Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]": '55758-7' from "LOINC" display 'Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]'
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
  - code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
  - code "PROMIS-29 Depression score T-score": '71965-8' from "LOINC" display 'PROMIS-29 Depression score T-score'
  - code "Symptoms of depression (finding)": '394924000' from "SNOMEDCT" display 'Symptoms of depression (finding)'
  - code "Total score [CUDOS]": '90221-3' from "LOINC" display 'Total score [CUDOS]'
  - code "Total score [M3]": '71777-7' from "LOINC" display 'Total score [M3]'

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table PND-E-1/2: Data Elements for Prenatal Depression Screening and Follow-Up

Metric	Data Element	Reporting Instructions
Screening	InitialPopulationByEHR	Repeat per Metric
FollowUp	InitialPopulationByCaseManagement	Repeat per Metric
	InitialPopulationByHIERegistry	Repeat per Metric
	InitialPopulationByAdmin	Repeat per Metric
	InitialPopulation	(Sum over SSoRs)
	ExclusionsByEHR	Repeat per Metric
	ExclusionsByCaseManagement	Repeat per Metric
	ExclusionsByHIERegistry	Repeat per Metric
	ExclusionsByAdmin	Repeat per Metric
	Exclusions	(Sum over SSoRs)
	Denominator	For each Metric
	NumeratorByEHR	For each Metric
	NumeratorByCaseManagement	For each Metric
	NumeratorByHIERegistry	For each Metric
	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Prenatal Depression Screening and Follow-Up

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	NA	There is no age criteria for this measure.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Value sets, Direct Reference Codes and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	Yes, with limits	Apply exclusions according to specified value sets. Organizations may choose to not exclude deliveries that occurred at less than 37 weeks gestation.
Exclusion: Hospice	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Depression Screening • Follow-Up on Positive Screen	No	Value sets, Direct Reference Codes and logic may not be changed.

Prenatal Immunization Status (PRS-E)*

***Developed with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO).**

SUMMARY OF CHANGES FOR HEDIS MY 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the *Technical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

Description	The percentage of deliveries in the Measurement Period in which women had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.
Measurement period	January 1–December 31.
Clinical recommendation statement	Advisory Committee on Immunization Practices (ACIP) clinical guidelines recommend that all women who are pregnant or who might be pregnant in the upcoming influenza season receive inactivated influenza vaccines. ACIP also recommends that pregnant women receive one dose of Tdap during each pregnancy, preferably during the early part of gestational weeks 27–36, regardless of prior history of receiving Tdap.
Citations	Freedman, M.S., P. Hunter, K. Ault, A. Kroger. 2020. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older—United States, 2020." *MMWR Morb Mortal Wkly Rep* 69:133–5. DOI: http://dx.doi.org/10.15585/mmwr.mm6905a4
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	1. Commercial. 2. Medicaid.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.

Participation Period	28 days prior to the delivery date through the delivery date.
Pregnancy Episode	A pregnancy episode in which the delivery date occurs during the Measurement Period.
Initial Population	Deliveries during the Measurement Period where the member also meets the criteria for Participation.
Exclusions	• Deliveries that occurred at less than 37 weeks gestation. • Deliveries in which members were in hospice or using hospice services any time during the Measurement Period.
Denominator	The Initial Population, minus Exclusions.
Numerator	**Numerator 1—Immunization Status: Influenza** Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the Measurement Period and the delivery date. **Numerator 2—Immunization Status: Tdap** • Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), ***or*** • Deliveries where members had any of the following: – Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date. – Encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date. **Numerator 3—Immunization Status: Combination** Deliveries that met criteria for both Numerator 1 ***and*** Numerator 2.

