OHIC Measure Alignment Work Group
2022 Annual Review of the Behavioral Health Hospital Aligned Measure Set
Measure Specifications

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)

c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775436944

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

30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)

CMIT Family ID: 00003 | **CMIT ID:** 02800-C-IPFQR | **Measure Type:** Outcome

Date of Information: Not Available | **Revision:** 4 | **Program:** Inpatient Psychiatric Facility Quality Reporting

View Description

Properties

Date of Information	Not Available
Abbreviated Measure Title	Not Available
Description	This facility-level measure estimates an unplanned, 30-day, risk-standardized readmission rate for adult Medicare fee-for-service (FFS) patients with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The performance period used to identify cases in the denominator is 24 months. Data from 12 months prior to the start of the performance period through the performance period are used to identify risk factors.
Numerator	The risk-adjusted outcome measure does not have a traditional numerator and denominator. Here we describe the outcome being measured. A readmission is defined as any admission, for any reason, to an IPF or a short-stay acute care hospital (including Critical Access Hospitals) that occurs within 3-30 days after the discharge date from an eligible index admission to an IPF, except those considered planned. Subsequent admissions on Days 0, 1, and 2 are not counted as readmissions due to transfers/interrupted stay policy. The measure uses the CMS 30-day HWR Measure Planned Readmission Algorithm, Version 4.0.
Denominator	The risk-adjusted outcome measure does not have a traditional numerator and denominator. Here we describe the target population for measurement. The target population for this measure is adult Medicare FFS beneficiaries discharged from an IPF. The measure is based on all eligible index admissions from the target population. A readmission within 30 days will also be eligible as an index admission if it meets all other eligibility

	criteria. Patients may have more than one index admission within the measurement period. The denominator includes admissions to IPFs for patients: - Admitted to an IPF - Discharged with a principal diagnosis that indicates psychiatric disorder (AHRQ CCS 650-670) - Discharged alive - Age 18 or older at admission - Enrolled in Medicare FFS Parts A and B during the 12 months before the admission date, month of admission, and at least one month after the month of discharge from the index admission
Denominator Exclusions	The denominator excludes admissions for patients: 1. Discharged against medical advice (AMA) 2. With unreliable data (e.g. has a death date but also admissions afterwards) 3. With a subsequent admission on day of discharge or following 2 days (transfers/interrupted stay period).
Rationale	Benefits have been seen in other sectors of care that have a readmission performance measure. The 30-day readmission rate for acute care hospitals held at a constant rate of 19% between 2007 and 2011. After the Hospital Readmissions Reduction Program began in 2012, readmission rates fell to 18.5%, and recent data suggest that these rates continue to decline. This decrease translates to 130,000 fewer hospital readmissions over an eight-month period (Centers for Medicare & Medicaid Services, 2013). Moreover, because readmission is an outcome measure that is influenced by multiple care processes and structures, as well as the entire healthcare team, it promotes a systems approach to improvement and providing care. A readmission measure promotes shared accountability and collaboration with patients, families, and providers in other settings of care.
Evidence	Not Available
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	Yes
Program Status	Not Available

Measure Information Form

Measure Set: Substance Use Measures (SUB)

Set Measure ID: SUB-3

Set Measure ID	Performance Measure Name
SUB-3	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge
SUB-3a	Alcohol & Other Drug Use Disorder Treatment at Discharge

Performance Measure Name: Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge

Description:
SUB-3 Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment.
SUB-3a Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.

The measure is reported as an overall rate which includes all patients to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included.

Rationale: Excessive use of alcohol and drugs has a substantial harmful impact on health and society in the United States. It is a drain on the economy and a source of enormous personal tragedy (The National Quality Forum, A Consensus Report 2007). In 1998 the economic costs to society were $185 billion dollars for alcohol misuse, and 143 billion dollars for drug misuse (Harwood 2000). Health care spending was 19 billion dollars for alcohol problems, and 14 billion dollars was spent treating drug problems.

Nearly a quarter of a trillion dollars per year in lost productivity is attributable to substance use. More than 537,000 die each year as a consequence of alcohol, drug, and tobacco use making use of these substances the cause of one out of four deaths in the United States (Mokdad 2005).

An estimated 22.6 million adolescents and adults meet criteria for a substance use disorder. In a multi-state study that screened 459,599 patients in general hospital and medical settings, 23% of patients screened positive (Madras 2009).

Clinical trials have demonstrated that brief interventions, especially prior to the onset of addiction, significantly improve health and reduce costs, and that similar benefits occur in those with addictive disorders who are re-

ferred to treatment (Fleming 2002).

In a study on the provision of evidence-based care and preventive services provided in hospitals for 30 different medical conditions, quality varied substantially according to diagnosis. Adherence to recommended practices for treatment of substance use ranked last, with only 10% of patients receiving proper care (Gentilello 2005). Currently, less than one in twenty patients with an addiction are referred for treatment (Gentilello 1999).

Hospitalization provides a prime opportunity to address the entire spectrum of substance use problems within the health care system (Gentilello 2005, 1999). Approximately 8% of general hospital inpatients and 40 to 60 percent of traumatically-injured inpatients and psychiatric inpatients have substance use disorders (Gentilello 1999).

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement:
SUB-3: The number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder OR received or refused a referral for addictions treatment.

SUB-3a: The number of patients who received a prescription at discharge for medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment.

> **Included Populations:**
>
> **Sub-3**
> Patients who refused a prescription for FDA-approved medication for treatment of an alcohol or drug dependence. Patients who refused a referral for addictions treatment.
>
> **Sub-3a**
> Not Applicable
>
> **Excluded Populations: SUB-3 and SUB-3a**
> None
>
> **Data Elements:**
>
> - *Prescription for Alcohol or Drug Disorder Medication*
> - *Referral for Addictions Treatment*

Denominator Statement: The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder.

> **Included Populations:**

- Patients with ICD-10-CM Principal or Other Diagnosis Code for alcohol or drug use disorder listed on Table 13.1 and 13.2
- Patients with a Principal or Other ICD-10-PCS Procedure Code listed on Table 13.3

Excluded Populations:

- Patients less than 18 years of age
- Patient drinking at unhealthy levels who do not meet criteria for an alcohol use disorder
- Patients who are cognitively impaired
- Patients who expire
- Patients discharged to another hospital
- Patients who left against medical advice
- Patients discharged to another healthcare facility
- Patients discharged to home or another healthcare facility for hospice care
- Patients who have a duration of stay less than or equal to one day or greater than 120 days
- Patients who do not reside in the United States
- Patients receiving *Comfort Measures Only* documented

Data Elements:

- *Admission Date*
- *Alcohol Use Status*
- *Birthdate*
- *Comfort Measures Only*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10 diagnosis and procedure codes, which require retrospective data entry.Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10 diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: Data accuracy is enhanced when all definitions are used without modification. The data dictionary should be referenced for definitions and abstraction notes when questions arise during data collection.

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

Measure Analysis Suggestions: Hospitals may wish to analyze data to show patients that refused both a medication prescription and referral and those who refused only one or the other.

Sampling: Yes. Yes, please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

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

Selected References:

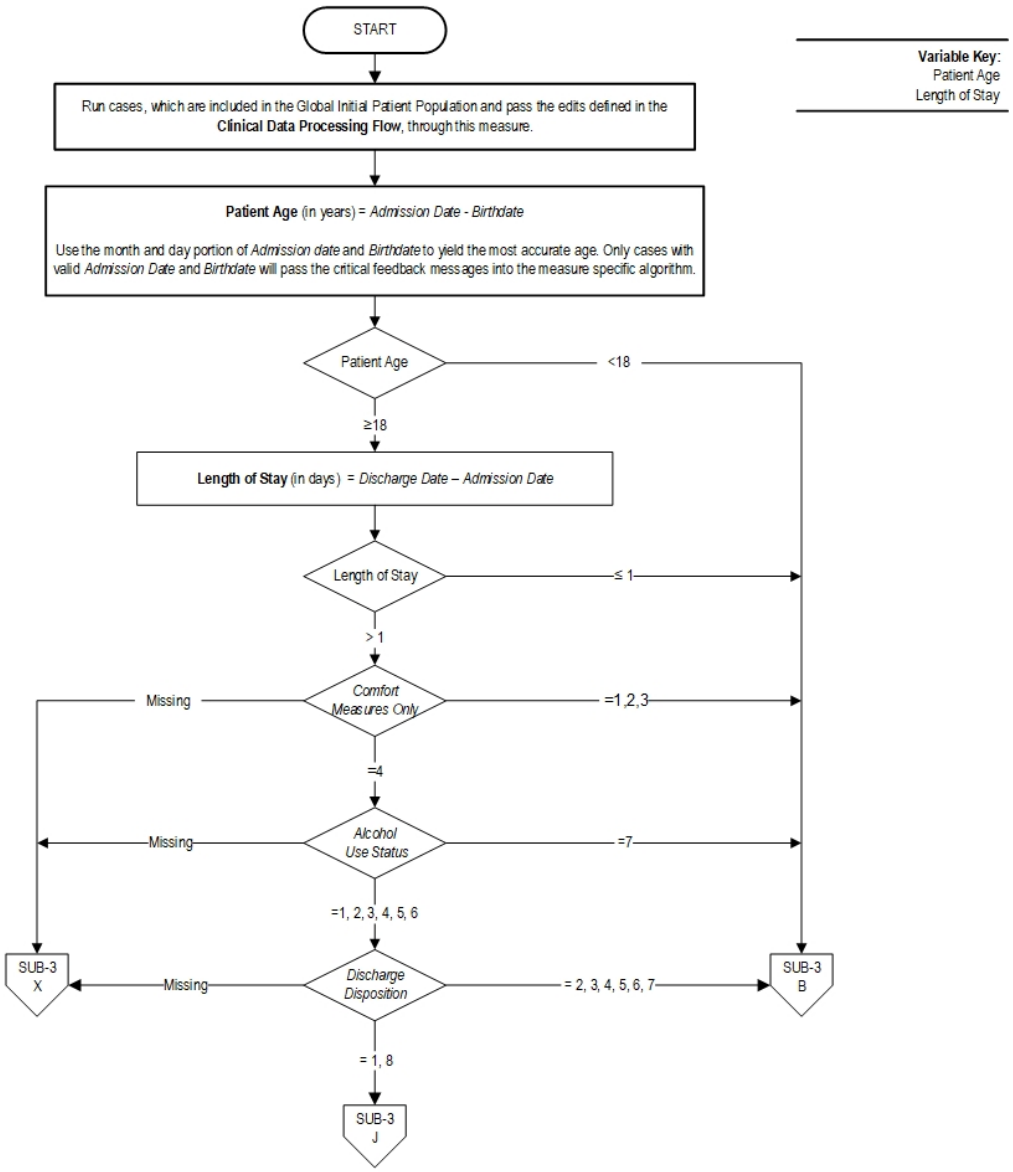
- Bernstein J, Bernstein E, Tassiopoulos K, Heren T, Levenson S, Hingson R. Brief motivational interventions at a clinic visit reduces cocaine and heroin use. Drug Alcohol Depend. 2005 Jan 7;77(1):49-59.
- Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: Long-term efficacy and cost-benefit analysis. Alcohol Clin Exp Res. 2002 Jan;26(1):36-43.
- Gentilello LM, Ebel BE, Wickizer TM, Salkever DS Rivera FP. Alcohol interventions for trauma patients treated in emergency departments and hospitals: A cost benefit analysis. Ann Surg. 2005 Apr;241(4):541-50.
- Gentilello LM, Villaveces A, Ries RR, Nason KS, Daranciang E, Donovan DM Copass M, Jurkovich GJ Rivara FP. Detection of acute alcohol intoxication and chronic alcohol dependence by trauma center staff. J Trauma. 1999 Dec;47(6):1131-5; discussion 1135-9.
- Harwood, HJ, 2000. Updating Estimates of the Economic Costs of Alcohol Abuse in the United States. National Institute on Alcohol Abuse and Alcoholism. Available from: http://pubs.niaaa.nih.gov/publications/economic-2000/, Office of National Drug Control Policy. The Economic Costs of Drug Abuse in the United States: 1992–2002. Washington, DC: Executive Office of the President (Publication No. 207303), 2004.
- Havassy BE, Alvidrez J, Owen KK. Comparisons of patients with comorbid psychiatric and substance use disorders: implications for treatment and service delivery. Am J Psychiatry. 2004 Jan;161(1):139-45.
- Kirchner JE, Owen RR, Nordquist C, Fischer EP. Diagnosis and management of substance use disorders among inpatients with schizophrenia. Psychiatr Serv. 1998 Jan;49(1):82-5.
- Madras BK, Compton WM, Avula D, Stegbauer T, Stein JB, Clark HW. Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. Drug Alcohol Depend. 2009 Jan 1;99(1-3):280-95. Epub 2008 Oct 16.
- Mokdad AH, Marks JS, Stroup DS, Gerberding JL. Actual Causes of Death in the United States, 2000. JAMA. 2004 Mar 10;291(10):1238-45 (Erratum in: JAMA. 2005 Jan 19;293(3):293-4.)
- McGlynn EA, Asch SM, Adams J. The Quality of Healthcare Delivered to Adults in the United States. N Engl J Med. 2003 Jun 26;348(26):2635-45.
- Prochaska JJ, Gill PH, Stephen E, Hall SM. Identification and Treatment of Substance Misuse on an Inpatient Psychiatry Unit. Psychiatr Serv. 2005 Mar;56(3):347-9.
- Smothers BA, Yahr HT, Ruhl CE. Detection of alcohol use disorders in general hospital admissions in the United States. Arch Intern Med. 2004 Apr 12;164(7):749-56.
- The National Quality Forum, National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices; A Consensus Report; 2007.

