DRAFT PREVIEW
DSRIP Category C
Measure Specifications

Measure Set **Page #**

BUNDLE A1: IMPROVED CHRONIC DISEASE MANAGEMENT: DIABETES CARE

A1-111: Comprehensive Diabetes Care: Eye Exam (retinal) performed

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.

DY7/DY8 Program ID	111
NQF Number	0055
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0055
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.6807 **MPL:** 0.4453
Numerator Description	Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following: -A retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year OR -A negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. For exams performed in the year prior to the measurement year, a result must be available.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

A1-112: Comprehensive Diabetes Care: Foot Exam

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.

DY7/DY8 Program ID	112
NQF Number	0056
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0056
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who received a foot exam (visual inspection and sensory exam with monofilament and pulse exam) during the measurement year.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

A1-113: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.

DY7/DY8 Program ID	113
NQF Number	0057
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0057
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.9288 **MPL:** 0.8298
Numerator Description	Patients who had an HbA1c test performed during the measurement year.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures;

A1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Measure Description:

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

DY7/DY8 Program ID	115
NQF Number	0059
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0059
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.2936 **MPL:** 0.522
Numerator Description	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year. The outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy
Measure Point Value	3
Additional Notes	

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

A1-116: Comprehensive Diabetes Care: Medical Attention for Nephropathy

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement year.

DY7/DY8 Program ID	116
NQF Number	0062
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0062
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.9348 **MPL:** 0.8857
Numerator Description	Patients who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement year.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

A1-207: Diabetes care: BP control (<140/90mm Hg)

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure level taken during the measurement year is <140/90 mm Hg.

DY7/DY8 Program ID	207
NQF Number	0061
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0061
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7564 **MPL:** 0.5229
Numerator Description	Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year. The outcome being measured is a blood pressure reading of <140/90 mm Hg, which indicates adequately controlled blood pressure. Adequately controlled blood pressure in patients with diabetes reduces cardiovascular risks and microvascular diabetic complications.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and type 2) during the measurement year or the year prior to the measurement year. See question S.7 Denominator Details for methods to identify patients with diabetes.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did NOT have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year. AND either: -A diagnosis of polycystic ovaries, in any setting, any time in the patient's history through December 31 of the measurement year, or -A diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Other, Paper Records, Pharmacy
Measure Point Value	3
Additional Notes	

A1-208: Comprehensive Diabetes Care LDL-C Screening

Measure Description:
The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an LDL-C test during the measurement year.

DY7/DY8 Program ID	208
NQF Number	0063
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0063
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Members who had an LDL-C test performed during the measurement year.
Denominator Description	Members 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year. Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year. Risk Adjustment:
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only)
Measure Point Value	1
Additional Notes	

A1-247: Reduce Emergency Department visits for Diabetes

Measure Description:
Rate of ED utilization for preventable Diabetes conditions or complications

DY7/DY8 Program ID	247
NQF Number	NA
Measure Steward	None
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of ED Visits with a primary or secondary diagnosis of diabetes for any individual 18 years and older during the measurement period
Denominator Description	Total number of ED visits for individuals 18 years or older during the measurement period
Inclusions	Preventable diabetes conditions as those associated with the Diabetes ACSC diagnostic codes: 250.0, 250.1, 250.2, 250.3, 250.8, 250.9 (http://www.mdch.state.mi.us/CHI/HOSP/ICD9CM1.HTM)
Exclusions	Exclude diabetes with renal manifestations [250.4], diabetes with ophthalmic manifestations [250.5], diabetes with neurological manifestations [250.6] and diabetes with peripheral circulatory disorders [250.7]
DSRIP Specified Setting	ED
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Measure Point Value	3
Additional Notes	

A1-321: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation (eMeasure)

Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months

DY7/DY8 Program ID	321
NQF Number	0417
Measure Steward	American Podiatric Medical Association
Link to Measure Citation	http://www.qualityforum.org/QPS/0417
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who had a lower extremity neurological exam performed at least once within 12 months Definition: Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and should include: 10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold), however the clinician should perform all necessary tests to make the proper evaluation. Numerator Quality-Data Coding Options for Reporting Satisfactorily: Lower Extremity Neurological Exam Performed G8404: Lower extremity neurological exam performed and documented OR Lower Extremity Neurological Exam not Performed for Documented Reasons G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure OR Lower Extremity Neurological Exam not Performed G8405: Lower extremity neurological exam not performed
Denominator Description	All patients aged 18 years and older with a diagnosis of diabetes mellitus
Inclusions	None listed by measure steward.
Exclusions	Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee, patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer´s, etc.), patient has previously documented diabetic peripheral neuropathy with loss of protective sensation.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Other, Paper Records
Measure Point Value	1

Additional Notes	

MACRA MIPS Measure.

BUNDLE A2: IMPROVED CHRONIC DISEASE MANAGEMENT: HEART DISEASE

A2-103: Controlling High Blood Pressure

Measure Description:
The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

DY7/DY8 Program ID	103
NQF Number	0018
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0018
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7041 **MPL:** 0.4687
Numerator Description	The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.
Denominator Description	Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude all patients with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD. Exclude all patients with a diagnosis of pregnancy during the measurement year. Exclude all patients who had an admission to a nonacute inpatient setting during the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	3
Additional Notes	BAT Recommendation to allow follow-up home blood pressure readings recorded in E H R/medical record

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus Core Set: Cardiovascular Measures; MACRA MIPS Measure.

A2-104: Medical Assistance with Smoking and Tobacco Use Cessation (MSC) - Modified Denominator

Measure Description:
Assesses different facets of providing medical assistance with smoking and tobacco use cessation:

Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.

Discussing Cessation Medications: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.

Discussing Cessation Strategies: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

DY7/DY8 Program ID	104
NQF Number	0027 (Modified)
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0027
Measure Parts	3
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** Advising Smokers to Quit: 0.8185 Discussing Cessation Medications: 0.5839 Discussing Cessation Strategies: 0.5175 **MPL:** Advising Smokers to Quit: 0.7314 Discussing Cessation Medications: 0.4301 Discussing Cessation Strategies: 0.3886
Numerator Description	Component 1: Advising Smokers and Tobacco Users to Quit (ASTQ) Patients who received advice to quit smoking or using tobacco from their doctor or health provider Component 2: Discussing Cessation Medications (DSCM) Patients who discussed or received recommendations on smoking or tobacco cessation medications from their doctor or health provider Component 3: Discussing Cessation Strategies (DSCS) Patients who discussed or received recommendations on smoking or tobacco cessation methods and strategies other than medication from their doctor or health provider
Denominator Description	Patients 18 years and older who indicated that they were current smokers or tobacco users during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Patient Reported Data
Measure Point Value	1

Additional Notes	

CMS Alignment: Adult Core Set;

A2-147: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Measure Description:
Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter

Normal Parameters:

Age 65 years and older BMI >= 23 and < 30

Age 18 – 64 years BMI >= 18.5 and < 25

DY7/DY8 Program ID	147
NQF Number	0421 / 2828 eMeasure
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0421 http://www.qualityforum.org/QPS/2828
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.9254 **MPL:** 0.7651
Numerator Description	Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.
Denominator Description	There are two (2) Initial Patient Populations for this measure: Initial Patient Population 1: All patients 18 through 64 years on the date of the encounter with at least one eligible encounter during the measurement period. Initial Patient Population 2: All patients 65 years of age and older on the date of the encounter with at least one eligible encounter during the measurement period.
Inclusions	None listed by measure steward.
Exclusions	Initial Patient Population 1: Patients who are pregnant or encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient´s health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate. Initial Patient Population 2: Encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient´s health status, or there is any other reason documented in the medical

	record by the provider explaining why BMI measurement was not appropriate.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Other
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure; CCBHC Measure.

A2-206: Cholesterol management for patients with cardiovascular conditions

Measure Description:
Percentage of patients 18 to 75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year: • Low-density lipoprotein cholesterol (LDL-C) screening performed • LDL-C control (less than 100 mg/dL)

DY7/DY8 Program ID	206
NQF Number	NA
Measure Steward	NCQA
Link to Measure Citation	https://www.qualitymeasures.ahrq.gov/summaries/summary/47175
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Percentage of patients 18 to 75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year: • Low-density lipoprotein cholesterol (LDL-C) screening performed • LDL-C control (less than 100 mg/dL)
Denominator Description	Patients age 18 to 75 years as of the last day of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	3
Additional Notes	

A2-208: Comprehensive Diabetes Care LDL-C Screening

Measure Description:
The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an LDL-C test during the measurement year.

DY7/DY8 Program ID	208
NQF Number	0063
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0063
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Members who had an LDL-C test performed during the measurement year.
Denominator Description	Members 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year. Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year. Risk Adjustment:
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only)
Measure Point Value	1
Additional Notes	

A2-210: PQRS #317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Measure Description:
Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated

DY7/DY8 Program ID	210
NQF Number	NA
Measure Steward	CMS
Link to Measure Citation	https://pqrs.cms.gov/dataset/2016-PQRS-Measure-317-11-17-2015/bqda-3reh
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is pre-hypertensive or hypertensive NUMERATOR NOTE: Although the recommended screening interval for a normal BP reading is every 2 years, to meet the intent of this measure, BP screening and follow-up must be performed once per measurement period. For patients with Normal blood pressure a follow-up plan is not required.
Denominator Description	All patients aged 18 years and older
Inclusions	Denominator Criteria (Eligible Cases): Patients aged ≥ 18 years AND Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90880, 92002, 92004, 92012, 92014, 96118, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99281, 99282, 99283, 99284, 99285, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0402, G0438, G0439
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

A2-246: Reduce Emergency Department visits for Selected Condition or Conditions: CHF, Diabetes, Angina/Hypertension, Behavioral Health & Substance Abuse, COPD, or Dental

Measure Description:
Rate of ED utilization for selected preventable conditions or complications. Providers will select one or more targeted conditions from the approved list.

DY7/DY8 Program ID	246
NQF Number	NA
Measure Steward	None
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Rate of ED utilization for selected preventable conditions or complications. Providers will select one or more targeted conditions from the approved list.
Denominator Description	Total number of ED Visits with a primary or secondary diagnosis of selected condition for any individual 18 years and older during the measurement period
Inclusions	Various
Exclusions	Various
DSRIP Specified Setting	ED
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Measure Point Value	3
Additional Notes	

A2-384: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following chronic obstructive pulmonary disease (COPD) hospitalization

Measure Description:

The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients discharged from the hospital with either a principal discharge diagnosis of COPD or a principal discharge diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD. The outcome (readmission) is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of planned readmissions do not count in the readmission outcome. CMS annually reports the measure for patients who are 65 years or older, are enrolled in fee-for-service (FFS) Medicare, and hospitalized in non-federal hospitals.

DY7/DY8 Program ID	384
NQF Number	1891
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/1891
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The outcome for this measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from the index admission for patients discharged from the hospital with a principal discharge diagnosis of COPD or principal discharge diagnosis of respiratory failure with a secondary discharge diagnosis of acute exacerbation of COPD. If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only the first one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission.
Denominator Description	This claims-based measure can be used in either of two patient cohorts: (1) patients aged 65 years or older or (2) patients aged 40 years or older. We have explicitly tested the measure in both age groups. The cohort includes admissions for patients discharged from the hospital with either a principal discharge diagnosis of COPD (see codes below) OR a principal discharge diagnosis of respiratory failure (see codes below) with a secondary discharge diagnosis of acute exacerbation of COPD (see codes below) and with a complete claims history for the 12 months prior to admission. The measure is currently

	publicly reported by CMS for those patients 65 years and older who are Medicare FFS beneficiaries admitted to non-federal hospitals. Additional details are provided in S.9 Denominator Details.
Inclusions	None listed by measure steward.
Exclusions	The readmission measures exclude index admissions for patients: 1. Without at least 30 days post-discharge enrollment in FFS Medicare. 2. Discharged against medical advice (AMA); 3. Admitted within 30 days of a prior index admission.
DSRIP Specified Setting	Hospital
Data Source	Claims (Only)
Measure Point Value	3
Additional Notes	

BUNDLE B1: CARE TRANSITIONS & HOSPITAL READMISSIONS

B1-124: Medication Reconciliation Post-Discharge

Measure Description:
The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.

DY7/DY8 Program ID	124
NQF Number	0097
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0097
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
Denominator Description	All discharges from an in-patient setting for patients who are 18 years and older.
Inclusions	None listed by measure steward.
Exclusions	The following exclusions are applicable to the Health Plan Level measure. - Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. - If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the patient was transferred.
DSRIP Specified Setting	Hospital
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS High Priority Measure.

B1-141: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) for selected conditions: heart failure hospitalization, coronary artery bypass graft (CABG) surgery, CHF, Diabetes, AMI, Stroke, COPD, Behavioral Health, Substance Use (BAT Recommends a

Measure Description:

The measure estimates a hospital-level risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of heart failure (HF). The outcome (readmission) is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of planned readmissions do not count in the readmission outcome. The target population is patients 18 and over.

DY7/DY8 Program ID	**141**
NQF Number	0330 / 2515 / other
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0330
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	TBD
Denominator Description	TBD
Inclusions	TBD
Exclusions	TBD
DSRIP Specified Setting	Hospital
Data Source	Claims (Only)
Measure Point Value	3
Additional Notes	BAT Recommends a Standardized Risk Adjusting Methodololgy for all providers in DY7 - DY8

CMS Alignment: CMS Consensus Core Set: Cardiovascular Measures;

B1-217: Risk Adjusted All-Cause Readmission

Measure Description:
Risk adjusted rate of hospital admissions (stays) for with a subsequent readmission for any reason within 30 days of discharge for patients 18 years of age and older.

A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.

DY7/DY8 Program ID	217
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission during the measurement year The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk admissions during the measurement period.
Denominator Description	Expected (risk-adjusted) rate of readmissions for all-causes during the measurement year. The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Inpatient
Data Source	Administrative Claims, Electronic Medical Records
Measure Point Value	3
Additional Notes	BAT Recommends a Standardized Risk Adjusting Methodololgy for all providers in DY7 - DY8

B1-252: Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

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

DY7/DY8 Program ID	252
NQF Number	0649
Measure Steward	AMA
Link to Measure Citation	http://www.qualityforum.org/QPS/0649
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: •Summary of major procedures and tests performed during ED visit, AND •Principal clinical diagnosis at discharge which may include the presenting chief complaint, AND •Patient instructions, AND •Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND •List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each
Denominator Description	All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health care
Inclusions	None listed by measure steward.
Exclusions	Exclusions: Patients who died Patients who left against medical advice (AMA) or discontinued care Exceptions: Patients who declined receipt of transition record Patients for whom providing the information contained in the transition record would be prohibited by state or federal law
DSRIP Specified Setting	Hospital
Data Source	Claims (Only), Other, Paper Records
Measure Point Value	1
Additional Notes	

B1-253: Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)

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

DY7/DY8 Program ID	**253**
NQF Number	0647
Measure Steward	AMA
Link to Measure Citation	http://www.qualityforum.org/QPS/0647
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements: Inpatient Care • Reason for inpatient admission, AND • Major procedures and tests performed during inpatient stay and summary of results, AND • Principal diagnosis at discharge Post-Discharge/ Patient Self-Management • Current medication list, AND • Studies pending at discharge (eg, laboratory, radiological), AND • Patient instructions Advance Care Plan • Advance directives or surrogate decision maker documented OR Documented reason for not providing advance care plan Contact Information/Plan for Follow-up Care • 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND • Contact information for obtaining results of studies pending at discharge, AND • Plan for follow-up care, AND • Primary physician, other health care professional, or site designated for follow-up care
Denominator Description	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.
Inclusions	None listed by measure steward.
Exclusions	Patients who died. Patients who left against medical advice (AMA) or discontinued care.

DSRIP Specified Setting	Hospital
Data Source	Claims (Only), Other, Paper Records
Measure Point Value	1
Additional Notes	

B1-287: Documentation of Current Medications in the Medical Record

Measure Description:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

DY7/DY8 Program ID	287
NQF Number	0419
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0419
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The Numerator statement for the most recent versions of the measure is as follows (for both the 2016 Claims and Registry version and the 2017 e Measure version): Eligible professional attests to documenting, updating, or reviewing a patient´s current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route of administration
Denominator Description	The 2016 Claims and Registry denominator statement is as follows: "All visits for patients aged 18 years and older." The 2017 eMeasure denominator statement is as follows: "All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period."
Inclusions	None listed by measure steward.
Exclusions	The 2016 Claims and Registry version contains the following Other Performance Exclusion: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional. A patient is not eligible if the following reason is documented: the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status The eMeasure includes the following denominator exception: Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital, Behavioral Health Outpatient
Data Source	Claims (Only), Electronic Health Record (Only), Registry
Measure Point Value	1

Additional Notes	

MACRA MIPS High Priority Measure.

B1-351: INR Monitoring for individuals on warfarin after hospital discharge,

Measure Description:
Percentage of adult inpatient hospital discharges to home for which the individual was on warfarin and discharged with a non-therapeutic International Normalized Ratio (INR) who had an INR test within 14 days of hospital discharge

DY7/DY8 Program ID	351
NQF Number	2732
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/2732
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Individuals in the denominator who had an INR test within 14 days of discharge
Denominator Description	Adult inpatient discharges to home for which the individual had active warfarin therapy within 1 day prior to discharge and the last monitored INR within 7 days of discharge was <=1.5 or >= 4
Inclusions	None listed by measure steward.
Exclusions	The following inpatient discharges are excluded from the denominator. The following exclusion is identified from the Medication Administration Record (MAR) within the patient's EHR. 1) Inpatient discharges for which the individuals received dabigatran, rivaroxaban, or apixaban within one day prior to discharge The following exclusions are identified from Part A and Part B Medicare Administrative Claims. 2) Inpatient discharges for which the individuals are monitoring INR at home 3) Inpatient discharges for which the individuals expired within 14 days post-discharge 4) Inpatient discharges for which the individuals received hospice care within 14 days post-discharge 5) Inpatient discharges for which the individuals had a hospital inpatient admission within 14 days post-discharge 6) Inpatient discharges for which the individuals were admitted to a skilled nursing facility (SNF) within 14 days post-discharge 7) Inpatient discharges for which the end date of the 14-day follow-up period occurs after the end of the measurement period 8) Inpatient discharges for which the individual is not enrolled in Medicare Part A and Part B at the time of discharge and during the 14-day follow-up period post discharge.
DSRIP Specified Setting	Hospital
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Other, Pharmacy
Measure Point Value	1
Additional Notes	

BUNDLE B2: PATIENT NAVIGATION & ED DIVERSION

B2-242: Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)

Measure Description:
Rate of Emergency Department (ED) utilization for ACSC:

- Grand mal status and other epileptic convulsions

- Chronic obstructive pulmonary diseases

- Asthma

- Heart failure and pulmonary edema

- Hypertension

- Angina, or

- Diabetes

DY7/DY8 Program ID	242
NQF Number	NA
Measure Steward	None
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of ED Visits with a primary or secondary ACSC diagnosis for any individual 18 years and older during the measurement period
Denominator Description	Total number of ED visits for individuals 18 years or older during the measurement period
Inclusions	Any ED visits with a primary or secondary ACSC diagnosis for any individual 18 years and older during the measurement period: Grand mal status and other epileptic convulsions: 345 Chronic obstructive pulmonary diseases: 466.0 (only with secondary diagnosis of 491, 492, 494, 496), 491, 492, 494, 496 Asthma: 493 Heart failure and pulmonary edema: 402.01, 402.11, 402.91, 428, 518.4 Hypertension: 401.0, 401.9, 402.00, 402.10, 402.90 Angina: 411.1, 411.8, 413 Diabetes: 250.0, 250.1, 250.2, 250.3,250.8, 250.9
Exclusions	The following diagnostic codes should be excluded: Grand mal status and other epileptic convulsions: None Chronic obstructive pulmonary diseases: None

	Asthma: None Heart failure and pulmonary edema: Procedure codes 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7 Hypertension: procedures: Procedure codes 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7 Angina: Procedure codes 01-86.99 Diabetes: Diabetes with renal manifestations [250.4], diabetes with ophthalmic manifestations [250.5], diabetes with neurological manifestations [250.6] and diabetes with peripheral circulatory disorders [250.7]
DSRIP Specified Setting	ED
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Measure Point Value	3
Additional Notes	

B2-246: Reduce Emergency Department visits for Selected Condition or Conditions: CHF, Diabetes, Angina/Hypertension, Behavioral Health & Substance Abuse, COPD, or Dental

Measure Description:
Rate of ED utilization for selected preventable conditions or complications. Providers will select one or more targeted conditions from the approved list.

DY7/DY8 Program ID	246
NQF Number	NA
Measure Steward	None
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Rate of ED utilization for selected preventable conditions or complications. Providers will select one or more targeted conditions from the approved list.
Denominator Description	Total number of ED Visits with a primary or secondary diagnosis of selected condition for any individual 18 years and older during the measurement period
Inclusions	Various
Exclusions	Various
DSRIP Specified Setting	ED
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Measure Point Value	3
Additional Notes	

B2-250: Reduce low acuity ED visits

Measure Description:
Rate of ED utilization among low acuity presenting patients

DY7/DY8 Program ID	250
NQF Number	NA
Measure Steward	AHRQ
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of patients triaged as low acuity (ESI 3, 4 or 5) and receives treatment in the Emergency Department during the measurement period
Denominator Description	Total number of patients triaged as low acuity (ESI 3, 4 or 5) upon presentation to the Emergency Department during the measurement period
Inclusions	Denominator: Patients triaged as low acuity (ESI 3, 4 or 5) upon presentation to the Emergency Department during the measurement period Numerator: Acuity scores of 3, 4,and 5 are assessed using the Emergency Severity Index: http://www.ahrq.gov/professionals/systems/hospital/esi/esi4.html
Exclusions	None listed by measure steward.
DSRIP Specified Setting	ED
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Measure Point Value	1
Additional Notes	

B2-251: Emergency department (ED) visits where patients left without being seen

Measure Description:
The percentage of patients presenting to the emergency department (ED) who did not wait after having clinical information documented about their presenting complaint, during the measurement period.

DY7/DY8 Program ID	251
NQF Number	NA
Measure Steward	Australian Council on Healthcare Standards
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of patients presenting to the emergency department (ED) who did not wait* after having clinical information documented** about their presenting complaint, during the time period
Denominator Description	Total number of patients presenting to the emergency department (ED), during the time period
Inclusions	*Did not wait is defined as any person who leaves before treatment is commenced by a clinician. A diagnosis is not required. **Documentation of clinical information is defined as an entry in either the medical record or emergency department information system that indicates that the patient provided information about their presenting complaint to a clinician during the triage process.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	ED
Data Source	Electronic Health Record, Clinical Data, Registration data
Measure Point Value	1
Additional Notes	

B2-352: Heart Failure: Post-Discharge Appointment for Heart Failure Patients

Measure Description:
2455: Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified)

2439: Patients for whom a follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time.