Data criteria (element level)

Value Sets:

- **NCQA_Hospice-1.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **PRSE_HEDIS_MY2022-1.0.0**
  - 37 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1509)
  - 38 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1510)
  - 39 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1511)
  - 40 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1512)
  - 41 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1513)
  - 42 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1514)
  - 43 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1515)
  - Adult Influenza Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1913)

- Adult Influenza Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1914)
- Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2240)
- Deliveries (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1072)
- Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2241)
- Tdap Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1791)
- Tdap Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1792)
- Weeks of Gestation Less Than 37 (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1479)

Direct Reference Codes and Codesystems:

- **NCQA_Terminology-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode’
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"
- **PRSE_HEDIS_MY2022-1.0.0**
  - codesystem "SNOMEDCT": 'http://snomed.info/sct'
  - code "Length of gestation at birth (observable entity)": '412726003' from "SNOMEDCT" display 'Length of gestation at birth (observable entity)'

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements.

Table PRS-E: 1/2 Data Elements for Prenatal Immunization Status

Metric	Data Element	Reporting Instructions
Influenza	InitialPopulationByEHR	Repeat per Metric
Tdap	InitialPopulationByCaseManagement	Repeat per Metric
Combination	InitialPopulationByHIERegistry	Repeat per Metric
	InitialPopulationByAdmin	Repeat per Metric
	InitialPopulation	(Sum over SSoRs)
	ExclusionsByEHR	Repeat per Metric
	ExclusionsByCaseManagement	Repeat per Metric
	ExclusionsByHIERegistry	Repeat per Metric
	ExclusionsByAdmin	Repeat per Metric
	Exclusions	(Sum over SSoRs)
	Denominator	Repeat per Metric
	NumeratorByEHR	For each Metric
	NumeratorByCaseManagement	For each Metric
	NumeratorByHIERegistry	For each Metric
	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Prenatal Immunization Status

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	NA	There is no age criteria for this measure.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events or diagnoses that contain (or map to) codes in the VSDs may be used to identify visits with a diagnosis. The VSDs and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	Yes, with limits	Apply exclusions according to specified value sets. Organizations may choose to not exclude deliveries that occurred at less than 37 weeks gestation.
Exclusion: Hospice	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Influenza • Tdap • Combination	No	Value sets, Direct Reference Codes and logic may not be changed.

Screening for Social Drivers of Health Measure and the Screen Positive to Social Drivers of Health Measure

In the FY 2023 IPPS/LTCH PPS proposed rule, CMS proposed that hospitals participating in the Hospital Inpatient Quality Reporting (IQR) Program be required to report on two new measures, the Screening for Social Drivers of Health Measure and the Screen Positive Rate for Social Drivers of Health.

Performance Measure Name: Screening for Social Drivers of Health

Description: If finalized, this measure would assess whether a hospital implements screening for all patients that are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. To report on this measure, hospitals would provide: (1) The number of inpatients admitted to hospital who are 18 years or older at time of admission and who are screened for each of the five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; and (2) the total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted.

Measure Numerator: The numerator consists of the number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for one or all of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay.

Measure Denominator: The denominator consists of the number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

Exclusions: The following patients would be excluded from the denominator: (1) Patients who opt-out of screening; and (2) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay.

Clarifying Information: The Screening for Social Drivers of Health measure would be calculated as the number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission screened for one or all five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) divided by the total number of patients 18 years or older on the date of admission admitted to the hospital. Hospitals would report using their CCN through the Hospital Quality Reporting (HQR) System.

Performance Measure Name: Screen Positive Rate for Social Drivers of Health

Description: If finalized, the Screen Positive Rate for Social Drivers of Health would provide information on the percent of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, were screened for an HSRN, and who screen positive for one or more of the following five HRSNs: Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

Measure Numerator: The numerator consists of the number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for an HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety.

Measure Denominator: The denominator consists of the number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for an HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

Exclusions: The following patients would be excluded from the denominator: 1) Patients who opt-out of screening; and 2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay.

Clarifying Information: The result of this measure would be calculated as five separate rates. Each rate is derived from the number of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.

