OHIC Measure Alignment Work Group
2021 Annual Review of the Behavioral Health Hospital Aligned Measure Set
Measure Specifications

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Replaced “mental health practitioner” with “mental health provider.”
- Removed the mental health provider requirement for follow-up visits for intensive outpatient encounters, partial hospitalizations, community mental health centers and electroconvulsive therapy settings.
- Added visits in a behavioral healthcare setting to the numerator.
- Added telephone visits to the numerator.
- Deleted the Mental Health Practitioner Value Set.
- Revised the instructions in the *Notes* for identifying mental health providers.

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

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice*.

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	No gaps in enrollment.
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.

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.

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.

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

	Administrative
Measurement year	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*Each of the 2 rates for each age stratification and total*
Numerator events by supplemental data	*Each of the 2 rates for each age stratification and total*
Reported rate	*Each of the 2 rates for each age stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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**
Optional Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

Measure #3: Timely Transmission of Transition Record

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

Measure Components

Numerator Statement ➢ **See "Additional Information" for clarification on the bundling of measures 1, 2, & 3**	Patients for whom a transition record[a] was transmitted[b] to the facility or primary physician or other health care professional designated for follow-up care[c] within 24 hours of discharge 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. 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) *c.* Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional
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. **Coordinating Clinicians** Communication and information exchange between the Medical Home and the receiving provider should occur in an amount of time that will allow the receiving provider to effectively treat the patient. This communication should ideally occur whenever patients are at a transition of care; eg, at discharge from the inpatient setting. The timeliness of this communication should be consistent with the patient's clinical presentation and, in the case of a patient being discharged, the urgency of the follow-up required. Communication and information exchange between the MH and the physician may be in the form of a call, voicemail, fax, or other secure, private, and accessible means, including mutual access to an EHR. (TOCCC, 2008)[21] **Standard PC.02.02.01** The [organization] coordinates the [patient]'s care, treatment, and services based on the [patient]'s needs.

1. The hospital has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services. (See also PC.04.02.01, EP 1) (The Joint Commission, 2009)[23]

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.

1. 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)

Safe Practice #8: Communication of Critical Information
Ensure that care information is transmitted and appropriately documented in a timely manner and in a clearly understandable form to patients and to all of the patient's healthcare providers/professionals, within and between care settings, who need that information to provide continued care. (National Quality Forum Safe Practices, 2006)[26]

Safe Practice #11: Discharge Systems
A "discharge plan" must be prepared for each patient at the time of hospital discharge, and a concise discharge summary must be prepared for and relayed to the clinical caregiver accepting responsibility for postdischarge care in a timely manner.

Organizations must ensure that there is confirmation of the receipt of the discharge information by the independent licensed practitioner who will assume the responsibility for care after discharge.

- A discharge summary must be provided to the clinical provider who accepts the patient's care after hospital discharge. At a minimum, the discharge summary should include the following:
  - the reason for hospitalization;
  - significant findings;
  - procedures performed and care, treatment, and services provided to the patient
  - the patient's condition at discharge
  - information provided to the patient and family
  - a comprehensive and reconciled medication list; and
  - a list of acute medical issues and tests and studies for which confirmed results were unavailable at the time of discharge that require follow-up

The organization should ensure and document the receipt of the discharge information by caregivers who assume responsibility for postdischarge care. This confirmation may occur via telephone, fax, e-mail response, or other electronic response using health information technologies. (National Quality Forum Safe Practices, 2006)[26]

Measure Importance

Relationship to	The availability of the patient's discharge information at the first post-discharge physician visit

desired outcome	improves the continuity of care and may be associated with a decreased risk of rehospitalization.[18]
Opportunity for Improvement	A recent literature summary found that direct communication between hospital physicians and primary care physicians occurred infrequently (in 3-20% of cases studied) and that the availability of a discharge summary at the first post-discharge visit was low (12-34%) and did not improve greatly even after 4 weeks (51-77%), affecting the quality of care in approximately 25% of follow-up visits.[17]
IOM Domains of Health Care Quality Addressed[25]	• Safe • Patient-centered • Timely • 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 (included in tool for Measure #2 above).
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 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.

Transmitting the Transition Record with Specified Elements
The Transition Record should be transmitted to the next provider(s) of care 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 (https://ecqi.healthit.gov/qdm). 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 that the Transition Record was transmitted within 24 hours of discharge
To systematically identify the transition records that were transmitted within 24 hours of discharge, a discrete data field and code may be needed in the EHR. This discrete data field will facilitate external reporting of the information.

Technical Specifications: Retrospective Data Collection Flowsheet

See Measure #2: Transition Record with Specified Elements Received by Discharged Patients (above)

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.

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)

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)

Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an inpatient psychiatric facility (IPF)

NQF Endorsement Status	Endorsed
NQF ID	2860
Measure Type	Outcome
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

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.

Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an inpatient psychiatric facility (IPF)

	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

Developer/Steward

Steward	Centers for Medicare & Medicaid Services (CMS)

Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an inpatient psychiatric facility (IPF)

Contact	Not Available
Measure Developer	Health Services Advisory Group (HSAG)
Development Stage	Fully Developed

Characteristics

Measure Type	Outcome
Meaningful Measure Area	Admissions and Readmissions to Hospitals
Healthcare Priority	Promote Effective Communication & Coordination of Care
eCQM Spec Available	No
NQF Endorsement Status	Endorsed
NQF ID	2860
Last NQF Update	2019-06-12
Target Population Age	18+
Target Population Age (High)	Not Available
Target Population Age (Low)	18
Reporting Level	Facility
Conditions	Behavioral/Mental Health
Subconditions	Dementia
Care Settings	Hospital Inpatient; IPF

Groups

Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an inpatient psychiatric facility (IPF)

Core Measure Set	Not Available

Measure Group	Group Identifier
READM	30-IPF

Measure Links

Measure Program: Inpatient Psychiatric Facility Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Claims Data
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2017-01-01
Data Reporting End Date	Not Available

Measure Program Links

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

Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an inpatient psychiatric facility (IPF)

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

Milestones

Milestone: Implemented

Effective Date	2018-10-01
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

Milestone: Finalized

Effective Date	2016-08-22	
Comments	Not Available	
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf	
Other Data	**Name**	**Value**
	MUC Year	2015
	MUC ID	MUC15-1082

Milestone: Proposed

Effective Date	2016-04-27
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-04-27/pdf/2016-09120.pdf

Milestone: Considered

Effective Date	2015-12-01
Comments	Not Available

Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an inpatient psychiatric facility (IPF)

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html#17

Measure Program: Hospital Compare

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

Measure Program Links

Milestones

Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an inpatient psychiatric facility (IPF)

Milestone: Implemented

Effective Date	2020-01-01
Comments	Not Available
Milestone Links	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

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

referred 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.
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- 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.
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- 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.
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- 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.

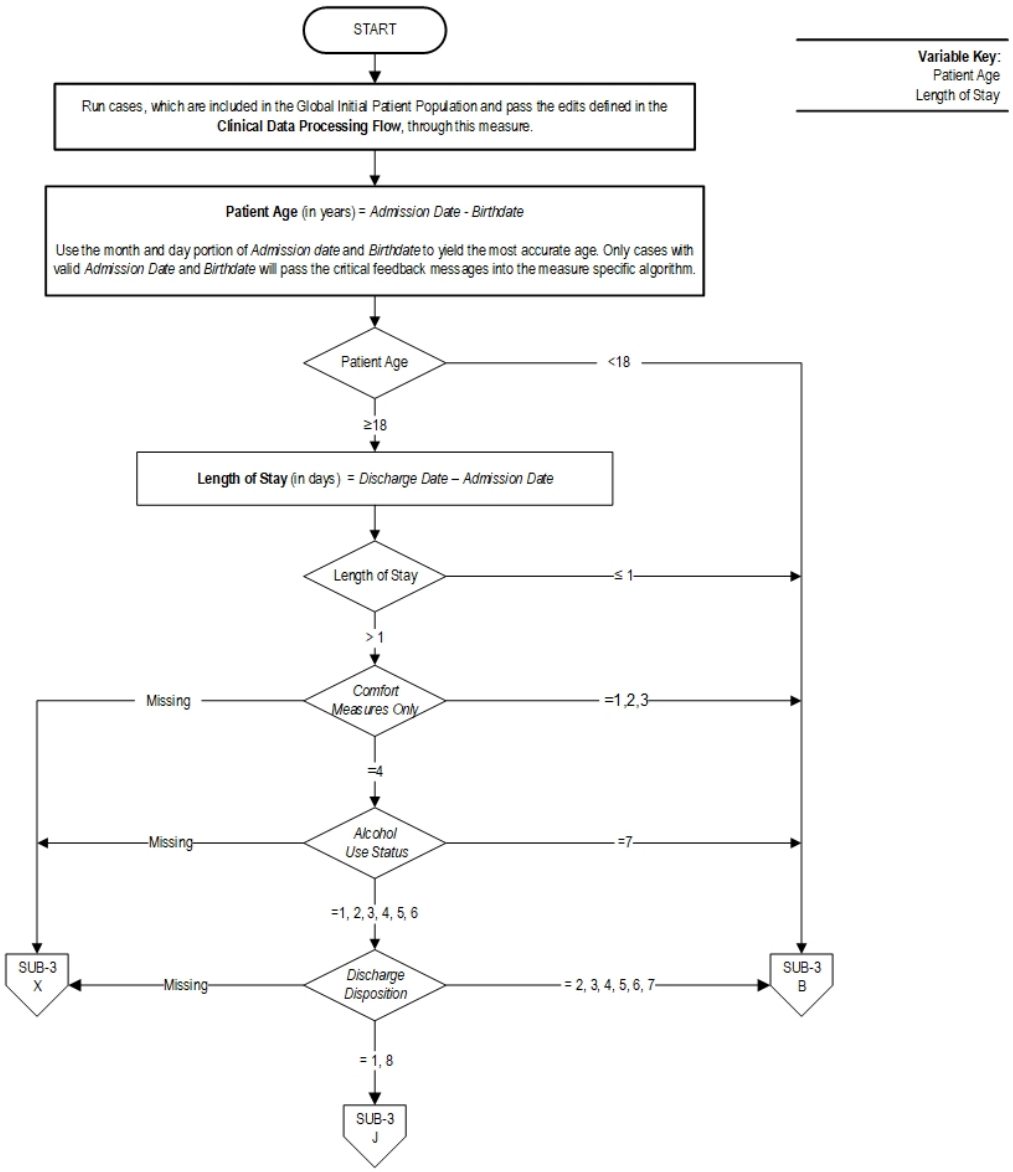
- The National Quality Forum, National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices; A Consensus Report; 2007.

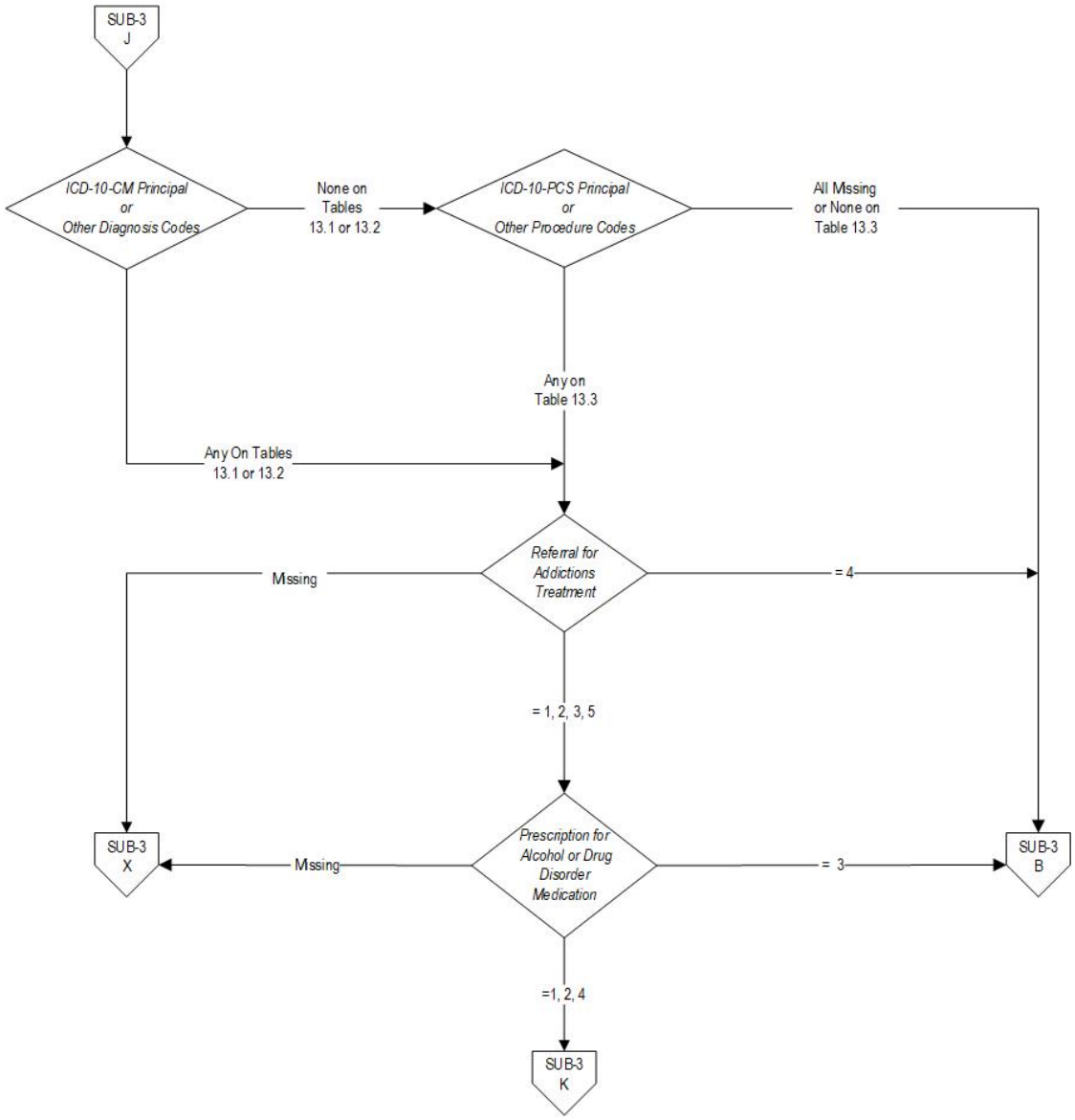
Measure Algorithm:

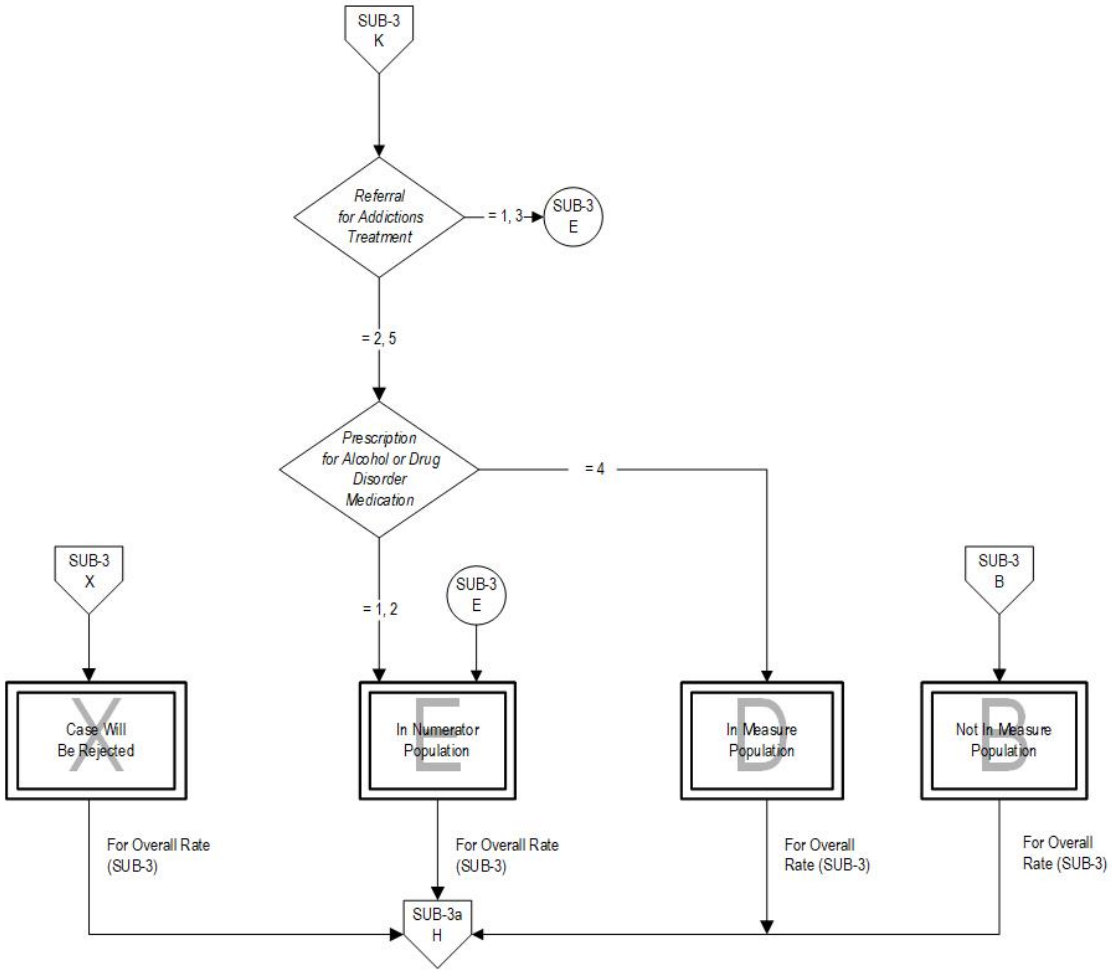
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge

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.



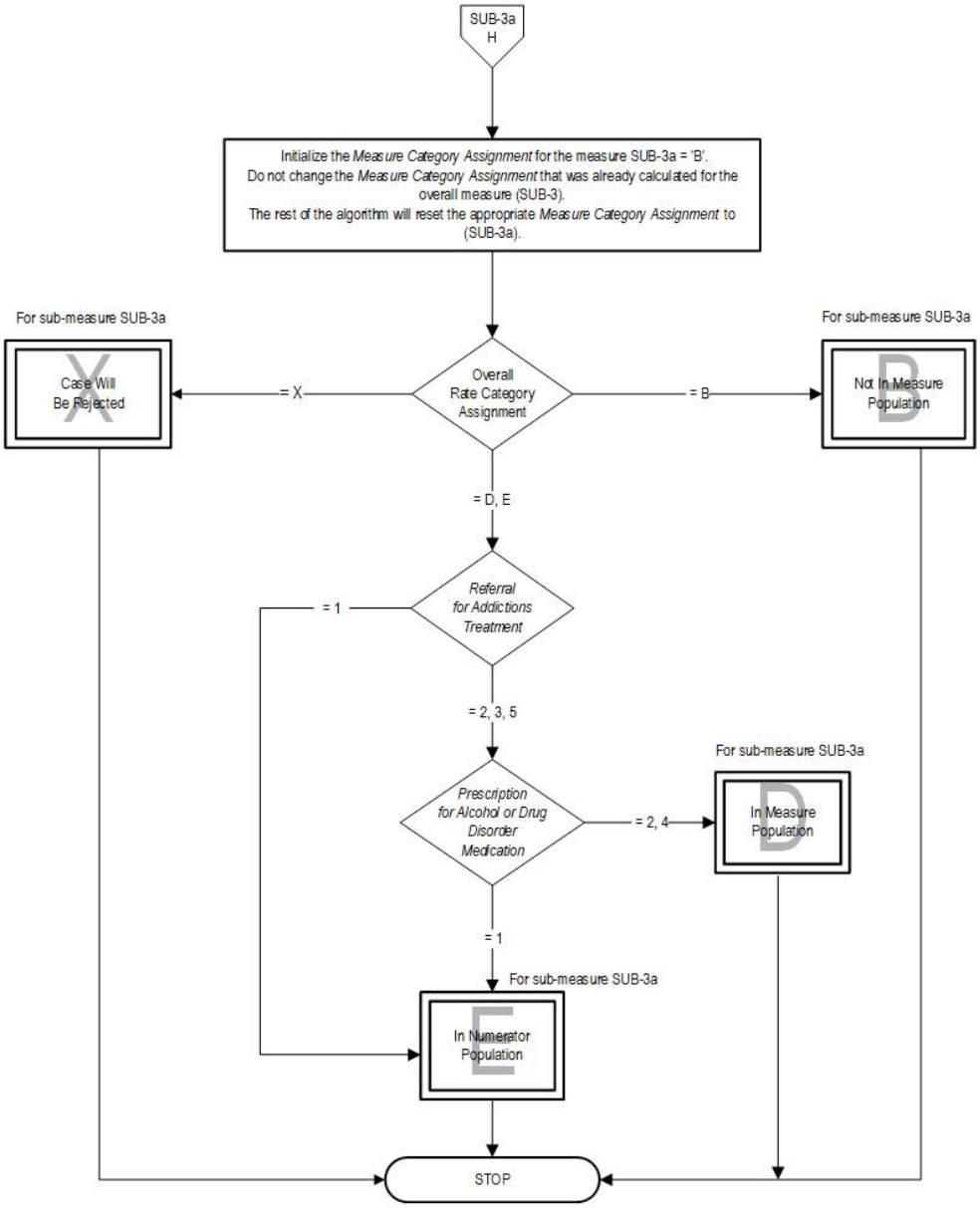




SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge

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.



****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:

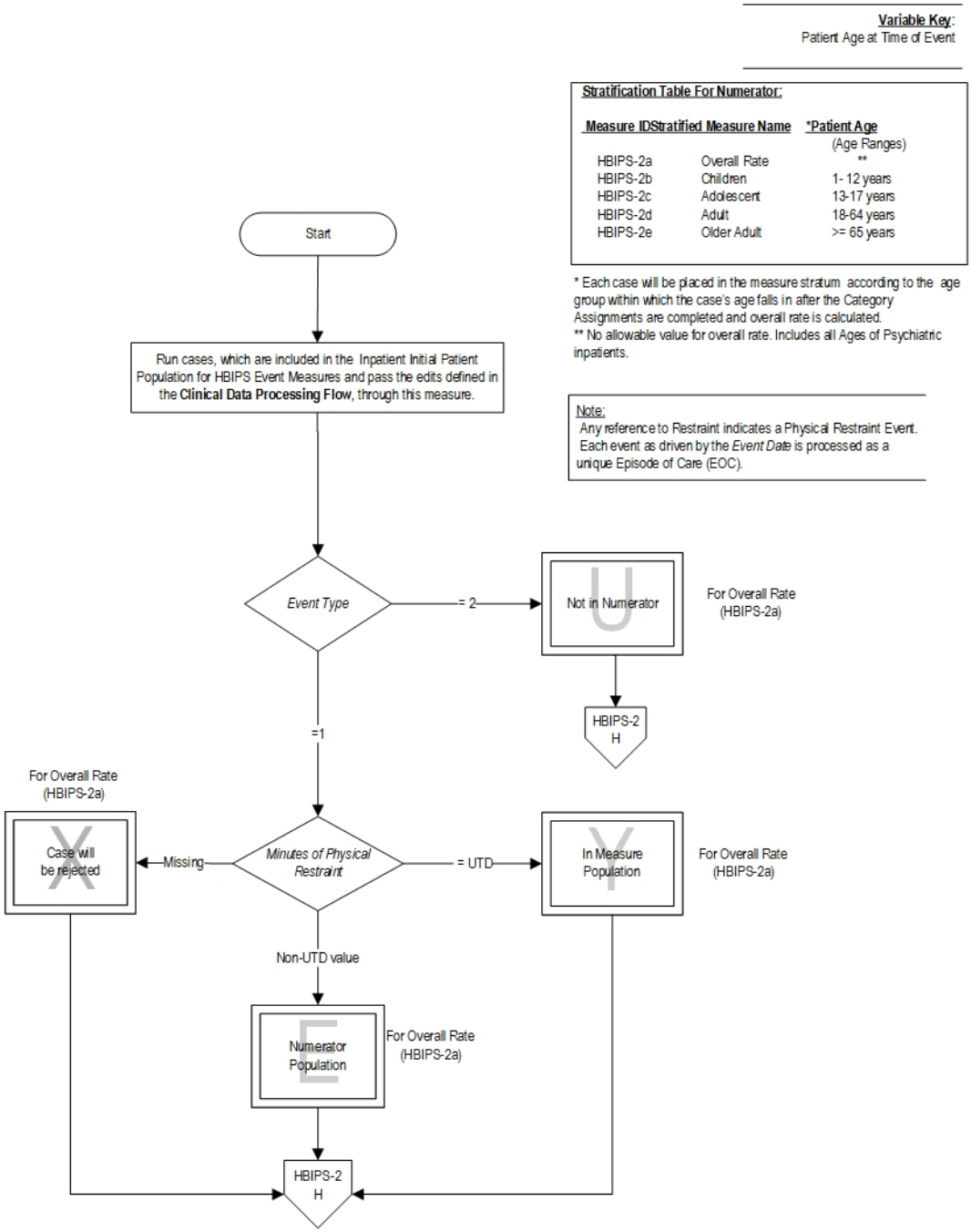
- Donat, D. (August, 2003). An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. *Psychiatric Services*. 54(8): 1119-1123.
- Fisher, W. A. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, 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