DY7/DY8 Program ID	352
NQF Number	2455 & 2439 (BAT Reccomendation to modify for additional conditions)
Measure Steward	2455: AHA/ASA, 2439: TJC
Link to Measure Citation	http://www.qualityforum.org/QPS/2455
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	2455: Patients for whom a follow up appointment was scheduled and documented prior to discharge including either: - an office visit for management for heart failure with a physician OR advanced practice nurse OR physician assistant OR - a home health visit for management of heart failure 2439: Patients for whom a follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time.
Denominator Description	2455: All patients, regardless of age, discharged from an inpatient facility (ie, hospital inpatient or observation) to ambulatory care (home/self care) of home health care with a principle discharge diagnosis of heart failure 2439: All heart failure patients discharged from a hospital inpatient setting to home or home care.
Inclusions	None listed by measure steward.
Exclusions	2455: Denominator exclusions include: Patient was discharged to a health care facility for hospice care, to home for hospice care, or to a rehabilitation facility. Patient left against medical advice. Patient expired. Denominator exceptions include: Documentation of medical reason(s) for not documenting that a follow up appointment was scheduled Documentation of patient reason(s) for not documenting that a follow up appointment was scheduled (eg, international patients, patients from state and/or local corrections facilities for whom scheduling the appointment is prohibited) 2439: Excluded Populations:

	• Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-10-PCS procedure code for LVAD and heart transplant as defined in Appendix A, Table 2.2) • Patients less than 18 years of age • Patient who have a Length of Stay greater than 120 days • Patients with Comfort Measures Only documented • Patients enrolled in a Clinical Trial • Patients discharged to locations other than home, home care, or law enforcement • Patients with a documented Reason for No Post-Discharge Appointment Within 7 Days • Patients who left against medical advice (AMA)
DSRIP Specified Setting	Hospital
Data Source	2455: Registry 2439: Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	BAT recommendation to expand to principle diagnosis of Diabetic Ketoacidosis, CAD, COPD, and to specify post-discharge appointment scheduled prior to discharge or the end of the next business day if discharge was completed outside of business hours

B2-353: Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit

Measure Description:

This measure describes the incidence rate of emergency department visits for children ages 2 to 21 who are being managed for identifiable asthma. This measure characterizes care that precedes Emergency Department visits for children ages 2- 21 who can be identified as having asthma, using the specified definitions. The developers sought to identify children with ongoing asthma who should be able to be identified by their healthcare providers and/or healthcare plans as having asthma. The operational definition of an identifiable asthmatic is a child who has utilized healthcare services that suggest the healthcare system has enough information to conclude that the child has an asthma diagnosis that requires ongoing care. Specifically, this measure identifies the use of primary care services and medications prior to ED visits and/or hospitalizations for children with asthma.

DY7/DY8 Program ID	**353**
NQF Number	3170 (Under Review)
Measure Steward	University Hospitals Cleveland Medical Center
Link to Measure Citation	
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Evidence of connection to the primary care medical system prior to first ED visit and/or hospitalization that has a primary or secondary diagnosis of asthma among children whom our specifications identify with asthma.
Denominator Description	All first ED visits and/or hospitalizations, in which asthma was a primary or secondary diagnosis in children age 2-21 who meet criteria for being managed for identifiable asthma in the assessment period and have been enrolled for the 6 consecutive months prior to the ED visit/admission.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	ED
Data Source	Claims (Only)
Measure Point Value	1
Additional Notes	

B2-354: Post-discharge evaluation for heart failure patients (BAT recommendation to expand to principle diagnosis of Diabetic Ketoacidosis, CAD, and COPD)

Measure Description:

Patients who receive a re-evaluation for symptoms worsening and treatment compliance by a program team member within 72 hours after inpatient discharge.

DY7/DY8 Program ID	354
NQF Number	2443
Measure Steward	The Joint Commission
Link to Measure Citation	http://www.qualityforum.org/QPS/2443
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who have a documented re-evaluation conducted via phone call or home visit within 72 hours after discharge.
Denominator Description	All heart failure patients discharged from a hospital inpatient setting to home or home care AND patients leaving against medical advice (AMA).
Inclusions	None listed by measure steward.
Exclusions	Excluded Populations: • Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-10-PCS procedure code for LVAD and heart transplant as defined in Appendix A, Table 2.2) • Patients less than 18 years of age • Patient who have a Length of Stay greater than 120 days • Patients with Comfort Measures Only documented • Patients enrolled in a Clinical Trial • Patients discharged to locations other than home, home care or law enforcement.
DSRIP Specified Setting	Hospital
Data Source	Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	BAT recommendation to expand to principle diagnosis of Diabetic Ketoacidosis, CAD, and COPD

BUNDLE C1: PRIMARY CARE PREVENTION - HEALTHY TEXANS

C1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

Measure Description:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

DY7/DY8 Program ID	105
NQF Number	0028
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0028
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for tobacco use* at least once within 24 months AND who received tobacco cessation counseling intervention** if identified as a tobacco user *Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy
Denominator Description	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, other
Data Source	Claims (Only), Electronic Health Record (Only), Other, Paper Records, Registry
Measure Point Value	1
Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus Core Set: Cardiovascular Measures; MACRA MIPS Measure; CCBHC Measure.

C1-113: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.

DY7/DY8 Program ID	113
NQF Number	0057
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0057
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.9288 **MPL:** 0.8298
Numerator Description	Patients who had an HbA1c test performed during the measurement year.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures;

C1-147: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Measure Description:
Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter

Normal Parameters:

Age 65 years and older BMI >= 23 and < 30

Age 18 – 64 years BMI >= 18.5 and < 25

DY7/DY8 Program ID	147
NQF Number	0421 / 2828 eMeasure
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0421 http://www.qualityforum.org/QPS/2828
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.9254 **MPL:** 0.7651
Numerator Description	Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.
Denominator Description	There are two (2) Initial Patient Populations for this measure: Initial Patient Population 1: All patients 18 through 64 years on the date of the encounter with at least one eligible encounter during the measurement period. Initial Patient Population 2: All patients 65 years of age and older on the date of the encounter with at least one eligible encounter during the measurement period.
Inclusions	None listed by measure steward.
Exclusions	Initial Patient Population 1: Patients who are pregnant or encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient´s health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate. Initial Patient Population 2: Encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient´s health status, or there is any other reason documented in the medical

	record by the provider explaining why BMI measurement was not appropriate.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Other
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure; CCBHC Measure.

C1-268: Pneumonia vaccination status for older adults

Measure Description:
Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination.

DY7/DY8 Program ID	268
NQF Number	0043
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0043
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of patients in the denominator who responded "Yes" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."
Denominator Description	CAHPS respondents age 65 or older as of the last day of the measurement year who responded "Yes" or "No" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Patient Reported Data
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

C1-269: Preventive Care and Screening: Influenza Immunization

Measure Description:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

DY7/DY8 Program ID	269
NQF Number	0041 / 3070 eMeasure
Measure Steward	AMA / PCPI
Link to Measure Citation	http://www.qualityforum.org/QPS/0041 http://www.qualityforum.org/QPS/3070
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization
Denominator Description	All patients aged 6 months and older seen for a visit between October 1 and March 31
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons) Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons) Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)
DSRIP Specified Setting	Primary Care
Data Source	Electronic Health Record (Only), Registry
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

C1-272: Adults (18+ years) Immunization status

Measure Description:
Percentage of adult patients 18 years and older who are up-to-date with the following immunizations:

-One tetanus and diphtheria toxoids (Td) vaccine in the last 10 years

-Varicella – two doses or history of disease up to year 1995

-Pneumococcal polysaccharide vaccine (PPSV23) for patients 65 and older

-One influenza within last year

-Herpes zoster/shingles (patients 60 years and older)

DY7/DY8 Program ID	272
NQF Number	NA
Measure Steward	Institute for Clinical Systems Improvement
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of patients who are up-to-date with following immunizations: -One tetanus and diphtheria toxoids (Td) vaccine in the last 10 years -Varicella – two doses or history of disease up to year 1995 -Pneumococcal polysaccharide vaccine (PPSV23) for patients 65 and older -One influenza dose within the last year -Herpes zoster/shingles (patients 60 years and older)
Denominator Description	Number of patients 18 years and older during the specified measurement period*
Inclusions	None listed by measure steward.
Exclusions	Denominator Exclusions: Patients with immunization contraindications listed in the medical record should be excluded
DSRIP Specified Setting	Primary Care
Data Source	Clinical Data, Electronic Health Record, Administrative Claims
Measure Point Value	1
Additional Notes	

C1-280: Chlamydia Screening in Women (CHL)

Measure Description:
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

DY7/DY8 Program ID	280
NQF Number	0033
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0033
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.6892 **MPL:** 0.4881
Numerator Description	Females who were tested for chlamydia during the measurement year.
Denominator Description	Females 16-24 years who had a claim or encounter indicating sexual activity.
Inclusions	None listed by measure steward.
Exclusions	Females who received a pregnancy test to determine contraindications for medication (isotretinoin) or x-ray.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Imaging-Diagnostic, Laboratory, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure.

C1-285: Advance Care Plan

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

DY7/DY8 Program ID	285
NQF Number	0326
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0326
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.
Denominator Description	All patients aged 65 years and older.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital
Data Source	Claims (Only), Electronic Health Record (Only)
Measure Point Value	1
Additional Notes	

MACRA MIPS High Priority Measure.

C1-389: Human Papillomavirus Vaccine (age 14 -26)

Measure Description:
TBD

DY7/DY8 Program ID	389
NQF Number	
Measure Steward	0
Link to Measure Citation	TBD
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	TBD
Denominator Description	TBD
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

BUNDLE C2: PRIMARY CARE PREVENTION - CANCER SCREENING & FOLLOW-UP

C2-106: Cervical Cancer Screening

Measure Description:
Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years.

- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

DY7/DY8 Program ID	106
NQF Number	0032
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0032
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.6983 **MPL:** 0.4834
Numerator Description	The number of women who were screened for cervical cancer.
Denominator Description	Women 24-64 years of age as of the end of the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude: Women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	2
Additional Notes	

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus OB/GYN Measures; MACRA MIPS Measure; Proposed 2018 MCO P4Q Measure.

C2-107: Colorectal Cancer Screening

Measure Description:
The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.

DY7/DY8 Program ID	107
NQF Number	0034
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0034
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	One or more screenings for colorectal cancer. Any of the following meet criteria: - Fecal occult blood test (FOBT) during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type. - Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. - Colonoscopy during the measurement year or the nine years prior to the measurement year.
Denominator Description	Patients 51–75 years of age as of the end of the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients with a diagnosis of colorectal cancer or total colectomy
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Imaging-Diagnostic, Laboratory, Paper Records
Measure Point Value	2
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

C2-162: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Measure Description:
Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.

DY7/DY8 Program ID	162
NQF Number	0658
Measure Steward	American Gastroenterological Association
Link to Measure Citation	http://www.qualityforum.org/QPS/0658
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report
Denominator Description	All patients aged 50 years and older and receiving screening a screening colonoscopy without biopsy or polypectomy
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, inadequate prep, other medical reasons)
DSRIP Specified Setting	Clinician Office/Clinic
Data Source	Claims (Only), Electronic Health Record (Only), Imaging-Diagnostic, Other, Registry
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: Gastroenterology Measures; MACRA MIPS High Priority Measure.

C2-186: Breast Cancer Screening

Measure Description:
The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

DY7/DY8 Program ID	186
NQF Number	2372
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/2372
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7144 **MPL:** 0.5228
Numerator Description	Women who received a mammogram to screen for breast cancer.
Denominator Description	Women 52-74 years as of December 31 of the measurement year Note: this denominator statement captures women age 50-74 years; it is structured to account for the look-back period for mammograms.
Inclusions	None listed by measure steward.
Exclusions	Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy: 1) Bilateral mastectomy 2) Unilateral mastectomy with a bilateral modifier 3) Two unilateral mastectomies on different dates of service and 4) Both of the following (on the same date of service): Unilateral mastectomy with a right-side modifier and unilateral mastectomy with a left-side modifier.
DSRIP Specified Setting	Clinician Office/Clinic
Data Source	Claims (Only), Electronic Health Record (Only)
Measure Point Value	2
Additional Notes	

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus OB/GYN Measures; MACRA MIPS Measure.

C2-199: PQRS #439: Age Appropriate Screening Colonoscopy

Measure Description:
The percentage of patients greater than 85 years of age who received a screening colonoscopy from January 1 to December 31

DY7/DY8 Program ID	199
NQF Number	NA
Measure Steward	American Gastroenterological Association
Link to Measure Citation	https://pqrs.cms.gov/dataset/2016-PQRS-Measure-439-11-17-2015/c5y7-sabu
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	All patients greater than 85 years of age included in the denominator who did NOT have a history of colorectal cancer or a valid medical reason for the colonoscopy, including: iron deficiency anemia, lower gastrointestinal bleeding, Crohn's Disease (i.e. regional enteritis), familial adenomatous polyposis, Lynch Syndrome (i.e., hereditary non-polyposis colorectal cancer), inflammatory bowel disease, ulcerative colitis, abnormal findings of gastrointestinal tract, or changes in bowel habits. Colonoscopy examinations performed for screening purposes only. Numerator Instructions: INVERSE MEASURE - A lower calculated performance rate for this measure indicates better clinical care or control. The "Performance Not Met" numerator option for this measure is the representation of the better clinical quality or control. Reporting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control, and therefore an inverse measure at 100% does not qualify for reporting purposes, however any reporting rate less than 100% does qualify.
Denominator Description	Colonoscopy examinations performed on patients greater than 85 years of age during the encounter period Denominator Instructions: Clinicians who indicate that the colonoscopy procedure is incomplete or was discontinued should use the procedure number and the addition (as appropriate) of modifier 52, 53, 73, or 74. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will not qualify for inclusion in this measure. Denominator Criteria (Eligible Cases): All patients greater than 85 years of age on date on encounter receiving a colonoscopy for screening purposes only AND

	Patient encounter during the reporting period (CPT or HCPCS): 45378, 45380, 45381, 45384, 45385, G0121
Inclusions	None listed by measure steward.
Exclusions	Performance Not Met: Documentation of medical reason(s) for a colonoscopy performed on a patient greater than 85 years of age (e.g., last colonoscopy incomplete, last colonoscopy had inadequate prep, iron deficiency anemia, lower gastrointestinal bleeding, Crohn's Disease (i.e., regional enteritis), familial history of adenomatous polyposis, Lynch Syndrome (i.e., hereditary non-polyposis colorectal cancer), inflammatory bowel disease, ulcerative colitis, abnormal finding of gastrointestinal tract, or changes in bowel habits) (G9660) OR Performance Not Met: Patients greater than 85 years of age who received a routine colonoscopy for a reason other than the following: an assessment of signs/symptoms of GI tract illness, and/or the patient is considered high risk, and/or to follow-up on previously diagnoses advance lesions (G9661)
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Not listed
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: Gastroenterology Measures; MACRA MIPS High Priority Measure.

C2-274: Mammography follow-up rate

Measure Description:
This measure is used to assess the percentage of patients with mammography screening studies that are followed by a diagnostic mammography, ultrasound or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting within 45 days.

DY7/DY8 Program ID	274
NQF Number	NA
Measure Steward	CMS
Link to Measure Citation	https://www.qualitymeasures.ahrq.gov/summaries/summary/50665
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Of studies identified in the denominator, the number of studies with diagnostic mammography, ultrasound, or magnetic resonance imaging (MRI) of the breast (i.e., within 45, of the screening mammography study) (see the related "Numerator Inclusions/Exclusions" field)
Denominator Description	The number of patients who had received a screening mammography study (see the related "Denominator Inclusions/Exclusions" field)
Inclusions	Numerator Inclusions: Of studies identified in the denominator, the number of studies with diagnostic mammography, ultrasound, or magnetic resonance imaging (MRI) of the breast (i.e., within 45 days, of the screening mammography) Note: The numerator measurement of a diagnostic mammography, ultrasound or MRI study is based on the claim date of the screening mammography from the denominator. The 45-day time window includes the same day that the screening was performed; that is, the numerator would include diagnostic mammography or ultrasound on the same day as the screening mammogram. Medicare will reimburse for both the screening mammography and diagnostic mammography procedures for a screening mammogram and a diagnostic mammogram performed on the same patient on the same day (section 4601.2 [I] of the Medicare Carriers Manual - Transmittal #1724). Refer to the original measure documentation for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. Denominator Inclusions: The number of patients who had received a screening mammography study Note: Initial Patient Population: This measure applies only to Medicare beneficiaries enrolled in original, fee-for-service (FFS) Medicare who were treated as outpatients in hospital facilities reimbursed through the Outpatient Prospective Payment System (OPPS). These measures do not include Medicare managed care beneficiaries, non-Medicare patients, or beneficiaries who were admitted to the hospital as inpatients.

	Beneficiaries included in the measure's initial patient population had documentation of a mammography screening performed from July 1 through May 15 during the measurement period. Beneficiaries can be included in the measure's initial patient population multiple times; each mammography screening performed at a facility measured by OPPS is counted once in the measure's denominator. Refer to the original measure documentation for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Administrative clinical data
Measure Point Value	3
Additional Notes	

C2-275: Abnormal Pap test follow-up rate

Measure Description:
Percentage of women aged 12 to 65 years old who undergo follow-up colposcopy after a Pap test identification of high-grade squamous intraepithelial lesions (HSIL), atypical squamous cells (ASC-H), atypical glandular cells (AGC), or cancer-in-situ.

DY7/DY8 Program ID	275
NQF Number	NA
Measure Steward	American College of Obstetrics and Gynecology
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of women aged 12 to 65 years old who undergo follow-up colposcopy after a Pap test identification of high-grade squamous intraepithelial lesions (HSIL), atypical squamous cells (ASC-H), atypical glandular cells (AGC), or cancer-in-situ.
Denominator Description	The number of women aged 12 to 65 years old with a Pap test identification of high-grade squamous intraepithelial lesions (HSIL), atypical squamous cells (ASC-H), atypical glandular cells (AGC), or cancer-in-situ.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Administrative/Clinical data sources
Measure Point Value	3
Additional Notes	

BUNDLE C3: HEPATITIS C

C3-202: PQRS #401: Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis

Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) at least once within the 12 month reporting period

DY7/DY8 Program ID	202
NQF Number	NA
Measure Steward	American Gastroenterological Association
Link to Measure Citation	https://pqrs.cms.gov/dataset/2016-PQRS-Measure-401-11-17-2015/xgtb-359z
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who underwent abdominal imaging with either ultrasound, contrast enhanced CT or MRI
Denominator Description	All patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis
Inclusions	Denominator Criteria (Eligible Cases): Patients aged ≥ 18 years on date of encounter AND Diagnosis for chronic hepatitis C (ICD-10-CM): B18.2, B19.20, B19.21 AND Diagnosis for cirrhosis (ICD-10-CM): K70.30, K70.31, K74.60, K74.69 AND Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 Numerator: Performance Met: Patient underwent abdominal imaging with ultrasound, contrast enhanced CT or contrast MRI for HCC (G9455)
Exclusions	Numerator: Other Performance Exclusion: Documentation of medical or patient reason(s) for not ordering or performing screening for HCC. Medical reason: Comorbid medical conditions with expected survival <5 years, hepatic decompensation and not a candidate for liver transplantation, or other medical reasons. Patient reasons: Patient declined or other patient reasons (e.g., cost of tests, time related to accessing testing equipment) (G9456) OR

	Performance Not Met: Patient did not undergo abdominal imaging and did not have a documented reason for not undergoing abdominal imaging in the reporting period (G9457)
DSRIP Specified Setting	Primary Care
Data Source	Not listed
Measure Point Value	2
Additional Notes	BAT recommendation that denominator is specific to individuals managming treatment for HCV in a primary care setting (not specialty care)

CMS Alignment: CMS Consensus Core Set: Hep C Core Measures; MACRA MIPS Measure.

C3-203: PQRS #400: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk

Measure Description:
Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965 who received one- time screening for hepatitis C virus (HCV) infection

DY7/DY8 Program ID	203
NQF Number	NA / 3059 eMeasure
Measure Steward	AMA-PCPI
Link to Measure Citation	https://pqrs.cms.gov/dataset/2016-PQRS-Measure-400-11-17-2015/kx88-j5sg http://www.qualityforum.org/QPS/3059
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who received one-time screening for HCV infection
Denominator Description	All patients aged 18 years and older who were seen twice for any visit or who had at least one preventive visit within the 12 month reporting period with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965
Inclusions	None listed by measure steward.
Exclusions	Denominator Exclusions: Patients with a diagnosis of chronic hepatitis C Denominator Exceptions: Documentation of medical reason(s) for not receiving one-time screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons) Documentation of patient reason(s) for not receiving one-time screening for HCV infection (eg, patient declined, other patient reasons)
DSRIP Specified Setting	Primary Care
Data Source	Electronic Health Record (Only), Other
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: Hep C Core Measures; MACRA MIPS Measure.

C3-311: PQRS #390 Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options

Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of hepatitis C with whom a physician or other qualified healthcare professional reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient. To meet the measure, there must be documentation in the patient record of a discussion between the physician or other qualified healthcare professional and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward treatment

DY7/DY8 Program ID	311
NQF Number	NA
Measure Steward	American Gastroenterological Association
Link to Measure Citation	https://pqrs.cms.gov/dataset/2016-PQRS-Measure-390-11-17-2015/2dh2-wj4r
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients with whom a physician or other qualified healthcare professional reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient
Denominator Description	All patients aged 18 years and older with a diagnosis of chronic hepatitis C
Inclusions	Denominator: Denominator Criteria (Eligible Cases): Patients aged ≥ 18 years on date of encounter AND Diagnosis for chronic hepatitis C (ICD-10-CM): B18.2, B19.20, B19.21 AND Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 Numerator: Numerator Options: Performance Met: Documentation in the patient record of a discussion between the physician/clinician and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward the outcome of the treatment (G9399)
Exclusions	Numerator: Other Performance Exclusion: Documentation of medical or patient reason(s) for not discussing treatment options. Medical reasons: Patient is not a candidate for treatment due to advanced physical or mental health comorbidity (including active substance use); currently

	receiving antiviral treatment; successful antiviral treatment (with sustained virologic response) prior to reporting period; other documented medical reasons. Patient reasons: Patient unable or unwilling to participate in the discussion or other patient reasons (G9400) No documentation of a discussion in the patient record of a discussion between the physician or other qualified healthcare professional and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward treatment (G9401)
DSRIP Specified Setting	Primary Care
Data Source	None listed
Measure Point Value	1
Additional Notes	

MACRA MIPS High Priority Measure.