Additional Resources:

For more information about the CMMI Accountable Health Communities Model screening tool and case studies about implementing SDOH screening: https://innovation.cms.gov/innovation-models/ahcm

For a listing of various screening tools, including those that include the five SDOH domains specified in the measure:

https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison

Find an eCQM

Severe Obstetric Complications

Receive updates on this topic (/user/login)

Measure Information(/quicktabs/nojs/tabs_pre_rule_measure/0)

Specifications and Data Elements(/quicktabs/nojs/tabs_pre_rule_measure/1)

Measure Information

CMS Measure ID	CMS1028v1
Short Name	ePC-07
NQF #	Not Applicable
Measure Description	Patients with severe obstetric complications which occur during the inpatient delivery hospitalization.
Initial Population	Inpatient hospitalizations for patients age >= 8 years and < 65 admitted to the hospital for inpatient acute care who undergo a delivery procedure with a discharge date that ends during the measurement period
Denominator Statement	Inpatient hospitalizations for patients delivering stillborn or live birth with >= 20 weeks, 0 days gestation completed

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Measure Information	
Denominator Exclusions	Inpatient hospitalizations for patients with confirmed diagnosis of COVID with COVID-related respiratory condition or patients with confirmed diagnosis of COVID with COVID-related respiratory procedure
Numerator Statement	Inpatient hospitalizations for patients with severe obstetric complications (not present on admission that occur during the current delivery encounter) including the following: - Severe maternal morbidity diagnoses (see list below) - Severe maternal morbidity procedures (see list below) - Discharge disposition of expired Severe Maternal Morbidity Diagnoses: - Cardiac Acute heart failure Acute myocardial infarction Aortic aneurysm Cardiac arrest/ventricular fibrillation Heart failure/arrest during procedure or surgery - Hemorrhage Disseminated intravascular coagulation Shock - Renal Acute renal failure - Respiratory Adult respiratory distress syndrome Pulmonary edema - Sepsis - Other OB Air and thrombotic embolism Amniotic fluid embolism Eclampsia Severe anesthesia complications - Other Medical

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Measure Information	
	Puerperal cerebrovascular disorder Sickle cell disease with crisis Severe Maternal Morbidity Procedures: - Blood transfusion - Conversion of cardiac rhythm - Hysterectomy - Temporary tracheostomy - Ventilation
Numerator Exclusions	Not applicable
Denominator Exceptions	None
Measure Steward	The Joint Commission (/measure-stewards/joint-commission)
Measure Scoring	Proportion measure (/mcw/list/ecqm-measure-score/proportion-measure)
Measure Type	Outcome measure (/mcw/list/ecqm-score-type/outcome-measure)
Improvement Notation	Improvement noted as a decrease in the rate.
Guidance	In the case of multiple births, map the first delivery date/time (Baby A) as the delivery date/time for the encounter. This measure allows for 2 approaches to determine estimated gestational age (EGA) in the following order of precedence: 1. The EGA is calculated using the American College of Obstetricians and Gynecologists ReVITALize guidelines.* 2. The EGA is obtained from a discrete field in the electronic health record. This option is only used when the calculated EGA is not available.

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Measure Information	
	Wherever gestational age is mentioned, relative to the delivery, the intent is to capture the last estimated gestational age prior to or at the time of delivery. *ACOG ReVITALize Guidelines for Calculating Gestational Age: Gestational Age = (280-(EDD minus Reference Date))/7 --Estimated Due Date (EDD): The best obstetrical Estimated Due Date is determined by last menstrual period if confirmed by early ultrasound or no ultrasound performed, or early ultrasound if no known last menstrual period or the ultrasound is not consistent with last menstrual period, or known date of fertilization (eg, assisted reproductive technology) --Reference Date is the date on which you are trying to determine gestational age. For purposes of this eCQM, Reference Date would be the Date of Delivery. Note however the calculation may yield a non-whole number and gestational age should be rounded off to the nearest completed week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks. This eCQM is an episode-based measure. An episode is defined as each inpatient hospitalization or encounter that ends during the measurement period. This version of the eCQM uses QDM version 5.6. Please refer to the QDM page (/qdm) for more information on the QDM.
Meaningful Measure	Safety (/mcw/list/meaningful-measure/safety)

Last Updated: May 04, 2022

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Meaningful Measures (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy)

Measures Management System (https://mmshub.cms.gov/)

Quality Payment Program (https://qpp.cms.gov/)

QualityNet (http://qualitynet.cms.gov)

Accessibility (http://www.hhs.gov/accessibility.html)

Privacy Policy (http://www.hhs.gov/privacy.html)

HHS Vulnerability Disclosure (https://www.hhs.gov/vulnerability-disclosure-policy/index.html)

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Proposed New Measure for HEDIS®[1] Measurement Year (MY) 2023: Social Need Screening and Intervention (SNS-E)

NCQA seeks comments on a proposed new measure for inclusion in HEDIS MY 2023.