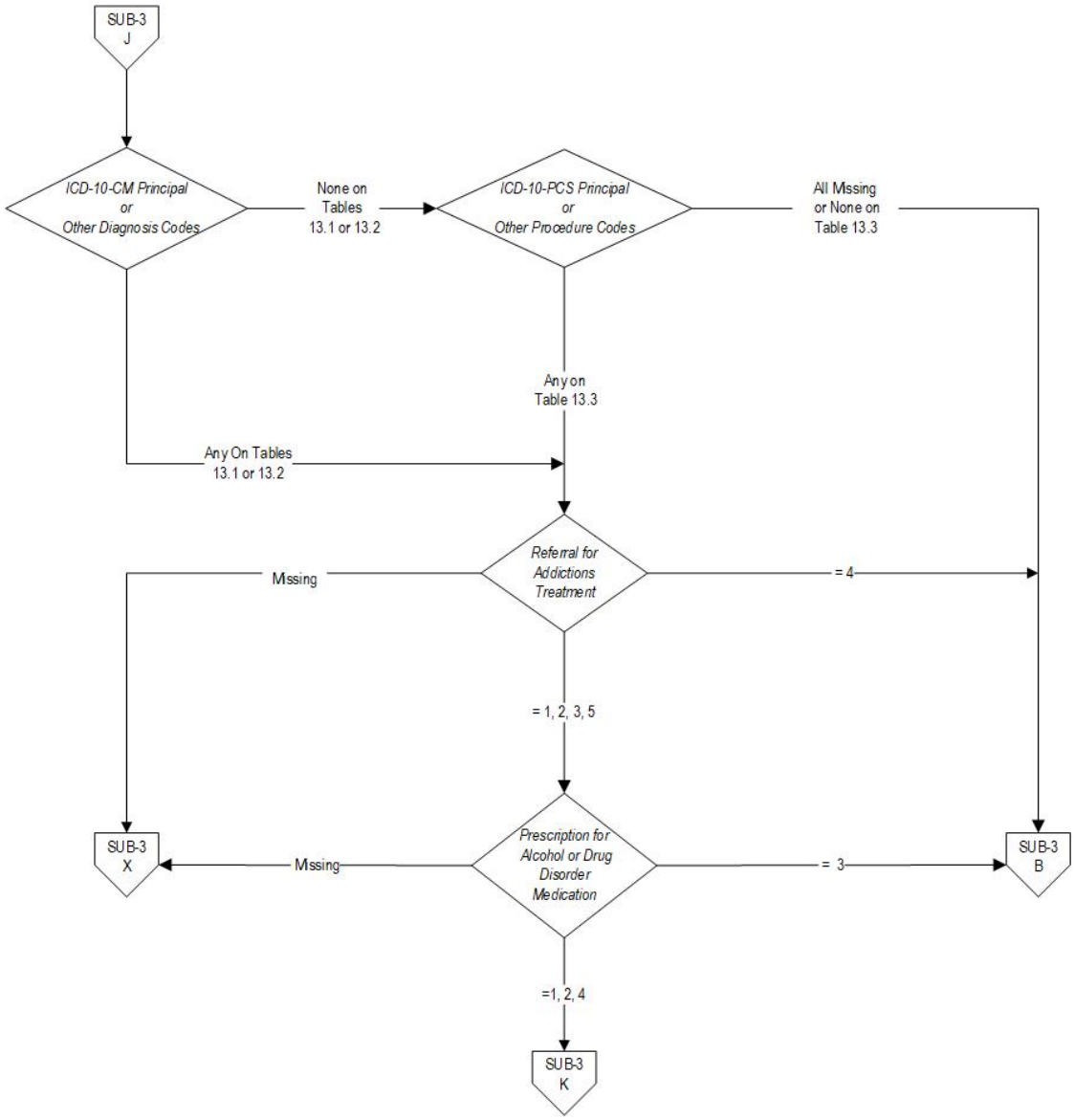
Measure Algorithm:

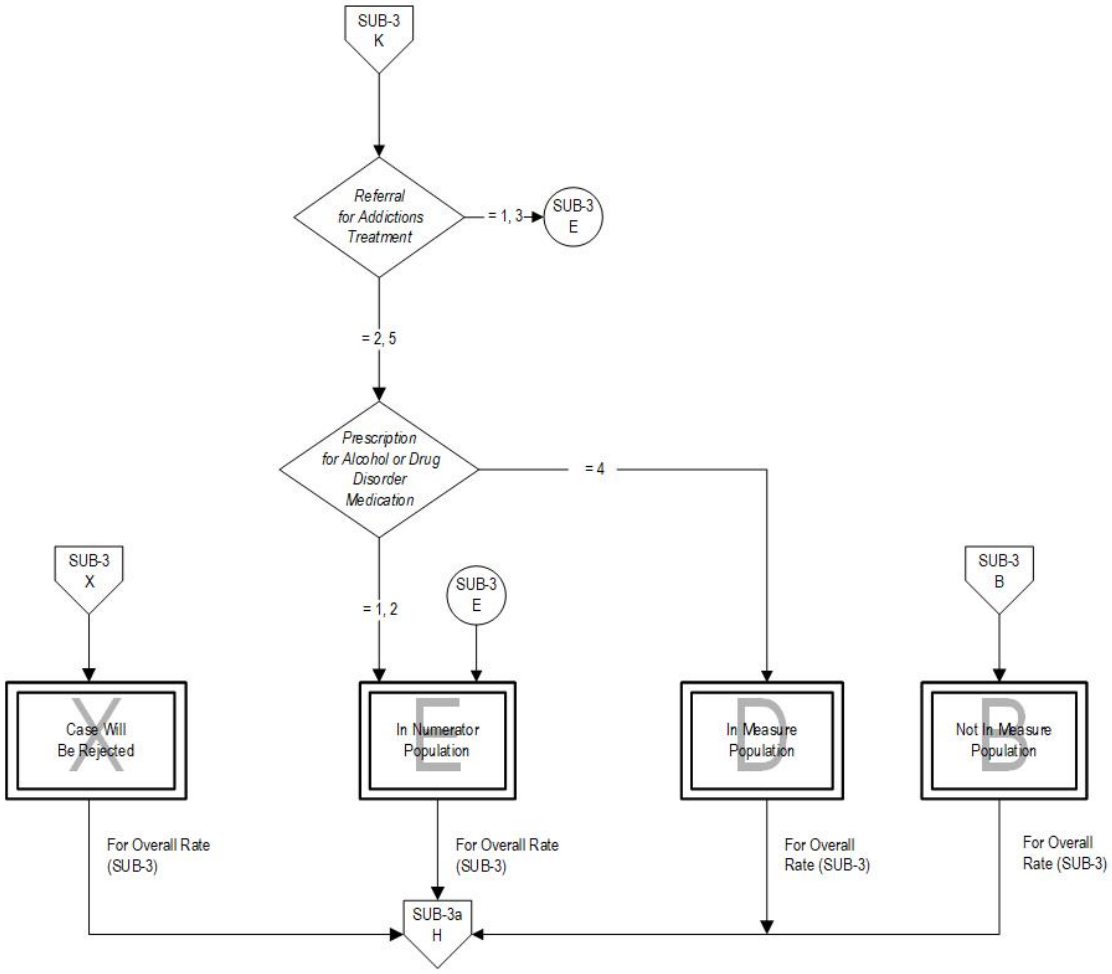
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge

Numerator: The number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder OR received or refused a referral for addictions treatment.

Denominator: The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder.



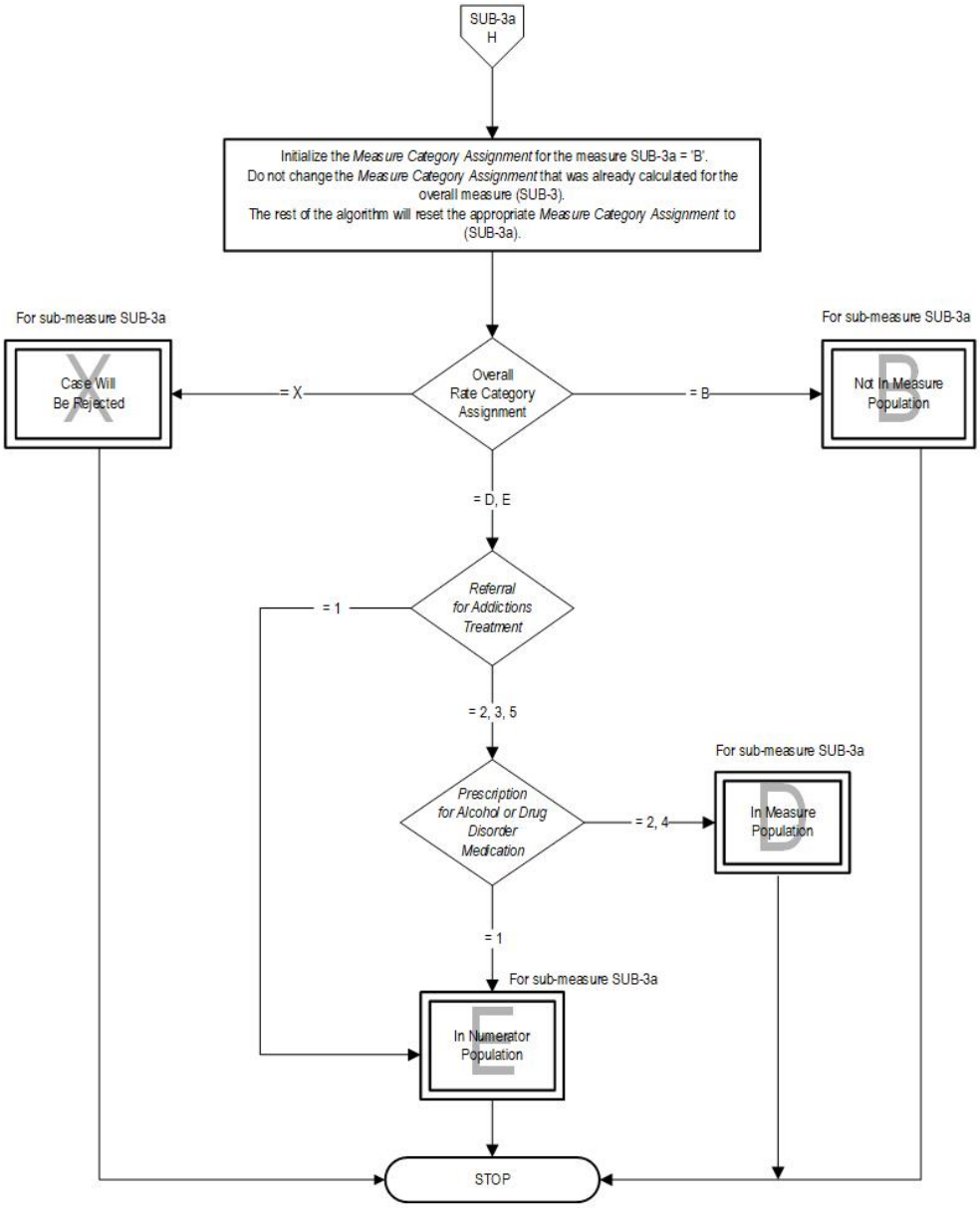




SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge

Numerator: The number of patients who received a prescription at discharge for medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment.