C3-328: Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection (eMeasure)

Measure Description:
Percentage of patients aged 18 years and older with either (1) a positive HCV antibody test result and a positive HCV RNA test result 1or (2) a positive HCV antibody test result and an absent HCV RNA test result who are prescribed treatment or are referred to evaluation or treatment services

DY7/DY8 Program ID	328
NQF Number	3061 (Approved for Trial Use)
Measure Steward	PCPI
Link to Measure Citation	http://www.qualityforum.org/QPS/3061
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who are prescribed treatment or are referred to evaluation or treatment services
Denominator Description	All patients aged 18 years and older who are seen twice for any visit or who had at least one preventive visit with either (1) a positive HCV antibody test result and a positive HCV RNA test result or (2) a positive HCV antibody test result and an absent HCV RNA test result
Inclusions	None listed by measure steward.
Exclusions	Denominator Exclusions: Patients with a negative HCV RNA result, patients with a diagnosis of chronic hepatitis C Denominator Exceptions: Documentation of medical reason(s) for not prescribing treatment or being referred to evaluation or treatment services (eg, participation in a clinical trial, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons) Documentation of patient reason(s) for not prescribing treatment or being referred to evaluation or treatment services (eg, patient declined, other patient reasons)
DSRIP Specified Setting	Primary Care
Data Source	Electronic Health Record (Only), Other
Measure Point Value	1
Additional Notes	

C3-368: Hepatitis C: Hepatitis A Vaccination

Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who have received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A

DY7/DY8 Program ID	368
NQF Number	0399
Measure Steward	American Gastroenterological Association
Link to Measure Citation	http://www.qualityforum.org/QPS/0399
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who have received at least one injection of hepatitis A vaccine, or who have documented immunity to Hepatitis A
Denominator Description	All patients aged 18 years and older with a diagnosis of chronic hepatitis C
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not administering at least one injection of hepatitis A vaccine (eg, allergy or intolerance to a known component of the vaccine, other medical reasons) Documentation of patient reason(s) for not administering at least one injection of hepatitis A vaccine (eg, patient declined, insurance coverage, other patient reasons)
DSRIP Specified Setting	Primary Care
Data Source	Electronic Health Record (Only), Laboratory, Other, Registry
Measure Point Value	1
Additional Notes	

C3-369: Hepatitis C: Hepatitis B Vaccination

Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who have received at least one injection of hepatitis B vaccine, or who have documented immunity to hepatitis B

DY7/DY8 Program ID	369
NQF Number	0400
Measure Steward	AMA-convened Physician Consortium for Performance Improvement
Link to Measure Citation	http://www.qualityforum.org/QPS/0400
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who have received at least one injection of Hepatitis B vaccine, or who have documented immunity to Hepatitis B
Denominator Description	All patients aged 18 years and older with a diagnosis of hepatitis C
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not receiving at least one injection of hepatitis B vaccine Documentation of patient reason(s) for not receiving at least one injection of hepatitis B vaccine
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Other, Registry
Measure Point Value	1
Additional Notes	

BUNDLE D1: PEDIATRIC PRIMARY CARE

D1-108: Childhood Immunization Status (CIS)

Measure Description:
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine.

DY7/DY8 Program ID	108
NQF Number	0038
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0038
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.4647 **MPL:** 0.2599
Numerator Description	Children who have evidence showing they received all recommended vaccines by their second birthday: • Four diphtheria, tetanus and acellular pertussis (DtaP) • Three polio (IPV) • One measles, mumps and rubella (MMR) • Three H influenza type B (HiB) • Three hepatitis B (HepB) • One chicken pox (VZV) • Four pneumococcal conjugate (PCV) • One hepatitis A (HepA) • Two or three rotavirus (RV); and, • Two influenza (flu)
Denominator Description	Children who turn 2 years of age during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates. The denominator for all rates must be the same.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records, Registry
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure; Proposed 2018 MCO P4Q Measure.

D1-211: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure Description:
Percentage of children 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of:

Rate #1: Body Mass Index (BMI) percentile documentation

Rate #2: Counseling for nutrition, and

Rate #3: Counseling for physical activity.

DY7/DY8 Program ID	211
NQF Number	0024
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0024
Measure Parts	3
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** BMI Percentile: 0.8637 Counseling for Nutrition: 0.7952 Counseling for Physical Activity: 0.7158 **MPL:** BMI Percentile: 0.545 Counseling for Nutrition: 0.5184 Counseling for Physical Activity: 0.4509
Numerator Description	Children ages 3-17 with evidence of each of the following: Rate #1: Documented body mass index (BMI) percentile Rate #2: Counseling for nutrition Rate #3: Counseling for physical activity during the measurement year
Denominator Description	Children 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or obstetrician-gynecologist (OB-GYN) during the measurement period.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who have a diagnosis of pregnancy during the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure; Proposed 2018 MCO P4Q Measure; CCBHC Measure.

D1-212: Appropriate Testing for Children With Pharyngitis

Measure Description:
The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

DY7/DY8 Program ID	212
NQF Number	0002
Measure Steward	AHRQ
Link to Measure Citation	http://www.qualityforum.org/QPS/0002
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.8659 **MPL:** 0.6324
Numerator Description	A group A streptococcus test (Group A Strep Tests Value Set) in the seven-day period from three days prior to the Index Episode Start Date (IESD) through three days after the IESD.
Denominator Description	Children age 2 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of measurement year who had an outpatient or ED visit with only a diagnosis of pharyngitis and were dispensed an antibiotic for the episode of care during the 6 months prior to through the 6 months after the beginning of the measurement year.
Inclusions	None listed by measure steward.
Exclusions	1) Exclude encounters with more than one diagnosis and ED visits that result in an inpatient admission. 2) Exclude episodes if the patient did not receive antibiotics on or within three days after the date of service. 3) Exclude episodes where a new or refill prescription for an antibiotic medication (Table CWP-C) was filled 30 days prior to the date of service or which was active on the date of service.
DSRIP Specified Setting	Primary Care, Urgent Care, Outpatient Specialty Care
Data Source	Claims (Only), Laboratory, Pharmacy
Measure Point Value	3
Additional Notes	

D1-237: Well-Child Visits in the First 15 Months of Life (6 or more visits)

Measure Description:
The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.

DY7/DY8 Program ID	237
NQF Number	1392
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/1392
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7388 **MPL:** 0.5349
Numerator Description	Children who received the following number of well-child visits with a PCP during their first 15 months of life: - No well-child visits - One well-child visit - Two well-child visits - Three well-child visits - Four well-child visits - Five well-child visits - Six or more well-child visits
Denominator Description	Children 15 months old during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; Proposed 2018 MCO P4Q Measure.

D1-238: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Measure Description:
The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.

DY7/DY8 Program ID	238
NQF Number	1516
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/1516
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.8297 **MPL:** 0.6472
Numerator Description	Children who received at least one well-child visit with a PCP during the measurement year.
Denominator Description	Children 3-6 years of age during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set;

D1-240: Adolescent Well-Care Visits (AWC)

Measure Description:
This measure is used to assess the percentage of enrolled members 12 to 21 years of age who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year.

DY7/DY8 Program ID	240
NQF Number	NA
Measure Steward	NCQA
Link to Measure Citation	https://www.qualitymeasures.ahrq.gov/summaries/summary/49821
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.6604 **MPL:** 0.4088
Numerator Description	At least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year (see the related "Numerator Inclusions/Exclusions" field)
Denominator Description	Members age 12 to 21 years as of December 31 of the measurement year (see the related "Denominator Inclusions/Exclusions" field)
Inclusions	Denominator: Members age 12 to 21 years as of December 31 of the measurement year Note: Members must have been continuously enrolled during the measurement year. Allowable Gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage. Numerator: At least one comprehensive well-care visit (Well-Care Value Set) with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the member.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care
Data Source	Administrative clinical data, Paper medical record
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; Proposed 2018 MCO P4Q Measure.

D1-271: Immunization for Adolescents- Tdap/TD and MCV

Measure Description:
The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday.

DY7/DY8 Program ID	271
NQF Number	1407
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/1407
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.8657 **MPL:** 0.6603
Numerator Description	Adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Denominator Description	Adolescents who turn 13 years of age during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered. Either of the following meet exclusion criteria: • Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday. • Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	Updated to include HPV

CMS Alignment: Child Core Set; MACRA MIPS Measure.

D1-284: Appropriate Treatment for Children with Upper Respiratory Infection (URI)

Measure Description:
Percentage of children 3 months to 18 years of age with a diagnosis of upper respiratory infection (URI) who were not dispensed an antibiotic medication.

DY7/DY8 Program ID	284
NQF Number	0069
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0069
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.9608 **MPL:** 0.8492
Numerator Description	Patients who were dispensed antibiotic medication on or within 3 days after an outpatient or ED encounter for upper respiratory infection (URI) during the intake period (a higher rate is better). The measure is reported as an inverted rate (i.e. 1- numerator/denominator) to reflect the number of children that were not dispensed an antibiotic.
Denominator Description	All children age 3 months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year who had an ED or outpatient visit with only a diagnosis of nonspecific upper respiratory infection (URI) during the intake period (July 1st of the year prior to the measurement year to June 30th of the measurement year).
Inclusions	None listed by measure steward.
Exclusions	Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or was active on the Episode Date. Exclude Episode Dates where the patient had a claim/encounter with a competing diagnosis on or three days after the Episode Date.
DSRIP Specified Setting	Primary Care, Urgent Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Pharmacy
Measure Point Value	1
Additional Notes	

MACRA MIPS High Priority Measure; Proposed 2018 MCO P4Q Measure.

D1-301: Maternal Depression Screening

Measure Description:
The percentage of children 6 months of age who had documentation of a maternal depression screening for the mother.

DY7/DY8 Program ID	301
NQF Number	1401
Measure Steward	National Committee for Quality Assurance
Link to Measure Citation	http://www.qualityforum.org/QPS/1401
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Children who had documentation of a maternal depression screening for the mother at least once between 0 and 6 months of life.
Denominator Description	Children with a visit who turned 6 months of age in the measurement year.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care
Data Source	Electronic Health Record (Only), Other, Paper Records
Measure Point Value	1
Additional Notes	

BUNDLE D3: PEDIATRIC HOSPITAL SAFETY

D3-330: Pediatric CLABSI

Measure Description:
This measure answers the question: How often is a patient harmed due to central line associated blood stream infections?

DY7/DY8 Program ID	330
NQF Number	NA
Measure Steward	Children's Hospitals' Solutions for Patient Safety National Children's Network
Link to Measure Citation	http://www.solutionsforpatientsafety.org/wp-content/uploads/sps-operating-definitions.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Numerator: Number of patients contracting an infection, as defined by CDC guidelines. Multiple infection sites due to the same organism are counted as one infection. For this measure, distinction is not made between an infection due to CVC/PICC insertion and one due to maintenance practices. HEM/ONC patients residing in HEM/ONC units by: CLABSI, Secondary infections, Single positive cultures Number of events outside of HEM/ONC units with MBI, based on geography
Denominator Description	Denominator: Total number of central line days during the time period. Two analyses: a) Number of blood stream infections per 1000 central line days (Numerator/Denominator) x 1000 b) Total number of blood stream infections Process Data: Observations collected by unit: PICU, CICU, NICU, Hematology-Oncology and all other units.
Inclusions	All patients are included who are defined as inpatient or under observation at the hospital including two calendar days post discharge.
Exclusions	Infection must not be incubating at the time of the admission into the hospital. For most infections, this means that the infection does not become evident until two calendar days or more after admission, but each infection must be assessed individually.
DSRIP Specified Setting	Hospital
Data Source	Each hospital will report data using their own collection methods until specific high detection methods are prescribed by the network.
Measure Point Value	2
Additional Notes	

D3-331: Pediatric CAUTI

Measure Description:
This measure answers the question: How often are patients harmed by the occurrence of a catheter associated urinary tract infections?

DY7/DY8 Program ID	331
NQF Number	NA
Measure Steward	Children's Hospitals' Solutions for Patient Safety National Children's Network
Link to Measure Citation	http://www.solutionsforpatientsafety.org/wp-content/uploads/sps-operating-definitions.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Events per Catheter Day: Numerator: Number of patients contracting an infection, as defined by CDC guidelines. Catheter Days per Patient Days Numerator: Number of catheter days.
Denominator Description	Events per Catheter Day: Denominator: Total number of indwelling urinary catheter days during the time period. Number of urinary tract infections per 1000 urinary catheter days (Numerator/Denominator) x 1000 Catheter Days per Patient Days: Denominator: Total number of patient days (excluding NICU) Number of catheter per 1000 patient days (Numerator/Denominator) x 1000
Inclusions	All patients admitted to an inpatient unit are included who are defined as inpatient or under observation at the hospital with an indwelling urinary catheter.
Exclusions	Observation patients admitted to observation units and patients admitted to neonatal intensive care units will be excluded. Infection must not be incubating at the time of the admission into the hospital. For most infections, this means that the infection does not become evident until 48 hours or more after admission, but each infection must be assessed individually. There is no minimum period of time that the catheter must be in place in order for the UTI to be considered catheter associated.
DSRIP Specified Setting	Hospital
Data Source	Each hospital will report data using their own collection methods until specific high detection methods are prescribed by the network.
Measure Point Value	2
Additional Notes	

D3-333: Pediatric Surgical site infections (SSI)

Measure Description:
This measure answers the question: How often is a patient harmed due to surgical site infections in high risk surgeries? The current version of the National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol will serve as the official reference guide for rules around reporting surgical site infections.

DY7/DY8 Program ID	333
NQF Number	NA
Measure Steward	Children's Hospitals' Solutions for Patient Safety National Children's Network
Link to Measure Citation	http://www.solutionsforpatientsafety.org/wp-content/uploads/sps-operating-definitions.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of SSIs related to designated surgical procedures.
Denominator Description	Number of patient trips to the operating room for designated surgical procedures during the applicable reporting period. Note: A patient trip to the operating room is counted only once, regardless of the number of procedures performed. (Numerator/Denominator) x 100 (Note: reported as SSIs per 100 patient trips to the operating room.)
Inclusions	All patients who experience one of the above surgical procedures
Exclusions	Patients with physician/advanced practice nurse/physician assistant of documentation of an active infection at the time of the surgical procedure. Signs/symptoms of infection can include but not be limited to: fever, redness/tenderness, elevated white blood cell count, positive culture. Spine refusion procedures will be excluded.
DSRIP Specified Setting	Hospital
Data Source	Each hospital will report data using their own collection methods utilizing the procedure
Measure Point Value	2
Additional Notes	

D3-334: Pediatric Adverse Drug Events

Measure Description:
This measure answers the question: How often do is a patient harmed due to drugs given to them? Adverse drug events will be defined per the National Coordinating Council for Medication Error Reporting and Prevention's Index for Categorizing Medication Errors.

DY7/DY8 Program ID	334
NQF Number	NA
Measure Steward	Children's Hospitals' Solutions for Patient Safety National Children's Network
Link to Measure Citation	http://www.solutionsforpatientsafety.org/wp-content/uploads/sps-operating-definitions.pdf
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of adverse drug events per NCC MERP's Index for Categorizing Medication Errors. Numerators will be reported as Level E and combined Level F-I as defined below. E = An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention F = An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization G = An error occurred that may have contributed to or resulted in permanent patient harm H = An error occurred that required intervention necessary to sustain life I = An error occurred that contributed to or resulted in the patient's death
Denominator Description	Denominator: Total number patient days. Number adverse drug events in category E per number patient days per 1000 patients (Numerator/Denominator) * 1000 Number of adverse drug events in categories F-I (combined) per number of patient days per 1000 patients (Numerator/Denominator) * 1000
Inclusions	All patients are included who are defined as inpatient or under observation at the hospital.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Hospital
Data Source	codes listed in appendix A or other methods that reliably collect the cases listed above.
Measure Point Value	2
Additional Notes	

D3-335: Pediatric Pressure Injuries

Measure Description:
This measure answers the question: How often is a patient harmed due to pressure injury? The National Pressure Ulcer Advisory Panel (NPUAP) will serve as the guide

for the defining and staging of pressure injury. The Solutions for Patient Safety (SPS) operational definition will serve as the official guide for the reporting of all hospital acquired pressure injuries detected during hospitalization.

DY7/DY8 Program ID	335
NQF Number	NA
Measure Steward	Children's Hospitals' Solutions for Patient Safety National Children's Network
Link to Measure Citation	http://www.solutionsforpatientsafety.org/wp-content/uploads/sps-operating-definitions.pdf
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	All Harm Numerator: Number of Mucosal, Stage 2, 3, 4, deep tissue pressure injuries (DTPI), and unstageable pressure injuries as defined below. Serious Harm Numerator: Number of Stage 3, 4, and unstageable pressure injuries as defined below.
Denominator Description	Denominator for both All Harm and Serious Harm: Total number patient days.
Inclusions	All patients are included who are defined as inpatient or under observation at the hospital.
Exclusions	Any patient who has a PI documented upon admission to the hospital, would be excluded because this would be considered a non-facility acquired PI (unless the PI progresses to a stage 3, 4, or unstageable during their hospital stay). All Harm Excludes Stage I pressure injury: Intact skin with a localized area of non-blanch able erythema, which may appear differently in darkly pigmented skin. Presence of blanch able erythema or change sin sensation, temperature or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Serious Harm Excludes: Stage 1, 2, Mucosal Injuries, and DTPI.
DSRIP Specified Setting	Hospital
Data Source	Each hospital will report data using their own collection methods until specific high detection methods are prescribed by the network.
Measure Point Value	2
Additional Notes	

BUNDLE D4: PEDIATRIC CHRONIC DISEASE MANAGEMENT: ASTHMA

D4-139: Asthma Admission Rate (PDI14) (BAT recommendation to report for ages 5 - 18)

Measure Description:
Admissions with a principal diagnosis of asthma per 100,000 population, ages 2 through 17 years. Excludes cases with a diagnosis code for cystic fibrosis and anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.

DY7/DY8 Program ID	139
NQF Number	0728
Measure Steward	AHRQ
Link to Measure Citation	http://www.qualityforum.org/QPS/0728
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Discharges, for patients ages 2 through 17 years, with a principal diagnosis code for asthma.
Denominator Description	Population ages 2 through 17 years in metropolitan area(1)or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Hospital
Data Source	Claims (Only)
Measure Point Value	3
Additional Notes	Admissions for ages 5 - 18

D4-173: Medication Management for People with Asthma (75%)

Measure Description:
The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. One rate is reported: the percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.

DY7/DY8 Program ID	173
NQF Number	1799
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/1799
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.4839 **MPL:** 0.2508
Numerator Description	The number of patients who achieved a PDC* of at least 75% for their asthma controller medications during the measurement year. A higher rate is better. *PDC is the proportion of days covered by at least one asthma controller medication prescription, divided by the number of days in the treatment period. The treatment period is the period of time beginning on the earliest prescription dispensing date for any asthma controller medication during the measurement year through the last day of the measurement year.
Denominator Description	All patients 5–64 years of age as of December 31 of the measurement year who have persistent asthma by meeting at least one of the following criteria during both the measurement year and the year prior to the measurement year: • At least one emergency department visit with asthma as the principal diagnosis • At least one acute inpatient claim/encounter with asthma as the principal diagnosis • At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events. Visit type need not be the same for the four visits. • At least four asthma medication dispensing events
Inclusions	None listed by measure steward.
Exclusions	1) Exclude patients who had any of the following diagnoses any time during the patient's history through the end of the measurement year (e.g., December 31): -COPD -Emphysema -Obstructive Chronic Bronchitis -Chronic Respiratory Conditions Due To Fumes/Vapors -Cystic Fibrosis

	-Acute Respiratory Failure 2) Exclude any patients who had no asthma controller medications dispensed during the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only)
Measure Point Value	3
Additional Notes	Rate 1 only (75%)

CMS Alignment: Child Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

D4-209: Asthma Percent of Opportunity Achieved

Measure Description:
This measure is an asthma composite measure and is calculated by adding or "rolling up" the number of times recommended care was provided over all the process measures in the given measure set and dividing this sum by the total number of opportunities for providing this recommended care.

DY7/DY8 Program ID	209
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** NA **MPL:** NA
Numerator Description	The number of times that each of the asthma opportunities (processes) listed below were completed/fulfilled at least once during the measurement year for all individuals with asthma (any age) : 1.) Documentation of Action/Management Plan, 2.) Severity Assessment 3.) Controller Therapy for those who are eligible, and 4.) Documentation of spirometry assessment completed within last two years.
Denominator Description	The total number of opportunities can be calculated in the following manner- For each individual with an asthma diagnosis assign a count one for each of the four processes that should have been completed (should be 3-4 counts per patient) at least once during the measurement period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Clinical data; Electronic health records; Administrative claims.
Measure Point Value	3
Additional Notes	

D4-249: Pediatric/Young Adult Asthma Emergency Department Visits

Measure Description:
Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period.

DY7/DY8 Program ID	249
NQF Number	1381
Measure Steward	Alabama Medicaid Agency
Link to Measure Citation	http://www.qualityforum.org/QPS/1381
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Measuring percentage of people with Asthma that have an emergency room visit during a 12 month measurement period.
Denominator Description	Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period.
Inclusions	None listed by measure steward.
Exclusions	Excludes children less than age two or greater than age twenty.
DSRIP Specified Setting	ED
Data Source	Claims (Only)
Measure Point Value	3
Additional Notes	

D4-375: Asthma: Pharmacologic Therapy for Persistent Asthma (rate 3) (Rate 3 only)

Measure Description:
Percentage of patients aged 5 years and older with a diagnosis of persistent asthma who were prescribed long-term control medication

Three rates are reported for this measure:

1. Patients prescribed inhaled corticosteroids (ICS) as their long term control medication

2. Patients prescribed other alternative long term control medications (non-ICS)

3. Total patients prescribed long-term control medication

DY7/DY8 Program ID	375
NQF Number	0047
Measure Steward	The American Academy of Asthma Allergy and Immunology
Link to Measure Citation	http://www.qualityforum.org/QPS/0047
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were prescribed long-term control medication
Denominator Description	All patients aged 5 years and older with a diagnosis of persistent asthma
Inclusions	None listed by measure steward.
Exclusions	Denominator Exceptions: Documentation of patient reason(s) for not prescribing inhaled corticosteroids or alternative long-term control medication (eg, patient declined, other patient reason) The AAAAI follows PCPI exception methodology and PCPI distinguishes between measure exceptions and measure exclusions. 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. For this measure, exceptions may include patient reason(s) (eg, patient declined). Although this methodology does not require the external reporting of more detailed exception data, the AAAAI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. In further accordance with PCPI exception methodology, the AAAAI advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records, Registry

Measure Point Value	1
Additional Notes	Rate 3 only

D4-376: Asthma Quality of Life Assessment Tool

Measure Description:
0

DY7/DY8 Program ID	376
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	TBD
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	TBD
Denominator Description	TBD
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

BUNDLE E1: IMPROVED MATERNAL CARE

E1-148: PC-01 Elective Delivery (Patients with elective vaginal deliveries or elective cesarean)

Measure Description:
This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)

DY7/DY8 Program ID	148
NQF Number	0469 / 2829 eMeasure
Measure Steward	The Joint Commission
Link to Measure Citation	http://www.qualityforum.org/QPS/0469 http://www.qualityforum.org/QPS/2829
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients with elective deliveries with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for one or more of the following: • Medical induction of labor as defined in Appendix A, Table 11.05 available at: http://manual.jointcommission.org/releases/TJC2016A/ while not in Labor prior to the procedure • Cesarean birth as defined in Appendix A, Table 11.06 and all of the following: o not in Labor o no history of a Prior Uterine Surgery available at: http://manual.jointcommission.org/releases/TJC2016A/
Denominator Description	Patients delivering newborns with >= 37 and < 39 weeks of gestation completed with ICD-10-PCS Principal or Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 available at: http://manual.jointcommission.org/releases/TJC2016A/ and with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1 available at: http://manual.jointcommission.org/releases/TJC2016A/
Inclusions	None listed by measure steward.
Exclusions	• ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Gestational Age < 37 or >= 39 weeks or UTD

DSRIP Specified Setting	Hospital
Data Source	Electronic Health Record (Only), Paper Records
Measure Point Value	3
Additional Notes	

CMS Alignment: CMS Consensus OB/GYN Measures;

E1-150: PC-02 Cesarean Section (Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section)

Measure Description:

This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. This measure is part of a set of five nationally implemented measures that address perinatal care.