Social Need Screening and Intervention: The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported:

- *Food screening*: The percentage of members who were screened for unmet food needs.
- *Food intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet food needs.
- *Housing screening*: The percentage of members who were screened for unmet housing needs.
- *Housing intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet housing needs.
- *Transportation screening*: The percentage of members who were screened for unmet transportation needs.
- *Transportation intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet transportation needs.

The measure excludes individuals who are enrolled in hospice or in Institutional Special Needs Plans (I-SNP), or who reside in long-term care institutions (LTI). It is stratified by age (≤17, 18–64, 65+). Screening instruments and intervention codes included in the measure have been identified as appropriate for each domain by The Gravity Project consensus process, a multi-stakeholder, public collective initiative aimed at developing standardized terminology for documentation and exchange of data on social determinants of health (SDOH).

NCQA developed this measure as part of an organization wide effort to advance health equity and hold health plans accountable for assessing and addressing the food, housing and transportation needs of their patient populations. These social needs have been identified as high priority and actionable by a multitude of health system entities, including health plans, providers and other key stakeholders, yet most health care quality measures continue to focus on *clinical* processes and outcomes—there are currently no national health plan measures that assess and address a patient's social needs. NCQA sees this as a critical quality measurement gap to fill.

Disparities in morbidity and mortality across social needs have been well documented over the last few decades, as leading health organizations increasingly elevate health equity as a priority.[2,3] Organizations such as the Centers for Disease Control and Prevention and the World Health Organization, and policy initiatives like Healthy People 2030, have indicated the need to pursue health equity in the face of widening disparities between subgroups in the United States.[4,5] Additionally, there is wide acknowledgment that social factors such as access to food, housing, transportation and social supports contribute significantly to health

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] Baciu, A., Y. Negussie, A. Geller, J.N. Weinstein. 2017. *The State of Health Disparities in the United States.* National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK425844/
[3] Penman-Aguilar, A., M. Talih, D. Huang, R. Moonesinghe, K. Bouye, & G. Beckles. 2016. "Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity." *Journal of Public Health Management and Practice*, *22*, S33. https://doi.org/10.1097/PHH.0000000000000373
[4] CDC. 2019. *Attaining Health Equity—Healthy Communities Program*. https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm
[5] Pendo, E., L.I. Iezzoni. 2020. *The Role of Law and Policy in Achieving Healthy People's Disability and Health Goals around Access to Health Care, Activities Promoting Health and Wellness, Independent Living and Participation, and Collecting Data in the United States.* Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://www.healthypeople.gov/sites/default/files/LHP_Disability-Health-Policy_2020.03.12_508_0.pdf

outcomes. In fact, 30%–55% of health outcomes are attributed to SDOH.[6] The proposed measure would encourage health plans to identify specific needs and connect members with the resources necessary to overcome social barriers to their wellness.

Testing confirmed a large performance gap in terms of documenting results of screening for social needs. In Medicare, screening performance rates were highest for food (12.6%), followed by transportation (3.5%) and then housing (3.3%). Intervention performance rates were high compared to screening, with highest rates for food (75.1%) followed by transportation (68.5%) and housing (24.3%). Denominator sizes were small (<30) for some intervention indicators, particularly housing and transportation, suggesting that some plans may struggle to meet the minimum denominator size for reporting the intervention indicators.