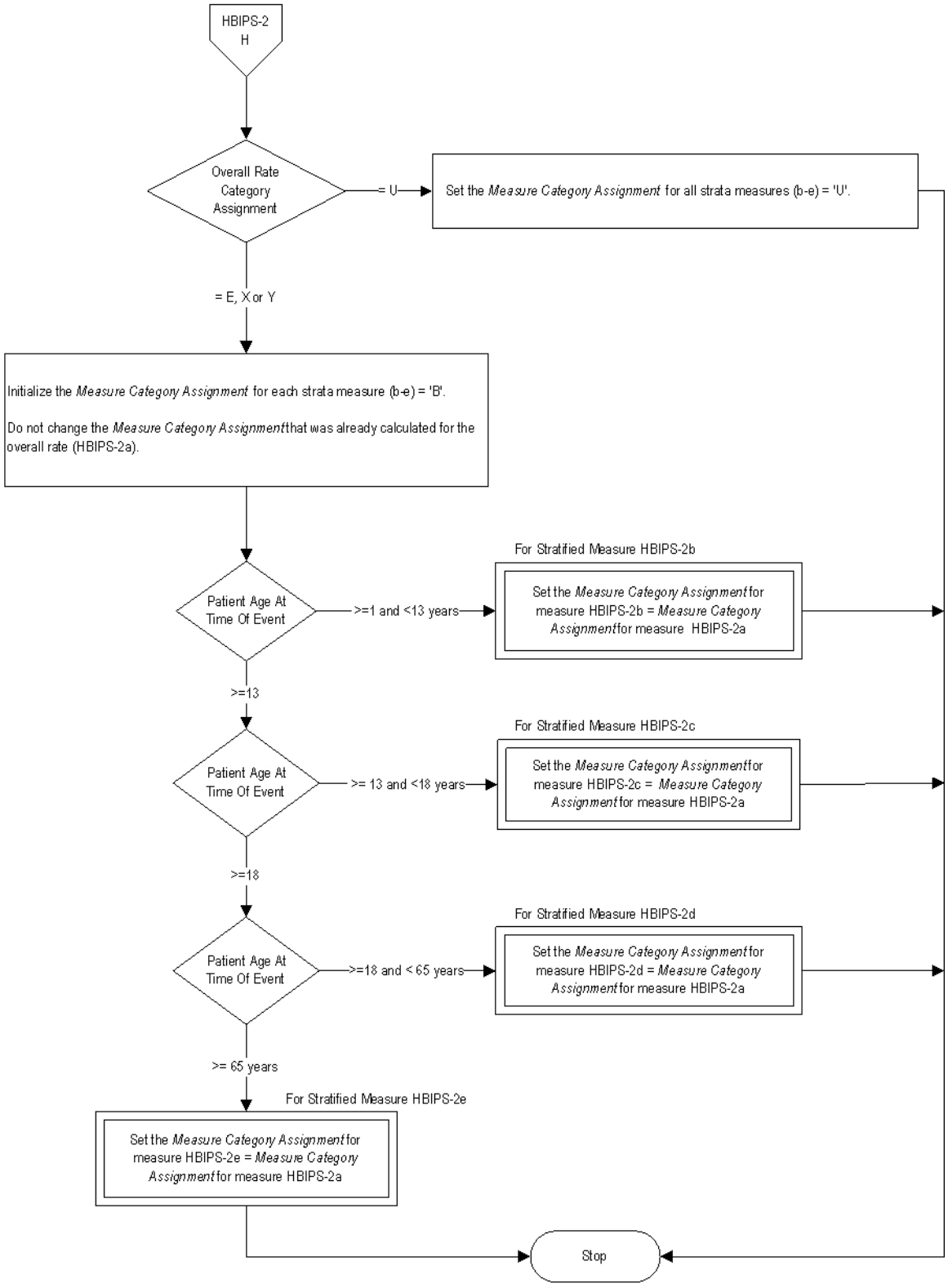
Measure Algorithm:

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:

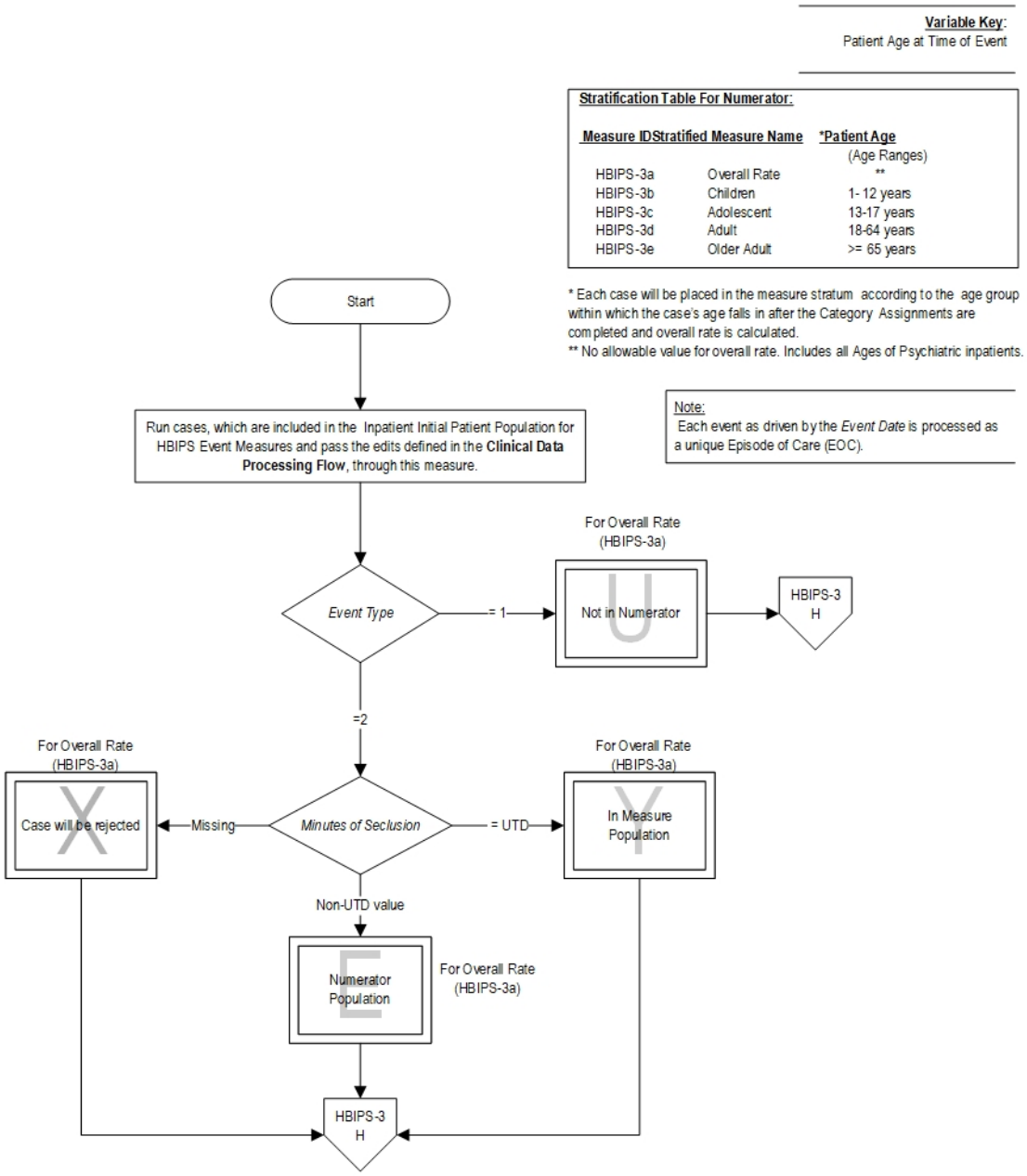
- Donat, D. (August, 2003). An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. *Psychiatric Services*. 54(8): 1119-1123.
- Fisher, W. A. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, 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

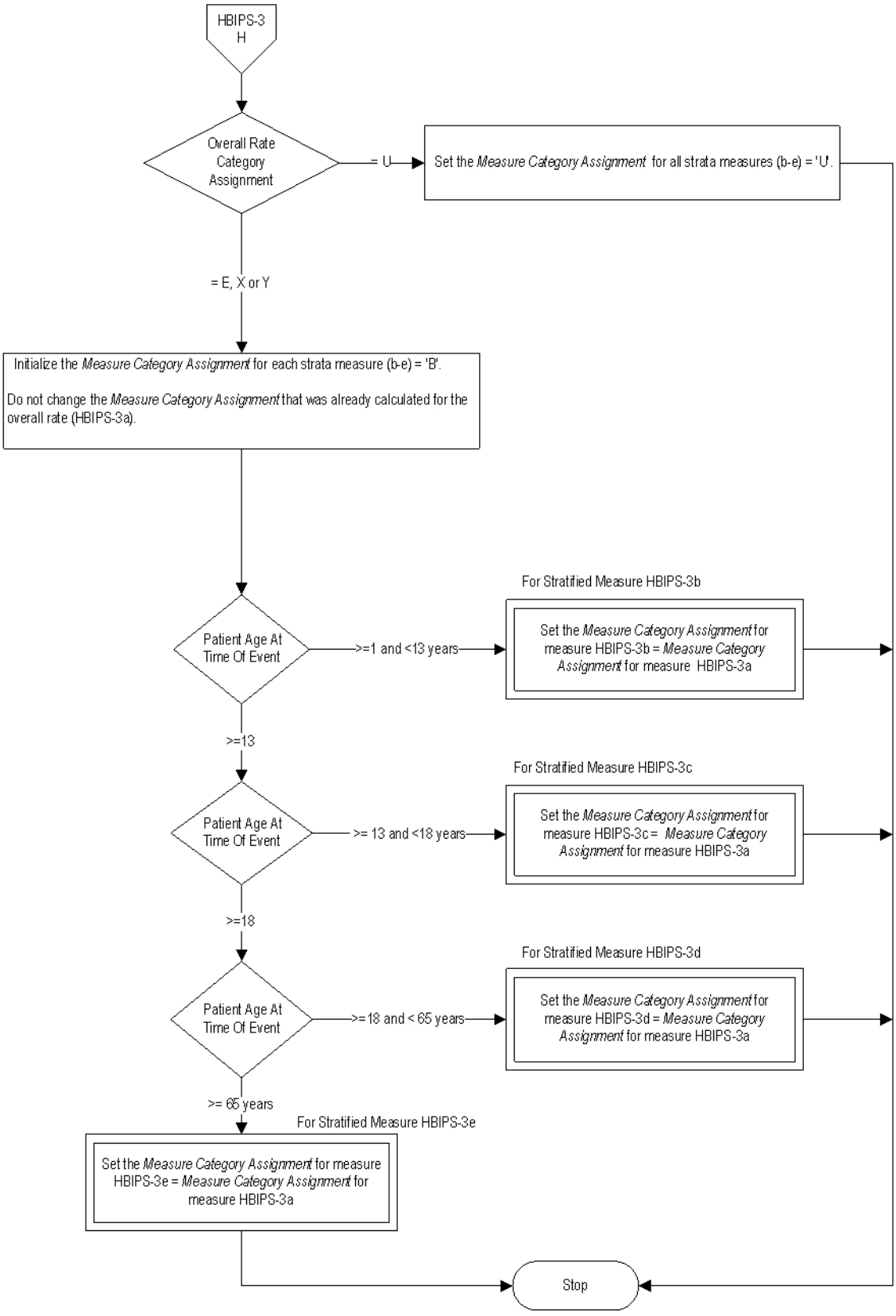
Measure Algorithm:

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 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, Salvatore, 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.