Denominator: The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder.



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.

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

Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measure ID: HBIPS-2

Set Measure ID	Performance Measure Name
HBIPS-2a	Physical Restraint- Overall Rate
HBIPS-2b	Physical Restraint- Children (1 through 12 years)
HBIPS-2c	Physical Restraint- Adolescent (13 through 17 years)
HBIPS-2d	Physical Restraint- Adult (18 through 64 years)
HBIPS-2e	Physical Restraint- Older Adult (≥ 65 years)

Performance Measure Name: Hours of physical restraint use

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.

Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).

Type Of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: The total number of hours that all psychiatric inpatients were maintained in physical restraint

Numerator Basis: The numerator evaluates the number of hours of physical restraint; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

> **Included Populations:**
>
> - Patients for whom at least one physical restraint event is reported during the month

Excluded Populations: None

Data Elements:

- *Event Date*
- *Event Type*
- *Minutes of Physical Restraint*

Denominator Statement: Number of psychiatric inpatient days

Denominator Basis: per 1,000 hours

Included Populations:

- All psychiatric inpatient days

Excluded Populations:

- Total leave days

Data Elements:

- *Admission Date*
- *Birthdate*
- *Psychiatric Care Setting*
- *Psychiatric Inpatient Days - Medicare Only*
- *Psychiatric Inpatient Days-Non-Medicare Only*
- *Total Leave Days - Medicare Only*
- *Total Leave Days-Non-Medicare Only*

Risk Adjustment: No.

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

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: In order to further examine the issue of restraint use within a facility it may be useful to study the incidence of physical restraint use by collecting additional information about the clinical justification for use.

Sampling: No.

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

Selected References:

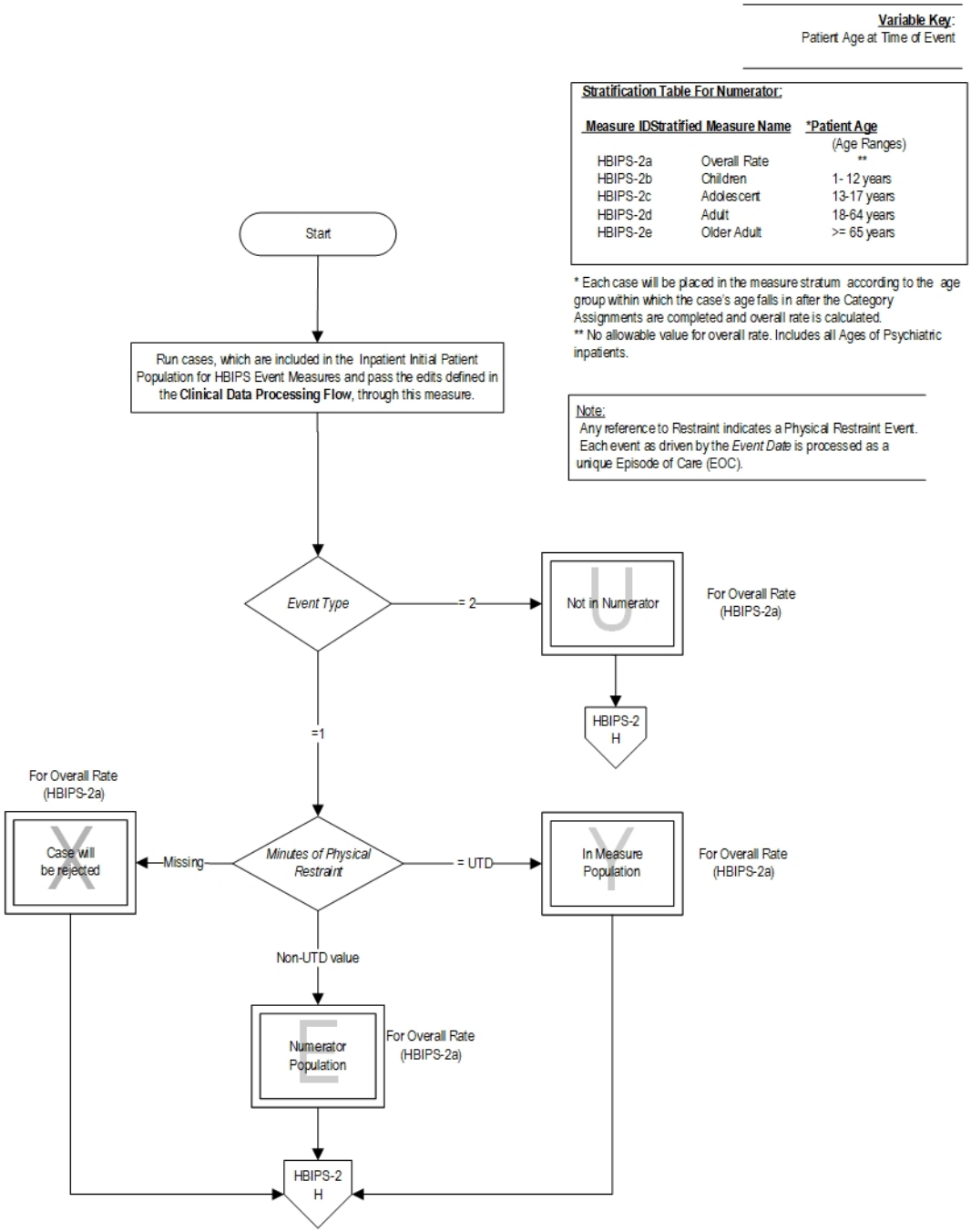
- Donat, D. (August, 2003). An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. *Psychiatric Services*. 54(8): 1119-1123.
- Fisher, W. A. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *Journal of Psychiatric Practice*, 9(1), 7-15.
- Huckshorn, K.A. (2004/September). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services*. 42(9). Pp. 22-31.
- Mohr, W. K., & Anderson, J. A. (2001). Faulty assumptions associated with the use of restraints with children. *Journal of Child and Adolescent Psychiatric Nursing*, 14(3), 141- 151.
- Special Section on Seclusion and Restraint, (2005, Sept). *Psychiatric Services*, 56 (9), 1104-1142.
- *Success Stories and Ideas for Reducing Restraint/Seclusion*. (2003). A compendium of strategies created by the American Psychiatric Association (APA), the American Psychiatric Nurses Association (APNA), the National Association of Psychiatric Health Systems (NAPHS), and the American Hospital Association Section for Psychiatric and Substance Abuse Services (AHA). Retrieved from the Internet on February 10, 2010 at http://www.naphs.org

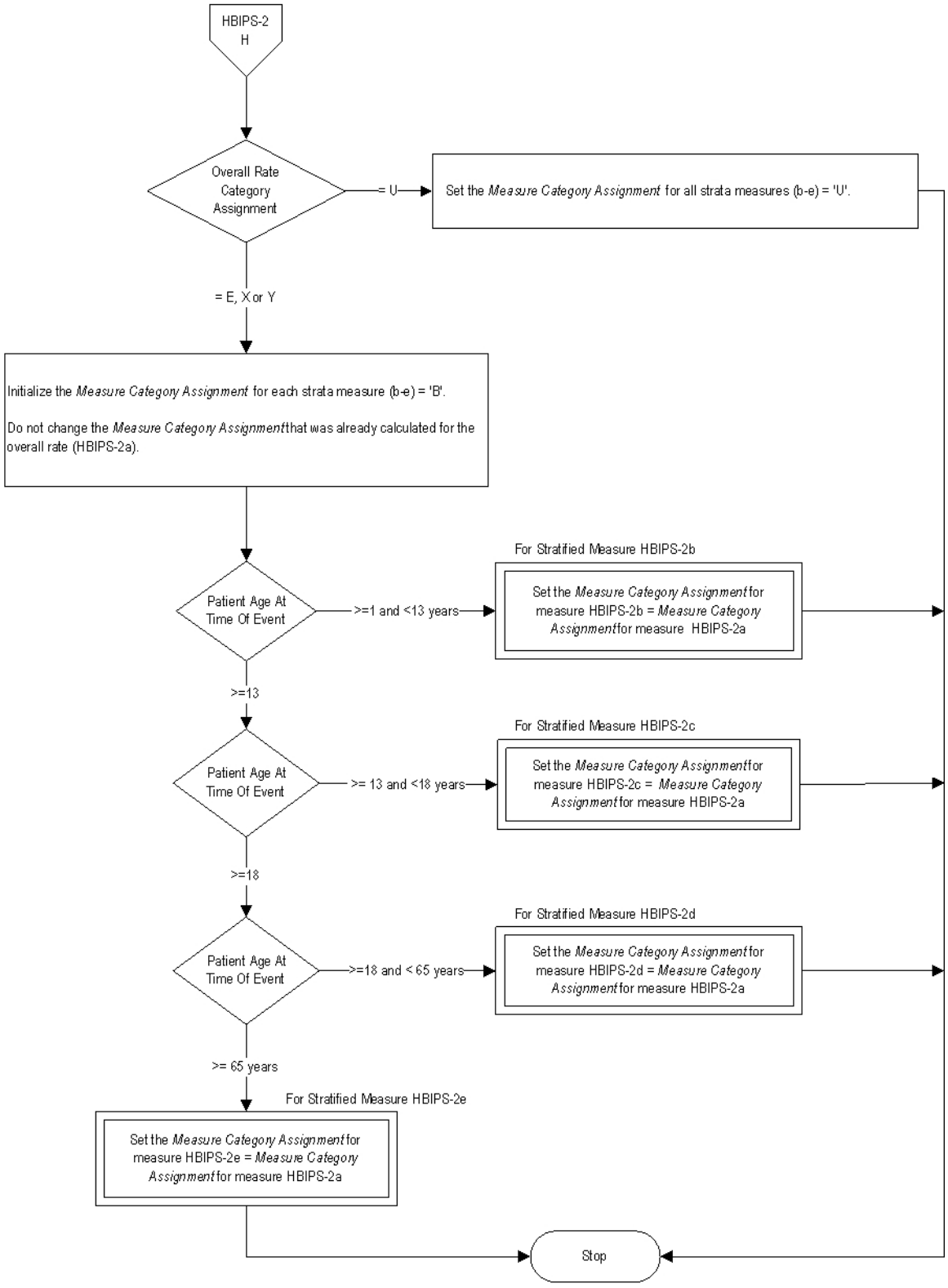
Measure Algorithm:

HBIPS-2: Hours of Physical Restraint Use

Numerator Statement: The total number of hours that all psychiatric inpatients spent in physical restraint

Denominator Statement: Number of psychiatric inpatient days





Measure Calculation for Aggregated Denominator

Denominator
For the overall measure and each strata measure calculate the denominator by aggregating the Psychiatric Inpatient Days and Leave Days:

Number of Denominator Cases for the overall measure = (*Psychiatric Inpatient Days – Leave Days*)
for all patients for the reporting month

Number of Denominator Cases for each strata measure = (*Psychiatric Inpatient Days – Leave Days*)
for all patients with a **Patient Age (Reporting Date - *Birthdate*)** appropriate for the strata for the reporting month
where Reporting Date is the last date of the reporting month that the census data is being reported.

Performance Measurement Systems can refer to the Joint Commission's ORYX Technical Implementation Guide for information concerning the aggregation of HCO level data, including the *Observed Rate* and Population Size for this measure.