NCQA seeks general feedback on the measure and specific feedback on the following:

1. *Phasing in the intervention indicators*. Should NCQA implement the measure with the intervention indicators or introduce the intervention component at a later time, given the current small denominators (which may be a barrier to reporting for some plans)?
2. *Follow-up time frame.* If the intervention indicators are retained in the measure, should NCQA shorten the follow-up time frame from 30 days (e.g., 1 week,2 weeks)?
3. *Exclusion of members in I-SNPs and LTIs*. Should NCQA exclude members who receive these services?
4. *Screening instruments specified*. Current measure specifications require a limited set of standardized, social needs screening instruments: the Accountable Health Communities Health-Related Social Needs screening tool, the PRAPARE, We Care, WellRx and the Hunger Vital Sign. Is this list appropriate? Should NCQA include additional tools in the measure?

NCQA expert panel members strongly support the proposed measure and believe it is an important step toward holding health plans accountable for addressing the social needs of their members.

Supporting documents include the draft measure specification and evidence workup.

NCQA acknowledges the contributions of the Health Equity Expert and Care Coordination Work Groups, and the Geriatric and Technical Measurement Advisory Panels.

[6] World Health Organization (WHO). (n.d.). *Social Determinants of Health*. https://www.who.int/westernpacific/health-topics/social-determinants-of-health

Measure title	Social Need Screening and Intervention	**Measure ID**	SNS-E
Description	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported: • *Food screening*: The percentage of members who were screened for unmet food needs. • *Food intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet food needs. • *Housing screening*: The percentage of members who were screened for unmet housing needs. • *Housing intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet housing needs. • *Transportation screening*: The percentage of members who were screened for unmet transportation needs. • *Transportation intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet transportation needs.		
Measurement period	January 1–December 31.		
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	Unadjusted Uncertified Measures: A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on unadjusted HEDIS specifications, may not be called a "Health Plan HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as **"Uncertified, Unaudited Health Plan HEDIS Rates."** Adjusted Uncertified Measures: A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called an "Adjusted HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as **"Adjusted, Uncertified, Unaudited HEDIS Rates."** 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. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications. The American Medical Association holds a copyright to the CPT® codes contained in the measure specifications. The American Hospital Association holds a copyright to the Uniform Billing Codes ("UB") contained in the measure specifications. The UB Codes in the HEDIS specifications are included with the permission of the AHA. All uses of the UB Codes may require a license from the AHA. Anyone desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@aha.org. Some measure specifications contain coding from LOINC® (http://loinc.org). The LOINC table, LOINC codes, LOINC panels and form file, LOINC linguistic variants file, LOINC/RSNA Radiology Playbook, and LOINC/IEEE Medical Device Code Mapping Table are copyright © 1995–2021 Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee and are available at no cost under the license at http://loinc.org/terms-of-use. "SNOMED" and "SNOMED CT" are registered trademarks of the International Health Terminology Standards Development Organisation (IHTSDO). "HL7" is the registered trademark of Health Level Seven International. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording or any information storage and retrieval system, without the written permission of NCQA. © 2022 by the National Committee for Quality Assurance 1100 13th Street, NW, Third Floor Washington, DC 20005 All rights reserved. NCQA Customer Support: 888-275-7585 NCQA Fax: 202-955-3599 NCQA Website: www.ncqa.org Submit policy clarification support questions via My NCQA (http://my.ncqa.org).
Clinical recommendation statement	**American Academy of Family Physicians:** The AAFP urges health insurers and payors to provide appropriate payment to support health care practices to identify, monitor, assess and address SDoH. **American Academy of Pediatrics:** The AAP recommends surveillance for risk factors related to social determinants of health during all patient encounters.

