



**Quality Measures Inventory  
User Guide and Data Dictionary**

Updated June 2016

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## Abbreviations

<b>Abbrev.</b>	<b>Definition</b>
ACA	Patient Protection and Affordable Care Act of 2010
ASCQR	Ambulatory Surgical Center Quality Reporting Program
CAH	Critical Access Hospitals
CDP	Consensus Development Process (NQF)
CMS	Centers for Medicare and Medicaid Services
HHS	Department of Health and Human Services
eCQM	Electronic Clinical Quality Measure
EH	Eligible Hospital
EHR	Electronic Health Record
ESRD	End-Stage Renal Disease
ESRD QIP	End-Stage Renal Disease Quality Incentive Program
HACRP	Hospital-Acquired Condition Reduction Program
HHS	Department of Health and Human Services
HHQRP	Home Health Quality Reporting Program
HIQR	Hospital Inpatient Quality Reporting Program
HOQR	Hospital Outpatient Quality Reporting Program
HQMF	Health Quality Measures Format
HQRP	Hospice Quality Reporting Program
HRRP	Hospital Readmissions Reduction Program
HVBP	Hospital Value-Based Purchasing Program
IPFQR	Inpatient Psychiatric Facility Quality Reporting Program
IRF QRP	Inpatient Rehabilitation Facility Quality Reporting Program
LTCH QRP	Long-Term Care Hospital Quality Reporting Program
MAP	Measure Applications Partnership
MAT	Measure Authoring Tool
MIF	Measure Information Form
MIPS	Merit-based Incentive Payment System
MSSP	Medicare Shared Savings Program
MUC	Measures under Consideration
MUD	Measures under Development
NQF	National Quality Forum
PCHQR	Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program
PDF	Portable Document Format
PPS	Prospective Payment System
QHP QRS	Qualified Health Plan Quality Rating System
SNF QRP	Skilled Nursing Facility Quality Reporting Program
SNF VBP	Skilled Nursing Facility Value-Based Purchasing Program

## Updates

June 2016: Addition of Measures under Development Chapter  
Updates to programs listed in Quality Measures Inventory

## **INTRODUCTION**

The Centers for Medicare and Medicaid Services (CMS) publishes the CMS Quality Measures Inventory to comply with Section 3014 of the Patient Protection and Affordable Care Act of 2010 (ACA), which created sections 1890A of the Social Security Act and requires the Department of Health and Human Services (HHS) to develop a process for dissemination of quality measures. CMS posts a full list of quality measures used within CMS programs bi-annually. Measures include those which have been proposed, finalized, or removed through the federal rulemaking process. The CMS Quality Measures Inventory lists each measure by program, reporting measure specifications including, but not limited to, numerator, denominator, exclusion criteria, National Quality Strategy (NQS) domain, measure type, and National Quality Forum (NQF) endorsement status.

### ***Purpose***

CMS created this document to provide definitions of terms used within the Measures Inventory, as well as, assist stakeholders in utilizing the CMS Quality Measures Inventory.

The CMS Quality Measures Inventory is maintained by the CMS Measures Management System (MMS) Contractor. Questions regarding the Measures Inventory or this User Guide can be sent to the MMS Support Desk at the email listed below.

#### **Helpful Hints:**

For help with the CMS Quality Measures Inventory or this User Guide, email the CMS MMS Helpdesk at [mmssupport@battelle.org](mailto:mmssupport@battelle.org)

## ***How to Navigate the Document***

Headings in this document have been bookmarked to facilitate navigation. Where possible, screen shots have also been added to aid in the Measures Inventory navigation process.

Slight differences between the screen shots and text in this User Guide compared with the posted Measures Inventory may be noted. Differences can result from users utilizing different versions of Excel to view the CMS Quality Measures Inventory. Users can refer to Excel assistance tools such as <https://support.office.com/en-us/excel>.

## **CHAPTER 1: PROGRAMS**

### ***1.1 Represented Programs***

The CMS Quality Measures Inventory contains measures utilized within the following Programs.

- Ambulatory Surgical Center Quality Reporting Program
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Home Health Quality Reporting Program
- Home Health Value Based Purchasing Program
- Hospice Quality Reporting Program
- Hospital-Acquired Condition Reduction Program
- Hospital Compare
- Hospital Inpatient Quality Reporting Program
- Hospital Outpatient Quality Reporting Program
- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing Program
- Inpatient Psychiatric Facility Quality Reporting Program
- Inpatient Rehabilitation Facility Quality Reporting Program
- Long-Term Care Hospital Quality Reporting Program
- Medicaid Adult Core Measure Set
- Medicaid Child Core Measure Set
- Medicare Physician Quality Reporting System (PQRS) Program
- Medicare Shared Savings Program (MSSP)
- Merit-Based Incentive Payment System (MIPS)
- Million Hearts
- Physician Compare
- Physician Feedback/Quality and Resource Use Reports (QRUR) Program
- Physician Value-Based Payment Modifier (VBM) Program
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program
- Quality Health Plan Quality Rating System (QHP QRS)
- Skilled Nursing Facility Quality Reporting Program
- Skilled Nursing Facility Value-Based Purchasing Program