DY7/DY8 Program ID	150
NQF Number	0471
Measure Steward	The Joint Commission
Link to Measure Citation	http://www.qualityforum.org/QPS/0471
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The outcome being measured is: Patients with cesarean births with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for cesarean birth as defined in Appendix A, Table 11.06 available at: http://manual.jointcommission.org/releases/TJC2016A/
Denominator Description	The outcome target population being measured is: Nulliparous patients delivered of a live term singleton newborn in vertex presentation ICD-10-PCS Principal or Other Diagnosis Codes for delivery as defined in Appendix A, Tables 11.01.1 available at: http://manual.jointcommission.org/releases/TJC2016A/
Inclusions	None listed by measure steward.
Exclusions	• ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations and other presentations as defined in Appendix A, Table 11.09 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Gestational Age < 37 weeks or UTD
DSRIP Specified Setting	Hospital
Data Source	Paper Records
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; CMS Consensus OB/GYN Measures;

E1-151: PC-03 Antenatal Steroids

Measure Description:
This measure assesses patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care.

DY7/DY8 Program ID	151
NQF Number	0476
Measure Steward	The Joint Commission
Link to Measure Citation	http://www.qualityforum.org/QPS/0476
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients with antenatal steroids initiated prior to delivering preterm newborns (refer to Appendix C, Table 11.0, antenatal steroid medications available at: http://manual.jointcommission.org/releases/TJC2016A/)
Denominator Description	Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed with ICD-10-PCS Principal or Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 available at: http://manual.jointcommission.org/releases/TJC2016A/
Inclusions	None listed by measure steward.
Exclusions	• Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Documented Reason for Not Initiating Antenatal Steroids • ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for fetal demise as defined in Appendix A, Table 11.09.1 available at: http://manual.jointcommission.org • Gestational Age < 24 or >= 34 weeks or UTD
DSRIP Specified Setting	Hospital
Data Source	Paper Records
Measure Point Value	1
Additional Notes	

CMS Alignment: Adult Core Set; CMS Consensus OB/GYN Measures;

E1-193: Contraceptive Care – Postpartum Women Ages 15–44 (CCP-AD)*

Measure Description:
Among women ages 15 through 44 who had a live birth, the percentage that is provided:

1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery.

2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care.

DY7/DY8 Program ID	**193**
NQF Number	2902
Measure Steward	US Office of Population Affairs
Link to Measure Citation	http://www.qualityforum.org/QPS/2902
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Primary measure: Women ages 15 through 44 who had a live birth and were provided a most (sterilization, intrauterine device, implant) or moderately (pill, patch, ring, injectable, diaphragm) effective method of contraception within 3 and 60 days of delivery. Sub-measure: Women ages 15 through 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.
Denominator Description	Women ages 15 through 44 who had a live birth in a 12-month measurement year.
Inclusions	None listed by measure steward.
Exclusions	The following categories are excluded from the denominator: (1) deliveries that did not end in a live birth (i.e., miscarriage, ectopic, stillbirth or induced abortion); and (2) deliveries that occurred during the last two months of the measurement year.
DSRIP Specified Setting	OB
Data Source	Claims (Only)
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; Adult Core Set;

E1-232: Timeliness of Prenatal/Postnatal Care

Measure Description:
The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

DY7/DY8 Program ID	232
NQF Number	1517
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/1517
Measure Parts	2
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** Timeliness of Prenatal Care: 0.91 Postpartum Care: 0.7361 **MPL:** Timeliness of Prenatal Care: 0.7421 Postpartum Care: 0.5547
Numerator Description	This measure assesses whether pregnant women had timely prenatal and postpartum care visits. It has two rates, one assessing the timeliness of prenatal visits, and one assessing the timeliness of postpartum visits. Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
Denominator Description	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Non-live births
DSRIP Specified Setting	OB
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	Rate 1 only, HHSC is dicussiong reporting rate for Medicaid only with possible alignment with MCOs

Proposed 2018 MCO P4Q Measure

E1-235: Post-Partum Follow-Up and Care Coordination (PQRS #336)

Measure Description:
Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for post-partum care within 8 weeks of giving birth who received a breast feeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning

DY7/DY8 Program ID	**235**
NQF Number	NA
Measure Steward	CMS
Link to Measure Citation	https://pqrs.cms.gov/dataset/2016-PQRS-Measure-317-11-17-2015/bqda-3reh
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients receiving the following at a post-partum visit: - Breast feeding evaluation and education, including patient-reported breast feeding - Post-partum depression screening - Post-partum glucose screening for gestational diabetes patients and - Family and contraceptive planning Definitions: Breast Feeding Evaluation and Education – Patients who were evaluated for breast feeding before or at 8 weeks post-partum. Post-Partum Depression Screening – Patients who were screened for post-partum depression before or at 8 weeks post-partum. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated depression screening tool (e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS). Post-Partum Glucose Screening for Gestational Diabetes – Patients who were diagnosed with gestational diabetes during pregnancy who were screened with a glucose screen before or at 8 weeks post-partum. Family and Contraceptive Planning – Patients who were provided family and contraceptive planning and education (including contraception, if necessary) before or at 8 weeks post-partum. Numerator Instruction: To satisfactorily meet the numerator ALL components (breast feeding evaluation and education, post-partum depression screening, family and contraceptive planning and post-partum glucose screening for patients with gestational diabetes) must be performed.

Denominator Description	All patients, regardless of age, who gave birth during a 12-month period seen for post-partum care visit before or at 8 weeks of giving birth
Inclusions	Denominator: All patients, regardless of age AND Patient encounter during reporting period (CPT): 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622 AND Post-partum Care Visit before or at 8 weeks post-delivery Numerator: Performance Met: Post-partum screenings, evaluations and education performed (G9357)
Exclusions	Numerator: Performance Not Met: Post-partum screenings, evaluations and education not performed (G9358)
DSRIP Specified Setting	OB
Data Source	None listed
Measure Point Value	3
Additional Notes	

CMS Alignment: Adult Core Set;

E1-300: Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)

Measure Description:
Percentage of women, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression screening, alcohol use screening, tobacco use screening, drug use screening (illicit and prescription, over the counter), and intimate partner violence screening.

DY7/DY8 Program ID	300
NQF Number	NA
Measure Steward	AMA-PCPI
Link to Measure Citation	https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who received the following behavioral health screening risk assessments at the first prenatal visit. Depression screening • Patients who were screened for depression at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer-administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated depression screening tool [e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)]. Alcohol use screening • Patients who were screened for any alcohol use at the first visit Tobacco use screening • Patients who were screened for tobacco use at the first visit Drug use (illicit and prescription, over the counter) screening • Patients who were screened for any drug use at the first visit Intimate partner violence screening • Patients who were screened for intimate partner violence/abuse at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Intimate partner violence screening may include a self-reported validated depression screening tool (e.g., Hurt, Insult, Threaten, and Scream [HITS], Woman Abuse Screening Tool [WAST], Partner Violence Screen [PVS], Abuse Assessment Screen [AAS]). To satisfactorily meet the numerator, ALL screening components must be performed.
Denominator Description	All patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.

DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, OB, Hospital
Data Source	TBD
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set;

E1-378: Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision – Cesarean section.

Measure Description:
Percentage of patients undergoing cesarean section who receive appropriate prophylactic antibiotics within 60 minutes of the start of the cesarean delivery, unless the patient is already receiving appropriate antibiotics

DY7/DY8 Program ID	378
NQF Number	0472
Measure Steward	Massachusetts General Hospital/Partners Health Care System
Link to Measure Citation	http://www.qualityforum.org/QPS/0472
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Percentage of women who receive recommended antibiotics within one hour before the start of cesarean section. This requires that (a) the antibiotic selection is consistent with current evidence and practice guidelines, and (b) that the antibiotics are given within an hour before delivery. If the patient is already receiving appropriate antibiotics, for example for chorioamnionitis, additonal dosing is not necessary.
Denominator Description	All patients undergoing cesarean section without evidence of prior infection or already receiving prophylactic antibiotics for other reasons. Patients with significant allergies to penicillin and/or cephalosporins AND allegies to gentamicin and/or clindamycin are also excluded.
Inclusions	None listed by measure steward.
Exclusions	Women with evidence of prior infection or already receiving prophylactic antibiotics for other reasons; or with significant allergies to penicillin and/or cephalosporins AND allegies to gentamicin and/or clindamycin. We do not exclude patients having emergency cesarean deliveries. We recognize that while in the case of most urgent and emergent cesarean deliveries administering timely antibiotic prophylaxis will be possible, very rarely clinical circumstances may not permit administration of antibiotic prophylaxis before skin incisions. Specifying these unusual circumstances, especially from readily abstracted medical record data, is not possible/feasible. Allowing a self-defined exclusion risks inappropriate definition. Instead we recognize that ideal performance on this measure may not be 100% given the small number of unusual emergencies and/or other circumstances. Providers/facilities should however target a 100% goal by, among other efforts, considering how antibiotic prophylaxis will be appropriately delivered even in the case of emergencies
DSRIP Specified Setting	Hospital
Data Source	Claims (Only), Electronic Health Record (Only), Other, Paper Records
Measure Point Value	1

Additional Notes	

BUNDLE F1: IMPROVED ACCESS TO ADULT DENTAL CARE

F1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

Measure Description:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

DY7/DY8 Program ID	105
NQF Number	0028
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0028
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for tobacco use* at least once within 24 months AND who received tobacco cessation counseling intervention** if identified as a tobacco user *Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy
Denominator Description	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, other
Data Source	Claims (Only), Electronic Health Record (Only), Other, Paper Records, Registry
Measure Point Value	1
Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus Core Set: Cardiovascular Measures; MACRA MIPS Measure; CCBHC Measure.

F1-226: Chronic Disease Patients Accessing Dental Services

Measure Description:
Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider

DY7/DY8 Program ID	226
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of chronic disease patients who access dental services as the result of a referral
Denominator Description	Total number of referrals for dental services for chronic disease patients by medical providers
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Dental Clinic
Data Source	Administrative/Clinical data sources; Supplemental data sources
Measure Point Value	3
Additional Notes	

F1-227: Dental Caries: Adults

Measure Description:
Percentage of adults aged 18 or more years with untreated dental decay

DY7/DY8 Program ID	227
NQF Number	NA
Measure Steward	Healthy People 2020
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of adults aged 18 years or more with coronal caries that has not been restored in at least one permanent tooth
Denominator Description	Number of adults aged 18 or more years with at least one permanent tooth present and valid coronal caries codes for at least one permanent tooth
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Dental Clinic
Data Source	Administrative/Clinical data sources; Supplemental data sources
Measure Point Value	3
Additional Notes	Measure title changed to Dental Caries: Adults

BUNDLE F2: PREVENTIVE PEDIATRIC DENTAL

F2-224: Dental Sealant: Children

Measure Description:
Increase the proportion of children aged 6 to 9 years who have received dental sealants on one or more of their permanent first molar teeth

DY7/DY8 Program ID	224
NQF Number	NA
Measure Steward	Healthy People 2020
Link to Measure Citation	https://www.healthypeople.gov/node/5001/data_details
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of children aged 6 to 9 with a clinical confirmation of dental sealants applied to one or more first permanent molars
Denominator Description	Number of children aged 6 to 9 with at least one permanent first molar present and valid sealant codes for at least one permanent first molar
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Dental Clinic
Data Source	TBD
Measure Point Value	1
Additional Notes	

F2-225: Dental Caries: Children

Measure Description:
Percentage of children with untreated dental caries

DY7/DY8 Program ID	225
NQF Number	NA
Measure Steward	Healthy People 2020
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of children with untreated dental caries
Denominator Description	Total number of children that have seen a dental provider within the measurement period
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Dental Clinic
Data Source	Administrative/Clinical data sources; supplemental data sources
Measure Point Value	3
Additional Notes	

F2-229: Oral Evaluation: Children - Modified Denominator

Measure Description:
Percentage of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation within the reporting year.

DY7/DY8 Program ID	229
NQF Number	2517 (Modified)
Measure Steward	American Dental Association
Link to Measure Citation	http://www.qualityforum.org/QPS/2517
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Unduplicated number of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation as a dental service
Denominator Description	Unduplicated number of all children under age 21 with at least one (1) visit in the prior or current year.
Inclusions	None listed by measure steward.
Exclusions	Medicaid/CHIP programs should exclude those individuals who do not qualify for dental benefits. The exclusion criteria should be reported along with the number and percentage of members excluded There are no other exclusions.
DSRIP Specified Setting	Dental Clinic
Data Source	Claims (Only)
Measure Point Value	1
Additional Notes	

F2-231: Preventive Services for Children at Elevated Caries Risk - Modified Denominator

Measure Description:
Percentage of enrolled children who are at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants within the reporting year

DY7/DY8 Program ID	231
NQF Number	NA
Measure Steward	American Dental Association
Link to Measure Citation	http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2017_Dental_Services_Preventive_Services.pdf?la=en
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Unduplicated number of children at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants as a dental service
Denominator Description	Unduplicated number of enrolled children at "elevated" risk (i.e., "moderate" or "high")
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Dental Clinic
Data Source	Administrative enrollment and claims data
Measure Point Value	1
Additional Notes	

BUNDLE G1: PALLIATIVE CARE

G1-276: Hospice and Palliative Care – Pain assessment

Measure Description:
Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

DY7/DY8 Program ID	276
NQF Number	1637
Measure Steward	University of North Carolina-Chapel Hill
Link to Measure Citation	http://www.qualityforum.org/QPS/1637
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.
Denominator Description	Patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the admission evaluation / initial encounter.
Inclusions	None listed by measure steward.
Exclusions	Patients with length of stay < 1 day in palliative care. Patients who screen negative for pain are excluded from the denominator.
DSRIP Specified Setting	Hospice, Hospital
Data Source	Electronic Health Record (Only), Other
Measure Point Value	1
Additional Notes	

G1-277: Hospice and Palliative Care – Treatment Preferences

Measure Description:
Percentage of patients with chart documentation of preferences for life sustaining treatments.

DY7/DY8 Program ID	277
NQF Number	1641
Measure Steward	University of North Carolina-Chapel Hill
Link to Measure Citation	http://www.qualityforum.org/QPS/1641
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients whose medical record includes documentation of life sustaining preferences
Denominator Description	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.
Inclusions	None listed by measure steward.
Exclusions	Patients with length of stay < 1 day in hospice or palliative care
DSRIP Specified Setting	Hospice, Hospital
Data Source	Electronic Health Record (Only), Other
Measure Point Value	1
Additional Notes	

G1-278: Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.

Measure Description:

This measure reflects the percentage of hospice patients with documentation of a discussion of spiritual/religious concerns or documentation that the patient/caregiver/family did not want to discuss.

DY7/DY8 Program ID	278
NQF Number	1647
Measure Steward	University of North Carolina-Chapel Hill
Link to Measure Citation	http://www.qualityforum.org/QPS/1647
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients whose medical record includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.
Denominator Description	Seriously ill patients 18 years of age or older enrolled in hospice.
Inclusions	None listed by measure steward.
Exclusions	Testing has only been done with the adult population; thus patients younger than 18 are excluded.
DSRIP Specified Setting	Hospice
Data Source	Electronic Health Record (Only), Other
Measure Point Value	1
Additional Notes	

G1-285: Advance Care Plan

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

DY7/DY8 Program ID	285
NQF Number	0326
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0326
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.
Denominator Description	All patients aged 65 years and older.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital
Data Source	Claims (Only), Electronic Health Record (Only)
Measure Point Value	1
Additional Notes	

MACRA MIPS High Priority Measure.

G1-361: Patients Treated with an Opioid who are Given a Bowel Regimen

Measure Description:
Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed

DY7/DY8 Program ID	361
NQF Number	1617
Measure Steward	RAND Corporation/UCLA
Link to Measure Citation	http://www.qualityforum.org/QPS/1617
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed
Denominator Description	Vulnerable adults who are given a prescription for an opioid
Inclusions	None listed by measure steward.
Exclusions	Non-hospice outpatients who are already taking an opioid at the time of the study period opioid prescription
DSRIP Specified Setting	Hospice, Hospital
Data Source	Paper Records
Measure Point Value	1
Additional Notes	

G1-362: Hospice and Palliative Care -- Dyspnea Treatment

Measure Description:
Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.

DY7/DY8 Program ID	362
NQF Number	1638
Measure Steward	University of North Carolina-Chapel Hill
Link to Measure Citation	http://www.qualityforum.org/QPS/1638
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who screened positive for dyspnea who received treatment within 24 hours of screening.
Denominator Description	Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.
Inclusions	None listed by measure steward.
Exclusions	Patients with length of stay < 1 day in palliative care, patients who were not screened for dyspnea, and/or patients with a negative screening.
DSRIP Specified Setting	Hospice, Hospital
Data Source	Electronic Health Record (Only), Other
Measure Point Value	1
Additional Notes	

G1-363: Hospice and Palliative Care -- Dyspnea Screening

Measure Description:
Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.

DY7/DY8 Program ID	363
NQF Number	1639
Measure Steward	University of North Carolina-Chapel Hill
Link to Measure Citation	http://www.qualityforum.org/QPS/1639
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.
Denominator Description	Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.
Inclusions	None listed by measure steward.
Exclusions	Patients with length of stay < 1 day in palliative care.
DSRIP Specified Setting	Hospice, Hospital
Data Source	Electronic Health Record (Only), Other
Measure Point Value	1
Additional Notes	

G1-364: Patients with Advanced Cancer Screened for Pain at Outpatient Visits

Measure Description:
Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit

DY7/DY8 Program ID	364
NQF Number	1628
Measure Steward	RAND Corporation
Link to Measure Citation	http://www.qualityforum.org/QPS/1628
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool
Denominator Description	Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit
Inclusions	None listed by measure steward.
Exclusions	None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Electronic Health Record (Only), Paper Records, Registry
Measure Point Value	1
Additional Notes	

BUNDLE H1: INTEGRATION OF BEHAVIORAL HEALTH IN A PRIMARY CARE SETTING

H1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

Measure Description:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

DY7/DY8 Program ID	105
NQF Number	0028
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0028
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for tobacco use* at least once within 24 months AND who received tobacco cessation counseling intervention** if identified as a tobacco user *Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy
Denominator Description	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, other
Data Source	Claims (Only), Electronic Health Record (Only), Other, Paper Records, Registry
Measure Point Value	1
Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus Core Set: Cardiovascular Measures; MACRA MIPS Measure; CCBHC Measure.

H1-146: Screening for Clinical Depression and Follow-Up Plan (CDF-AD)

Measure Description:
Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

DY7/DY8 Program ID	146
NQF Number	0418
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/418
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented The standardized screening tools help predict a likelihood of someone developing or having a particular disease. The screening tools suggested in this measure screen for possible depression. Questions within the suggested standardized screening tools may vary but the result of using a standardized screening tool is to determine if the patient screens positive or negative for depression. If the patient has a positive screen for depression using a standardized screening tool, the provider must have a follow-up plan as defined within the measure. If the patient has a negative screen for depression, no follow-up plan is required.
Denominator Description	All patients aged 12 years and older
Inclusions	None listed by measure steward.
Exclusions	Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist: • Patient refuses to participate • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases • Patient was referred with a diagnosis of depression • Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period • Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools
DSRIP Specified Setting	Primary Care, Specialty Care
Data Source	Claims (Only), Other, Paper Records
Measure Point Value	1

Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17 and to expand to screening for general behavioral health concerns including anxiety

CMS Alignment: Adult Core Set; MACRA MIPS Measure;CCBHC Measure.

H1-255: Follow-up Care for Children Prescribed ADHD Medication (ADD)

Measure Description:
The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.

An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

DY7/DY8 Program ID	255
NQF Number	0108
Measure Steward	National Committee for Quality Assurance
Link to Measure Citation	http://www.qualityforum.org/QPS/0108
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	This measure assesses the receipt of follow-up visits for children prescribed ADHD medication. Two rates are reported. 1. INITIATION PHASE: The percentage of children between 6 and 12 years of age who were newly prescribed ADHD medication who had one follow-up visit with a prescribing practitioner within 30 days. 2. CONTINUATION AND MAINTENANCE PHASE: The percentage of children between 6 and 12 years of age newly prescribed ADHD medication and remained on the medication for at least 210 days, who had, in addition to the visit in the Initiative Phase, at least two follow-up visits with a practitioner in the 9 months subsequent to the Initiation Phase.
Denominator Description	Children 6-12 years of age newly prescribed ADHD medication.
Inclusions	None listed by measure steward.
Exclusions	Children with a diagnosis of narcolepsy
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient
Data Source	Claims (Only), Electronic Health Record (Only), Pharmacy
Measure Point Value	3
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure.

H1-286: Depression Remission at Six Months

Measure Description:
Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator.

DY7/DY8 Program ID	286
NQF Number	0711
Measure Steward	MN Community Measurement
Link to Measure Citation	http://www.qualityforum.org/QPS/0711
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score of less than five.
Denominator Description	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine.
Inclusions	None listed by measure steward.
Exclusions	Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health: Outpatient
Data Source	Electronic Health Record (Only), Other, Paper Records
Measure Point Value	3
Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17

MACRA MIPS High Priority Measure.