	American Diabetes Association: Assess food insecurity, housing insecurity/homelessness, financial barriers, and social capital/social community support and apply that information to treatment decisions. **A** Refer patients to local community resources when available. **B**
Citations	American Academy of Pediatrics. (2015). *Promoting Food Security for All Children.* https://pediatrics.aappublications.org/content/136/5/e1431. American Academy of Pediatrics. (2016). *Poverty and Child Health in the United States.* https://pediatrics.aappublications.org/content/137/4/e20160339#sec-12 American Academy of Pediatrics. (2013). *Policy Statement. Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity.* https://pediatrics.aappublications.org/content/131/6/1206 American Diabetes Association (2021). *Improving Care and Promoting Health in Populations: Standards of Medical Care in Diabetes—2021*. Diabetes Care, 44(Supplement 1), S7–S14. https://doi.org/10.2337/dc21-S001
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Product line: – Commercial. – Medicaid. – Medicare. • Age: – ≤17 years. – 18–64 years. – 65 and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in *General Guideline 17* for identification of hospice members using the monthly

<table>
<tr><td></td><td>membership detail data files are not included in the measure calculation logic and need to be programmed manually.

Reporting:
The total is the sum of the age stratifications.

Product line stratifications are not included in the measure calculation logic and need to be programmed manually.</td></tr>
<tr><td colspan="2">Definitions</td></tr>
<tr><td>Participation</td><td>The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.</td></tr>
<tr><td>Participation period</td><td>The measurement period.</td></tr>
<tr><td>Food screening instrument</td><td>Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Instruments</th><th>Screening Item</th><th>Positive Finding</th></tr>
<tr><td rowspan="2">Accountable Health-Communities Health Related Social Needs Screening Tool (AHC HRSN)</td><td>Within the past 12 months, you worried that your food would run out before you got money to buy more.</td><td>Often true
Sometimes true</td></tr>
<tr><td>Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.</td><td>Often true
Sometimes true</td></tr>
<tr><td>Comprehensive Universal Behavior Screen (CUBS)</td><td>Tell us about your household and how you purchase food</td><td>I can meet basic food needs, but require occasional assistance
My household is on food stamps
I have no food or means to prepare it. I rely to a significant degree on other sources of free or low-cost food</td></tr>
<tr><td>Hunger Vital Sign (HVS)</td><td>Food insecurity risk</td><td>At risk</td></tr>
<tr><td>Protocol for Responding to and Assessing Patients Assets, Risks and Experiences (PRAPARE)</td><td>Have you or any family members you live with been unable to get any of the following when it was</td><td>Food</td></tr>
</table></td></tr>
</table>

		really needed in past 1 year?	
	U.S. Food Security Survey (Household, Adult, Child, 6-item)	Food security status	Low food security Very low food security
	We Care	Do you always have enough food for your family?	No
	WellRX	In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?	Yes

Housing screening instrument

Eligible screening instruments with thresholds for positive findings include:

Instruments	Screening Item	Positive Finding(s)
Accountable Health-Communities Health Relates Social Needs Screening Tool (AHC HRSN)	What is your living situation today?	I have a place to live today, but I am worried about losing it in the future I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
	Think about the place you live. Do you have problems with any of the following?	Pests, such as bugs, ants, or mice Oven or stove not working Mold Smoke detectors missing or not working Lead paint or pipes Water leaks Lack of heat
Comprehensive Universal Behavior Screen (CUBS)	Tell us about your housing	I'm in stable housing that is safe but only marginally adequate I'm in transitional, temporary or substandard housing; and/or current

			rent/mortgage is unaffordable (over 30% of income) I'm homeless or threatened with eviction
	Protocol for Responding to and Assessing Patients Assets, Risks and Experiences (PRAPARE)	What is your housing situation today?	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park
		Are you worried about losing your housing?	Yes
	We Care	Do you think you are at risk of becoming homeless?	Yes
	WellRx	Are you homeless? Or worried that you might be in the future?	Yes
Transportation screening instrument	Eligible transportation screening instruments with thresholds for positive findings include:		

Instruments	Screening Item	Positive Finding(s)
Accountable Health-Communities Health Relates Social Needs Survey (AHC HRSN)	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	Yes
Comprehensive Universal Behavior Screen (CUBS)	Access to transportation/mobility status	My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured My transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.