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

Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measure ID: HBIPS-3

Set Measure ID	Performance Measure Name
HBIPS-3a	Seclusion- Overall Rate
HBIPS-3b	Seclusion- Children (1 through 12 years)
HBIPS-3c	Seclusion- Adolescent (13 through 17 years)
HBIPS-3d	Seclusion- Adult (18 through 64 years)
HBIPS-3e	Seclusion- Older Adult (≥ 65 years)

Performance Measure Name: Hours of seclusion use

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.

Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).

Type Of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: The total number of hours that all psychiatric inpatients were held in seclusion

Numerator Basis: The numerator evaluates the number of hours of seclusion; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

> **Included Populations:**
>
> - Patients for whom at least one seclusion event is reported during the month
>
> **Excluded Populations:** None

> **Data Elements:**
>
> - *Event Date*
> - *Event Type*
> - *Minutes of Seclusion*

Denominator Statement: Number of psychiatric inpatient days

Denominator Basis: per 1,000 hours

> **Included Populations:**
>
> - All psychiatric inpatient days
>
> **Excluded Populations:**
>
> - Total leave days
>
> **Data Elements:**
>
> - *Admission Date*
> - *Birthdate*
> - *Psychiatric Care Setting*
> - *Psychiatric Inpatient Days - Medicare Only*
> - *Psychiatric Inpatient Days-Non-Medicare Only*
> - *Total Leave Days - Medicare Only*
> - *Total Leave Days-Non-Medicare Only*

Risk Adjustment: No.

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

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: In order to further examine the issue of seclusion use within your facility it may be useful to study the incidence of seclusion use by collecting additional information about the clinical justification for use.

Sampling: No.

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

Selected References:

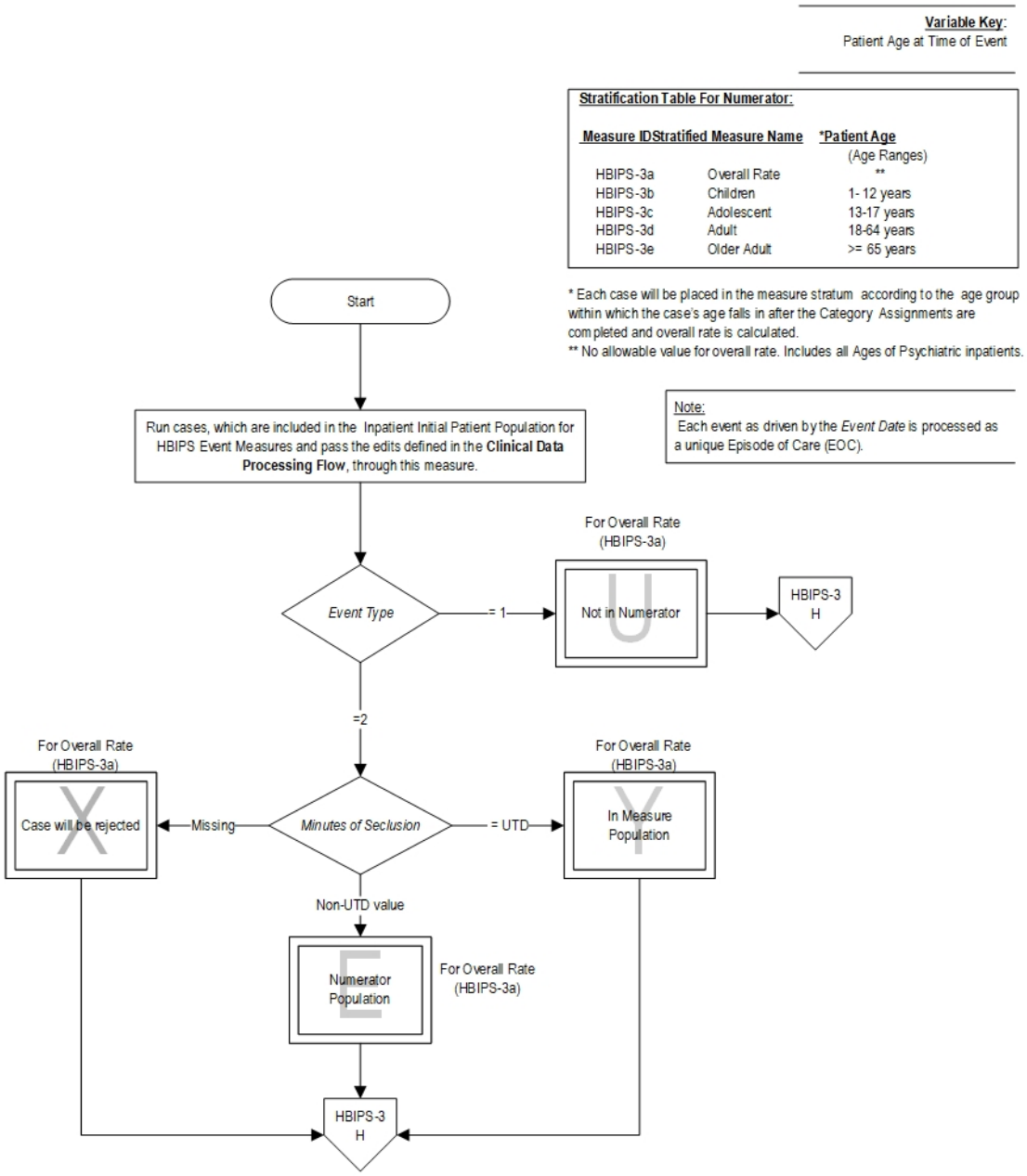
- Donat, D. (August, 2003). An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. *Psychiatric Services*. 54(8): 1119-1123.
- Fisher, W. A. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *Journal of Psychiatric Practice*, 9(1), 7-15.
- Huckshorn, K.A. (2004/September). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services*. 42(9). Pp. 22-31.
- Mohr, W. K., & Anderson, J. A. (2001). Faulty assumptions associated with the use of restraints with children. *Journal of Child and Adolescent Psychiatric Nursing*, 14(3), 141- 151.
- Special Section on Seclusion and Restraint, (2005, Sept). *Psychiatric Services*, 56 (9), 1104-1142.
- *Success Stories and Ideas for Reducing Restraint/Seclusion*. (2003). A compendium of strategies created by the American Psychiatric Association (APA), the American Psychiatric Nurses Association (APNA), the National Association of Psychiatric Health Systems (NAPHS), and the American Hospital Association Section for Psychiatric and Substance Abuse Services (AHA). Retrieved from the Internet on February 10, 2010 at http://www.naphs.org

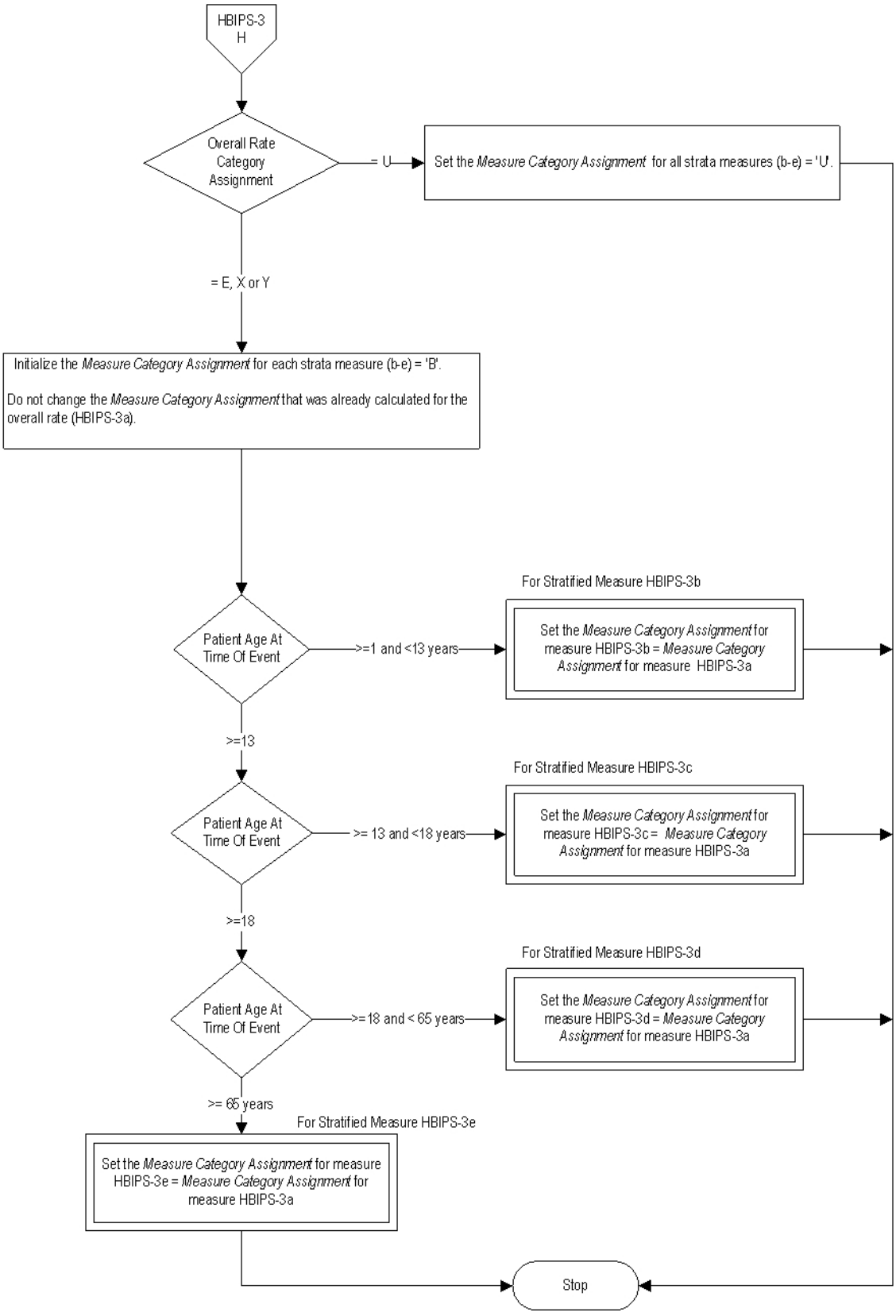
Measure Algorithm:

HBIPS-3: Hours of Seclusion Use

Numerator Statement: The total number of hours that all psychiatric inpatients spent in seclusion

Denominator Statement: Number of psychiatric inpatient days





Measure Calculation for Aggregated Denominator

Denominator
For the overall measure and each strata measure calculate the denominator rate by aggregating the *Psychiatric Inpatient Days* and *Leave Days*:

Number of Denominator Cases for the overall measure = (*Psychiatric Inpatient Days – Leave Days*)
for all patients for the reporting month

Number of Denominator Cases for each strata measure = (*Psychiatric Inpatient Days – Leave Days*)
for all patients with a **Patient Age (Reporting Date - *Birthdate*)** appropriate for the strata for the reporting month
where Reporting Date is the last date of the reporting month that the census data is being reported.

Performance Measurement Systems can refer to the Joint Commission's ORYX Technical Implementation Guide for information concerning the aggregation of HCO level data, including the *Observed Rate* and Population Size for this measure.