H1-317: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description:
Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user

DY7/DY8 Program ID	317
NQF Number	2152
Measure Steward	AMA-convened Physician Consortium for Performance Improvement
Link to Measure Citation	http://www.qualityforum.org/QPS/2152
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user
Denominator Description	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care
Data Source	Electronic Health Record (Only), Registry
Measure Point Value	1
Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17

MACRA MIPS Measure; CCBHC Measure.

BUNDLE H2: BEHAVIORAL HEALTH AND APPROPRIATE UTILIZATION

H2-160: Follow-Up After Hospitalization for Mental Illness

Measure Description:
The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge

- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

DY7/DY8 Program ID	160
NQF Number	0576
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0576
Measure Parts	2
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 30 Days: 0.7852 7 Days: 0.6423 **MPL:** 30 Days: 0.5408 7 Days: 0.342
Numerator Description	30-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.
Denominator Description	Patients 6 years and older as of the date of discharge who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (e.g., January 1 to December 1).
Inclusions	None listed by measure steward.
Exclusions	Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first 11 months of the measurement year (e.g., after December 1). Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).

	These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.
DSRIP Specified Setting	Behavioral Health: Inpatient, Behavioral Health: Outpatient, Hospital
Data Source	Claims (Only), Electronic Health Record (Only)
Measure Point Value	3
Additional Notes	

CMS Alignment: Child Core Set; Adult Core Set; MACRA MIPS Measure.

H2-216: Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate

Measure Description:
Risk adjusted rate of hospital admissions for Behavioral Health /Substance Abuse (BH/SA) that had at least one readmission for any reason within 30 days of discharge for patients 18 years of age and older.

A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.

DY7/DY8 Program ID	216
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for BH/SA during the measurement year. The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk BH/SA admissions during the measurement period.
Denominator Description	Expected (risk-adjusted) rate of readmissions for BH/SA during the measurement year. The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Measure Point Value	3
Additional Notes	

H2-259: Assignment of Primary Care Physician to Individuals with Schizophrenia

Measure Description:
The percentage of individuals with a primary diagnosis of schizophrenia that have been assigned a primary care physician.

DY7/DY8 Program ID	259
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=UTAH0004D&POP=0
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of individuals in the denominator who were assigned a primary care physician.
Denominator Description	Enrollees who had either one inpatient admission or two outpatient visits with a primary diagnosis of schizophrenia within a 12 month period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

H2-265: Housing Assessment for Individuals with Schizophrenia

Measure Description:
The percentage of individuals with Schizophrenia whose housing quality was assessed

DY7/DY8 Program ID	265
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=UTAH0005D&POP=11
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of individuals in the denominator whose housing quality was assessed with medical record documentation indicating that a trained professional (e.g., social worker, visiting nurse) saw the quality of the individual's housing and/or made an effort to modify the individual's housing situation.
Denominator Description	Enrollees who had either one inpatient admission or two outpatient visits with a primary diagnosis of schizophrenia within a 12 month period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

H2-266: Independent Living Skills Assessment for Individuals with Schizophrenia

Measure Description:
The percentage of patients who received an assessment of independent living skills

DY7/DY8 Program ID	266
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=UTAH0001D&POP=11
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients in the denominator who received an assessment of independent living skills.
Denominator Description	Patients who had either one inpatient admission or two outpatient visits with a primary diagnosis of schizophrenia within a 12 month period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

H2-305: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH)

Measure Description:
Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk

DY7/DY8 Program ID	305
NQF Number	1365
Measure Steward	AMA-convened Physician Consortium for Performance Improvement
Link to Measure Citation	http://www.qualityforum.org/QPS/1365
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patient visits with an assessment for suicide risk
Denominator Description	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, Hospital
Data Source	Electronic Health Record (Only): Electronic Health Record
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure; CCBHC Measure.

H2-316: Alcohol Screening and Follow-up for People with Serious Mental Illness

Measure Description:
The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.

DY7/DY8 Program ID	316
NQF Number	2599
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/2599
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.
Denominator Description	All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year (see Alcohol Disorders Value Set).
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, Hospital
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

H2-319: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)

Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

DY7/DY8 Program ID	319
NQF Number	0104
Measure Steward	AMA-convened Physician Consortium for Performance Improvement
Link to Measure Citation	http://www.qualityforum.org/QPS/0104
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified
Denominator Description	All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, Hospital
Data Source	Electronic Health Record (Only), Registry
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure; CCBHC Measure.

H2-387: Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)

Measure Description:

Rate of ED utilization for substance use conditions or complications

DY7/DY8 Program ID	387
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of ED Visits with a primary or secondary diagnosis of (excluding tobacco) substance abuse for any individual 18 years and older during the measurement period
Denominator Description	Total number of ED visits for individuals 18 years or older during the measurement period
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	ED
Data Source	TBD
Measure Point Value	3
Additional Notes	Reported as two rates

BUNDLE H3: CHRONIC NON-MALIGNANT PAIN MANAGEMENT

H3-144: Screening for Clinical Depression and Follow-Up Plan (CDF-AD) for individuals with a diagnosis of chronic pain

Measure Description:
Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

DY7/DY8 Program ID	144
NQF Number	0418
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/3148
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented The standardized screening tools help predict a likelihood of someone developing or having a particular disease. The screening tools suggested in this measure screen for possible depression. Questions within the suggested standardized screening tools may vary but the result of using a standardized screening tool is to determine if the patient screens positive or negative for depression. If the patient has a positive screen for depression using a standardized screening tool, the provider must have a follow-up plan as defined within the measure. If the patient has a negative screen for depression, no follow-up plan is required.
Denominator Description	All patients aged 12 years and older
Inclusions	None listed by measure steward.
Exclusions	Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist: • Patient refuses to participate • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases • Patient was referred with a diagnosis of depression • Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period • Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where

	depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital, Inpatient Rehabilitation Facility, Other
Data Source	Claims (Only), Other, Paper Records
Measure Point Value	1
Additional Notes	Denominator subset of chronic pain

CMS Alignment: Adult Core Set; MACRA MIPS Measure.

H3-197: Use of Opioids at High Dosage - modified denominator

Measure Description:
The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.

DY7/DY8 Program ID	197
NQF Number	2940 (Modified)
Measure Steward	Pharmacy Quality Alliance
Link to Measure Citation	http://www.qualityforum.org/QPS/2940
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer
Denominator Description	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.
Inclusions	None listed by measure steward.
Exclusions	Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator (Medicare Part D) from the enrollment database.
DSRIP Specified Setting	Other, Pharmacy
Data Source	Claims (Only)
Measure Point Value	3
Additional Notes	

CMS Alignment: Adult Core Set;

H3-257: Care Planning for Dual Diagnosis

Measure Description:
Percentage of patients with dual diagnosis undergoing case management services who have a documented plan to address both conditions.

DY7/DY8 Program ID	257
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=TENN0017D&POP=5
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Those individuals from the denominator for whom a case manager has documented a plan of care that addresses the consumer's need for treatment of both conditions.
Denominator Description	The number of individuals participating in a case management program who are dually diagnosed with a mental disorder and a substance abuse disorder during a six-month period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

H3-287: Documentation of Current Medications in the Medical Record

Measure Description:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

DY7/DY8 Program ID	287
NQF Number	0419
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0419
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The Numerator statement for the most recent versions of the measure is as follows (for both the 2016 Claims and Registry version and the 2017 e Measure version): Eligible professional attests to documenting, updating, or reviewing a patient´s current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route of administration
Denominator Description	The 2016 Claims and Registry denominator statement is as follows: "All visits for patients aged 18 years and older." The 2017 eMeasure denominator statement is as follows: "All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period."
Inclusions	None listed by measure steward.
Exclusions	The 2016 Claims and Registry version contains the following Other Performance Exclusion: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional. A patient is not eligible if the following reason is documented: the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status The eMeasure includes the following denominator exception: Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital, Behavioral Health Outpatient
Data Source	Claims (Only), Electronic Health Record (Only), Registry
Measure Point Value	1

Additional Notes	

MACRA MIPS High Priority Measure.

H3-288: Pain Assessment and Follow-up

Measure Description:
Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

DY7/DY8 Program ID	288
NQF Number	0420
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0420
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.
Denominator Description	All visits for patients aged 18 years and older
Inclusions	None listed by measure steward.
Exclusions	Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented: Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, Outpatient Rehabilitation
Data Source	Claims (Only), Paper Records
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

BUNDLE H4: INTEGRATED CARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESS

H4-182: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)

Measure Description:
The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

DY7/DY8 Program ID	182
NQF Number	1932
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/1932
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.8717 **MPL:** 0.7737
Numerator Description	Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.
Denominator Description	Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.
Inclusions	None listed by measure steward.
Exclusions	Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients with diabetes during the measurement year or the year prior to the measurement year. Exclude patients who had no antipsychotic medications dispensed during the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: Adult Core Set; Proposed 2018 MCO P4Q Measure.

H4-258: Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)

Measure Description:

The percentage of patients 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

DY7/DY8 Program ID	258
NQF Number	1933
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/1933
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.8837 **MPL:** 0.7353
Numerator Description	One or more LDL-C tests performed during the measurement year.
Denominator Description	Patients 18-64 years of age as of the end of the measurement year with a diagnosis of schizophrenia and cardiovascular disease.
Inclusions	None listed by measure steward.
Exclusions	Not applicable.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory
Measure Point Value	1
Additional Notes	

H4-260: Annual Physical Exam for Persons with Mental Illness

Measure Description:
The percentage of individuals receiving services for a primary psychiatric disorder whose medical records document receipt of a physical exam during the measurement year.

DY7/DY8 Program ID	260
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=MHSI0002D&POP=0
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Individuals from the denominator whose medical record documents receipt of a physical examination within the specified 12-month period.
Denominator Description	The total number of individuals receiving services for a primary psychiatric disorder during a specified 12- month reporting period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

BUNDLE I1: SPECIALTY CARE

I1-385: Assessment of Funcitonal Status or QoL (Modified from NQF# 0260/2624)

Measure Description:
Percent of eligible patients who completed a health-related quality of life assessment or functional assessment using a standardized tool at least once during the measurement period.

DY7/DY8 Program ID	385
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	NA
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of eligible patients who completed a health-related quality of life assessment or functional assessment using a standardized tool at least once during the measurement period.
Denominator Description	Number of eligible individuals receiving specialty care services during the measurement period
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

I1-386: Improvement in Functional Status or QoL (Modified from PQRS #435)

Measure Description:
Percent of patients who had a follow up health-related quality of life or functional status assessed during the measurement period whose score stayed the same or improved.

DY7/DY8 Program ID	386
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	TBD
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients whose score stayed the same or improved.
Denominator Description	Patients who had a follow up health-related quality of life or functional status assessed during the measurement period
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

BUNDLE J1: HOSPITAL SAFETY

J1-218: Central line-associated bloodstream infections (CLABSI) rates

Measure Description:
Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in bedded inpatient care locations.

This includes acute care general hospitals, long-term acute care hospitals, rehabilitation hospitals, oncology hospitals, and behavioral health hospitals.

DY7/DY8 Program ID	218
NQF Number	0139
Measure Steward	CDC
Link to Measure Citation	http://www.qualityforum.org/QPS/0139
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of observed healthcare-associated CLABSI among patients in bedded inpatient care locations.
Denominator Description	Total number of central line days for each location under surveillance for CLABSI during the data period.
Inclusions	None listed by measure steward.
Exclusions	1. Pacemaker wires and other non-lumened devices inserted into central blood vessels or the heart are excluded as CLs. 2. Extracoporeal membrane oxygenation lines, femoral arterial catheters, intraaortic balloon pump devices, and hemodialysis reliable outflow catheters (HeRO) are excluded as CLs. 3. Peripheral intravenous lines are excluded as CLs.
DSRIP Specified Setting	Behavioral Health: Inpatient, Hospice, Hospital, Inpatient Rehabilitation Facility, Long Term Acute Care, Other
Data Source	Electronic Health Record (Only), Laboratory, Other, Paper Records
Measure Point Value	2
Additional Notes	

J1-219: Catheter-associated Urinary Tract Infections (CAUTI) rates

Measure Description:
Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (UTI) will be calculated among patients in bedded inpatient care locations, except level II or level III neonatal intensive care units (NICU).

This includes acute care general hospitals, long-term acute care hospitals, rehabilitation hospitals, oncology hospitals, and behavior health hospitals.

DY7/DY8 Program ID	**219**
NQF Number	0138
Measure Steward	CDC
Link to Measure Citation	http://www.qualityforum.org/QPS/0138
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of observed healthcare-associated CAUTI among patients in bedded inpatient care locations (excluding patients in Level II or III neonatal ICUs).
Denominator Description	Total number of indwelling urinary catheter days for each location under surveillance for CAUTI during the data period.
Inclusions	None listed by measure steward.
Exclusions	The following are not considered indwelling catheters by NHSN definitions: 1.Suprapubic catheters 2.Condom catheters 3.“In and out” catheterizations 4. Nephrostomy tubes Note, that if a patient has either a nephrostomy tube or a suprapubic catheter and also has an indwelling urinary catheter, the indwelling urinary catheter will be included in the CAUTI surveillance.
DSRIP Specified Setting	Behavioral Health: Inpatient, Hospice, Hospital, Long Term Acute Care, Nursing Home / SNF, Other
Data Source	Electronic Health Record (Only), Laboratory, Other, Paper Records
Measure Point Value	2
Additional Notes	

J1-220: Surgical site infections (SSI) rates

Measure Description:
Percentage of surgical site infections occurring within thirty days after the operative procedure if no implant is left in place or with one year if an implant is in place in patients who had an NHSN operative procedure performed during a specified time period and the infection appears to be related to the operative procedure.

DY7/DY8 Program ID	**220**
NQF Number	0299
Measure Steward	CDC
Link to Measure Citation	http://www.qualityforum.org/QPS/0299
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of surgical site infections occurring within thirty days after the operative procedure if no implant is left in place or with one year if an implant is in place in patients who had an NHSN operative procedure performed during a specified time period and the infection appears to be related to the operative procedure. Infections are identified on original admission or upon readmission to the facility of original operative procedure within the relevant time frame (30 days for no implants; within 1 year for implants). Two types of CDC-defined SSIs are included: (1) A deep incisional SSI must meet the following criteria: • Infection occurs within 30 days after the operative procedure if no implant is left or within one year if implant is in place and the infection appears to be related to the operative procedure and • involves deep soft tissues (e.g., fascial and muscle layers) of the incision and • patient has at least one of the following: a) purulent drainage from the deep incision but not from the organ/space component of the surgical site b) a deep incision spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured when the patient has at least one of the following signs or symptoms: fever (>38°C), or localized pain or tenderness. A culture-negative finding does not meet this criterion. c) an abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination d) diagnosis of a deep incisional SSI by a surgeon or attending physician. Note: There are two specific types of deep incisional SSIs:

	1) Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CABG) 2) Deep Incisional Secondary (DIS) - a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site [leg] incision for CBGB) (2) An organ/space SSI must meet the following critieria: • Infection occurs within 30 days after the operative procedure if no implant is left or within one year if implant is in place and the infection appears to be related to the operative procedure and • infection involves any part of the body, excluding the skin incision, fascia, or muscle layers, that is opened or manipulated during the operative procedure and • patient has at least one of the following: a). purulent drainage from a drain that is placed through a stab wound into the organ/space b). organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space c). an abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination d) diagnosis of an organ/space SSI by a surgeon or attending physician. Specific sites of an organ/space SSI may be identified
Denominator Description	Number of NHSN operative procedures performed during a specified time period stratified by: • Type of NHSN operative procedure and • NNIS SSI risk index: Every patient having the selected procedure is assigned one (1) risk point for each of the following three factors: o Surgical wound classification = clean contaminated or dirty o American Society of Anesthesiologists (ASA) preoperative severity of illness score = 3, 4, or 5 o Duration of operation >t hours, where t varies by type of NHSN operative procedure and is the approximate 75th percentile of the duration of the procedure rounded to the nearest whole number of hours. Note: For operative procedures performed using lapyroscopes and endoscopes the use of a lapyroscope is an additional factor that modifies the risk index.
Inclusions	None listed by measure steward.
Exclusions	Exclude Procedures Not Included Under The Definition Of NHSN Operative Procedure And Excludes Superficial SSI.

DSRIP Specified Setting	Behavioral Health: Inpatient, Hospice, Hospital, Long Term Acute Care, Nursing Home / SNF, Other
Data Source	Paper Records
Measure Point Value	2
Additional Notes	

J1-221: Patient Fall Rate

Measure Description:
All documented falls, with or without injury, experienced by patients on eligible unit types in a calendar quarter. Reported as Total Falls per 1,000 Patient Days.

(Total number of falls / Patient days) X 1000

DY7/DY8 Program ID	221
NQF Number	0141
Measure Steward	American Nurses Association
Link to Measure Citation	http://www.qualityforum.org/QPS/0141
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of patient falls (with or without injury to the patient and whether or not assisted by a staff member) by hospital unit during the calendar month X 1000. Target population is adult acute care inpatient and adult rehabilitation patients. Eligible unit types include adult critical care, adult step-down, adult medical, adult surgical, adult medical-surgical combined, critical access, adult rehabilitation in-patient.
Denominator Description	Denominator Statement: Patient days by hospital unit during the calendar month times 1000.
Inclusions	Denominator Inclusions: •Inpatients, short stay patients, observation patients, and same day surgery patients who receive care on eligible inpatient units for all or part of a day on the following unit types: •Adult critical care, step-down, medical, surgical, medical-surgical combined, critical access, and adult rehabilitation units. •Patients of any age on an eligible reporting unit are included in the patient day count.
Exclusions	Excluded Populations: Other unit types (e.g., pediatric, psychiatric, obstetrical, etc.)
DSRIP Specified Setting	Behavioral Health: Inpatient, Hospice, Hospital, Long Term Acute Care, Nursing Home / SNF, Other
Data Source	Electronic Health Record (Only), Other, Paper Records
Measure Point Value	2
Additional Notes	

J1-222: Severe Sepsis and Septic Shock: Management Bundle

Measure Description:
This measure will focus on patients aged 18 years and older who present with symptoms of severe sepsis or septic shock. These patients will be eligible for the 3 hour (severe sepsis) and/or 6 hour (septic shock) early management bundle.

DY7/DY8 Program ID	222
NQF Number	0500
Measure Steward	Henry Ford Hospital
Link to Measure Citation	http://www.qualityforum.org/QPS/0500
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	If: A. measure lactate level B. obtain blood cultures prior to antibiotics C. administer broad spectrum antibiotics D. administer 30 ml/kg crystalloid for hypotension or lactate = 4 mmol/L E. apply vasopressors (for hypotension that does not respond to initial fluid resuscitation to maintain a mean areterial pressure = 65) F. in the event of persistent hypotension after initial fluid administration (MAP < 65 mm Hg) or if initial lactate was = 4 mmol/L, re-assess volume status and tissue perfusion and document findings.* * To meet the requirements, a focused exam† by a licensed independent practitioner (LIP) or any 2 other items are required: • Measure CVP • Measure ScvO2 • Bedside cardiovascular ultrasound • Dynamic assessment of fluid responsiveness with passive leg raise or fluid challenge • Focused exam† including vital signs, cardiopulmonary, capillary refill, pulse and skin findings. G. remeasure lactate if initial lactate is elevated represent processes of care: Numerator statement: Patients from the denominator who received all the following: A, B, and C within 3 hours of time of presentation† AND IF septic shock is present (as either defined as hypotension* or lactate >=4 mmol/L) who also received D and E and F and G within 6 hours of time of presentation. † ”time of presentation” is defined as the time of triage in the Emergency Department or, if presenting from another care venue, from the earliest chart annotation consistent with all elements severe sepsis or septic shock ascertained through chart review.

	* “hypotension” is defined as systolic blood pressure (SBP) <90 mm Hg or mean arterial pressure (MAP) <70 mm Hg or a SBP decrease >40 mm Hg or <2 SD below normal for age or known baseline. Denominator Statement: Number of patients presenting with severe sepsis or septic shock.
Denominator Description	Number of patients presenting with severe sepsis or septic shock.
Inclusions	None listed by measure steward.
Exclusions	A) Patients with advanced directives for comfort care are excluded. B) Clinical conditions that preclude total measure completion should be excluded (e.g. mortality within the first 6 hours of presentation as defined above in 2a1.1). C) Patients for whom a central line is clinically contraindicated (e.g. coagulopathy that cannot be corrected, inadequate internal jugular or subclavian central venous access due to repeated cannulations). D) Patients for whom a central line was attempted but could not be successfully inserted. E) Patient or surrogate decision maker declined or is unwilling to consent to such therapies or central line placement. F) Patients transferred to an acute care facility from another acute care facility.
DSRIP Specified Setting	Behavioral Health: Inpatient, Hospice, Hospital, Long Term Acute Care, Nursing Home / SNF, Other
Data Source	Electronic Health Record (Only), Other, Paper Records, Registry
Measure Point Value	2
Additional Notes	

J1-372: National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure

Measure Description:
Standardized infection ratio (SIR) and Adjusted Ranking Metric (ARM)of hospital-onset unique blood source MRSA Laboratory-identified events (LabID events) among all inpatients in the facility

DY7/DY8 Program ID	372
NQF Number	1716
Measure Steward	Centers for Disease Control and Prevention
Link to Measure Citation	http://www.qualityforum.org/QPS/1716
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of observed hospital-onset unique blood source MRSA LabID events among all inpatients in the facility
Denominator Description	Total number of expected hospital-onset unique blood source MRSA LabID events, calculated using the facility´s number of inpatient days, bedsize, affiliation with medical school, and community-onset MRSA bloodstream infection admission prevalence rate.
Inclusions	None listed by measure steward.
Exclusions	Data from patients who are not assigned to an inpatient bed are excluded from the denominator counts. These include outpatient clinic and emergency department visits.
DSRIP Specified Setting	Hospital
Data Source	Electronic Health Record (Only), Laboratory, Other, Paper Records
Measure Point Value	2
Additional Notes	

BUNDLE K1: RURAL PREVENTIVE CARE

K1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

Measure Description:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

DY7/DY8 Program ID	105
NQF Number	0028
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0028
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for tobacco use* at least once within 24 months AND who received tobacco cessation counseling intervention** if identified as a tobacco user *Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy
Denominator Description	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, other
Data Source	Claims (Only), Electronic Health Record (Only), Other, Paper Records, Registry
Measure Point Value	1
Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus Core Set: Cardiovascular Measures; MACRA MIPS Measure; CCBHC Measure.

K1-112: Comprehensive Diabetes Care: Foot Exam

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.