<table>
<tr><td></td><td>
<table>
<tr><td></td><td></td><td>I have no access to transportation, public or private; may have car that is inoperable</td></tr>
<tr><td>Protocol for Responding to and Assessing Patients Assets, Risks and Experiences (PRAPARE)</td><td>Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living</td><td>Yes, it has kept me from medical appointments or from getting my medications
Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need</td></tr>
<tr><td>PROMIS</td><td>Current level of confidence I can use public transportation</td><td>I am not at all confident
I am a little confident
I am somewhat confident</td></tr>
<tr><td>WellRx</td><td>Do you have trouble finding or paying for transportation?</td><td>Yes</td></tr>
</table>
</td></tr>
<tr><td>Interventions</td><td>An intervention on, or up to 30 days after, the date of the first positive screening.</td></tr>
<tr><td>Initial population</td><td>Members enrolled at the start of the measurement period who also meet criteria for participation.</td></tr>
<tr><td>Exclusions</td><td>Members in hospice or using hospice services during the measurement period.
Members who meet either of the following:
Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The initial population, minus exclusions.
Denominator 2
All members in numerator 1 with a positive food screen finding between January 1 and December 1 of the measurement period.
Denominator 3
Equal to denominator 1.
Denominator 4
All members in numerator 3 with a positive housing screen finding between January 1 and December 1 of the measurement period.</td></tr>
</table>

	Denominator 5 Equal to denominator 1. **Denominator 6** All members in numerator 5 with a positive transportation screen finding between January 1 and December 1 of the measurement period.
Numerator	**Numerator 1** Members in denominator 1 with a documented result for food screening performed between January 1 and December 1 of the Measurement Period. **Numerator 2** Members in denominator 2 receiving a food intervention on or up to 30 days after the date of the first positive food screen (31 days total). **Numerator 3** Members in denominator 3 with a documented result for housing screening performed between January 1 and December 1 of the Measurement Period. **Numerator 4** Members in denominator 4 receiving a housing intervention on or up to 30 days after the date of the first positive housing screen (31 days total). **Numerator 5** Members in denominator 5 with a documented result for transportation screening performed between January 1 and December 1 of the Measurement Period. **Numerator 6** Members in denominator 6 receiving a transportation intervention on or up to 30 days after the date of the first positive transportation screen (31 days total).
Data criteria (element level)	
Value Sets: • **SNIE_HEDIS_MY2023-1.0.0** – Food Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2262) – Housing Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2263) – Transportation Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2264) • **NCQA_Hospice-1.0.0** – Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761) – Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)	

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table SNS-E-: Metadata Elements for Social Need Screening and Intervention

Metric	Age	Data Element	Reporting Instructions
FoodScreening	0-17	InitialPopulation	For each Metric and Stratification
FoodIntervention	18-64	ExclusionsByEHR	For each Metric and Stratification
HousingScreening	65+	ExclusionsByCaseManagement	For each Metric and Stratification
HousingIntervention	Total	ExclusionsByHIERegistry	For each Metric and Stratification
TransportationScreening		ExclusionsByAdmin	For each Metric and Stratification
TransportationIntervention		Exclusions	(Sum over SSoRs)
		Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Topical Fluoride for Children (TFC)

SUMMARY OF CHANGES TO HEDIS MY 2023

- First-year measure.

Description

The percentage of members 1–20 years of age who received at least two topical fluoride applications during the measurement year.

Eligible Population

Product line	Medicaid.
Ages	1–20 years as of December 31 of the measurement year. Report four age stratifications and a total rate. • 1–2 years. • 3–5 years. • 6–14 years. • 15–20 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 31 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Dental or medical.
Event/diagnosis	None.
Required exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator[1] Two or more fluoride applications (Topical Application of Fluoride Value Set) during the measurement year on different dates of service.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table TFC-1: Data Elements for Topical Fluoride for Children

Metric	Age Stratification	Data Element	Reporting Instructions
TopicalFluorideforChildren	1-2	Benefit	Metadata
	3-5	EligiblePopulation	For each Stratification
	6-14	ExclusionAdminRequired	For each Stratification
	15-20	NumeratorByAdmin	For each Stratification
	Total	Rate	(Percent)

[1]The NCQA Value Set Directory includes Current Dental Terminology (CDT) codes, © 2022 American Dental Association. All rights reserved.
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