Medication Continuation Following Inpatient Psychiatric Discharge

CMIT Family ID: 00438 | **CMIT ID:** 05732-C-IPFQR | **Measure Type:** Process

Date of Information: Not Available | **Revision:** 4 | **Program:** Inpatient Psychiatric Facility Quality Reporting

View Description

Properties

Date of Information	Not Available
Abbreviated Measure Title	Not Available
Description	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. The performance period for the measure is two years.
Numerator	The numerator for the measure includes discharges for patients with a principal diagnosis of MDD, schizophrenia, or bipolar disorder in the denominator who were dispensed at least one evidence-based outpatient medication within 2 days prior to discharge through 30 days post discharge.
Denominator	The denominator for the measure includes Medicare fee-for service (FFS) beneficiaries with Part D coverage aged 18 years and older discharged to home or home health care from an IPF with a principal diagnosis of MDD, schizophrenia, or bipolar disorder
Denominator Exclusions	The denominator excludes discharged patients who received Electroconvulsive Therapy (ECT) during the inpatient stay or follow-up period, received Transcranial Magnetic Stimulation (TMS) during the inpatient stay or follow-up period, were pregnant at discharge, had a secondary diagnosis of delirium at discharge, or had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia at discharge.
Rationale	The aim of the measure is to address gaps in continuity of pharmaceutical treatment during the transition from inpatient care to outpatient care. Pharmacotherapy is the

Return to Top

	primary form of treatment for most patients discharged from an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder. The measure focuses on medication continuation because it is an essential step in medication adherence. Medication continuation is particularly important in the psychiatric patient population because psychotropic medication discontinuation can have a range of adverse effects, from mild withdrawal to life-threatening autonomic instability and psychiatric decompensation (Ward & Schwartz, 2013). Patients with MDD who do not remain on prescribed medication are more likely to have negative health outcomes, such as relapse and readmission, decreased quality of life, and increased healthcare costs. If untreated, MDD can contribute to or worsen chronic medical disorders (Geddes et al., 2003; Glue et al., 2010). The literature shows that among patients with schizophrenia, those who were good compliers according to the Medication Adherence Rating Scale had better outcomes in terms of rehospitalization rates and medication maintenance (Jaeger et al., 2012). Among patients with bipolar disorder, medication adherence was significantly associated with reduction in manic symptoms (Sylvia et al., 2013), while non-adherence was associated with increased suicide risk (OR 10.8, CI 1.57 74.4; Gonzalez-Pinto et al., 2006). Current facility-level performance indicates that there is a clear quality gap. Using 2013 2014 Medicare claims data, we found that there is about a 22 percentage point difference between the 10th and 90th percentiles (66.7%-88.3%) and a median score of 79.6%. By calculating the facility-level rates of medication continuation in Medicare FFS claims data, this measure can provide valuable information on areas where care transitions to the outpatient setting can be improved.
Evidence	Not Available
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	No
Program Status	Not Available

Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measure ID: HBIPS-5

Set Measure ID	Performance Measure Name
HBIPS-5a	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Overall Rate
HBIPS-5b	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Children (1 through 12 years)
HBIPS-5c	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Adolescent (13 through 17 years)
HBIPS-5d	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Adult (18 through 64 years)
HBIPS-5e	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Older Adult (≥ 65 years)

Performance Measure Name: Patients discharged on multiple antipsychotic medications with appropriate justification

Description: Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification

Rationale: Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in treatment resistant patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients without a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Sal-

vatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification

> **Included Populations:** Not applicable
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *Appropriate Justification for Multiple Antipsychotic Medications*

Denominator Statement: Psychiatric inpatient discharges

> **Included Populations:**
>
> - Patients with *ICD-10-CM Principal or Other Diagnosis Codes* for Mental Disorders as defined in Appendix A, Table 10.01 discharged on two or more routinely scheduled antipsychotic medications (refer to Appendix C, Table 10.0- Antipsychotic Medications).
>
> **Excluded Populations:**
>
> - Patients who expired
> - Patients with an unplanned departure resulting in discharge due to elopement
> - Patients with an unplanned departure resulting in discharge due to failing to return from leave
> - Patients with a length of stay ≤ 3 days
>
> **Data Elements:**
>
> - *Admission Date*
> - *Birthdate*
> - *Discharge Date*
> - *Discharge Disposition*
> - *ICD-10-CM Other Diagnosis Codes*
> - *ICD-10-CM Principal Diagnosis Code*
> - *Number of Antipsychotic Medications Prescribed at Discharge*
> - *Patient Status at Discharge*
> - *Psychiatric Care Setting*

Risk Adjustment: No.

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

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: For quality improvement purposes, the measurement system may want to create reports to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. This would allow healthcare organizations to target education efforts.

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 Psychiatric Association (APA). (2004). Steering Committee on Practice Guidelines. Practice guideline for the treatment of patients with schizophrenia, second edition. *Am J Psychiatry*. 161(2 Suppl):1-56
- Ananth, J., Parameswaran, S., & Gunatilake, S. (2004). Antipsychotic polypharmacy comparing monotherapy with polypharmacy and augmentation. *Curr Med Chem*. 11(3):313-327 *Curr Pharm Des*. 10(18):2231-2238.
- Centorrino, F., Gören, J.L., Hennen, J., Salvatore, P., Kelleher, J.P., & Baldessarini, R.J. (2004) Multiple versus single antipsychotic agents for hospitalized psychiatric patients: a case control study of risk versus benefit. *Am J Psychiatry*. 161 (4):700-706.
- Covell, N.H., Jackson, C.T., Evans, A.C., & Essock, S.M. (2002). Antipsychotic prescribing practices in Connecticut's public mental health system: rates of changing medication prescribing styles. *Schiz Bull*. 28(1):17-29,
- Ganguly, R., Kotzan, J.A., Miller, L.S., Kennedy, K., & Martin, B.C. (2004). Prevalence, trends, and factors associated with antipsychotic polypharmacy among Medicaid-eligible schizophrenia patients, 1998-2000. *J Clin Psychiatry*. 65(10):1377-88.
- Gilmer, T.P., Dolder, C.R., Folsom, D.P., Mastin, W., & Jeste, D.V. (2007), Antipsychotic polypharmacy trends among Medicaid beneficiaries with schizophrenia in San Diego County, 1999 - 2004. *Psychiatric Serv*. 59(7):1007-1010.
- Jaffe, A.B. & Levine, J. (2003). Antipsychotic medication co-prescribing in a large state hospital system. *Pharmacoepidemiol Drug Saf*.12:41-48.
- Kreyenbuhl, J., Valenstein, M., McCarthy, J.F., Ganocyz, D., & Blow, F.C. (2006). Long-term combination antipsychotic treatment in VA patients with schizophrenia. *Schiz Res*.84:90-99.
- National Association of State Mental Health Program Directors (NASMHPD). (2001).Technical report on psychiatric polypharmacy. Alexandria, VA.
- Potkin, S.G., Thyrum, P.T., Alva, G., Bera, R., Yeh, C., & Arvanitis, L.A. (2002). The safety and pharmacokinetics of quetiapine when coadministered with haloperidol, risperidone or thioridazine. *J Clin Psychopharmacol*. 22:121-130.
- Shim, J.C., Shin, J.G., Kelly, D.L., Jung, D.U., Seo, Y.S., Liu, K.H., et al. (2007). Adjunctive treatment with a dopamine partial agonist aripiprazole, for treatment of antipsychotic-induced hyperprolactinemia: A

placebo controlled trial. *Am J Psych.164*:1404-1410.

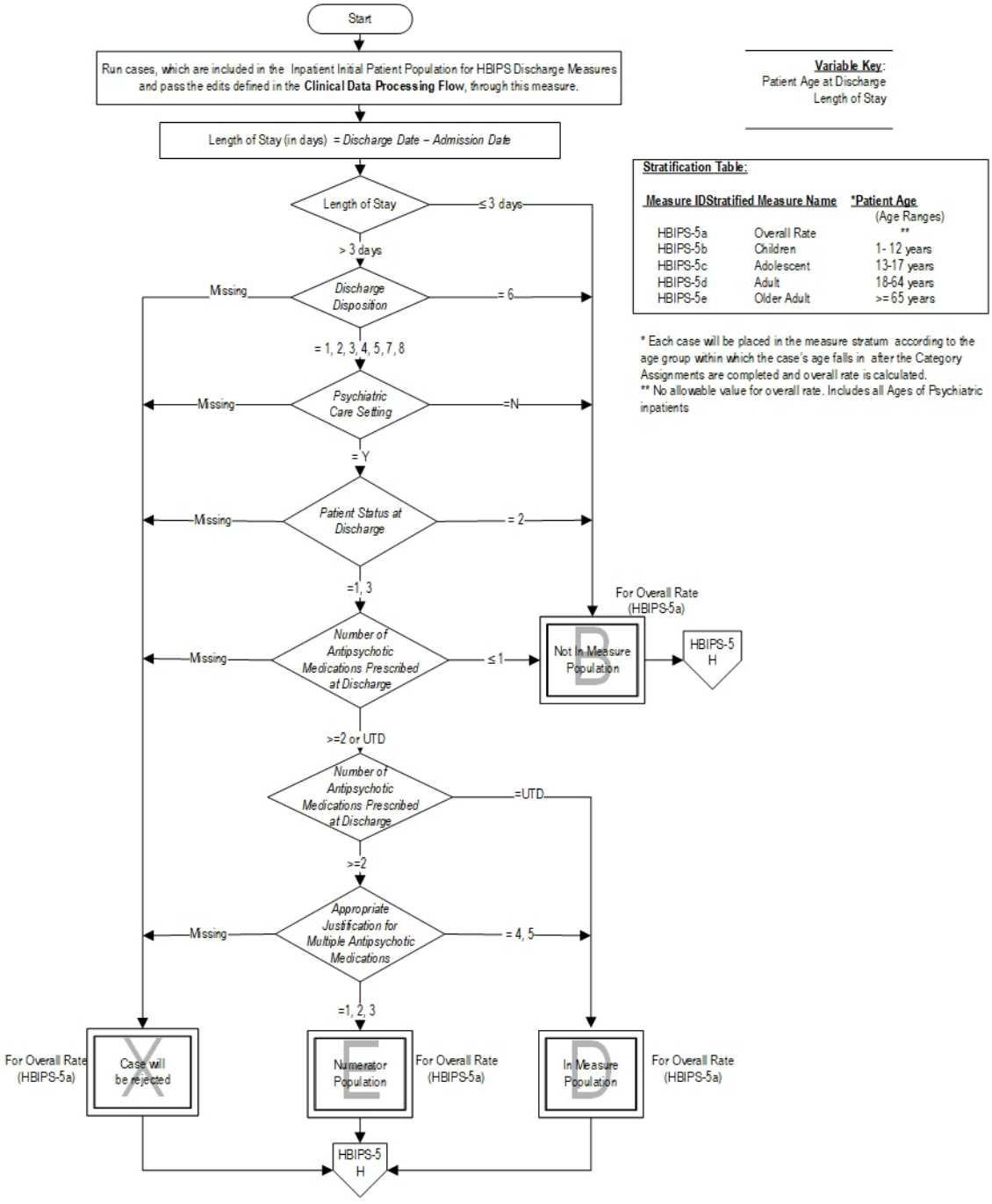
- Stahl, S.M. & Grady, M.M. (2004). A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy augmentation. *Curr Med Chem.11*:313-327.
- Tranulis, C., Skalli, L., Lalonde, P., & Nicole, L. (2008). Benefits and risks of antipsychotic polypharmacy. An evidence based review of the literature. *Drug Saf*.31(1):7-20
- University HealthSystem Consortium. (2006). Mental health performance measures field brief. Oakbrook, IL.