DY7/DY8 Program ID	112
NQF Number	0056
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0056
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who received a foot exam (visual inspection and sensory exam with monofilament and pulse exam) during the measurement year.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

K1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

DY7/DY8 Program ID	115
NQF Number	0059
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0059
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.2936 **MPL:** 0.522
Numerator Description	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year. The outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy
Measure Point Value	3
Additional Notes	

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

K1-146: Screening for Clinical Depression and Follow-Up Plan (CDF-AD)

Measure Description:
Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

DY7/DY8 Program ID	146
NQF Number	0418
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/418
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented The standardized screening tools help predict a likelihood of someone developing or having a particular disease. The screening tools suggested in this measure screen for possible depression. Questions within the suggested standardized screening tools may vary but the result of using a standardized screening tool is to determine if the patient screens positive or negative for depression. If the patient has a positive screen for depression using a standardized screening tool, the provider must have a follow-up plan as defined within the measure. If the patient has a negative screen for depression, no follow-up plan is required.
Denominator Description	All patients aged 12 years and older
Inclusions	None listed by measure steward.
Exclusions	Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist: • Patient refuses to participate • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases • Patient was referred with a diagnosis of depression • Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period • Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools
DSRIP Specified Setting	Primary Care, Specialty Care
Data Source	Claims (Only), Other, Paper Records
Measure Point Value	1

Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17 and to expand to screening for general behavioral health concerns including anxiety

CMS Alignment: Adult Core Set; MACRA MIPS Measure;CCBHC Measure.

K1-268: Pneumonia vaccination status for older adults

Measure Description:
Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination.

DY7/DY8 Program ID	268
NQF Number	0043
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0043
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of patients in the denominator who responded "Yes" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."
Denominator Description	CAHPS respondents age 65 or older as of the last day of the measurement year who responded "Yes" or "No" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Patient Reported Data
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

K1-285: Advance Care Plan

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

DY7/DY8 Program ID	285
NQF Number	0326
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0326
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.
Denominator Description	All patients aged 65 years and older.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital
Data Source	Claims (Only), Electronic Health Record (Only)
Measure Point Value	1
Additional Notes	

MACRA MIPS High Priority Measure.

K1-287: Documentation of Current Medications in the Medical Record

Measure Description:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

DY7/DY8 Program ID	287
NQF Number	0419
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0419
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The Numerator statement for the most recent versions of the measure is as follows (for both the 2016 Claims and Registry version and the 2017 e Measure version): Eligible professional attests to documenting, updating, or reviewing a patient´s current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route of administration
Denominator Description	The 2016 Claims and Registry denominator statement is as follows: "All visits for patients aged 18 years and older." The 2017 eMeasure denominator statement is as follows: "All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period."
Inclusions	None listed by measure steward.
Exclusions	The 2016 Claims and Registry version contains the following Other Performance Exclusion: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional. A patient is not eligible if the following reason is documented: the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status The eMeasure includes the following denominator exception: Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital, Behavioral Health Outpatient
Data Source	Claims (Only), Electronic Health Record (Only), Registry
Measure Point Value	1

Additional Notes	

MACRA MIPS High Priority Measure.

K1-300: Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)

Measure Description:
Percentage of women, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression screening, alcohol use screening, tobacco use screening, drug use screening (illicit and prescription, over the counter), and intimate partner violence screening.

DY7/DY8 Program ID	300
NQF Number	NA
Measure Steward	AMA-PCPI
Link to Measure Citation	https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who received the following behavioral health screening risk assessments at the first prenatal visit. Depression screening • Patients who were screened for depression at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer-administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated depression screening tool [e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)]. Alcohol use screening • Patients who were screened for any alcohol use at the first visit Tobacco use screening • Patients who were screened for tobacco use at the first visit Drug use (illicit and prescription, over the counter) screening • Patients who were screened for any drug use at the first visit Intimate partner violence screening • Patients who were screened for intimate partner violence/abuse at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Intimate partner violence screening may include a self-reported validated depression screening tool (e.g., Hurt, Insult, Threaten, and Scream [HITS], Woman Abuse Screening Tool [WAST], Partner Violence Screen [PVS], Abuse Assessment Screen [AAS]). To satisfactorily meet the numerator, ALL screening components must be performed.
Denominator Description	All patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.

DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, OB, Hospital
Data Source	TBD
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set;

K1-269: Preventive Care and Screening: Influenza Immunization

Measure Description:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

DY7/DY8 Program ID	269
NQF Number	0041 / 3070 eMeasure
Measure Steward	AMA / PCPI
Link to Measure Citation	http://www.qualityforum.org/QPS/0041 http://www.qualityforum.org/QPS/3070
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization
Denominator Description	All patients aged 6 months and older seen for a visit between October 1 and March 31
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons) Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons) Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)
DSRIP Specified Setting	Primary Care
Data Source	Electronic Health Record (Only), Registry
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

K1-358: Health literacy measure derived from the health literacy domain of the C-CAT (Tentatve Pending Further Review)

Measure Description:

0-100 measure of health literacy related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit

DY7/DY8 Program ID	358
NQF Number	1898
Measure Steward	American Medical Association
Link to Measure Citation	http://www.qualityforum.org/QPS/1898
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Health literacy component of patient-centered communication: an organization should consider the health literacy level of its current and potential populations and use this information to develop a strategy for the clear communication of medical information verbally, in writing and using other media. Measure is scored based on 15 items from the patient survey of the C-CAT and 13 items from the staff survey of the C-CAT. Minimum of 100 patients responses and 50 staff responses.
Denominator Description	There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses.
Inclusions	None listed by measure steward.
Exclusions	Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.
DSRIP Specified Setting	Primary Care
Data Source	Provider Tool
Measure Point Value	1
Additional Notes	Tentatve Pending Further Review

BUNDLE K2: RURAL EMERGENCY CARE

K2-223: Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls

Measure Description:
This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates:

A) Screening for Future Fall Risk:

Percentage of patients aged 65 years and older who were screened for future fall risk at least once within 12 months

B) Falls Risk Assessment:

Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months

C) Plan of Care for Falls:

Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

DY7/DY8 Program ID	223
NQF Number	0101
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0101
Measure Parts	3
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	This measure has three rates. The numerators for the three rates are as follows: A) Screening for Future Fall Risk: Patients who were screened for future fall* risk** at last once within 12 months B) Falls Risk Assessment: Patients who had a risk assessment*** for falls completed within 12 months C) Plan of Care for Falls: Patients with a plan of care**** for falls documented within 12 months. *A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force. **Risk of future falls is defined as having had had 2 or more falls in the past year or any fall with injury in the past year. ***Risk assessment is comprised of balance/gait assessment AND one or more of the following assessments: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months.

	****Plan of care must include consideration of vitamin D supplementation AND balance, strength and gait training.
Denominator Description	A) Screening for Future Fall Risk: All patients aged 65 years and older seen by an eligible provider in the past year. B & C) Falls Risk Assessment & Plan of Care for Falls: All patients aged 65 years and older seen by an eligible provider in the past year with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year).
Inclusions	None listed by measure steward.
Exclusions	Patients who have documentation of medical reason(s) for not screening for future fall risk, undergoing a risk-assessment or having a plan of care (e.g., patient is not ambulatory) are excluded from this measure.
DSRIP Specified Setting	Other
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

K2-285: Advance Care Plan

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

DY7/DY8 Program ID	285
NQF Number	0326
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0326
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.
Denominator Description	All patients aged 65 years and older.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital
Data Source	Claims (Only), Electronic Health Record (Only)
Measure Point Value	1
Additional Notes	

MACRA MIPS High Priority Measure.

K2-287: Documentation of Current Medications in the Medical Record

Measure Description:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

DY7/DY8 Program ID	287
NQF Number	0419
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0419
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The Numerator statement for the most recent versions of the measure is as follows (for both the 2016 Claims and Registry version and the 2017 e Measure version): Eligible professional attests to documenting, updating, or reviewing a patient´s current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route of administration
Denominator Description	The 2016 Claims and Registry denominator statement is as follows: "All visits for patients aged 18 years and older." The 2017 eMeasure denominator statement is as follows: "All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period."
Inclusions	None listed by measure steward.
Exclusions	The 2016 Claims and Registry version contains the following Other Performance Exclusion: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional. A patient is not eligible if the following reason is documented: the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status The eMeasure includes the following denominator exception: Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital, Behavioral Health Outpatient
Data Source	Claims (Only), Electronic Health Record (Only), Registry
Measure Point Value	1

Additional Notes	

MACRA MIPS High Priority Measure.

K2-355: Admit Decision Time to ED Departure Time for Admitted Patients

Measure Description:
Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status

DY7/DY8 Program ID	355
NQF Number	0497
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0497
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.
Denominator Description	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.
Inclusions	None listed by measure steward.
Exclusions	Patients who are not an ED Patient
DSRIP Specified Setting	Hospital
Data Source	Electronic Health Record (Only), Other, Paper Records
Measure Point Value	1
Additional Notes	

K2-359: Emergency Transfer Communication Measure

Measure Description:
Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that REQUIRED information was communicated to the receiving facility prior to departure (SUBSECTION 1) OR WITHIN 60 MINUTES OF TRANSFER (SUBSECTION 2-7)

DY7/DY8 Program ID	359
NQF Number	0291
Measure Steward	University of Minnesota Rural Health Research Center
Link to Measure Citation	http://www.qualityforum.org/QPS/0291
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative and clinical information was communicated to the receiving facility IN AN APPROPRIATE TIME FRAME • EDTC-SUB 1 Administrative communication - Nurse to nurse communication - Physician to physician communication • EDTC-SUB 2 Patient information - Name - Address - Age - Gender - Significant others contact information - Insurance • EDTC-SUB 3 Vital signs - Pulse - Respiratory rate - Blood pressure - Oxygen saturation - Temperature - Glasgow score or other neuro assessment for trauma, cognitively altered or neuro patients only • EDTC-SUB 4 Medication information - Medications administered in ED - Allergies - Home medications • EDTC-SUB 5 Physician or practitioner generated information - History and physical - Reason for transfer and/or plan of care • EDTC-SUB 6 Nurse generated information - Assessments/interventions/response - Sensory Status (formerly Impairments) - Catheters

	- Immobilizations - Respiratory support - Oral limitations • EDTC-SUB 7 Procedures and tests - Tests and procedures done - Tests and procedure results sent
Denominator Description	All emergency department patients who are transferred to another healthcare facility
Inclusions	None listed by measure steward.
Exclusions	All emergency department patients not discharged to another healthcare facility.
DSRIP Specified Setting	Hospital
Data Source	Claims (Only), Electronic Health Record (Only), Imaging-Diagnostic, Laboratory, Other, Paper Records, Pharmacy, Registry
Measure Point Value	1
Additional Notes	

L1: Local Health Departments

L1-103: Controlling High Blood Pressure

Measure Description:
The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

DY7/DY8 Program ID	103
NQF Number	0018
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0018
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7041 **MPL:** 0.4687
Numerator Description	The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.
Denominator Description	Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude all patients with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD. Exclude all patients with a diagnosis of pregnancy during the measurement year. Exclude all patients who had an admission to a nonacute inpatient setting during the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	3
Additional Notes	BAT Recommendation to allow follow-up home blood pressure readings recorded in E H R/medical record

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus Core Set: Cardiovascular Measures; MACRA MIPS Measure.

L1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

Measure Description:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

DY7/DY8 Program ID	105
NQF Number	0028
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0028
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for tobacco use* at least once within 24 months AND who received tobacco cessation counseling intervention** if identified as a tobacco user *Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy
Denominator Description	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, other
Data Source	Claims (Only), Electronic Health Record (Only), Other, Paper Records, Registry
Measure Point Value	1
Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus Core Set: Cardiovascular Measures; MACRA MIPS Measure; CCBHC Measure.

L1-107: Colorectal Cancer Screening

Measure Description:
The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.

DY7/DY8 Program ID	107
NQF Number	0034
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0034
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	One or more screenings for colorectal cancer. Any of the following meet criteria: - Fecal occult blood test (FOBT) during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type. - Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. - Colonoscopy during the measurement year or the nine years prior to the measurement year.
Denominator Description	Patients 51–75 years of age as of the end of the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients with a diagnosis of colorectal cancer or total colectomy
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Imaging-Diagnostic, Laboratory, Paper Records
Measure Point Value	2
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

L1-108: Childhood Immunization Status (CIS)

Measure Description:
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine.

DY7/DY8 Program ID	108
NQF Number	0038
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0038
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.4647 **MPL:** 0.2599
Numerator Description	Children who have evidence showing they received all recommended vaccines by their second birthday: • Four diphtheria, tetanus and acellular pertussis (DtaP) • Three polio (IPV) • One measles, mumps and rubella (MMR) • Three H influenza type B (HiB) • Three hepatitis B (HepB) • One chicken pox (VZV) • Four pneumococcal conjugate (PCV) • One hepatitis A (HepA) • Two or three rotavirus (RV); and, • Two influenza (flu)
Denominator Description	Children who turn 2 years of age during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates. The denominator for all rates must be the same.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records, Registry
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure; Proposed 2018 MCO P4Q Measure.

L1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

DY7/DY8 Program ID	115
NQF Number	0059
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0059
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.2936 **MPL:** 0.522
Numerator Description	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year. The outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy
Measure Point Value	3
Additional Notes	

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

L1-147: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Measure Description:
Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter

Normal Parameters:

Age 65 years and older BMI >= 23 and < 30

Age 18 – 64 years BMI >= 18.5 and < 25

DY7/DY8 Program ID	147
NQF Number	0421 / 2828 eMeasure
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0421 http://www.qualityforum.org/QPS/2828
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.9254 **MPL:** 0.7651
Numerator Description	Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.
Denominator Description	There are two (2) Initial Patient Populations for this measure: Initial Patient Population 1: All patients 18 through 64 years on the date of the encounter with at least one eligible encounter during the measurement period. Initial Patient Population 2: All patients 65 years of age and older on the date of the encounter with at least one eligible encounter during the measurement period.
Inclusions	None listed by measure steward.
Exclusions	Initial Patient Population 1: Patients who are pregnant or encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient´s health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate. Initial Patient Population 2: Encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient´s health status, or there is any other reason documented in the medical

	record by the provider explaining why BMI measurement was not appropriate.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Other
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure; CCBHC Measure.

L1-160: Follow-Up After Hospitalization for Mental Illness

Measure Description:
The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge

- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

DY7/DY8 Program ID	160
NQF Number	0576
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0576
Measure Parts	2
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 30 Days: 0.7852 7 Days: 0.6423 **MPL:** 30 Days: 0.5408 7 Days: 0.342
Numerator Description	30-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.
Denominator Description	Patients 6 years and older as of the date of discharge who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (e.g., January 1 to December 1).
Inclusions	None listed by measure steward.
Exclusions	Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first 11 months of the measurement year (e.g., after December 1). Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).

	These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.
DSRIP Specified Setting	Behavioral Health: Inpatient, Behavioral Health: Outpatient, Hospital
Data Source	Claims (Only), Electronic Health Record (Only)
Measure Point Value	3
Additional Notes	

CMS Alignment: Child Core Set; Adult Core Set; MACRA MIPS Measure.

L1-186: Breast Cancer Screening

Measure Description:
The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

DY7/DY8 Program ID	186
NQF Number	2372
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/2372
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7144 **MPL:** 0.5228
Numerator Description	Women who received a mammogram to screen for breast cancer.
Denominator Description	Women 52-74 years as of December 31 of the measurement year Note: this denominator statement captures women age 50-74 years; it is structured to account for the look-back period for mammograms.
Inclusions	None listed by measure steward.
Exclusions	Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy: 1) Bilateral mastectomy 2) Unilateral mastectomy with a bilateral modifier 3) Two unilateral mastectomies on different dates of service and 4) Both of the following (on the same date of service): Unilateral mastectomy with a right-side modifier and unilateral mastectomy with a left-side modifier.
DSRIP Specified Setting	Clinician Office/Clinic
Data Source	Claims (Only), Electronic Health Record (Only)
Measure Point Value	2
Additional Notes	

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus OB/GYN Measures; MACRA MIPS Measure.

L1-205: Third next available appointment

Measure Description:
This measure is used to assess the average number of days to the third next available appointment for an office visit* for each clinic and/or department. This measure does not differentiate between "new" and "established" patients.

*Office Visit: A patient encounter with a health care provider in an office, clinic, or ambulatory care facility as an outpatient.

DY7/DY8 Program ID	205
NQF Number	NA
Measure Steward	Wisconsin Collaborative for Healthcare Quality
Link to Measure Citation	https://www.qualitymeasures.ahrq.gov/summaries/summary/23918/access-time-to-third-next-available-appointment-for-an-office-visit
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. The measure will take into account calendar days, including weekends, holidays and clinician days off.
Denominator Description	This measure applies to providers within a reported clinic and/or department (see the related "Denominator Inclusions/Exclusions" field)
Inclusions	Providers: All providers are included. Full-time and part-time providers are included, regardless of the number of hours s/he practices per week. Providers who truly job share are counted as one provider (i.e., they share one schedule, and/or they work separate day and share coverage of one practice). When measuring a care team, each member of the care team is counted separately (i.e., MD, NP, PA). If a provider is practicing in a specialty other than the one which s/he is board certified, the provider should be included in the specialty in which s/he is practicing. For providers practicing at more than 1 location, measure days to third next available for only the provider's primary location as long as the provider is at that location 51%+ of their time. New providers who started seeing patients during the reporting period and have an active schedule should be included. Locums are included in the measure only if they are assigned to a specific site for an extended period of time (greater than 4 weeks) and provide continuity care to a panel of patients. Mid-Level providers are included in the measure (NP, PA, CNM). Mid-Level providers should have continuity practice and their own schedule available to see patients.

	Resident Providers are to be included if they have an active schedule AND are considered a Primary Care Provider within the organization. Providers with closed practices should be included. They still have to schedule their current patients. In addition, it may not be clear when they start seeing new patients again. Departments: Primary Care General Internal Medicine Family Practice Pediatrics with the focus on generalists, not specialists Med/Peds (physicians who see both adults and children) Specialty Care Obstetrics Physical exam - New OB visit
Exclusions	Exclude clinicians who do not practice for an extended period of time (greater than 4 weeks) due to maternity leave, sabbatical, family medical leave. Mid-Level providers who function only as an "extender," overflow to another practice, or urgent care should not be included. Exclude Resident Providers if they are not considered a Primary Care Provider, have an inconsistent schedule, and a restricted patient panel.
DSRIP Specified Setting	Any
Data Source	Provider data
Measure Point Value	1
Additional Notes	

L1-207: Diabetes care: BP control (<140/90mm Hg)

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure level taken during the measurement year is <140/90 mm Hg.

DY7/DY8 Program ID	207
NQF Number	0061
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0061
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7564 **MPL:** 0.5229
Numerator Description	Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year. The outcome being measured is a blood pressure reading of <140/90 mm Hg, which indicates adequately controlled blood pressure. Adequately controlled blood pressure in patients with diabetes reduces cardiovascular risks and microvascular diabetic complications.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and type 2) during the measurement year or the year prior to the measurement year. See question S.7 Denominator Details for methods to identify patients with diabetes.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did NOT have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year. AND either: -A diagnosis of polycystic ovaries, in any setting, any time in the patient's history through December 31 of the measurement year, or -A diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Other, Paper Records, Pharmacy
Measure Point Value	3
Additional Notes	

L1-210: PQRS #317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Measure Description:
Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated

DY7/DY8 Program ID	210
NQF Number	NA
Measure Steward	CMS
Link to Measure Citation	https://pqrs.cms.gov/dataset/2016-PQRS-Measure-317-11-17-2015/bqda-3reh
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is pre-hypertensive or hypertensive NUMERATOR NOTE: Although the recommended screening interval for a normal BP reading is every 2 years, to meet the intent of this measure, BP screening and follow-up must be performed once per measurement period. For patients with Normal blood pressure a follow-up plan is not required.
Denominator Description	All patients aged 18 years and older
Inclusions	Denominator Criteria (Eligible Cases): Patients aged ≥ 18 years AND Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90880, 92002, 92004, 92012, 92014, 96118, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99281, 99282, 99283, 99284, 99285, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0402, G0438, G0439
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

L1-211: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure Description:
Percentage of children 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of:

Rate #1: Body Mass Index (BMI) percentile documentation

Rate #2: Counseling for nutrition, and

Rate #3: Counseling for physical activity.

DY7/DY8 Program ID	211
NQF Number	0024
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0024
Measure Parts	3
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** BMI Percentile: 0.8637 Counseling for Nutrition: 0.7952 Counseling for Physical Activity: 0.7158 **MPL:** BMI Percentile: 0.545 Counseling for Nutrition: 0.5184 Counseling for Physical Activity: 0.4509
Numerator Description	Children ages 3-17 with evidence of each of the following: Rate #1: Documented body mass index (BMI) percentile Rate #2: Counseling for nutrition Rate #3: Counseling for physical activity during the measurement year
Denominator Description	Children 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or obstetrician-gynecologist (OB-GYN) during the measurement period.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who have a diagnosis of pregnancy during the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure; Proposed 2018 MCO P4Q Measure; CCBHC Measure.

L1-224: Dental Sealant: Children

Measure Description:
Increase the proportion of children aged 6 to 9 years who have received dental sealants on one or more of their permanent first molar teeth

DY7/DY8 Program ID	224
NQF Number	NA
Measure Steward	Healthy People 2020
Link to Measure Citation	https://www.healthypeople.gov/node/5001/data_details
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of children aged 6 to 9 with a clinical confirmation of dental sealants applied to one or more first permanent molars
Denominator Description	Number of children aged 6 to 9 with at least one permanent first molar present and valid sealant codes for at least one permanent first molar
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Dental Clinic
Data Source	TBD
Measure Point Value	1
Additional Notes	

L1-225: Dental Caries: Children

Measure Description:
Percentage of children with untreated dental caries

DY7/DY8 Program ID	225
NQF Number	NA
Measure Steward	Healthy People 2020
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of children with untreated dental caries
Denominator Description	Total number of children that have seen a dental provider within the measurement period
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Dental Clinic
Data Source	Administrative/Clinical data sources; supplemental data sources
Measure Point Value	3
Additional Notes	

L1-227: Dental Caries: Adults

Measure Description:
Percentage of adults aged 18 or more years with untreated dental decay

DY7/DY8 Program ID	227
NQF Number	NA
Measure Steward	Healthy People 2020
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of adults aged 18 years or more with coronal caries that has not been restored in at least one permanent tooth
Denominator Description	Number of adults aged 18 or more years with at least one permanent tooth present and valid coronal caries codes for at least one permanent tooth
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Dental Clinic
Data Source	Administrative/Clinical data sources; Supplemental data sources
Measure Point Value	3
Additional Notes	Measure title changed to Dental Caries: Adults

L1-231: Preventive Services for Children at Elevated Caries Risk - Modified Denominator

Measure Description:
Percentage of enrolled children who are at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants within the reporting year

DY7/DY8 Program ID	231
NQF Number	NA
Measure Steward	American Dental Association
Link to Measure Citation	http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2017_Dental_Services_Preventive_Services.pdf?la=en
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Unduplicated number of children at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants as a dental service
Denominator Description	Unduplicated number of enrolled children at "elevated" risk (i.e., "moderate" or "high")
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Dental Clinic
Data Source	Administrative enrollment and claims data
Measure Point Value	1
Additional Notes	

L1-235: Post-Partum Follow-Up and Care Coordination (PQRS #336)

Measure Description:
Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for post-partum care within 8 weeks of giving birth who received a breast feeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning

DY7/DY8 Program ID	235
NQF Number	NA
Measure Steward	CMS
Link to Measure Citation	https://pqrs.cms.gov/dataset/2016-PQRS-Measure-317-11-17-2015/bqda-3reh
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients receiving the following at a post-partum visit: - Breast feeding evaluation and education, including patient-reported breast feeding - Post-partum depression screening - Post-partum glucose screening for gestational diabetes patients and - Family and contraceptive planning Definitions: Breast Feeding Evaluation and Education – Patients who were evaluated for breast feeding before or at 8 weeks post-partum. Post-Partum Depression Screening – Patients who were screened for post-partum depression before or at 8 weeks post-partum. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated depression screening tool (e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS). Post-Partum Glucose Screening for Gestational Diabetes – Patients who were diagnosed with gestational diabetes during pregnancy who were screened with a glucose screen before or at 8 weeks post-partum. Family and Contraceptive Planning – Patients who were provided family and contraceptive planning and education (including contraception, if necessary) before or at 8 weeks post-partum. Numerator Instruction: To satisfactorily meet the numerator ALL components (breast feeding evaluation and education, post-partum depression screening, family and contraceptive planning and post-partum glucose screening for patients with gestational diabetes) must be performed.