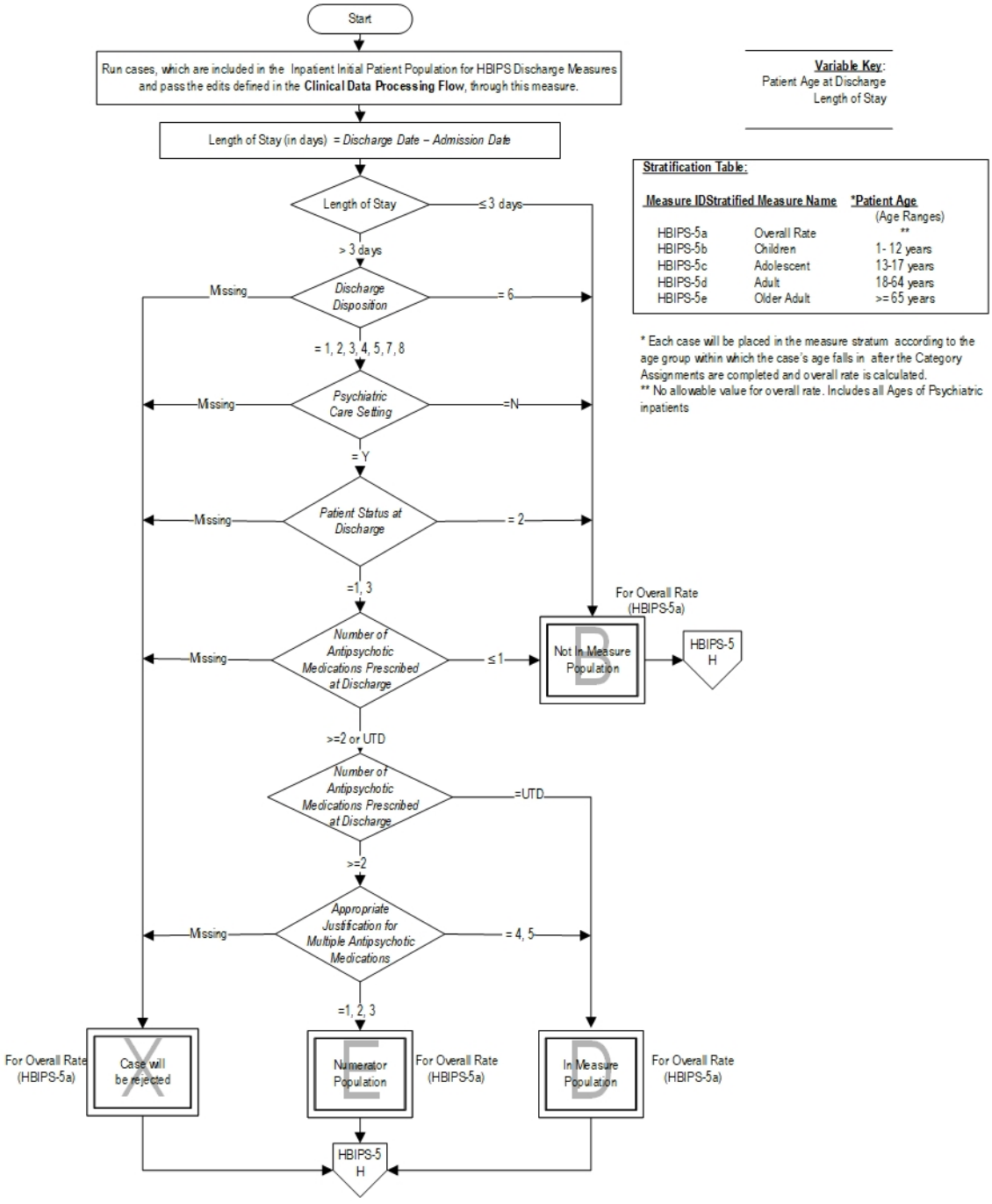
- Stahl, S.M. & Grady, M.M. (2004). A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy augmentation. *Curr Med Chem.11*:313-327.
- Tranulis, C., Skalli, L., Lalonde, P., & Nicole, L. (2008). Benefits and risks of antipsychotic polypharmacy. An evidence based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

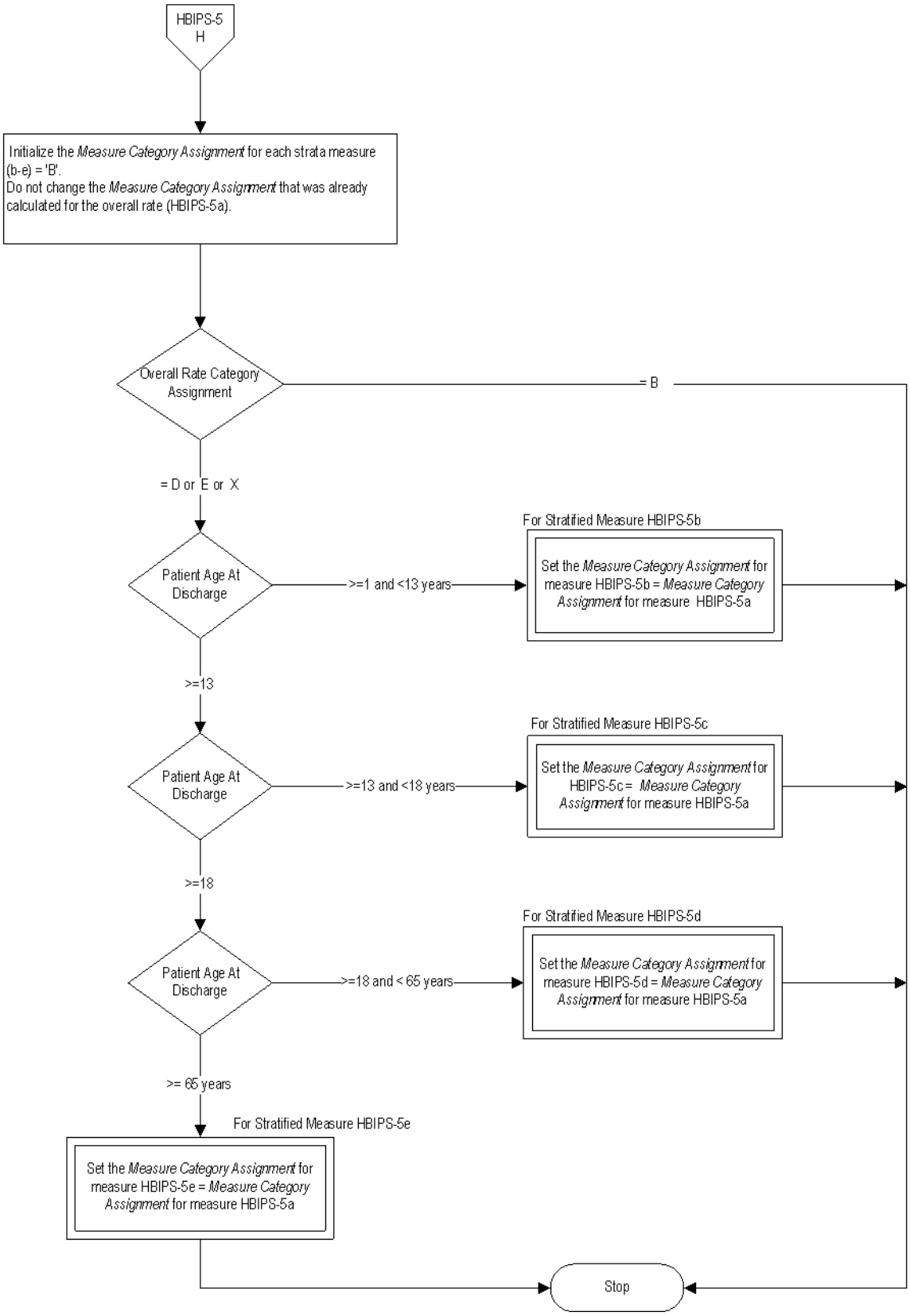
Measure Algorithm:

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.





Appendix B: Screening for Metabolic Disorders

Measure Information Form

Performance Measure Name: Screening for Metabolic Disorders

Description: Percentage of patients discharged from an Inpatient Psychiatric Facility (IPF) with a prescription for one or more routinely scheduled antipsychotic medications for which a structured metabolic screening for four elements was completed in the 12 months prior to discharge – either prior to or during the index IPF stay.

Rationale: Studies show that antipsychotics increase the risk of metabolic syndrome.[1] Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes.

In 2004, a consensus statement was released by the ADA, the APA, the AACE, and the NAASO regarding an association between the use of specific SGAs and diabetes and obesity.[1] This group recommended that providers obtain baseline screening for metabolic syndrome prior to or immediately after the initiation of antipsychotics to reduce the risk of preventable adverse events and improve the physical health status of the patient.

The Screening for Metabolic Disorders measure was developed to assess the percentage of patients discharged with antipsychotics from an IPF for which a structured metabolic screening for four elements was completed in the past year.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: The total number of patients who received a metabolic screening in the 12 months prior to discharge, either prior to or during the index IPF stay

Data Elements:

- Body Mass Index (BMI)
- Blood Pressure
- Blood Glucose
- Discharge Disposition
- Lipid Panel
- Reason for Incomplete Metabolic Screening

Denominator Statement: Discharges from an IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications

Included Populations: All patients discharged from IPFs with one or more routinely scheduled antipsychotic medications during the measurement period

Excluded Populations:

- Patients for whom a screening could not be completed due to the patient's enduring unstable medical condition or enduring unstable psychological condition

- Patients with a LOS equal to or greater than 365 days, or equal to or less than three days
- Patients who expired during the admission (Discharge Disposition = 6)

Data Elements:

- Admission Date
- Discharge Date
- Number of Antipsychotic Medications Prescribed at Discharge

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.

Screening Elements:

- The medical record must provide documentation of the completion of all four of the following tests/measurements:
    - BMI
    - Blood Pressure
    - Blood Glucose
    - Lipid Panel

Criteria for the Screening:

- Screenings can be conducted either at the reporting facility or another facility for which records are available to the reporting facility.
- The completion of each screening element is determined by identifying the documentation of at least one numeric result in the medical record reviewed.
- The report date for the screening must be within the 12 months prior to the patient's date of discharge.

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.

Sampling: For reporting to the IPFQR Program, two options are available for sampling, as described on pages 18–19 of this program manual.

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

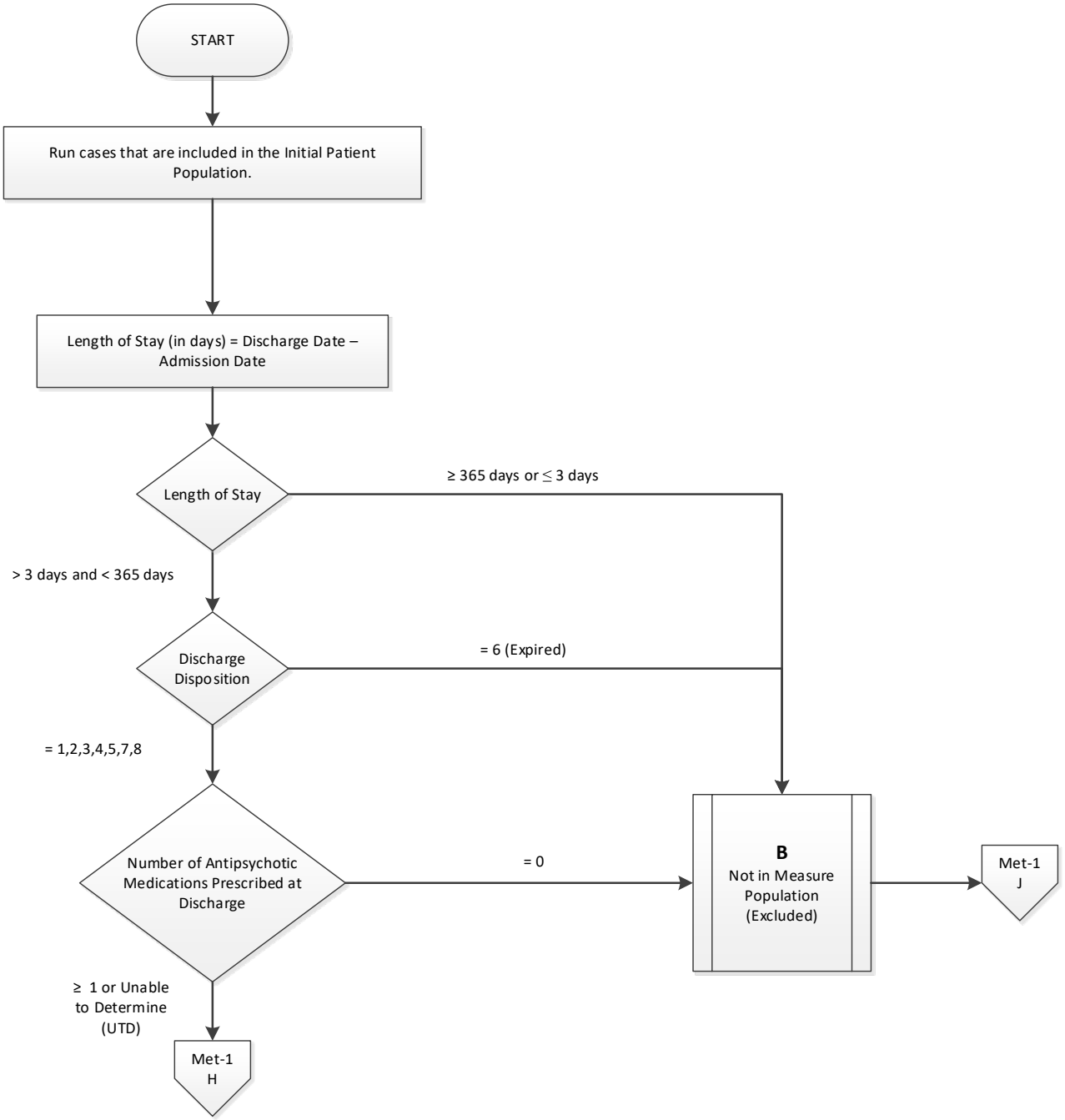
Selected Reference:

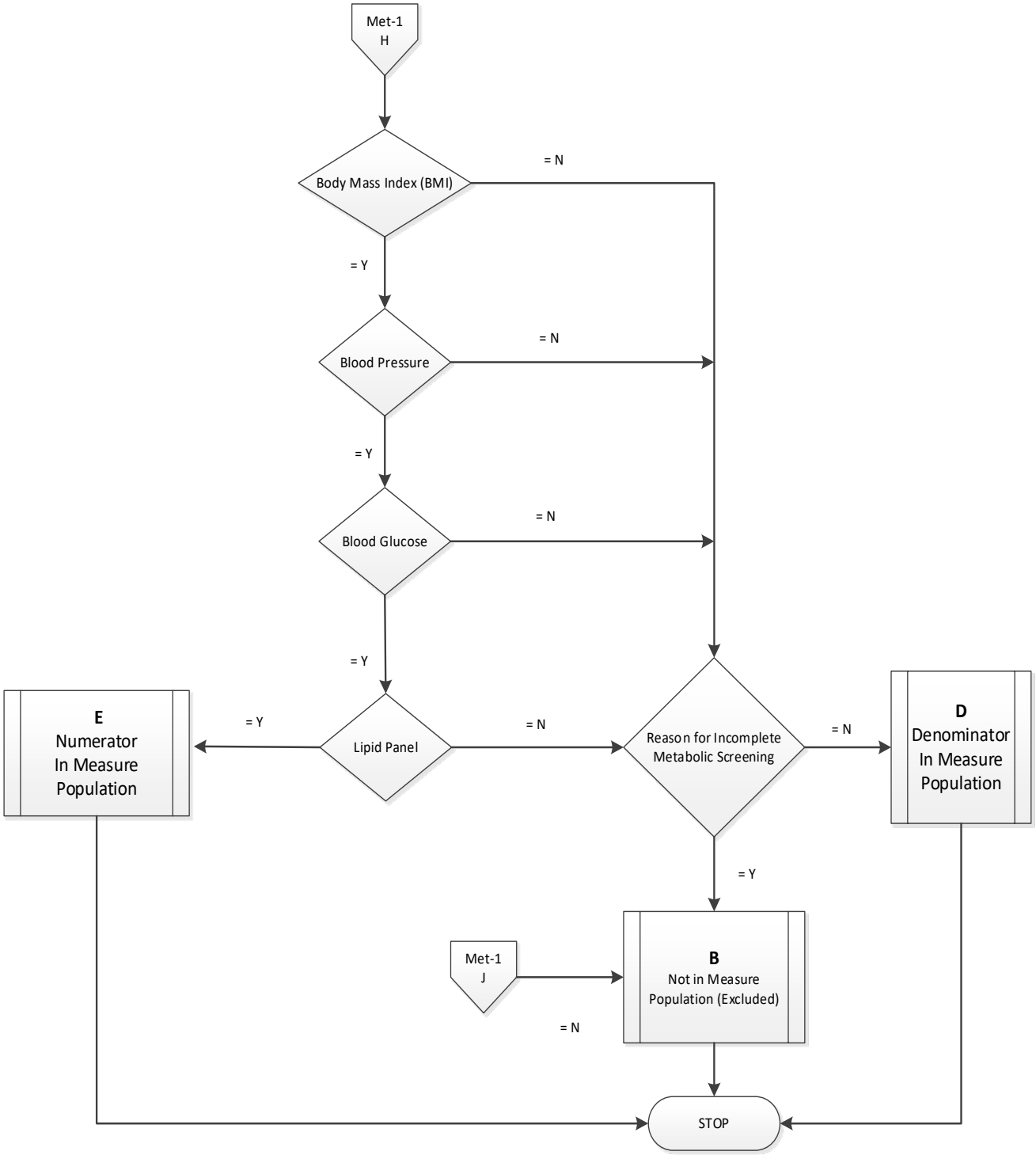
1. The American Diabetes Association, American Psychological Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care*. 2004;27(596–601).

Screening for Metabolic Disorders

Numerator: The total number of patients who received a metabolic screening in the 12 months prior to discharge–either prior to or during the index IPF stay

Denominator: Discharges from an IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications




Met-1
H
Body Mass Index (BMI)
= N
= Y
Blood Pressure
= N
= Y
Blood Glucose
= N
= Y
E
Numerator
In Measure
Population
= Y
Lipid Panel
= N
Reason for Incomplete
Metabolic Screening
= N
D
Denominator
In Measure
Population
= Y
Met-1
J
B
Not in Measure
Population (Excluded)
= N
STOP

Screening for Metabolic Disorders Narrative

Numerator: The total number of patients who received a metabolic screening in the 12 months prior to discharge–either prior to or during the index IPF stay

Denominator: Discharges from an IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications

1. Start processing. Run cases that are included in the Initial Patient Population.
2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date.
3. Check Length of Stay.
    a. If Length of Stay is equal to or greater than 365 days or equal to or less than 3 days, the record will proceed to Measure Category Assignment of B and will not be in the Measure Population (excluded). Stop processing.
    b. If Length of Stay is less than 365 days and greater than 3 days, proceed to Discharge Disposition.
4. Check Discharge Disposition.
    a. If Discharge Disposition equals 6, the record will proceed to Measure Category Assignment of B and will not be in the Measure Population (excluded). Stop processing.
    b. If Discharge Disposition equals 1, 2, 3, 4, 5, 7, or 8, proceed to Number of Antipsychotic Medications Prescribed at Discharge.
5. Check Number of Antipsychotic Medications Prescribed at Discharge.
    a. If Number of Antipsychotic Medications Prescribed at Discharge is equal to zero, the record will proceed to Measure Category Assignment of B and will not be in the Measure Population (excluded). Stop processing.
    b. If Number of Antipsychotic Medications Prescribed at Discharge is equal to or greater than 1 or unable to determine, proceed to Body Mass Index.
6. Check Body Mass Index.
    a. If Body Mass Index equals No, proceed to Reason for Incomplete Metabolic Screening.
    b. If Body Mass Index equals Yes, proceed to Blood Pressure.
7. Check Blood Pressure.
    a. If Blood Pressure equals No, proceed to Reason for Incomplete Metabolic Screening.
    b. If Blood Pressure equals Yes, proceed to Blood Glucose.
8. Check Blood Glucose.
    a. If Blood Glucose equals No, proceed to Reason for Incomplete Metabolic Screening.
    b. If Blood Glucose equals Yes, proceed to Lipid Panel.
9. Check Lipid Panel.
    a. If Lipid Panel equals No, proceed to Reason for Incomplete Metabolic Screening.
    b. If Lipid Panel equals Yes, the record will proceed to Measure Category Assignment of E and will be in the Numerator Measure Population. Stop processing.
10. Check Reason for Incomplete Metabolic Screening.
    a. If Reason for Incomplete Metabolic Screening equals No, the record will proceed to Measure Category Assignment of D and will be in the Denominator Measure Population. Stop processing.
    b. If Reason for Incomplete Metabolic Screening equals Yes, the record will proceed to Measure Category Assignment of B and will not be in the Measure Population (excluded). Stop processing.

Alphabetical Data Dictionary

(Select an element name to navigate to respective data element)

Index

Data Element Name: *Admission Date*

Definition: The month, day, and year of admission to an inpatient psychiatric facility

Suggested Data Collection Question: What is the date the patient was admitted to the inpatient psychiatric facility?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)

Notes for Abstraction:

- The intent of this data element is to determine the date that the patient was actually admitted to an IPF. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date from billing is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
- If using claim information, "Statement Covers Period" is not synonymous with "Admission Date" and should not be used to abstract this data element. These are two distinctly different identifiers:
  - The Admission Date is purely the date the patient was admitted as an inpatient to the facility.
  - The Statement Covers Period ("From" and "Through" dates) identifies the span of service dates included in a particular claim. The "From" Date is the earliest date of service on the claim.
- For patients who are admitted to observation status and subsequently admitted to inpatient psychiatric care, abstract the date that the determination was made to admit to inpatient psychiatric care and the order was written. Do not abstract the date that the patient was admitted to observation.

  Example:

  Medical record documentation reflects that the patient was admitted to observation on 04/05/2020. On 04/06/2020, the physician writes an order to admit to inpatient psychiatric care, effective 04/05/2020. The Admission Date would be abstracted as 04/06/2020; the date the determination was made to admit to inpatient psychiatric care and the order was written.
- The Admission Date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient psychiatric care, this date should not be used.
- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.

Suggested Data Sources:

Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other Only Allowable Sources to determine the *Admission Date*.

ONLY ALLOWABLE SOURCES:

1. Physician orders
2. Face sheet
3. UB-04

Excluded Data Sources: UB-04 "From" and "Through" dates
Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction:

- Admit to observation
- Arrival date

Data Element Name: *Blood Glucose*

Definition: A lab test of glucose levels in the blood

Suggested Data Collection Question: Is there documentation of a numerical value of blood glucose in the patient's medical record during this stay or at any time during the 12 months prior to discharge?

Format:

Length: 1
Type: Character
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record of the numerical value of blood glucose tested during the stay or at any time during the 12 months prior to discharge.

N (No) Documentation in the medical record does not include the numerical value of blood glucose tested during the stay or at any time during the 12 months prior to discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- To meet the screening element for Blood Glucose, the abstractor must identify at least one documented result of HbA1c, fasting blood glucose, or two-hour post blood glucose value during a 75 g Oral Glucose Tolerance Test (OGTT). Fasting is not required for an HbA1c.
- Blood glucose results can be derived from either plasma or serum and can be obtained as an independent test or as part of a Comprehensive Metabolic Panel or Basic Metabolic Panel. However, there must be explicit documentation associated with the glucose test that the patient fasted prior to the test. If there is no documentation that the patient fasted prior to performing the glucose test, that test cannot be used for this data element.
- Review only the medical record of the current patient stay. The record must contain at least one documented result for a qualifying test listed above with a result date within 12 months prior to the date of discharge. If the clinician accessed the medical record/EMR and obtained blood glucose results from a previous stay or visit within the 12 months prior to the date of discharge, documentation in the current record must also include the source of the result (e.g., medical record of prior hospital stay, EMR, or the name of the provider who ordered the test).
- If the patient refuses during this admission and no other documentation regarding a previous blood glucose result is found, select "No."

Suggested Data Sources:

- Emergency department record
- Consultation notes
- History and physical
- Initial (admission) assessment form
- Laboratory reports
- Nursing graphic sheets

- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form

Inclusion Guidelines for Abstraction:

- Fasting blood glucose from plasma or serum
- Fasting sugar
- HbA1c
- Two-hour post blood glucose value during a 75g OGTT

Exclusion Guidelines for Abstraction:

- Non-quantitative assessment of glucose test (i.e., normal, abnormal, etc.)
- Finger-stick blood sugar (FSBS)

Data Element Name: *Blood Pressure*

Definition: A reading of diastolic and systolic blood pressure

Suggested Data Collection Question: Was there a blood pressure (numerical systolic and diastolic values in mmHg) documented in the patient's medical record during this stay or at any time during the 12 months prior to discharge?

Format:

Length: 1
Type: Character
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record of the numerical value of blood pressure tested during the stay or at any time during the 12 months prior to discharge.
N (No) Documentation in the medical record does not include the numerical value of blood pressure tested during the stay or at any time during the 12 months prior to discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- To meet the screening element for Blood Pressure, the abstractor must identify at least one documented value.
- Review only the medical record of the current patient stay. The record must contain at least one documented result with a result date within 12 months prior to the date of discharge. If the clinician accessed the medical record/EMR and obtained blood pressure results from a previous stay or visit within the 12 months prior to the date of discharge, documentation in the current record must also include the source of the result (e.g., medical record of prior hospital stay, EMR, or name of provider who ordered the test).
- If the patient refuses during this admission and no other documentation regarding a previous blood pressure result is found, select "No."

Suggested Data Sources:

- Biopsychosocial assessment
- Emergency department record
- History and physical
- Initial (admission) assessment form
- Laboratory Report
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Vital record/flow sheet

Inclusion Guidelines for Abstraction:

- None

Exclusion Guidelines for Abstraction:

- Self-reported blood pressure
- Non-quantitative assessment of blood pressure (i.e. normal, abnormal, etc.)

Data Element Name: *Body Mass Index (BMI)*

Definition: A weight-to-height ratio calculated by dividing weight in kilograms (kg) by the square of height in meters (m). If the weight is in pounds (lb) and height is in feet (ft) or inches (in), conversion to the metric unit is needed prior to the BMI calculation.

Suggested Data Collection Question: Was there a numerical value of Body Mass Index (BMI) documented in the patient's medical record during this stay or at any time during the 12 months prior to discharge?

Format:

Length: 1
Type: Character
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record of the numerical value of BMI tested during the stay or at any time during the 12 months prior to discharge.
N (No) Documentation in the medical record does not include the numerical value of BMI tested during the stay or at any time during the 12 months prior to discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- To meet the screening element for BMI, the abstractor must identify at least one documented value. Documentation of height and weight only is NOT an acceptable substitute for BMI.
- Review only the medical record of the current patient stay. The record must contain at least one documented result with a result date within 12 months prior to the date of discharge. If the clinician accessed the medical record/EMR and obtained BMI from a previous stay or visit within the 12 months prior to the date of discharge, documentation in the current record must also include the source of the result (e.g., medical record of prior hospital stay, EMR or the name of the provider who ordered the test).
- If the patient refuses during this admission and no other documentation regarding a previous BMI is found, select "No."

Suggested Data Sources:

- Biopsychosocial assessment
- Emergency department record
- History and physical
- Initial (admission) assessment form
- Nursing graphic sheets
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form

Inclusion Guidelines for Abstraction:

- None

Exclusion Guidelines for Abstraction:

- Documentation of height and weight only
- Non-quantitative assessment of BMI (i.e., normal, abnormal, etc.)