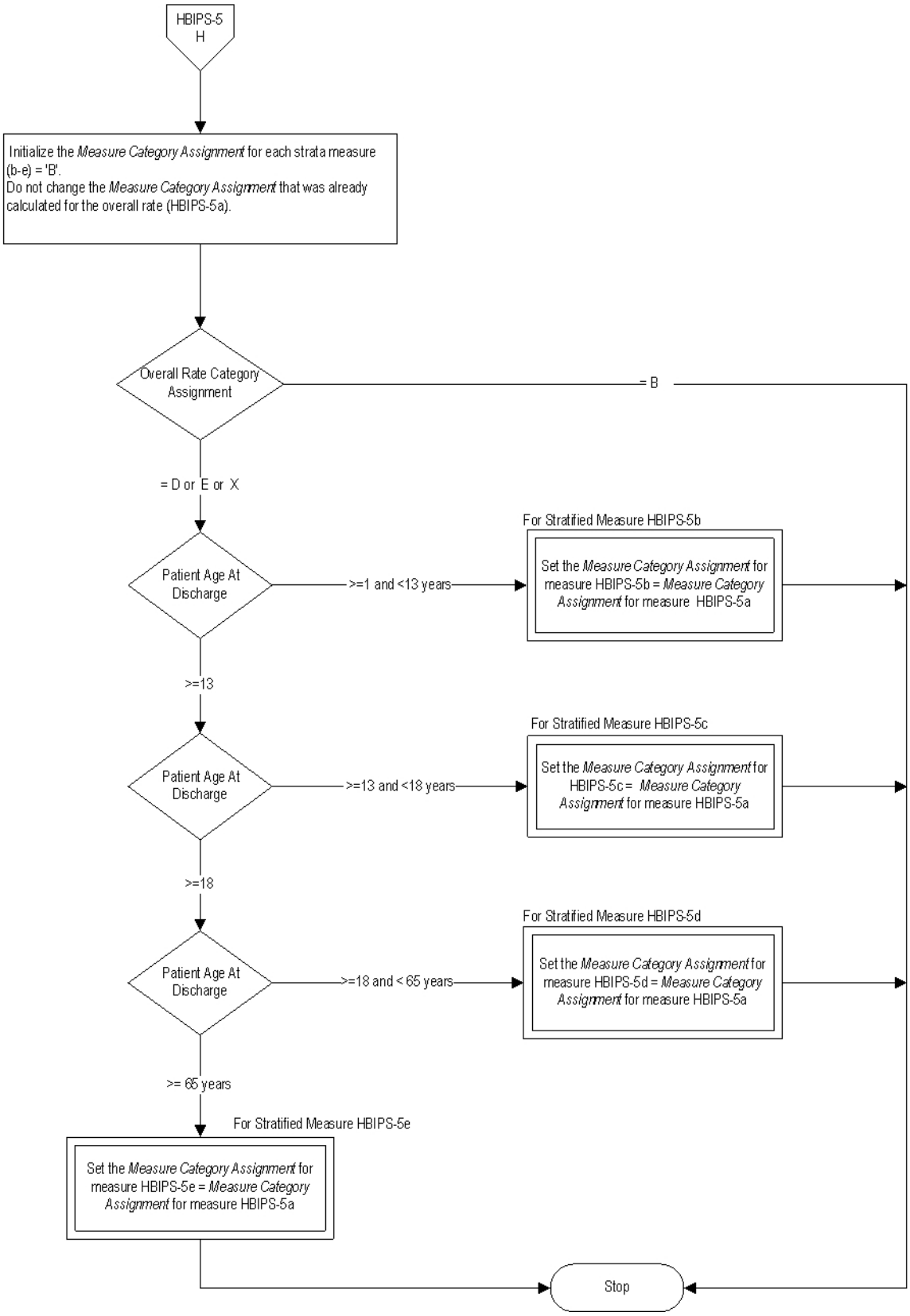
Measure Algorithm:

HBIPS-5: Patients Discharged On Multiple Antipsychotic Medications With Appropriate Justification

Numerator Statement: Psychiatric inpatients who are discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.

Denominator Statement: Psychiatric inpatients who are discharged on two or more routinely scheduled antipsychotic medications.





Measure Information Form

Measure Set: Tobacco Treatment Measures (TOB)

Set Measure ID: TOB-3

Set Measure ID	Performance Measure Name
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge
TOB-3a	Tobacco Use Treatment at Discharge

Performance Measure Name: Tobacco Use Treatment Provided or Offered at Discharge

Description:
TOB-3 Patients identified as tobacco product users who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge.
TOB-3a Patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication upon discharge as well as those who were referred to outpatient counseling and had reason for not receiving a prescription for medication.

The measure is reported as an overall rate which includes all patients to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment at discharge. The Provided or Offered rate (TOB-3) describes patients identified as tobacco product users who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge. The Tobacco Use Treatment at Discharge (TOB-3a) rate describes only those who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication upon discharge as well as those who were referred to outpatient counseling and had reason for not receiving a prescription for medication. Those who refused are not included.

Rationale: Tobacco use is the single greatest cause of disease in the United States today and accounts for more than 480,000 deaths each year (CDC MMWR 2014). Smoking is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases (DHHS 2014). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated to be at least $130 billion per year in direct medical expenses for adults, and over $150 billion in lost productivity (DHHS 2014).

There is strong and consistent evidence that tobacco dependence interventions, if delivered in a timely and effective manner, significantly reduce the user's risk of suffering from tobacco-related disease and improve outcomes for those already suffering from a tobacco-related disease (DHHS 2000; Baumeister 2007; Lightwood 2003 and 1997; Rigotti 2012). Effective, evidence-based tobacco dependence interventions have been clearly identified and include brief clinician advice, individual, group, or telephone counseling, and use of FDA-approved medications. These treatments are clinically effective and extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments. Hospitalization (both because hospitals are a tobacco-free environment and because patients may be more motivated to quit as a result of their illness) offers an

ideal opportunity to provide cessation assistance that may promote the patient's medical recovery. Patients who receive even brief advice and intervention from their care providers are more likely to quit than those who receive no intervention (DHHS, 2008).

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement:
TOB-3: The number of patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge.

TOB-3a: The number of patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication at discharge.

> **Included Populations:** Not applicable
>
> **TOB-3**
>
> - Patients who refused a prescription for FDA- Approved tobacco cessation medication at discharge.
> - Patients who refused a referral to evidence-based outpatient counseling.
>
> **TOB-3a**
>
> - Not Applicable
>
> **Excluded Populations:**
>
> **TOB-3 and TOB-3a**
> For FDA Approved Medications Only
>
> - Smokeless tobacco users
> - Pregnant smokers
> - Patients with reasons for not administering FDA-approved cessation medication.
>
> **Data Elements:**
>
> - *Prescription for Tobacco Cessation Medication*
> - *Reason for No Tobacco Cessation Medication at Discharge*
> - *Referral for Outpatient Tobacco Cessation Counseling*
> - *Tobacco Use Status*

Denominator Statement: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.

> **Included Populations:** Not applicable

Excluded Populations:

- Patients less than 18 years of age
- Patient who are cognitively impaired
- Patients who are not current tobacco users
- Patients who refused or were not screened for tobacco use status during the hospital stay
- Patients who have a duration of stay less than or equal to one day or greater than 120 days
- Patients who expired
- Patients who left against medical advice
- Patients discharged to another hospital
- Patients discharged to another health care facility
- Patients discharged to home for hospice care
- Patients who do not reside in the United States
- Patients with *Comfort Measures Only* documented

Data Elements:

- *Admission Date*
- *Birthdate*
- *Comfort Measures Only*
- *Discharge Date*
- *Discharge Disposition*
- *Tobacco Use Status*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10 diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: Data accuracy is enhanced when all definitions are used without modification. The data dictionary should be referenced for definitions and abstraction notes when questions arise during data collection.

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

Measure Analysis Suggestions: Hospitals may wish to identify those patients that refused either counseling or medications or both at discharge so as to have a better understanding of which treatment type was accepted or refused so that efforts can be directed toward improving care.

Sampling: Yes. Please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

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

Selected References:

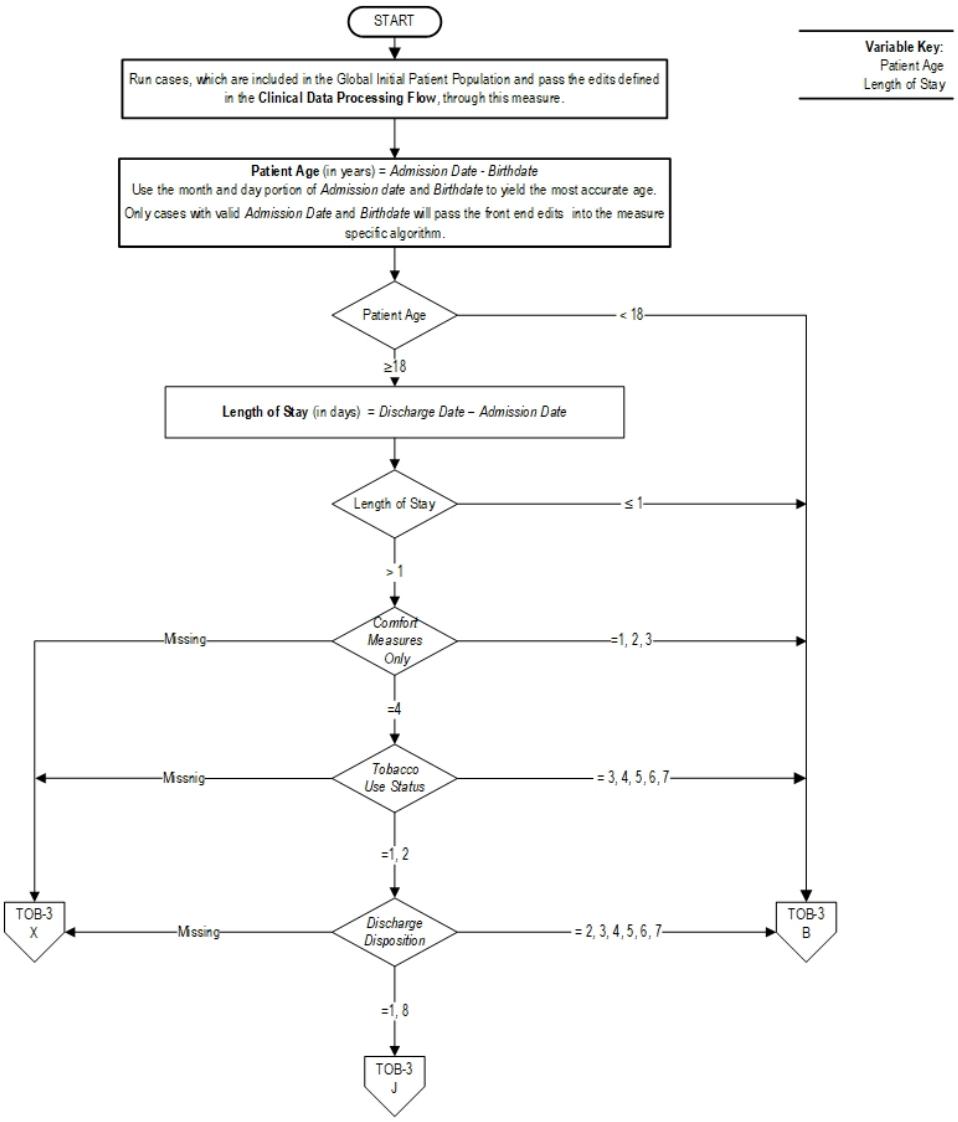
- Baumeister, S. E., Schumann, A., Meyer, C., John, U., Volzke, H., & Alte, D. (2007). Effects of smoking cessation on health care use: Is elevated risk of hospitalization among former smokers attributable to smoking-related morbidity? Drug and Alcohol Dependence, 88(2–3), 197–203.
- Centers for Disease Control and Prevention. (2014). Current cigarette smoking among adults—United States, 2005–2013. Morbidity and Mortality Weekly Report (MMWR), 63(47), 1108–1112. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6347a4.htm?s_cid=mm6347a4_w.
- Lightwood, J. M. (2003). The economics of smoking and cardiovascular disease. Progress in Cardiovascular Diseases, 46(1), 39–78.
- Lightwood, J. M., & Glantz, S. A. (1997). Short-term economic and health benefits of smoking cessation: Myocardial infarction and stroke. Circulation, 96(4), 1089–1096.
- Rigotti, N. A., Clair, C., Munafo, M. R., & Stead, L. F. (2012). Interventions for smoking cessation in hospitalised patients. Cochrane Database of Systematic Reviews. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/22592676.
- U.S. Department of Health and Human Services. (2014). The health consequences of smoking—50 years of progress: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved from http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf .
- U.S. Department of Health and Human Services. (2008). Tobacco use and dependence guideline panel. Treating tobacco use and dependence: 2008 update. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK63952/.
- U.S. Department of Health and Human Services. (2000). Reducing tobacco use: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