Denominator Description	All patients, regardless of age, who gave birth during a 12-month period seen for post-partum care visit before or at 8 weeks of giving birth
Inclusions	Denominator: All patients, regardless of age AND Patient encounter during reporting period (CPT): 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622 AND Post-partum Care Visit before or at 8 weeks post-delivery Numerator: Performance Met: Post-partum screenings, evaluations and education performed (G9357)
Exclusions	Numerator: Performance Not Met: Post-partum screenings, evaluations and education not performed (G9358)
DSRIP Specified Setting	OB
Data Source	None listed
Measure Point Value	3
Additional Notes	

CMS Alignment: Adult Core Set;

L1-237: Well-Child Visits in the First 15 Months of Life (6 or more visits)

Measure Description:
The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.

DY7/DY8 Program ID	237
NQF Number	1392
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/1392
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7388 **MPL:** 0.5349
Numerator Description	Children who received the following number of well-child visits with a PCP during their first 15 months of life: - No well-child visits - One well-child visit - Two well-child visits - Three well-child visits - Four well-child visits - Five well-child visits - Six or more well-child visits
Denominator Description	Children 15 months old during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; Proposed 2018 MCO P4Q Measure.

L1-241: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

Measure Description:
The percentage of individuals receiving the project intervention(s) who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period

DY7/DY8 Program ID	241
NQF Number	NA
Measure Steward	None
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period.
Denominator Description	Number of individuals receiving project intervention(s)
Inclusions	Denominator: Number of individuals receiving project intervention(s) Numerator: If an individual has more than one jail booking occurrence within the measurement period, that individual would only be counted once in the numerator
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Other
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data; Criminal justice system records, local mental health authority and state mental health data system records
Measure Point Value	3
Additional Notes	

L1-242: Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)

Measure Description:
Rate of Emergency Department (ED) utilization for ACSC:

- Grand mal status and other epileptic convulsions

- Chronic obstructive pulmonary diseases

- Asthma

- Heart failure and pulmonary edema

- Hypertension

- Angina, or

- Diabetes

DY7/DY8 Program ID	242
NQF Number	NA
Measure Steward	None
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of ED Visits with a primary or secondary ACSC diagnosis for any individual 18 years and older during the measurement period
Denominator Description	Total number of ED visits for individuals 18 years or older during the measurement period
Inclusions	Any ED visits with a primary or secondary ACSC diagnosis for any individual 18 years and older during the measurement period: Grand mal status and other epileptic convulsions: 345 Chronic obstructive pulmonary diseases: 466.0 (only with secondary diagnosis of 491, 492, 494, 496), 491, 492, 494, 496 Asthma: 493 Heart failure and pulmonary edema: 402.01, 402.11, 402.91, 428, 518.4 Hypertension: 401.0, 401.9, 402.00, 402.10, 402.90 Angina: 411.1, 411.8, 413 Diabetes: 250.0, 250.1, 250.2, 250.3,250.8, 250.9
Exclusions	The following diagnostic codes should be excluded: Grand mal status and other epileptic convulsions: None Chronic obstructive pulmonary diseases: None Asthma: None Heart failure and pulmonary edema: Procedure codes 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7

	Hypertension: procedures: Procedure codes 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7 Angina: Procedure codes 01-86.99 Diabetes: Diabetes with renal manifestations [250.4], diabetes with ophthalmic manifestations [250.5], diabetes with neurological manifestations [250.6] and diabetes with peripheral circulatory disorders [250.7]
DSRIP Specified Setting	ED
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Measure Point Value	3
Additional Notes	

L1-268: Pneumonia vaccination status for older adults

Measure Description:
Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination.

DY7/DY8 Program ID	268
NQF Number	0043
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0043
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of patients in the denominator who responded "Yes" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."
Denominator Description	CAHPS respondents age 65 or older as of the last day of the measurement year who responded "Yes" or "No" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Patient Reported Data
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

L1-269: Preventive Care and Screening: Influenza Immunization

Measure Description:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

DY7/DY8 Program ID	269
NQF Number	0041 / 3070 eMeasure
Measure Steward	AMA / PCPI
Link to Measure Citation	http://www.qualityforum.org/QPS/0041 http://www.qualityforum.org/QPS/3070
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization
Denominator Description	All patients aged 6 months and older seen for a visit between October 1 and March 31
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons) Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons) Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)
DSRIP Specified Setting	Primary Care
Data Source	Electronic Health Record (Only), Registry
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

L1-271: Immunization for Adolescents- Tdap/TD and MCV

Measure Description:
The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday.

DY7/DY8 Program ID	271
NQF Number	1407
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/1407
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.8657 **MPL:** 0.6603
Numerator Description	Adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Denominator Description	Adolescents who turn 13 years of age during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered. Either of the following meet exclusion criteria: • Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday. • Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	Updated to include HPV

CMS Alignment: Child Core Set; MACRA MIPS Measure.

L1-272: Adults (18+ years) Immunization status

Measure Description:
Percentage of adult patients 18 years and older who are up-to-date with the following immunizations:

-One tetanus and diphtheria toxoids (Td) vaccine in the last 10 years

-Varicella – two doses or history of disease up to year 1995

-Pneumococcal polysaccharide vaccine (PPSV23) for patients 65 and older

-One influenza within last year

-Herpes zoster/shingles (patients 60 years and older)

DY7/DY8 Program ID	272
NQF Number	NA
Measure Steward	Institute for Clinical Systems Improvement
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of patients who are up-to-date with following immunizations: -One tetanus and diphtheria toxoids (Td) vaccine in the last 10 years -Varicella – two doses or history of disease up to year 1995 -Pneumococcal polysaccharide vaccine (PPSV23) for patients 65 and older -One influenza dose within the last year -Herpes zoster/shingles (patients 60 years and older)
Denominator Description	Number of patients 18 years and older during the specified measurement period*
Inclusions	None listed by measure steward.
Exclusions	Denominator Exclusions: Patients with immunization contraindications listed in the medical record should be excluded
DSRIP Specified Setting	Primary Care
Data Source	Clinical Data, Electronic Health Record, Administrative Claims
Measure Point Value	1
Additional Notes	

L1-280: Chlamydia Screening in Women (CHL)

Measure Description:
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

DY7/DY8 Program ID	280
NQF Number	0033
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0033
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.6892 **MPL:** 0.4881
Numerator Description	Females who were tested for chlamydia during the measurement year.
Denominator Description	Females 16-24 years who had a claim or encounter indicating sexual activity.
Inclusions	None listed by measure steward.
Exclusions	Females who received a pregnancy test to determine contraindications for medication (isotretinoin) or x-ray.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Imaging-Diagnostic, Laboratory, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure.

L1-343: Syphilis positive screening rates

Measure Description:
The percentage of newly diagnosed primary or secondary syphilis during the measurement period. Providers will report three separate rates:

Rate #1: The percentage of newly diagnosed primary or secondary syphilis among all individuals (males and females) during the measurement period.

Rate #2: The percentage of newly diagnosed primary or secondary syphilis among males during the measurement period

Rate #3: The percentage of newly diagnosed primary or secondary syphilis among females during the measurement period

DY7/DY8 Program ID	343
NQF Number	NA
Measure Steward	CDC
Link to Measure Citation	http://www.healthindicators.gov/Indicators/Syphilis-primary-and-secondary-females-per-100000_1480/Profile
Measure Parts	3
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The numerators for the three rates to be reported: Rate #1: Number of new reported cases of primary and secondary syphilis among all individuals (males and females) during the measurement period Rate #2: Number of new reported cases of primary or secondary syphilis among males during the measurement period Rate #3: Number of new reported cases of primary and secondary syphilis among females during the measurement period
Denominator Description	The denominators for the three rates to be reported: Rate #1: Number of individuals (i.e. males and females) Rate #2: Number of males Rate #3: Number of females
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

L1-344: Follow-up after Treatment for Primary or Secondary Syphilis

Measure Description:
Percentage of individuals who undergo follow-up clinical and/or serologic evaluation at 6-months after treatment for primary or secondary syphilis

DY7/DY8 Program ID	344
NQF Number	NA
Measure Steward	CDC
Link to Measure Citation	http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of individuals who have undergone treatment for primary or secondary syphilis and complete clinical and/or serologic testing at 6 months
Denominator Description	Total number of individuals who have undergone treatment for primary or secondary syphilis.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	3
Additional Notes	

L1-345: Gonorrhea Positive Screening Rates

Measure Description:
The percentage of newly diagnosed cases of gonorrhea during the measurement period. Providers will report three separate rates:

Rate #1: The percentage of newly diagnosed gonorrhea among all individuals (males and females) during the measurement period.

Rate #2: The percentage of newly diagnosed gonorrhea among males during the measurement period

Rate #3: The percentage of newly diagnosed gonorrhea among females during the measurement period

DY7/DY8 Program ID	345
NQF Number	NA
Measure Steward	CDC
Link to Measure Citation	TBD
Measure Parts	3
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The numerators for the three rates to be reported: Rate #1: Number of new reported cases of gonorrhea among all cases (males and females) during the measurement period Rate #2: Number of new reported cases of gonorrhea among males during the measurement period Rate #3: Number of new reported cases of gonorrhea among females during the measurement period
Denominator Description	The denominators for the three rates to be reported: Rate #1: Number of individuals (i.e. total number of females and males) Rate #2: Number of males Rate #3: Number of females
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

L1-346: Follow-up testing for N. gonorrhoeae among recently infected men and women

Measure Description:
The proportion of men and women who undergo follow up testing for uncomplicated Gonorrhea 3-months after treatment during the measurement period.

DY7/DY8 Program ID	346
NQF Number	NA
Measure Steward	CDC
Link to Measure Citation	NA
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of individuals who undergo follow-up testing for uncomplicated Gonorrhea 3-months after treatment.
Denominator Description	Total number of individuals treated for uncomplicated Gonorrhea.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	3
Additional Notes	

L1-347: Latent Tuberculosis Infection (LTBI) treatment rate

Measure Description:
Percentage of patients with latent tuberculosis infection who complete a course of treatment.

DY7/DY8 Program ID	347
NQF Number	NA
Measure Steward	CDC
Link to Measure Citation	NA
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Individuals from the denominator that completed a LTBI treatment regimen
Denominator Description	Total number of individuals identified with Latent Tuberculosis Infection (LTBI) that initiated (accepted) a LTBI treatment regimen.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital, Other
Data Source	TBD
Measure Point Value	3
Additional Notes	

L1-387: Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)

Measure Description:

Rate of ED utilization for substance use conditions or complications

DY7/DY8 Program ID	387
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of ED Visits with a primary or secondary diagnosis of (excluding tobacco) substance abuse for any individual 18 years and older during the measurement period
Denominator Description	Total number of ED visits for individuals 18 years or older during the measurement period
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	ED
Data Source	TBD
Measure Point Value	3
Additional Notes	Reported as two rates

M1: Community Mental Health Centers

M1-100: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Measure Description:
The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following.

- Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

- Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

DY7/DY8 Program ID	100
NQF Number	0004
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0004
Measure Parts	2
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** Initiation: 0.4628 Engagement: 0.1695 **MPL:** Initiation: 0.3439 Engagement: 0.0692
Numerator Description	Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the index episode start date. Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).
Denominator Description	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. (See corresponding Excel document for the AOD Dependence Value Set) Exclude from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) patients whose initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.

DSRIP Specified Setting	Behavioral Health: Inpatient, Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, Hospital, Urgent Care - Ambulatory
Data Source	Claims (Only), Electronic Health Record (Only)
Measure Point Value	3
Additional Notes	

CMS Alignment: Adult Core Set; MACRA MIPS Measure.

M1-103: Controlling High Blood Pressure

Measure Description:
The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

DY7/DY8 Program ID	103
NQF Number	0018
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0018
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7041 **MPL:** 0.4687
Numerator Description	The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.
Denominator Description	Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude all patients with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD. Exclude all patients with a diagnosis of pregnancy during the measurement year. Exclude all patients who had an admission to a nonacute inpatient setting during the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	3
Additional Notes	BAT Recommendation to allow follow-up home blood pressure readings recorded in E H R/medical record

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus Core Set: Cardiovascular Measures; MACRA MIPS Measure.

M1-104: Medical Assistance with Smoking and Tobacco Use Cessation (MSC) - Modified Denominator

Measure Description:
Assesses different facets of providing medical assistance with smoking and tobacco use cessation:

Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.

Discussing Cessation Medications: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.

Discussing Cessation Strategies: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

DY7/DY8 Program ID	104
NQF Number	0027 (Modified)
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0027
Measure Parts	3
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** Advising Smokers to Quit: 0.8185 Discussing Cessation Medications: 0.5839 Discussing Cessation Strategies: 0.5175 **MPL:** Advising Smokers to Quit: 0.7314 Discussing Cessation Medications: 0.4301 Discussing Cessation Strategies: 0.3886
Numerator Description	Component 1: Advising Smokers and Tobacco Users to Quit (ASTQ) Patients who received advice to quit smoking or using tobacco from their doctor or health provider Component 2: Discussing Cessation Medications (DSCM) Patients who discussed or received recommendations on smoking or tobacco cessation medications from their doctor or health provider Component 3: Discussing Cessation Strategies (DSCS) Patients who discussed or received recommendations on smoking or tobacco cessation methods and strategies other than medication from their doctor or health provider
Denominator Description	Patients 18 years and older who indicated that they were current smokers or tobacco users during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Patient Reported Data
Measure Point Value	1

Additional Notes	

CMS Alignment: Adult Core Set;

M1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

Measure Description:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

DY7/DY8 Program ID	105
NQF Number	0028
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0028
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for tobacco use* at least once within 24 months AND who received tobacco cessation counseling intervention** if identified as a tobacco user *Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy
Denominator Description	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, other
Data Source	Claims (Only), Electronic Health Record (Only), Other, Paper Records, Registry
Measure Point Value	1
Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; CMS Consensus Core Set: Cardiovascular Measures; MACRA MIPS Measure; CCBHC Measure.

M1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

DY7/DY8 Program ID	115
NQF Number	0059
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0059
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.2936 **MPL:** 0.522
Numerator Description	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year. The outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy
Measure Point Value	3
Additional Notes	

CMS Alignment: Adult Core Set; CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure.

M1-124: Medication Reconciliation Post-Discharge

Measure Description:
The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.

DY7/DY8 Program ID	124
NQF Number	0097
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0097
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
Denominator Description	All discharges from an in-patient setting for patients who are 18 years and older.
Inclusions	None listed by measure steward.
Exclusions	The following exclusions are applicable to the Health Plan Level measure. - Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. - If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the patient was transferred.
DSRIP Specified Setting	Hospital
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS High Priority Measure.

M1-125: Antidepressant Medication Management (AMM-AD)

Measure Description:
The percentage of patients 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.

a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).

b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

DY7/DY8 Program ID	125
NQF Number	0105
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0105
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Adults 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.
Denominator Description	Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Exclude patients who filled a prescription for an antidepressant 105 days prior to the IPSD.
DSRIP Specified Setting	Behavioral Health: Outpatient
Data Source	Claims (Only), Electronic Health Record (Only), Pharmacy
Measure Point Value	3
Additional Notes	

CMS Alignment: Adult Core Set; MACRA MIPS Measure.

M1-146: Screening for Clinical Depression and Follow-Up Plan (CDF-AD)

Measure Description:
Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

DY7/DY8 Program ID	146
NQF Number	0418
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/418
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented The standardized screening tools help predict a likelihood of someone developing or having a particular disease. The screening tools suggested in this measure screen for possible depression. Questions within the suggested standardized screening tools may vary but the result of using a standardized screening tool is to determine if the patient screens positive or negative for depression. If the patient has a positive screen for depression using a standardized screening tool, the provider must have a follow-up plan as defined within the measure. If the patient has a negative screen for depression, no follow-up plan is required.
Denominator Description	All patients aged 12 years and older
Inclusions	None listed by measure steward.
Exclusions	Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist: • Patient refuses to participate • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases • Patient was referred with a diagnosis of depression • Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period • Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools
DSRIP Specified Setting	Primary Care, Specialty Care
Data Source	Claims (Only), Other, Paper Records
Measure Point Value	1

Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17 and to expand to screening for general behavioral health concerns including anxiety

CMS Alignment: Adult Core Set; MACRA MIPS Measure;CCBHC Measure.

M1-147: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Measure Description:
Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter

Normal Parameters:

Age 65 years and older BMI >= 23 and < 30

Age 18 – 64 years BMI >= 18.5 and < 25

DY7/DY8 Program ID	147
NQF Number	0421 / 2828 eMeasure
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0421 http://www.qualityforum.org/QPS/2828
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.9254 **MPL:** 0.7651
Numerator Description	Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.
Denominator Description	There are two (2) Initial Patient Populations for this measure: Initial Patient Population 1: All patients 18 through 64 years on the date of the encounter with at least one eligible encounter during the measurement period. Initial Patient Population 2: All patients 65 years of age and older on the date of the encounter with at least one eligible encounter during the measurement period.
Inclusions	None listed by measure steward.
Exclusions	Initial Patient Population 1: Patients who are pregnant or encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient´s health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate. Initial Patient Population 2: Encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient´s health status, or there is any other reason documented in the medical

	record by the provider explaining why BMI measurement was not appropriate.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Other
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure; CCBHC Measure.

M1-160: Follow-Up After Hospitalization for Mental Illness

Measure Description:
The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge

- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

DY7/DY8 Program ID	160
NQF Number	0576
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0576
Measure Parts	2
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 30 Days: 0.7852 7 Days: 0.6423 **MPL:** 30 Days: 0.5408 7 Days: 0.342
Numerator Description	30-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.
Denominator Description	Patients 6 years and older as of the date of discharge who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (e.g., January 1 to December 1).
Inclusions	None listed by measure steward.
Exclusions	Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first 11 months of the measurement year (e.g., after December 1). Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).

	These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.
DSRIP Specified Setting	Behavioral Health: Inpatient, Behavioral Health: Outpatient, Hospital
Data Source	Claims (Only), Electronic Health Record (Only)
Measure Point Value	3
Additional Notes	

CMS Alignment: Child Core Set; Adult Core Set; MACRA MIPS Measure.

M1-165: Depression Remission at 12 Months

Measure Description:
Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.

DY7/DY8 Program ID	165
NQF Number	0710
Measure Steward	MN Community Measurement
Link to Measure Citation	http://www.qualityforum.org/QPS/0710
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.
Denominator Description	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine.
Inclusions	None listed by measure steward.
Exclusions	Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care
Data Source	Electronic Health Record (Only), Other, Paper Records
Measure Point Value	3
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures; MACRA MIPS Measure; CCBHC Measure.

M1-180: Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD)

Measure Description:
Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).

DY7/DY8 Program ID	180
NQF Number	1879
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/1879
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7092 **MPL:** 0.528
Numerator Description	Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.
Denominator Description	Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).
Inclusions	None listed by measure steward.
Exclusions	Individuals with any diagnosis of dementia during the measurement period.
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Other, Pharmacy
Measure Point Value	3
Additional Notes	

CMS Alignment: Adult Core Set; MACRA MIPS Measure.

M1-181: Depression Response at Twelve Months- Progress Towards Remission

Measure Description:
Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at twelve months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment.

This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.

DY7/DY8 Program ID	181
NQF Number	1885
Measure Steward	MN Community Measurement
Link to Measure Citation	http://www.qualityforum.org/QPS/1885
Measure Parts	0
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve a response at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.
Denominator Description	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.
Inclusions	None listed by measure steward.
Exclusions	Patients who die, are a permanent resident of a nursing home or are enrolled in hospice or palliative care services are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.
DSRIP Specified Setting	Behavioral Health: Outpatient, Clinician Office/Clinic
Data Source	Electronic Health Record (Only), Other, Paper Records, Patient Reported Data
Measure Point Value	3
Additional Notes	

CMS Alignment: CMS Consensus Core Set: ACO and PCMH / Primary Care Measures;

M1-182: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)

Measure Description:
The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

DY7/DY8 Program ID	182
NQF Number	1932
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/1932
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.8717 **MPL:** 0.7737
Numerator Description	Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.
Denominator Description	Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.
Inclusions	None listed by measure steward.
Exclusions	Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients with diabetes during the measurement year or the year prior to the measurement year. Exclude patients who had no antipsychotic medications dispensed during the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: Adult Core Set; Proposed 2018 MCO P4Q Measure.

M1-203: PQRS #400: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk

Measure Description:
Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965 who received one- time screening for hepatitis C virus (HCV) infection

DY7/DY8 Program ID	203
NQF Number	NA / 3059 eMeasure
Measure Steward	AMA-PCPI
Link to Measure Citation	https://pqrs.cms.gov/dataset/2016-PQRS-Measure-400-11-17-2015/kx88-j5sg http://www.qualityforum.org/QPS/3059
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who received one-time screening for HCV infection
Denominator Description	All patients aged 18 years and older who were seen twice for any visit or who had at least one preventive visit within the 12 month reporting period with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965
Inclusions	None listed by measure steward.
Exclusions	Denominator Exclusions: Patients with a diagnosis of chronic hepatitis C Denominator Exceptions: Documentation of medical reason(s) for not receiving one-time screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons) Documentation of patient reason(s) for not receiving one-time screening for HCV infection (eg, patient declined, other patient reasons)
DSRIP Specified Setting	Primary Care
Data Source	Electronic Health Record (Only), Other
Measure Point Value	1
Additional Notes	

CMS Alignment: CMS Consensus Core Set: Hep C Core Measures; MACRA MIPS Measure.