Data Element Name: *Discharge Date*

Definition: The month, day, and year the patient was discharged from inpatient psychiatric care, left against medical advice, or expired during this stay

Suggested Data Collection Question: What is the date the patient was discharged from inpatient psychiatric care, left against medical advice (AMA), or expired?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)

Notes for Abstraction:

Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

Suggested Data Sources:

- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: *Discharge Disposition*

Definition: The final place or setting to which the patient was discharged on the day of discharge

Suggested Data Collection Question: What was the patient's discharge disposition on the day of discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 – Home
2 – Hospice: Home
3 – Hospice: Health Care Facility
4 – Acute Care Facility
5 – Other Health Care Facility
6 – Expired
7 – Left Against Medical Advice/AMA
8 – Not Documented or Unable to Determine (UTD)

Notes for Abstraction:

- Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.
  Example:
  Documentation in the Discharge Planning notes on 04/01/2020 state that the patient will be discharged back home. On 04/06/2020, the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04/06/2020 would be used to select value "5" (Other Health Care Facility).
- The medical record must be abstracted as documented (taken at "face value"). Inferences should not be made based on internal knowledge.
- If there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.
  Examples:
  - Discharge summary dictated two days after discharge states patient went home. Physician note on day of discharge further clarifies that the patient will be going home with hospice. Select value "2" (Hospice: Home).
  - Discharge planner note from day before discharge states XYZ Nursing Home. Discharge order from day of discharge states discharge home. With contradictory documentation, use latest. Select value "1" (Home).
  - Physician order on discharge states Discharge to assisted living facility (ALF). Discharge instruction sheet completed after the physician order states patient discharged to SNF. With contradictory documentation, use latest. Select value "5" (Other Health Care Facility).

- If documentation is contradictory and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. (See Inclusion lists for examples.)
    - Acute Care Facility
    - Hospice: Health Care Facility
    - Hospice: Home
    - Other Health Care Facility
    - Home
- Hospice (values "2" and "3") includes discharges with hospice referrals and evaluations.
- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value "4" (Acute Care Facility).
- If the medical record states the patient is being discharged to assisted living care or an assisted living facility (ALF) and the documentation also includes nursing home, intermediate care, or skilled nursing facility, select Value "1" ("Home").
- If the medical record states the patient is being discharged to nursing home, intermediate care, or skilled nursing facility without mention of assisted living care or assisted living facility (ALF), select Value "5" ("Other Health Care Facility").
- If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows) and does not reflect the type of facility or level of care, select value "5" (Other Health Care Facility).
- If the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged, select value "1" (Home).
- When determining whether to select value "7" (Left Against Medical Advice/AMA):
    - Explicit "left against medical advice" documentation is not required (e.g., Patient is refusing to stay for continued care.). Select value "7".
    - Documentation suggesting that the patient left before discharge instructions could be given does not count.
    - A signed AMA form is not required for the purposes of this data element.
    - Do not consider AMA documentation and other disposition documentation as contradictory. If any source states the patient left against medical advice, select value "7," regardless of whether the AMA documentation was written last (e.g., AMA form signed, and discharge instruction sheet states, "Discharged home with belongings."). Select "7".

Suggested Data Sources:

- Progress notes
- Physician orders
- Discharge summary
- Discharge instruction sheet
- Discharge planning notes
- Nursing discharge notes
- Social services notes
- Transfer record

Excluded Data Sources:

- Any documentation prior to the last two days of hospitalization
- Coding documents
- UB-04

Inclusion Guidelines for Abstraction:

Home (Value 1):

- Assisted Living Facilities (ALFs) – Includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities
- Court/Law Enforcement – Includes detention facilities, jails, and prison
- Home – Includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters
- Home with Home Health Services
- Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization

Hospice – Home (Value 2):

- Hospice in the home (or other Home setting as above in Value 1)

Hospice Health Care Facility (Value 3):

- Hospice – General Inpatient and Respite
- Hospice – Residential and Skilled Facilities
- Hospice – Other Health Care Facilities

Acute Care Facility (Value 4):

- Acute Short Term General and Critical Access Hospitals
- Cancer and Children's Hospitals
- Department of Defense and Veteran's Administration Hospitals

Other Health Care Facility (Value 5):

- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility including Veteran's Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)
- Veterans Home

Exclusion Guidelines for Abstraction: None

Data Element Name: *Lipid Panel*

Definition: A lab test including at least the following four components: total cholesterol, triglycerides, high-density lipoprotein cholesterol, and low-density lipoprotein cholesterol

Suggested Data Collection Question: Is there documentation of numerical values of all the components of a lipid panel (total cholesterol, triglycerides, high-density lipoprotein cholesterol, and low-density lipoprotein cholesterol) in the patient's medical record during this stay or at any time during the 12 months prior to discharge?

Format:

Length: 1
Type: Character
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record of the numerical values for all four components of the lipid panel tested during the stay or at any time during the 12 months prior to discharge.
N (No) Documentation in the medical record does not include the numerical values for all four components of the lipid panel tested during the stay or at any time during the 12 months prior to discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- To meet the screening element for Lipid Panel, the abstractor must identify at least one documented value for all four parts of the lipid panel: total cholesterol, triglycerides, high-density lipoprotein (HDL), and low-density lipoprotein (LDL). If any one of the parts is missing, select "No."
- If the lab report states a value was unable to be calculated, select "Yes."
- Review only the medical record of the current patient stay. The record must contain at least one documented result with a result date within 12 months prior to the date of discharge. If the clinician accessed the medical record/EMR and obtained a lipid panel from a previous stay or visit within the 12 months prior to the date of discharge, documentation in the current record must also include the source of the result (e.g., medical record of prior hospital stay, EMR, or the name of the provider who ordered the test).
- If the patient refuses during this admission and no other documentation regarding a previous lipid panel value is found, select "No."

Suggested Data Sources:

- Consultation notes
- History and physical
- Initial (admission) assessment form
- Laboratory reports
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form

Inclusion Guidelines for Abstraction:

There must be numerical values for all four lipid panel components documented in the medical record. This list is all inclusive:

- TC: total cholesterol
- TG: triglycerides
- HDL
- LDL
- HDL-C: high-density lipoprotein cholesterol
- LDL-C: low-density lipoprotein cholesterol

Exclusion Guidelines for Abstraction:

- Non-quantitative assessment of lipid panel (e.g., normal, abnormal)
- Results from point-of-care tests for any of the four lipid panel components

Data Element Name: *Number of Antipsychotic Medications Prescribed at Discharge*

Definition: The number of routinely scheduled antipsychotic medications prescribed to the patient at discharge as documented in the medical record

Suggested Data Collection Question: What is the documented number of antipsychotic medications prescribed for the patient at discharge?

Format:

Length: 2 or UTD
Type: Alphanumeric
Occurs: 1

Allowable Values:

- 0–99
- UTD (Unable to Determine)

Notes for Abstraction:

- An antipsychotic medication is defined as any of a group of drugs (such as phenothiazines, butyrophenones, or serotonin-dopamine antagonists) which are used to treat psychosis. An antipsychotic medication is also called neuroleptic.
    - To access the list of routinely scheduled antipsychotic medications, identify the *Specifications Manual for Joint Commission National Quality Measures* associated with the discharge time frame of the case being abstracted. The manuals are available at: https://manual.jointcommission.org/Manual/WebHome. Refer to Appendix C: Medication Tables, Table Number 10.0 Antipsychotic Medications for a list of medications. Please note that The Joint Commission may update the medications tables up to two times per year to ensure that they align with current clinical guidelines.
- Only use "Antipsychotic Not Otherwise Specified (NOS)" for new antipsychotics that are not listed in Table Number 10.0 Antipsychotic Medications.
    - Include "Antipsychotic Not Otherwise Specified (NOS)" in the count of the "Number of Antipsychotic Medications Prescribed at Discharge."
- All routinely scheduled antipsychotic medications should be counted regardless of the indication for use or the reason documented for prescribing the antipsychotic medication.
- PRN (as needed) antipsychotic medications or short-acting intramuscular antipsychotic medications should not be included in the count of the "Number of Antipsychotic Medications Prescribed at Discharge."
    - To access the list of short-acting intramuscular antipsychotic medications, identify the *Specifications Manual for Joint Commission National Quality Measures* associated with the discharge time frame of the case being abstracted. The manuals are available at: https://manual.jointcommission.org/Manual/WebHome. Refer to Appendix C: Medication Tables, Table Number 10.1 Short-acting Intramuscular Antipsychotic Medications for a list of medications. Please note that The Joint Commission may update the medications tables up to two times per year to ensure that they align with current clinical guidelines.
- If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

- If the patient is on two forms of the same medication (i.e., po and IM), this would be counted as one antipsychotic medication.

It is acceptable to use data derived from pharmacy reports or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the suggested data sources listed below.

Suggested Data Sources:

- Aftercare discharge plan
- Discharge plan
- Final discharge summary
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

Inclusion Guidelines for Abstraction:

Antipsychotic medications found on Table Number 10.0 - Antipsychotic Medications in the *Specifications Manual for Joint Commission National Quality Measures* associated with the discharge date of the case being abstracted are included in the count of the Number of Antipsychotic Medications Prescribed at Discharge.

Exclusion Guidelines for Abstraction:

- PRN antipsychotic medications
- Short-acting intramuscular antipsychotic medications found on Table Number 10.1 Short-acting Intramuscular Antipsychotic Medications in the *Specifications Manual for Joint Commission National Quality Measures* associated with the discharge date of the case being abstracted are excluded from the count of the Number of Antipsychotic Medications Prescribed at Discharge.

Data Element Name: *Reason for Incomplete Metabolic Screening*

Definition: A written statement by the physician/APN/PA in the current medical record indicating that the screening elements could not be completed due to patient's enduring unstable medical condition or enduring unstable psychological condition

Suggested Data Collection Question: Is there documentation in the medical record noting that the metabolic screening cannot be completed due to patient's enduring unstable medical or psychological condition?

Format:

Length: 1
Type: Character
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record for this stay specifies that the metabolic screening cannot be completed due to patient's enduring unstable medical condition or enduring unstable psychological condition.
N (No) Documentation in the medical record for this stay does not specify that the patient's enduring unstable medical or psychological condition was the reason that the metabolic screening cannot be completed or unable to be determined from medical record documentation.

Notes for Abstraction:

- There must be specific documentation by the physician/APN/PA in the medical record for this stay that contains the exact wording that the patient has an "enduring unstable medical condition" or an "enduring unstable psychological condition" that prevents completion of a metabolic screening.
- Documentation stating that the patient has an "enduring unstable medical or psychological condition" is not acceptable as it is not specific to the individual patient and does not indicate which of the two conditions is relevant for the patient.
- If both conditions apply to a patient, then there must be specific documentation by the physician/APN/PA in the medical record for this stay that contains the exact wording that the patient has an "enduring unstable medical condition and enduring unstable psychological condition."

Suggested Data Sources:

- Biopsychosocial assessment
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial (admission) assessment form
- Physician progress notes
- Psychiatrist assessment/admission form

Inclusion Guidelines for Abstraction:

This list is **all inclusive** and documentation must contain exact wording of:

- "Enduring unstable medical condition"
  OR
- "Enduring unstable psychological condition"
  OR
- "Enduring unstable medical condition and enduring unstable psychological condition

Exclusion Guidelines for Abstraction: None

Medication Continuation Following Inpatient Psychiatric Discharge

NQF Endorsement Status	Endorsed
NQF ID	3205
Measure Type	Outcome
Measure Content Last Updated	2021-06-30
Info As Of	Not Available

Properties

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 primary form of treatment for most patients discharged

Medication Continuation Following Inpatient Psychiatric Discharge

	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

Developer/Steward

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

Medication Continuation Following Inpatient Psychiatric Discharge

Characteristics

Measure Type	Outcome
Meaningful Measure Area	Medication Management
Healthcare Priority	Promote Effective Communication & Coordination of Care
eCQM Spec Available	No
NQF Endorsement Status	Endorsed
NQF ID	3205
Last NQF Update	2020-02-10
Target Population Age	18+
Target Population Age (High)	Not Available
Target Population Age (Low)	18
Reporting Level	Facility
Conditions	Behavioral/Mental Health
Subconditions	Bipolar Disorder; Depression; Schizophrenia
Care Settings	Hospital Inpatient; IPF

Groups

Core Measure Set	Not Available

Measure Links

Medication Continuation Following Inpatient Psychiatric Discharge

Measure Program: Hospital Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2019-04-01
Data Reporting End Date	Not Available

Measure Program Links

Milestones

Milestone: Rescinded

Effective Date	2017-08-14
Comments	Not Available
Milestone Links	https://www.federalregister.gov/documents/2017/08/14/2017-16434/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Milestone: Proposed

Medication Continuation Following Inpatient Psychiatric Discharge

Effective Date	2017-04-28
Comments	Not Available
Milestone Links	https://www.federalregister.gov/documents/2017/04/28/2017-07800/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Measure Program: Inpatient Psychiatric Facility Quality Reporting

Info As Of	Not Available
Program / Model Notes	
Data Sources	Claims Data
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2019-01-01
Data Reporting End Date	Not Available

Measure Program Links

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

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

Milestones

Milestone: Implemented

Medication Continuation Following Inpatient Psychiatric Discharge

Effective Date	2020-10-01
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2019-08-06/pdf/2019-16370.pdf

Milestone: Finalized

Effective Date	2019-08-06
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2019-08-06/pdf/2019-16370.pdf

Milestone: Proposed

Effective Date	2019-04-23
Comments	Not Available
Milestone Links	https://www.cms.gov/medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html https://www.govinfo.gov/content/pkg/FR-2019-04-23/pdf/2019-07884.pdf https://www.federalregister.gov/documents/2017/04/28/2017-07800/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Milestone: Rescinded

Effective Date	2017-08-14
Comments	Not Available
Milestone Links	https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf

Other Data

Name	Value
MUC ID	MUC16-48
MUC Year	2016

Medication Continuation Following Inpatient Psychiatric Discharge

Milestone: Considered

Effective Date	2016-11-22
Comments	Not Available

Measure Information Form

Measure Set: Tobacco Treatment Measures (TOB)

Set Measure ID: TOB-2

Set Measure ID	Performance Measure Name
TOB-2	Tobacco Use Treatment Provided or Offered
TOB-2a	Tobacco Use Treatment

Performance Measure Name: Tobacco Use Treatment Provided or Offered

Description:
TOB-2 Patients identified as tobacco product users who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the hospital stay.
TOB-2a Patients who received counseling AND medication as well as those who received counseling and had reason for not receiving the medication during the hospital stay.