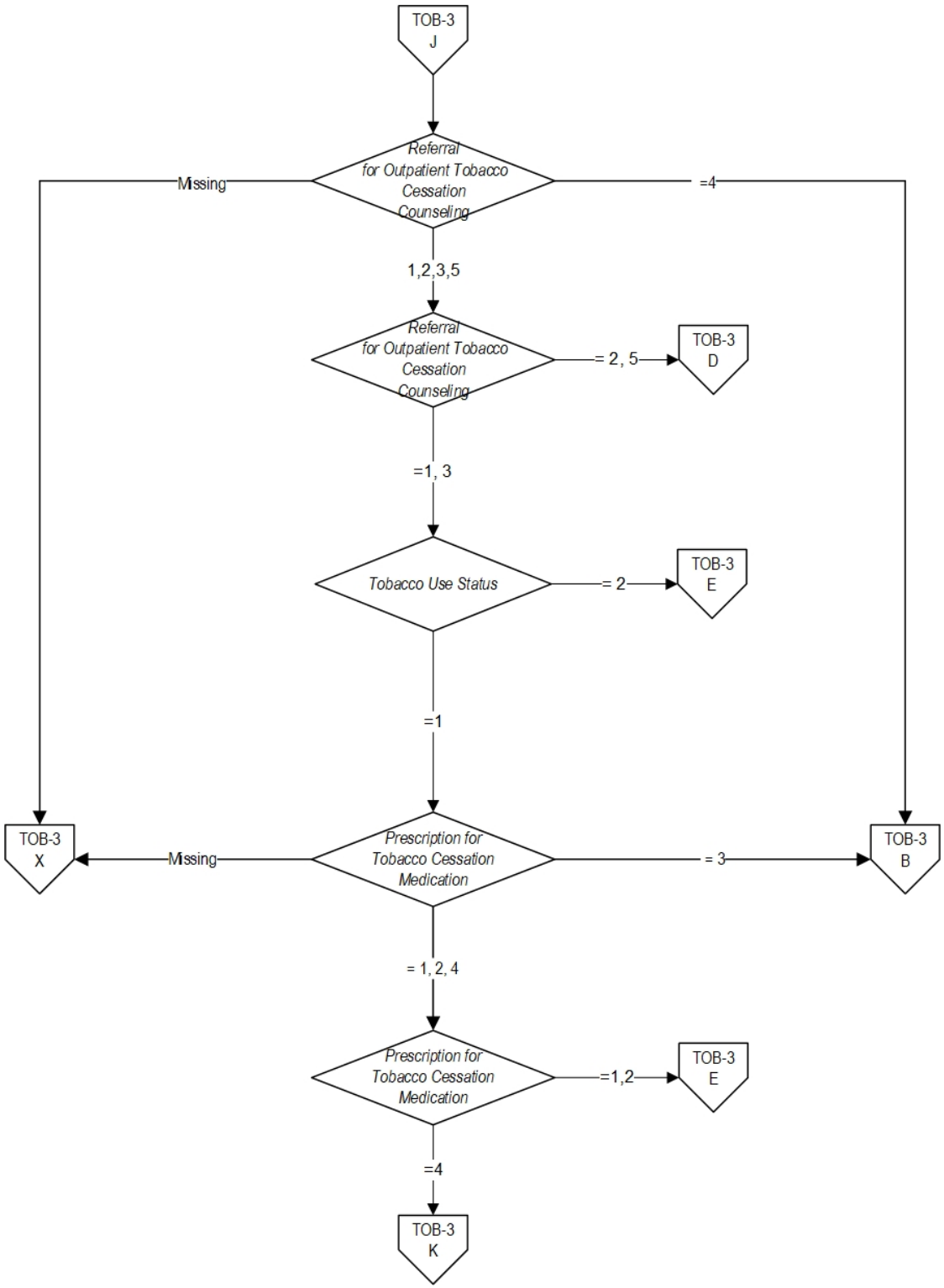
Measure Algorithm:

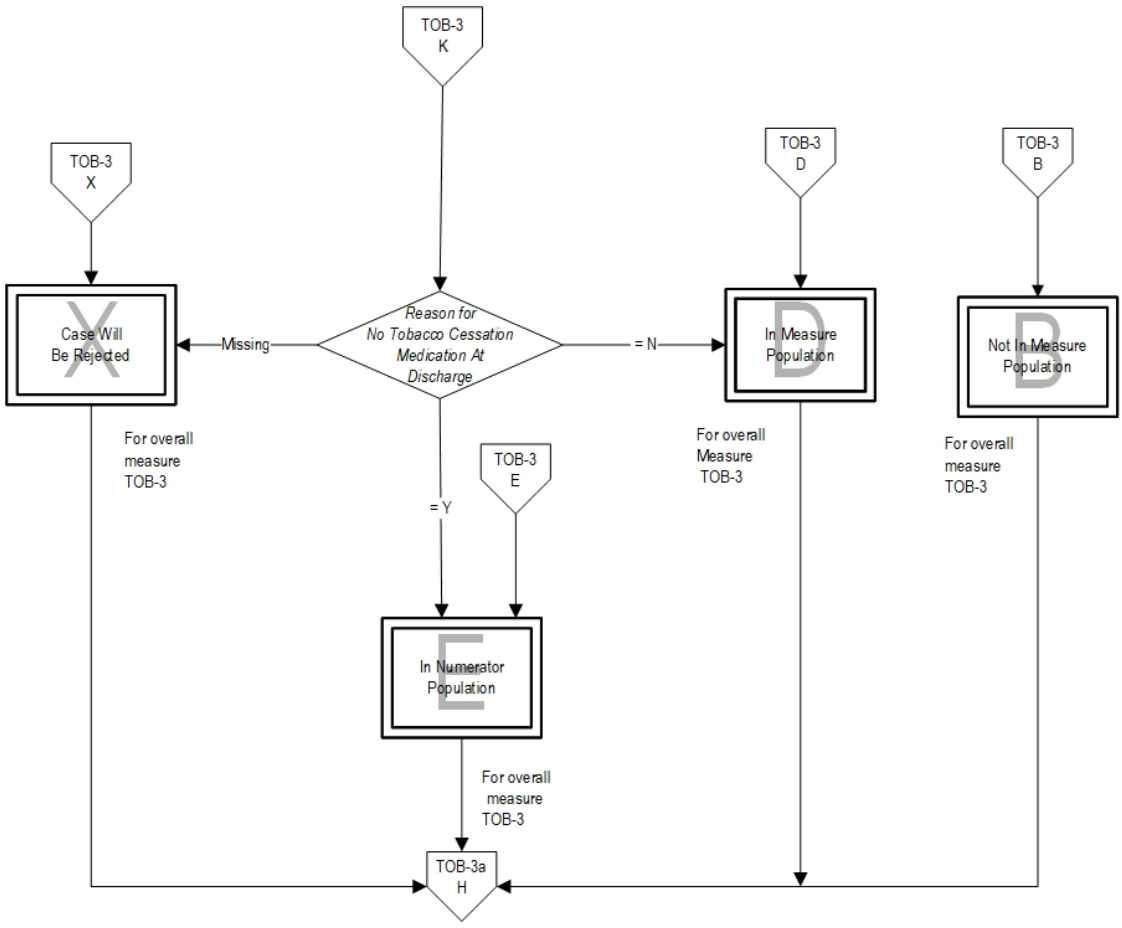
TOB-3: Tobacco Use Treatment Provided or Offered at Discharge

Numerator: The number of patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge.

Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.



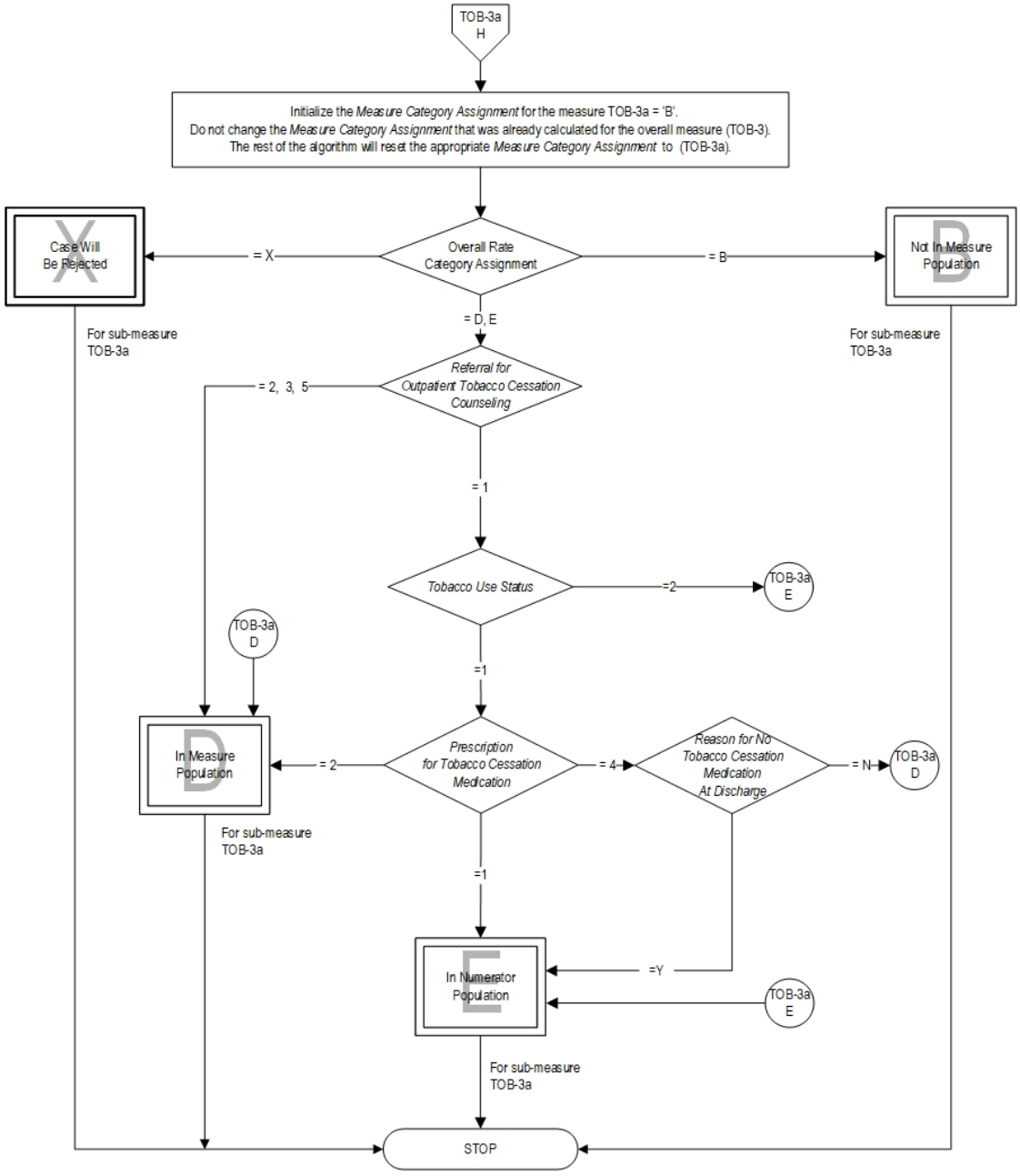




TOB-3a: Tobacco Use Treatment Provided or Offered at Discharge

Numerator: The number of patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA- approved cessation medication at discharge.

Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.