M1-205: Third next available appointment

Measure Description:
This measure is used to assess the average number of days to the third next available appointment for an office visit* for each clinic and/or department. This measure does not differentiate between "new" and "established" patients.

*Office Visit: A patient encounter with a health care provider in an office, clinic, or ambulatory care facility as an outpatient.

DY7/DY8 Program ID	205
NQF Number	NA
Measure Steward	Wisconsin Collaborative for Healthcare Quality
Link to Measure Citation	https://www.qualitymeasures.ahrq.gov/summaries/summary/23918/access-time-to-third-next-available-appointment-for-an-office-visit
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. The measure will take into account calendar days, including weekends, holidays and clinician days off.
Denominator Description	This measure applies to providers within a reported clinic and/or department (see the related "Denominator Inclusions/Exclusions" field)
Inclusions	Providers: All providers are included. Full-time and part-time providers are included, regardless of the number of hours s/he practices per week. Providers who truly job share are counted as one provider (i.e., they share one schedule, and/or they work separate day and share coverage of one practice). When measuring a care team, each member of the care team is counted separately (i.e., MD, NP, PA). If a provider is practicing in a specialty other than the one which s/he is board certified, the provider should be included in the specialty in which s/he is practicing. For providers practicing at more than 1 location, measure days to third next available for only the provider's primary location as long as the provider is at that location 51%+ of their time. New providers who started seeing patients during the reporting period and have an active schedule should be included. Locums are included in the measure only if they are assigned to a specific site for an extended period of time (greater than 4 weeks) and provide continuity care to a panel of patients. Mid-Level providers are included in the measure (NP, PA, CNM). Mid-Level providers should have continuity practice and their own schedule available to see patients.

	Resident Providers are to be included if they have an active schedule AND are considered a Primary Care Provider within the organization. Providers with closed practices should be included. They still have to schedule their current patients. In addition, it may not be clear when they start seeing new patients again. Departments: Primary Care General Internal Medicine Family Practice Pediatrics with the focus on generalists, not specialists Med/Peds (physicians who see both adults and children) Specialty Care Obstetrics Physical exam - New OB visit
Exclusions	Exclude clinicians who do not practice for an extended period of time (greater than 4 weeks) due to maternity leave, sabbatical, family medical leave. Mid-Level providers who function only as an "extender," overflow to another practice, or urgent care should not be included. Exclude Resident Providers if they are not considered a Primary Care Provider, have an inconsistent schedule, and a restricted patient panel.
DSRIP Specified Setting	Any
Data Source	Provider data
Measure Point Value	1
Additional Notes	

M1-207: Diabetes care: BP control (<140/90mm Hg)

Measure Description:
The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure level taken during the measurement year is <140/90 mm Hg.

DY7/DY8 Program ID	207
NQF Number	0061
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0061
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.7564 **MPL:** 0.5229
Numerator Description	Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year. The outcome being measured is a blood pressure reading of <140/90 mm Hg, which indicates adequately controlled blood pressure. Adequately controlled blood pressure in patients with diabetes reduces cardiovascular risks and microvascular diabetic complications.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and type 2) during the measurement year or the year prior to the measurement year. See question S.7 Denominator Details for methods to identify patients with diabetes.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did NOT have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year. AND either: -A diagnosis of polycystic ovaries, in any setting, any time in the patient's history through December 31 of the measurement year, or -A diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Laboratory, Other, Paper Records, Pharmacy
Measure Point Value	3
Additional Notes	

M1-208: Comprehensive Diabetes Care LDL-C Screening

Measure Description:
The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an LDL-C test during the measurement year.

DY7/DY8 Program ID	208
NQF Number	0063
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0063
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Members who had an LDL-C test performed during the measurement year.
Denominator Description	Members 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year. Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year. Risk Adjustment:
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only)
Measure Point Value	1
Additional Notes	

M1-210: PQRS #317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Measure Description:
Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated

DY7/DY8 Program ID	210
NQF Number	NA
Measure Steward	CMS
Link to Measure Citation	https://pqrs.cms.gov/dataset/2016-PQRS-Measure-317-11-17-2015/bqda-3reh
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is pre-hypertensive or hypertensive NUMERATOR NOTE: Although the recommended screening interval for a normal BP reading is every 2 years, to meet the intent of this measure, BP screening and follow-up must be performed once per measurement period. For patients with Normal blood pressure a follow-up plan is not required.
Denominator Description	All patients aged 18 years and older
Inclusions	Denominator Criteria (Eligible Cases): Patients aged ≥ 18 years AND Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90880, 92002, 92004, 92012, 92014, 96118, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99281, 99282, 99283, 99284, 99285, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0402, G0438, G0439
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure.

M1-211: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure Description:
Percentage of children 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of:

Rate #1: Body Mass Index (BMI) percentile documentation

Rate #2: Counseling for nutrition, and

Rate #3: Counseling for physical activity.

DY7/DY8 Program ID	211
NQF Number	0024
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0024
Measure Parts	3
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** BMI Percentile: 0.8637 Counseling for Nutrition: 0.7952 Counseling for Physical Activity: 0.7158 **MPL:** BMI Percentile: 0.545 Counseling for Nutrition: 0.5184 Counseling for Physical Activity: 0.4509
Numerator Description	Children ages 3-17 with evidence of each of the following: Rate #1: Documented body mass index (BMI) percentile Rate #2: Counseling for nutrition Rate #3: Counseling for physical activity during the measurement year
Denominator Description	Children 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or obstetrician-gynecologist (OB-GYN) during the measurement period.
Inclusions	None listed by measure steward.
Exclusions	Exclude patients who have a diagnosis of pregnancy during the measurement year.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure; Proposed 2018 MCO P4Q Measure; CCBHC Measure.

M1-216: Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate

Measure Description:
Risk adjusted rate of hospital admissions for Behavioral Health /Substance Abuse (BH/SA) that had at least one readmission for any reason within 30 days of discharge for patients 18 years of age and older.

A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.

DY7/DY8 Program ID	216
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for BH/SA during the measurement year. The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk BH/SA admissions during the measurement period.
Denominator Description	Expected (risk-adjusted) rate of readmissions for BH/SA during the measurement year. The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Measure Point Value	3
Additional Notes	

M1-241: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

Measure Description:
The percentage of individuals receiving the project intervention(s) who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period

DY7/DY8 Program ID	241
NQF Number	NA
Measure Steward	None
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period.
Denominator Description	Number of individuals receiving project intervention(s)
Inclusions	Denominator: Number of individuals receiving project intervention(s) Numerator: If an individual has more than one jail booking occurrence within the measurement period, that individual would only be counted once in the numerator
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Other
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data; Criminal justice system records, local mental health authority and state mental health data system records
Measure Point Value	3
Additional Notes	

M1-255: Follow-up Care for Children Prescribed ADHD Medication (ADD)

Measure Description:
The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.

An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

DY7/DY8 Program ID	255
NQF Number	0108
Measure Steward	National Committee for Quality Assurance
Link to Measure Citation	http://www.qualityforum.org/QPS/0108
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	This measure assesses the receipt of follow-up visits for children prescribed ADHD medication. Two rates are reported. 1. INITIATION PHASE: The percentage of children between 6 and 12 years of age who were newly prescribed ADHD medication who had one follow-up visit with a prescribing practitioner within 30 days. 2. CONTINUATION AND MAINTENANCE PHASE: The percentage of children between 6 and 12 years of age newly prescribed ADHD medication and remained on the medication for at least 210 days, who had, in addition to the visit in the Initiative Phase, at least two follow-up visits with a practitioner in the 9 months subsequent to the Initiation Phase.
Denominator Description	Children 6-12 years of age newly prescribed ADHD medication.
Inclusions	None listed by measure steward.
Exclusions	Children with a diagnosis of narcolepsy
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient
Data Source	Claims (Only), Electronic Health Record (Only), Pharmacy
Measure Point Value	3
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure.

M1-256: Initiation of Depression Treatment

Measure Description:
The proportion of individuals diagnosed with major depression that have filled at least one antidepressant prescription or had at least three psychotherapy visits during the 5-month period after diagnosis.

DY7/DY8 Program ID	256
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=ROST0002D&POP=0
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients in the denominator who filled at least one antidepressant prescription or had at least three psychotherapy visits during the 5-month period after diagnosis.
Denominator Description	All patients seen in primary care during a specified period who had major depression based on a structured assessment administered independent of the clinical visit.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient
Data Source	Medical Record; Patient Survey/Instrument
Measure Point Value	1
Additional Notes	

M1-257: Care Planning for Dual Diagnosis

Measure Description:
Percentage of patients with dual diagnosis undergoing case management services who have a documented plan to address both conditions.

DY7/DY8 Program ID	257
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=TENN0017D&POP=5
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Those individuals from the denominator for whom a case manager has documented a plan of care that addresses the consumer's need for treatment of both conditions.
Denominator Description	The number of individuals participating in a case management program who are dually diagnosed with a mental disorder and a substance abuse disorder during a six-month period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

M1-259: Assignment of Primary Care Physician to Individuals with Schizophrenia

Measure Description:
The percentage of individuals with a primary diagnosis of schizophrenia that have been assigned a primary care physician.

DY7/DY8 Program ID	259
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=UTAH0004D&POP=0
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of individuals in the denominator who were assigned a primary care physician.
Denominator Description	Enrollees who had either one inpatient admission or two outpatient visits with a primary diagnosis of schizophrenia within a 12 month period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

M1-260: Annual Physical Exam for Persons with Mental Illness

Measure Description:
The percentage of individuals receiving services for a primary psychiatric disorder whose medical records document receipt of a physical exam during the measurement year.

DY7/DY8 Program ID	260
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=MHSI0002D&POP=0
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Individuals from the denominator whose medical record documents receipt of a physical examination within the specified 12-month period.
Denominator Description	The total number of individuals receiving services for a primary psychiatric disorder during a specified 12- month reporting period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

M1-261: Assessment for Substance Abuse Problems of Psychiatric Patients

Measure Description:
The percentage of individuals who received an assessment for substance abuse problems.

DY7/DY8 Program ID	261
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=APAT0005D&POP=5
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of patients in the denominator whose medical record indicates explicit evidence of assessment of current and/or past substance use disorders.
Denominator Description	Total number of patients in a plan who received psychiatric evaluations within a specified period of time.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Behavioral Health Outpatient
Data Source	TBD
Measure Point Value	1
Additional Notes	

M1-262: Assessment of Risk to Self/Others

Measure Description:
The percentage of individuals with depression who received an evaluation of suicidal/homicidal ideation (SI/HI) and associated risks.

Individuals with major depression are at higher risk for suicide than individuals in the general population.

DY7/DY8 Program ID	262
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=JCAH0003D&POP=0
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients from the denominator whose medical record of the formal evaluation contains specific documentation of the patient's potential to harm self or others.
Denominator Description	The number of patients diagnosed with a depressive disorder during a formal evaluation.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Behavioral Health Outpatient
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

M1-263: Assessment for Psychosocial Issues of Psychiatric Patients

Measure Description:
The percentage of individuals who received an assessment of risk to self or others.

DY7/DY8 Program ID	263
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=APAG0003D&POP=0
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Individuals in the denominator whose medical record documents a psychosocial/developmental history. [Components include major life events, history of abuse or trauma, levels of functioning in family and social roles.]
Denominator Description	All individuals age 18 and older who undergo a psychiatric evaluation during a specified period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Behavioral Health Outpatient
Data Source	TBD
Measure Point Value	1
Additional Notes	

M1-264: Vocational Rehabilitation for Schizophrenia

Measure Description:
The percentage of individuals who received an assessment for Vocational Rehabilitation.

DY7/DY8 Program ID	264
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=PORT0011D&POP=0
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Individuals in the denominator who: i) Report participating in a program to help them find a job or vocational rehabilitation is prescribed in their treatment plan; or ii) Report receiving assistance from an employment specialist
Denominator Description	Individuals, 18 years or older, in active treatment for schizophrenia who at a specified point in time: i) Report in a survey that they are currently employed and they have a prior work history or are actively looking for a job; or ii) Are currently employed
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Behavioral Health Outpatient
Data Source	TBD
Measure Point Value	1
Additional Notes	

M1-265: Housing Assessment for Individuals with Schizophrenia

Measure Description:
The percentage of individuals with Schizophrenia whose housing quality was assessed

DY7/DY8 Program ID	265
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=UTAH0005D&POP=11
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of individuals in the denominator whose housing quality was assessed with medical record documentation indicating that a trained professional (e.g., social worker, visiting nurse) saw the quality of the individual's housing and/or made an effort to modify the individual's housing situation.
Denominator Description	Enrollees who had either one inpatient admission or two outpatient visits with a primary diagnosis of schizophrenia within a 12 month period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

M1-266: Independent Living Skills Assessment for Individuals with Schizophrenia

Measure Description:
The percentage of patients who received an assessment of independent living skills

DY7/DY8 Program ID	266
NQF Number	NA
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to Measure Citation	http://www.cqaimh.org/Report.asp?Code=UTAH0001D&POP=11
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients in the denominator who received an assessment of independent living skills.
Denominator Description	Patients who had either one inpatient admission or two outpatient visits with a primary diagnosis of schizophrenia within a 12 month period.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health Outpatient, Hospital
Data Source	Administrative Data; Medical Record
Measure Point Value	1
Additional Notes	

M1-280: Chlamydia Screening in Women (CHL)

Measure Description:
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

DY7/DY8 Program ID	280
NQF Number	0033
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/0033
Measure Parts	1
Benchmark Description	National Quality Compass 2016 - All LOBs: Average (90th and 25th percentiles) **HPL:** 0.6892 **MPL:** 0.4881
Numerator Description	Females who were tested for chlamydia during the measurement year.
Denominator Description	Females 16-24 years who had a claim or encounter indicating sexual activity.
Inclusions	None listed by measure steward.
Exclusions	Females who received a pregnancy test to determine contraindications for medication (isotretinoin) or x-ray.
DSRIP Specified Setting	Primary Care
Data Source	Claims (Only), Electronic Health Record (Only), Imaging-Diagnostic, Laboratory, Pharmacy
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set; MACRA MIPS Measure.

M1-286: Depression Remission at Six Months

Measure Description:
Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator.

DY7/DY8 Program ID	286
NQF Number	0711
Measure Steward	MN Community Measurement
Link to Measure Citation	http://www.qualityforum.org/QPS/0711
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score of less than five.
Denominator Description	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine.
Inclusions	None listed by measure steward.
Exclusions	Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Behavioral Health: Outpatient
Data Source	Electronic Health Record (Only), Other, Paper Records
Measure Point Value	3
Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17

MACRA MIPS High Priority Measure.

M1-287: Documentation of Current Medications in the Medical Record

Measure Description:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

DY7/DY8 Program ID	287
NQF Number	0419
Measure Steward	CMS
Link to Measure Citation	http://www.qualityforum.org/QPS/0419
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The Numerator statement for the most recent versions of the measure is as follows (for both the 2016 Claims and Registry version and the 2017 e Measure version): Eligible professional attests to documenting, updating, or reviewing a patient´s current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route of administration
Denominator Description	The 2016 Claims and Registry denominator statement is as follows: "All visits for patients aged 18 years and older." The 2017 eMeasure denominator statement is as follows: "All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period."
Inclusions	None listed by measure steward.
Exclusions	The 2016 Claims and Registry version contains the following Other Performance Exclusion: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional. A patient is not eligible if the following reason is documented: the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status The eMeasure includes the following denominator exception: Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
DSRIP Specified Setting	Primary Care, Outpatient Specialty Care, Hospital, Behavioral Health Outpatient
Data Source	Claims (Only), Electronic Health Record (Only), Registry
Measure Point Value	1

Additional Notes	

MACRA MIPS High Priority Measure.

M1-306: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)*

Measure Description:
Percentage of children and adolescents 1–17 years of age with a new prescription for an antipsychotic, but no indication for antipsychotics, who had documentation of psychosocial care as first-line treatment.

DY7/DY8 Program ID	306
NQF Number	2801
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/2801
Measure Parts	0
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Children and adolescents from the denominator who had psychosocial care as first-line treatment prior to (or immediately following) a new prescription of an antipsychotic.
Denominator Description	Children and adolescents who had a new prescription of an antipsychotic medication for which they do not have a U.S Food and Drug Administration primary indication.
Inclusions	None listed by measure steward.
Exclusions	Exclude children and adolescents with a diagnosis of a condition for which antipsychotic medications have a U.S. Food and Drug Administration indication and are thus clinically appropriate: schizophrenia, bipolar disorder, psychotic disorder, autism, tic disorders.
DSRIP Specified Setting	Behavioral Health Outpatient
Data Source	Claims (Only)
Measure Point Value	1
Additional Notes	

CMS Alignment: Child Core Set;

M1-316: Alcohol Screening and Follow-up for People with Serious Mental Illness

Measure Description:
The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.

DY7/DY8 Program ID	316
NQF Number	2599
Measure Steward	NCQA
Link to Measure Citation	http://www.qualityforum.org/QPS/2599
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.
Denominator Description	All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.
Inclusions	None listed by measure steward.
Exclusions	Active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year (see Alcohol Disorders Value Set).
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, Hospital
Data Source	Claims (Only), Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

M1-317: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description:
Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user

DY7/DY8 Program ID	317
NQF Number	2152
Measure Steward	AMA-convened Physician Consortium for Performance Improvement
Link to Measure Citation	http://www.qualityforum.org/QPS/2152
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user
Denominator Description	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Inclusions	None listed by measure steward.
Exclusions	Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care
Data Source	Electronic Health Record (Only), Registry
Measure Point Value	1
Additional Notes	BAT recommendation to stratify as two rates, ages 18+ and 12 - 17

MACRA MIPS Measure; CCBHC Measure.

M1-319: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)

Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

DY7/DY8 Program ID	319
NQF Number	0104
Measure Steward	AMA-convened Physician Consortium for Performance Improvement
Link to Measure Citation	http://www.qualityforum.org/QPS/0104
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified
Denominator Description	All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Behavioral Health: Outpatient, Primary Care, Outpatient Specialty Care, Hospital
Data Source	Electronic Health Record (Only), Registry
Measure Point Value	1
Additional Notes	

MACRA MIPS Measure; CCBHC Measure.

M1-339: SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge

Measure Description:
The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older 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.

These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge [temporarily suspended]).

DY7/DY8 Program ID	339
NQF Number	1664
Measure Steward	The Joint Commission
Link to Measure Citation	http://www.qualityforum.org/QPS/1664
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	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.
Denominator Description	The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder
Inclusions	None listed by measure steward.
Exclusions	There are 11 exclusions to the denominator as follows: • 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 length of stay less than or equal to three days or greater than 120 days • Patients who do not reside in the United States • Patients receiving Comfort Measures Only documented
DSRIP Specified Setting	Behavioral Health: Inpatient, Hospital
Data Source	Electronic Health Record (Only), Paper Records
Measure Point Value	1
Additional Notes	

M1-340: Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period.

Measure Description:

This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial and pharmacologic treatment options for opioid addiction within the 12 month reporting period.

DY7/DY8 Program ID	340
NQF Number	NA
Measure Steward	APA/NCQA/PCPI
Link to Measure Citation	https://www.qualitymeasures.ahrq.gov/summaries/summary/27958/
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period
Denominator Description	All patients aged 18 years and older with a diagnosis of current opioid addiction
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Behavioral Health Outpatient, Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

M1-341: Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting perio

Measure Description:
This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period.

DY7/DY8 Program ID	341
NQF Number	NA
Measure Steward	APA/NCQA/PCPI
Link to Measure Citation	https://www.qualitymeasures.ahrq.gov/summaries/summary/27965
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period
Denominator Description	All patients aged 18 years and older with a diagnosis of current alcohol dependence
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Behavioral Health Outpatient, Primary Care, Outpatient Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	

M1-342: Time to Initial Evaluation

Measure Description:
Metric #1: The percentage of new consumers with initial evaluation provided within 10 business days of first contact

Metric #2: The mean number of days until initial evaluation for new consumers

DY7/DY8 Program ID	342
NQF Number	NA
Measure Steward	SAMHSA/CCBHC
Link to Measure Citation	https://www.samhsa.gov/section-223/quality-measures
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	The number of consumers in the eligible population who received an initial evaluation within 10 business days of the first contact with the provider entity during the measurement year.
Denominator Description	The number of consumers in the eligible population. Report two age stratifications and a total rate: • 12–17 years as of the end of the measurement year • 18 years and older as of the end of the measurement year • Total (both age groups) Follow the steps below to identify the eligible population: Step 1: Identify new consumers who contacted the provider entity seeking services during the measurement year. Step 2: Identify consumers from step 1 aged 12 years and older as of the end of the measurement year.
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Behavioral Health Outpatient
Data Source	TBD
Measure Point Value	1
Additional Notes	

M1-385: Assessment of Funcitonal Status or QoL (Modified from NQF# 0260/2624)

Measure Description:
Percent of eligible patients who completed a health-related quality of life assessment or functional assessment using a standardized tool at least once during the measurement period.

DY7/DY8 Program ID	385
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	NA
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Number of eligible patients who completed a health-related quality of life assessment or functional assessment using a standardized tool at least once during the measurement period.
Denominator Description	Number of eligible individuals receiving specialty care services during the measurement period
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	For IDD Services

M1-386: Improvement in Functional Status or QoL (Modified from PQRS #435)

Measure Description:
Percent of patients who had a follow up health-related quality of life or functional status assessed during the measurement period whose score stayed the same or improved.

DY7/DY8 Program ID	386
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	TBD
Measure Parts	1
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Patients whose score stayed the same or improved.
Denominator Description	Patients who had a follow up health-related quality of life or functional status assessed during the measurement period
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	Specialty Care
Data Source	TBD
Measure Point Value	1
Additional Notes	For IDD Services

M1-387: Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)

Measure Description:

Rate of ED utilization for substance use conditions or complications

DY7/DY8 Program ID	387
NQF Number	NA
Measure Steward	NA
Link to Measure Citation	https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/DY5/Category-3-Outcomes-Compendium.pdf
Measure Parts	2
Benchmark Description	NA **HPL:** NA **MPL:** NA
Numerator Description	Total number of ED Visits with a primary or secondary diagnosis of (excluding tobacco) substance abuse for any individual 18 years and older during the measurement period
Denominator Description	Total number of ED visits for individuals 18 years or older during the measurement period
Inclusions	None listed by measure steward.
Exclusions	None listed by measure steward.
DSRIP Specified Setting	ED
Data Source	TBD
Measure Point Value	3
Additional Notes	Reported as two rates