The measure is reported as an overall rate which includes all patients to whom tobacco use treatment was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment. The Provided or Offered rate (TOB-2), describes patients identified as tobacco product users who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the hospital stay. The Tobacco Use Treatment (TOB-2a) rate describes only those who received counseling AND medication as well as those who received counseling and had reason for not receiving the 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-2: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the hospital stay.

TOB-2a: The number of patients who received practical counseling to quit AND received FDA-approved cessation medications during the hospital stay.

> **Included Populations:**
>
> **TOB-2:**
>
> - Patients who refuse counseling
> - Patients who refuse FDA- Approved cessation medication
>
> **TOB-2a:**
>
> - Not applicable
>
> **Excluded Populations:**
>
> **TOB-2 and TOB-2a**
> For FDA Approved Medications Only
>
> - Smokeless tobacco users
> - Pregnant smokers
> - Light smokers
> - Patients with reasons for not administering FDA-approved cessation medication.
>
> **Data Elements:**
>
> - *Reason for No Tobacco Cessation Medication During the Hospital Stay*
> - *Tobacco Use Status*
> - *Tobacco Use Treatment FDA-Approved Cessation Medication*
> - *Tobacco Use Treatment Practical Counseling*

Denominator Statement:

- TOB-2: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.
- TOB-2a: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users excluding those whose tobacco use status is unknown.

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 screening 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 with *Comfort Measures Only* documented

Data Elements:

- *Admission Date*
- *Birthdate*
- *Comfort Measures Only*
- *Discharge Date*
- *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 so as to have a better understanding of which treatment type is 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:

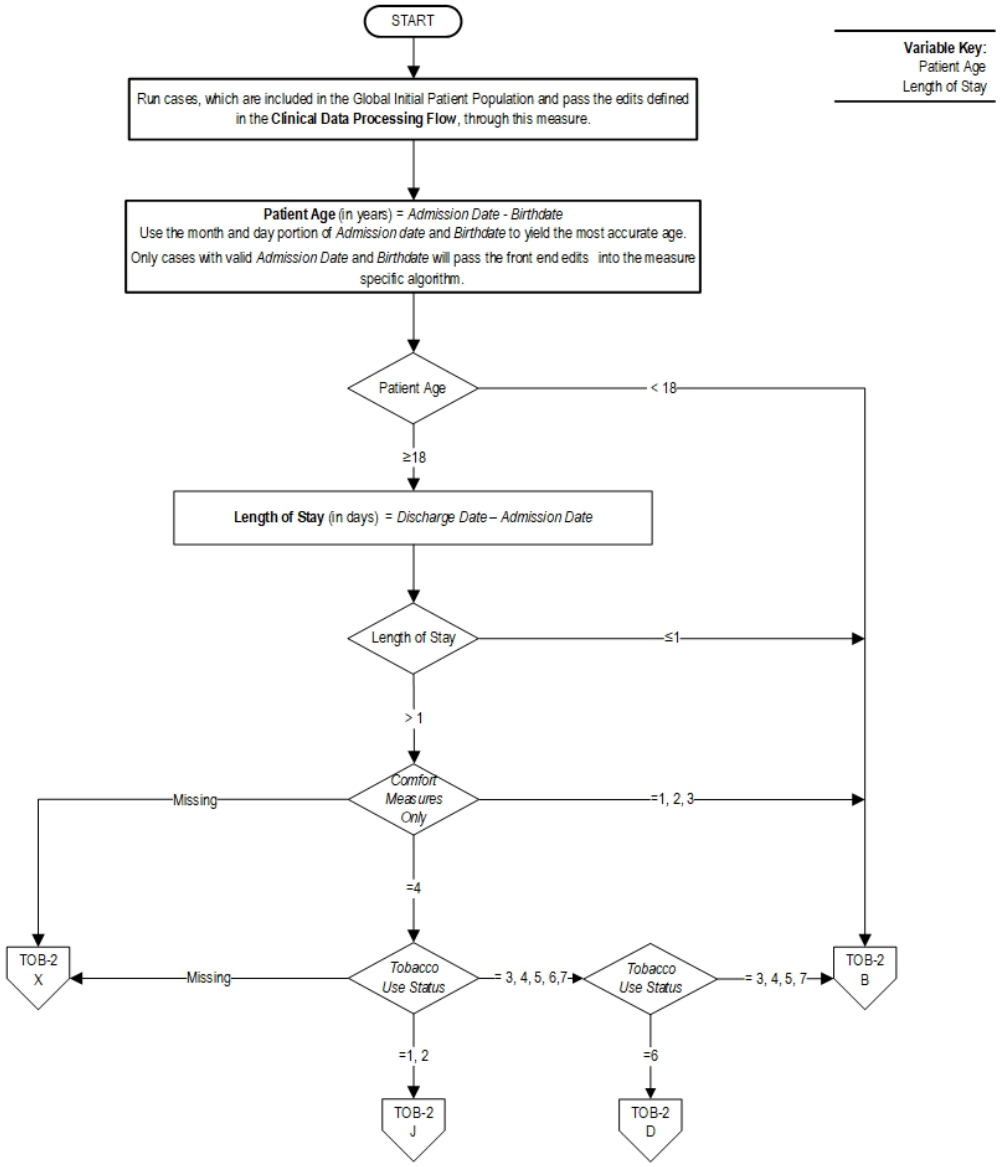
- Baumeister, S. E., Schumann, A., Meyer, C., John, U., Volzke, H., & Alte, D. (2007). *Effects of smoking cessation on health care use: Is elevated risk of hospitalization among former smokers attributable to smoking-related morbidity*? Drug and Alcohol Dependence, 88(2–3), 197–203.
- Centers for Disease 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.

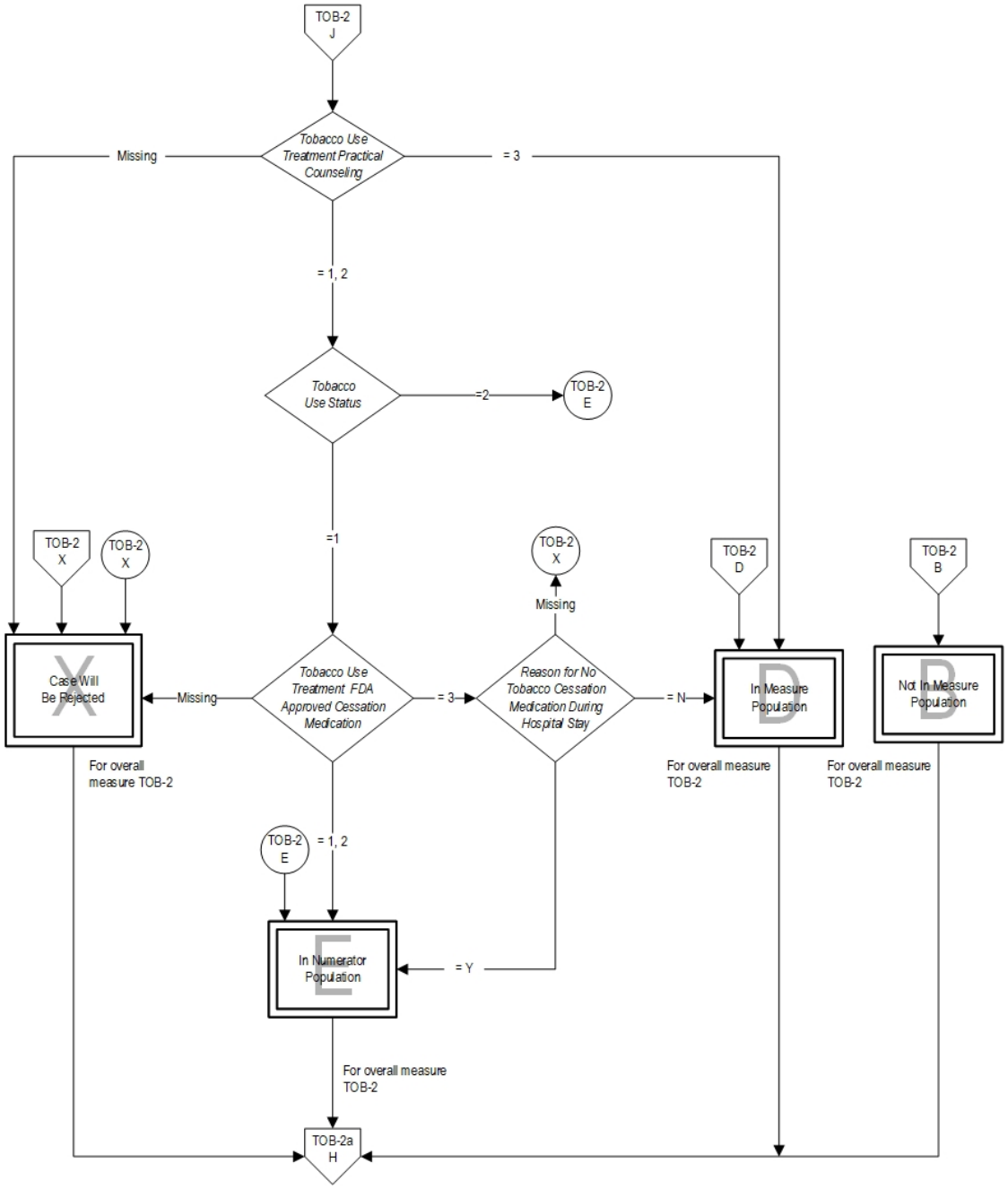
Measure Algorithm:

TOB-2: Tobacco Use Treatment Provided or Offered

Numerator: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the hospital stay.

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

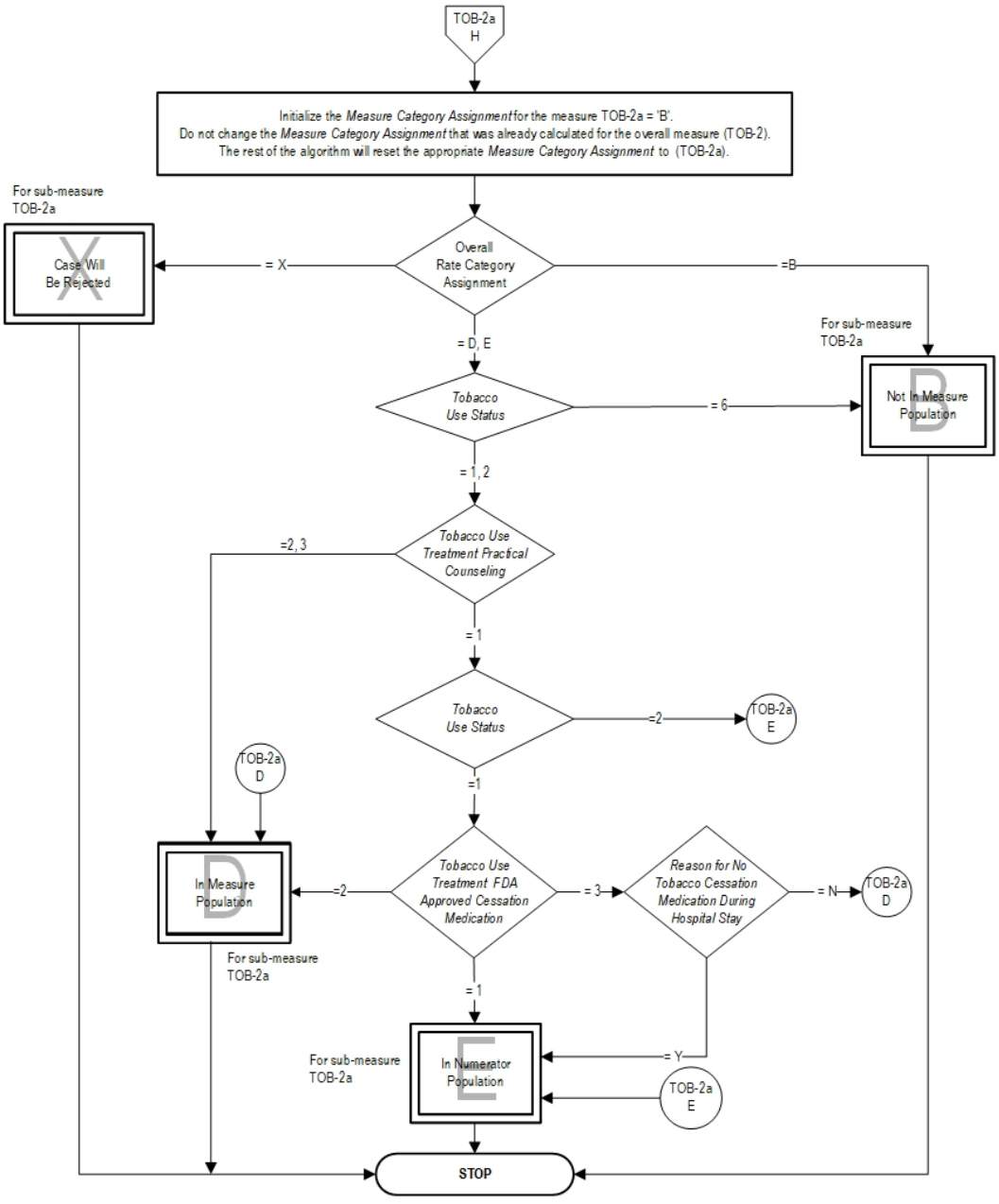




TOB-2a: Tobacco Use Treatment Provided or Offered

Numerator: The number of patients who received practical counseling to quit AND received FDA-approved cessation medications during the hospital stay.

Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users excluding those whose tobacco use status is unknown.



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
> - Light 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:

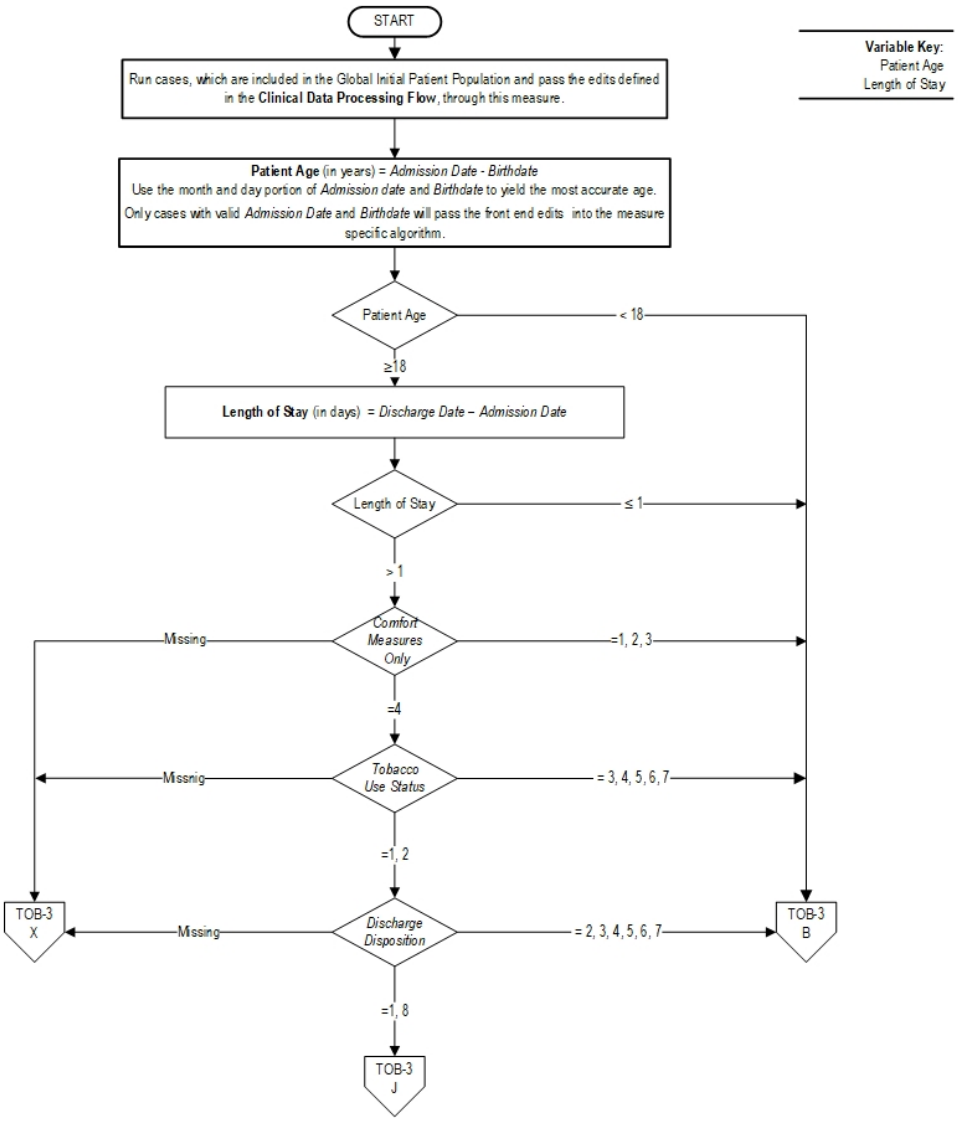
- Baumeister, S. E., Schumann, A., Meyer, C., John, U., Volzke, H., & Alte, D. (2007). Effects of smoking cessation on health care use: Is elevated risk of hospitalization among former smokers attributable to smoking-related morbidity? Drug and Alcohol Dependence, 88(2–3), 197–203.
- Centers for Disease 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.

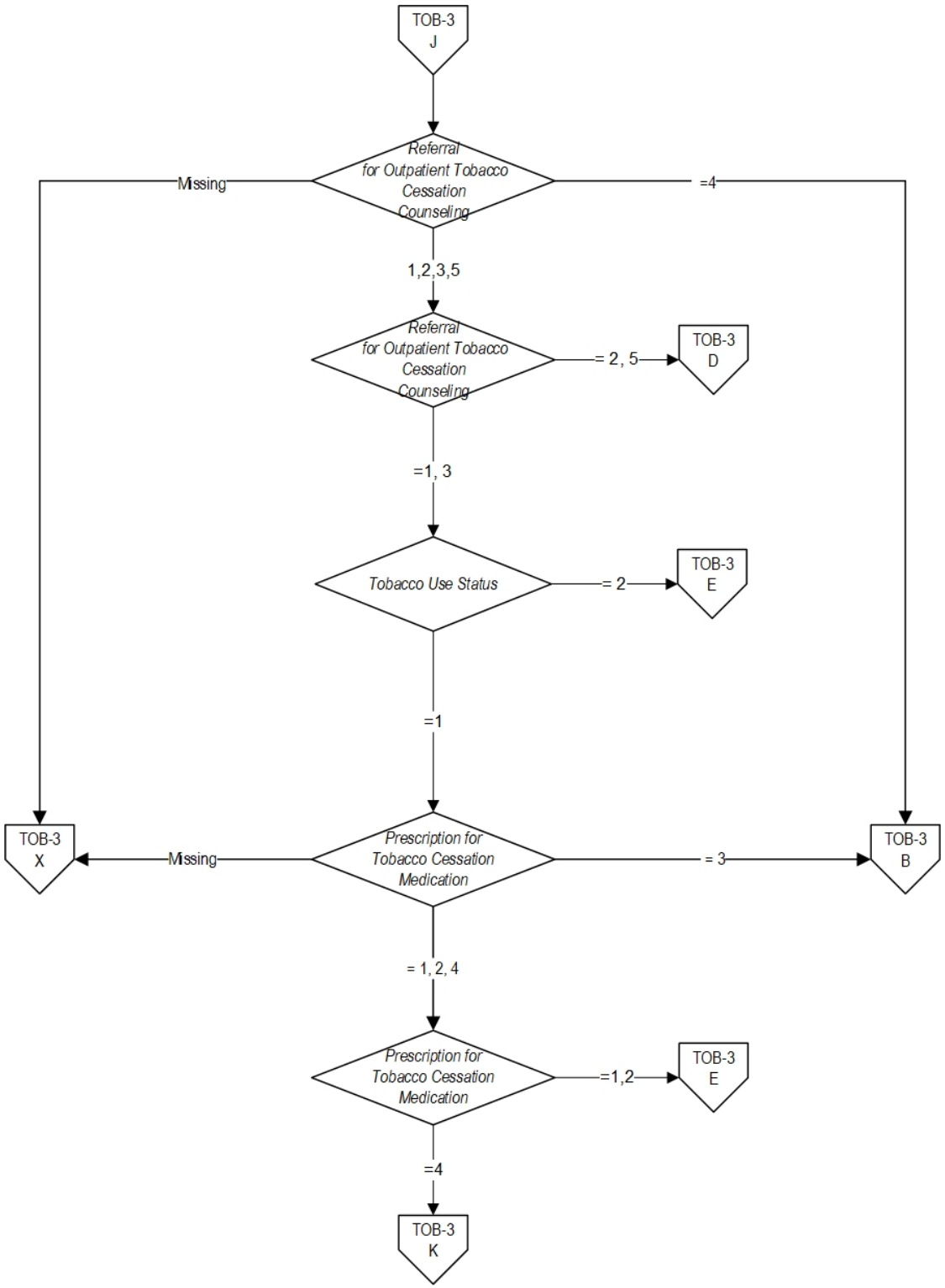
Measure Algorithm:

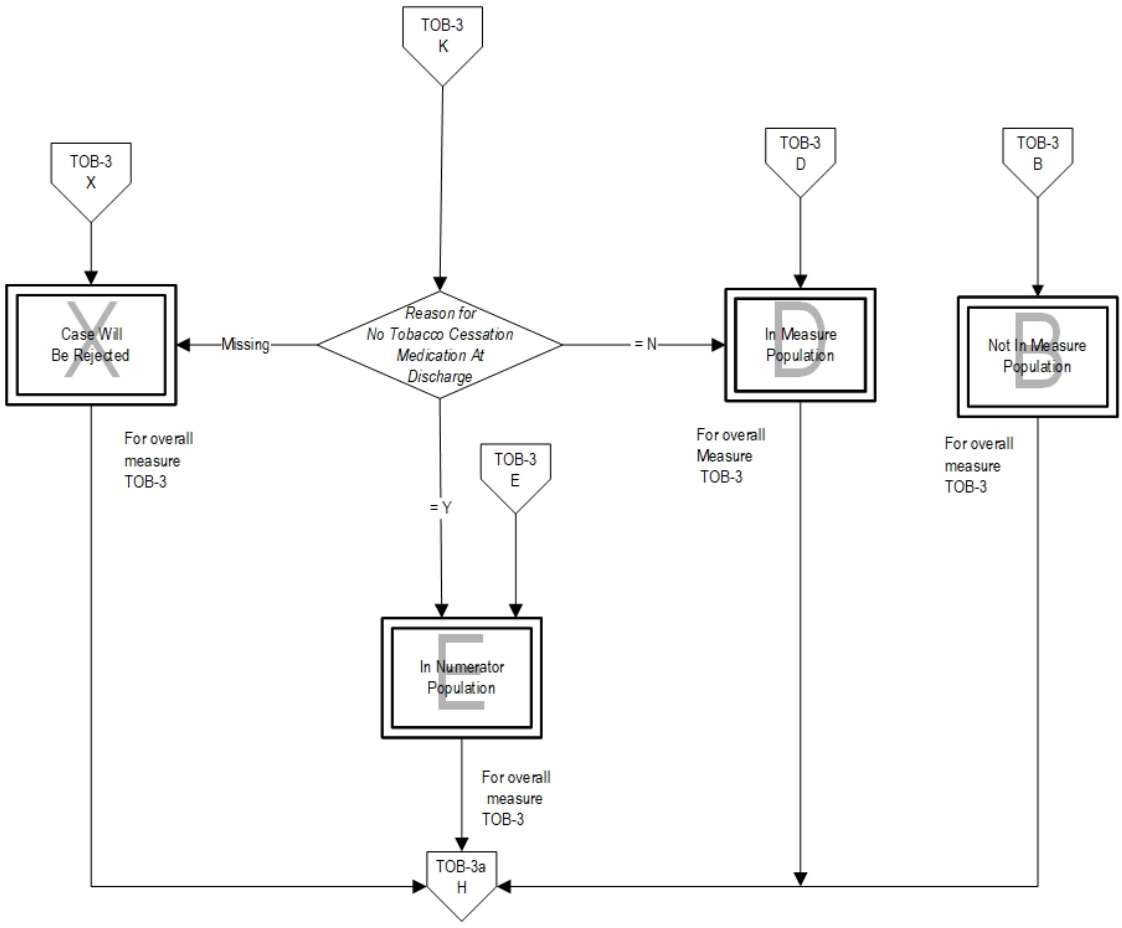
TOB-3: Tobacco Use Treatment Provided or Offered at Discharge

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.