Measure #2: Transition Record with Specified Elements Received by Discharged Patients

(Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

(facility-level measure; included in bundled measure set: Measures 1, 2, & 3)

Care Transitions

Measure Description

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

Measure Components

Numerator Statement

- **See "Additional Information" for clarification of numerator elements and the bundling of measures 1, 2, & 3**

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

Inpatient Care

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

Post-Discharge/ Patient Self-Management

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

Advance Care Plan

- Advance directives[c] or surrogate decision maker documented **OR** Documented reason for not providing advance care plan[d]

Contact Information/ Plan for Follow-up Care[e]

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

Numerator Element Definitions*:*

a. Transition record: a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.
b. Current medication list: all medications to be taken by patient after discharge, including all continued and new medications
c. Advance directives: eg, written statement of patient wishes regarding future use of life-

	sustaining medical treatment d. Documented reason for not providing advance care plan: documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship e. Contact information/ plan for follow-up care: For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the "receiving" facilities. f. Plan for follow-up care: may include any post-discharge therapy needed (eg, oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc. g. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional
Denominator Statement	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care
Denominator Exclusions	Patients who died Patients who left against medical advice (AMA) or discontinued care
Supporting Guideline & Other References	The following evidence statements are quoted verbatim from the referenced clinical guidelines. ***Transition record*** All transitions must include a transition record. There is a minimal set of data elements that should always be part of the transition record: – Principal diagnosis and problem list – Medication list (reconciliation) including OTC/ herbals, allergies and drug interactions – Clearly identifies the medical home/transferring coordinating physician/institution and their contact information – Patient's cognitive status – Test results/pending results (TOCCC, 2008) [21] Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transition record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive. (TOCCC, 2008) **Standard PC.04.02.01** When a [patient] is discharged or transferred, the [organization] gives information about the care, treatment, and services provided to the [patient] to other service providers who will provide the [patient] with care, treatment, or services. • At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, or services to the patient about the following: - The reason for the patient's discharge or transfer - The patient's physical and psychosocial status - A summary of care, treatment, and services it provided to the patient - The patient's progress toward goals - A list of community resources or referrals made or provided to the patient (See also PC.02.02.01, EP 1) (Joint Commission, 2009)[23]

	Standard PC.04.01.05 Before the [organization] discharges or transfers a [patient], it informs and educates the [patient] about his or her follow-up care, treatment, and services. 1. When the hospital determines the patient's discharge or transfer needs, it promptly shares this information with the patient. 2. Before the patient is discharged, the hospital informs the patient of the kinds of continuing care, treatment, and services he or she will need. 3. When the patient is discharged or transferred, the hospital provides the patient with information about why he or she is being discharged or transferred. 5. Before the patient is transferred, the hospital provides the patient with information about any alternatives to the transfer. 7. The hospital educates the patient about how to obtain any continuing care, treatment, and services that he or she will need. 8. The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand. (See also RI.01.01.03, EP 1) (Joint Commission, 2009) [23]

Measure Importance

Relationship to desired outcome	Providing detailed discharge information enhances patients' preparation to self-manage post-discharge care and comply with treatment plans. Additionally, randomized trials have shown that many hospital readmissions can be prevented by patient education, predischarge assessment, and domiciliary aftercare.[20] One recent study found that patients participating in a hospital program providing detailed, personalized instructions at discharge, including a review of medication routines and assistance with arranging follow-up appointments, had 30% fewer subsequent emergency visits and hospital readmissions than patients who received usual care at discharge.[5]
Opportunity for Improvement	A prospective, cross-sectional study of discharged patients found that approximately 40% have pending test results at the time of discharge and that 10% of these require some action; yet outpatient physicians and patients are unaware of these results.[11] A more recent literature summary found that discharge summaries often lacked information important for follow-up care, including diagnostic test results (missing in 33-63% of summaries), treatment or hospital course (7-22%), discharge medications (2-40%), test results pending at discharge (65%), and follow-up plans (2-43%).[17]
IOM Domains of Health Care Quality Addressed [25]	• Safe • Patient-centered • Efficient • Equitable
Exclusion Justification	Exclusions arise when patients who are included in the initial patient or eligible population for a measure do not meet the denominator criteria specific to the intervention required by the numerator. Exclusions are absolute and apply to all patients and therefore are not part of clinical judgment within a measure. Patients who expired and patients who left against medical advice (AMA) are categorized by inpatient facilities as having been "discharged" (with specific discharge status codes) and must therefore be excluded from the denominators for these measures. The Care Transitions Work Group acknowledges that it may be feasible to provide patients who leave AMA with a medication list and transition record (and to transmit this information to the facility/physician providing follow-up care), but not necessarily with the level of detail specified in

	these measures.
Harmonization with Existing Measures	Harmonization with existing measures was not applicable to this measure.

Measure Designation

Measure purpose	• Quality Improvement • Accountability
Type of measure	• Process
Level of Measurement	• Facility
Care setting	• Discharge from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility)
Data source	• Administrative data • Medical record • Electronic health record system • Retrospective data collection flowsheet

Technical Specifications: Administrative Data

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using medical record abstraction (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.
The specifications listed below are those needed for performance calculation.
Note: Facilities are responsible for determining the appropriate use of codes.

	Facility-Level Specifications
Denominator (Eligible Population)	Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0114 (Hospital Inpatient (Including Medicare Part A), Interim - Last Claim) • 0121 (Hospital Inpatient (Medicare Part B only), Admit through Discharge Claim) • 0124 (Hospital Inpatient (Medicare Part B only), Interim - Last Claim) • 0181 (Hospital - Swing Beds, Admit through Discharge Claim) • 0184 (Hospital - Swing Beds, Interim - Last Claim) • 0211 (Skilled Nursing-Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient (Including Medicare Part A), Interim - Last Claim) • 0221 (Skilled Nursing-Inpatient (Medicare Part B only), Admit through Discharge Claim) • 0224 (Skilled Nursing- Inpatient (Medicare Part B only), Interim - Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim - Last Claim) AND Discharge Status (Form Locator 17) • 01 (Discharged to home or self care (routine discharge) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to a facility that provides custodial or supportive care) • 05 (Discharged/transferred to a designated cancer center or children's hospital) • 06 (Discharged/transferred to home under care of an organized home health

service organization in anticipation of covered skilled care)
- 21 (Discharged/transferred to court/law enforcement)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 69 (Discharged/transferred to a designated disaster alternative care site)
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
- 81 (Discharged to home or self care with a planned acute care hospital inpatient readmission)
- 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)
- 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission)
- 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)
- 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission)
- 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)
- 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)
- 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
- 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission)
- 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission)
- 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission)
- 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission)
- 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission)
- 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission)
- 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission)

OR

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

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

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

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

AND
Discharge Status (Form Locator 17)

- 01 (Discharged to home or self care (routine discharge)
- 02 (Discharged/transferred to a short term general hospital for inpatient care)
- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to a facility that provides custodial or supportive care)
- 05 (Discharged/transferred to a designated cancer center or children's hospital
- 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care)
- 21 (Discharged/transferred to court/law enforcement)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 69 (Discharged/transferred to a designated disaster alternative care site)
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
- 81 (Discharged to home or self-care with a planned acute care hospital inpatient readmission)
- 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)
- 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission)
- 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)
- 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission)
- 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)
- 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)
- 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
- 89 (Discharged/transferred to a hospital-based Medicare approved swing bed

	with a planned acute care hospital inpatient readmission) • 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission) • 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission) • 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission) • 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission) • 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission) • 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission)
Numerator	**Numerator Elements to be identified through medical record abstraction:** See Sample Data Collection Tool below.
Denominator Exclusions	UB-04 (Form Locator 17 - Discharge Status): • 07 (Left against medical advice or discontinued care) • 20 (Expired) • 40 (Expired at home) • 41 (Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)) • 42 (Expired-place unknown)

Technical Specifications: Electronic Health Record System

The PCPI seeks to facilitate the integration of its measures into electronic health record (EHR) systems, registries, and applications used by physicians and other health care professionals that improve health care quality and prevent medical errors. In particular, it is valuable to have data for measurement and improvement available at the point of care and for practice-wide or facility-wide analysis as well as for external reporting.

The Care Transitions measures do not lend themselves to a "traditional specification" for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.

As the quality measures arena moves forward with EHR reporting, the Care Transitions measures will be aligned with the ONC Health IT Standards Committee (HITSC) recommendations that certain vocabulary standards be used for quality measure reporting, in accordance with the Quality Data Model (https://ecqi.healthit.gov/qdm).

Producing the Transition Record with Specified Elements

Facilities that have implemented an EHR should utilize their system to produce a standardized template that providers will complete to generate the Transition Record. A standardized template will ensure that all data elements specified in the performance measure are included each time a Transition Record is prepared. Each facility has the autonomy to customize the format of the Transition Record, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution

Transmitting the Transition Record with Specified Elements

This performance measure does not require that the Transition Record be transmitted to the next provider(s) of care. However, if the Transition Record is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model. In addition, the use of recognized interoperability standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR.

Systematic External Reporting of the Transition Record

In order to report, at the facility level, which of the discharged patients have received a Transition Record, a discrete data field and code indicating the patient received a Transition Record at discharge may be needed in the EHR.

Technical Specifications: Retrospective Data Collection Flowsheet

This form is intended to be used for patients who were discharged from the inpatient setting, does not include patients that left against medical advice (AMA) or patients that expired during their inpatient visit.

Transition Record with Specified Elements Received by Discharged Patients
and
Timely Transmission of Transition Record
(Inpatient Discharges to Home/Self Care or Any Other Site of Care)

Patient Name:

Medical Record Number or other patient identifier:

Date of Discharge:

Numerator:

		Yes	No	Instructions
Transition Record with all of the specified elements	**Did patient receive a Transition Record at discharge?** *(Underlined terms are defined below)*			If yes, answer questions below to determine that all appropriate elements were included in the Transition Record.
	Are the following elements included in Transition Record?	**Yes**	**No**	If a given element does not apply to patient, transition record should state the same (eg, no pending studies at discharge)
Inpatient Care	Reason for inpatient admission			
	Major procedures and tests, including summary of results			
	Principal diagnosis at discharge			
Post-Discharge/ Patient Self-Management	Current Medication List			
	Studies Pending at Discharge (or documentation that no studies are pending)			
	Patient Instructions			
Advance Care Plan	Advance directives or surrogate decision maker documented OR Documented reason for not providing advance care plan			
Contact Information/ Plan for Follow-Up Care	24-hour/7-day contact information including physician for emergencies related to inpatient stay			
	Contact information for obtaining results of studies pending at discharge			
	Plan for follow-up care			
	Primary physician, other health care professional, or site designated for follow-up care			

Transition Record with all of the specified elements	**Are ALL specified elements included in the transition record?**			*Review responses above to determine if all elements were included in transition record*

Discharge Information	Date and time patient was discharged from facility		
	Date and time Transition Record was transmitted to receiving facility, or physician, or other health care professional		
	Was Transition Record transmitted within 24 hours of discharge?	**Yes**	**No**

Definition of Terms:

Transition record	A core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in a printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. The Transition record may be provided only in electronic format if acceptable to patient.
Current medication list	All medications to be taken by patient after discharge, including all continued and new medications
Advance directives	eg, written statement of patient wishes regarding future use of life-sustaining medical treatment
Documented reason for not providing advance care plan	Documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship
Contact information/ plan for follow-up care	For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the "receiving" facilities.
Plan for follow-up care	May include any post-discharge therapy needed (eg, oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc.
Primary physician or other health care professional designated for follow-up care	May be designated primary care physician (PCP), medical specialist, or other physician or health care professional
Transmitted	Transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).

Additional Information

By requiring the completion and prompt transmission of a detailed "transition record" for discharged patients, these measures are promoting a significant enhancement to the customary use of the "discharge summary," the traditional means of information transfer for which existing standards require completion within 30 days. Numerous studies have documented the prevalence of communication gaps and discontinuities in care for patients after discharge,[9-11] and the significant effect of these lapses on hospital readmissions and other indicators of the quality of transitional care.[17-20] Current information and communication technology can facilitate the routine completion and transmission of a transition record within 24 hours of discharge, which could greatly reduce communication gaps and may have a positive downstream effect on patient outcomes.

Consistent with the cited Joint Commission standards, the information in the transition record should be provided in a manner that can be understood by patients or their caregivers. Patient/caregiver understanding of this information may be assessed by various methods, including "teach-back."

Measures 1, 2, & 3 address closely related, interdependent aspects of the transition in care for patients discharged from an inpatient facility and are therefore proposed as a bundled set of measures. The intent of this proposal is that the measures always be used together when assessing performance; no one of these measures should be selected for use independently. The bundling of the measures is *not* intended to suggest the use of any particular scoring methodology (ie, a composite score), nor does it imply either equality or difference in the relative "weights" of the three measures. A performance score for each of the three measures should be reported individually.

This rationale and methodology for a measure bundle are consistent with the definitions for "bundle" and "composite" provided by the Institute for Healthcare Improvement (IHI):

> Bundle – a series of interventions related to a specific condition that, when implemented together, will achieve significantly better outcomes than when implemented individually.
>
> Composite measure – a combination of two or more individual measures into a single measure that results in a single score. (www.ihi.org)

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

Top

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

Top

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.*

Top

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

Top

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)

Top

Top

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.

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.

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

Top

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

Top

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.

Top

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

Top

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)

Glossary (/glossary)

Contact Us (/contact)

Top

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.		
Copyright and disclaimer notice			

	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)