For more information the programs listed above and the Measures Management System visit:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/index.html>

## **1.2 Future Programs**

Upcoming versions of the CMS Quality Measures Inventory will include measures from additional or newly mandated programs such as, but not limited to:

- Electronic Clinical Quality Measures (eCQM)
- Core Quality Measures

### **Helpful Hints:**

To learn more about CMS Quality Strategy visit:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html>

## **CHAPTER 2: DATA DICTIONARY**

The following is a list of data fields used throughout the CMS Quality Measures Inventory and their definitions. Additional fields, such as condition, and Federal Register publication dates, will be added in future postings of the CMS Quality Measures Inventory.

### ***2.1 Measure Specifications***

**1. Measure ID:**

Unique measure identification number. This measure ID incorporates a program number and measure number. For example, a Home Health measure may contain a measure ID 0180, while Home Health Quality Reporting Program may be labeled as program number 10. Therefore the unique measure ID for this measure in Home Health Quality Reporting Program is 0180-10.

**2. Program:**

CMS Program as designated by legislation, rule or policy.

**3. Measure Group:**

Program- specific measure identification code or label used by programs to group common measures together; often reported on as a group, e.g., IMM-2, Diabetic Retinopathy Measures Group.

**4. Measure Title:**

Name of the measure as listed within the Federal Register or measure specification documents.

**5. Measure Description:**

Summary of measure specifications, such as medical conditions to be measured, particular outcomes or results that could or should result from the care specified in the measure for these patient populations.

**6. Numerator:**

The numerator reflects the subset of patients in the denominator for whom a particular service has been provided or for whom a particular outcome has been achieved.

**7. Denominator:**

The lower part of a fraction used to calculate a rate, proportion, or ratio. The denominator is associated with a given patient population that may be counted as eligible to meet a measure's inclusion requirements.

**8. Exclusions:**

Specifications of those characteristics that would cause groups of individuals to be removed from the numerator and/or denominator of a measure although they experience the denominator index event. For instance, the denominator index event may specify a discharge diagnosis, but patients with certain co-morbidities may be excluded.

**9. Status:**

Refers to the action taken by the program in the Federal Rule on a specific measure.

- Proposed      A measure proposed for use within a CMS Program via a Federal Rule.
- Rescinded      The proposal to incorporate a measure into a program has been rescinded via Federal Rule. The measure will not be finalized or implemented.
- Finalized      The proposal to incorporate a measure into a CMS program has been finalized per Federal Rule. The measure will be implemented within a designated timeframe.
- Implemented    A measure which is both finalized and currently used within a CMS program.
- Suspended      A finalized measure, which has been suspended from current use within a program. The measure is no longer implemented.
- Removed        A measure which has been removed from a CMS program via Federal Rule. The measure is no longer implemented.

## 10. Measure Type:

Refers to the domain of quality that a measure assesses

- Composite  
A measure that contains two or more individual measures, resulting in a single measure and a single score. Composite measures may be composed of one or more process measures and/or one or more outcome measures.
- Cost/Resource  
Broadly applicable and comparable measures of health service counts. A resource measure counts the frequency of defined health system resources; some may further apply a dollar amount to each unit of resource.
- Efficiency  
Refers to a measure concerning the cost of care associated with a specified level of health outcome.
- Outcome  
A measure that assesses the results of healthcare that are experienced by patients: clinical events, recovery and health status, experiences in the health system, and efficiency/cost.
- Process  
A measure that focuses on steps that should be followed to provide good care. There should be a scientific basis for believing that the process, when executed well, will increase the probability of achieving a desired outcome
- Patient Reported Outcome  
A measure that focuses on a patient's report concerning observations of and participation in health care.
- Structural  
A structural measure is one that assesses features of a healthcare organization or clinician relevant to its capacity to provide healthcare.

## 11. National Quality Forum (NQF) ID:

Identification number assigned by the National Quality Forum.

## **12. NQF Status:**

Status provided by the National Quality Forum

[http://www.qualityforum.org/Field\\_Guide/](http://www.qualityforum.org/Field_Guide/)

- Endorsed
- Endorsement Removed
- Endorsed-Time Limited
- Endorsed-Reserved
- Not Endorsed

## **13. National Quality Strategy (NQS) Domain:**

Six priorities supporting the National Quality Strategy three overarching aims: Better Care, Healthy People/ Healthy Communities and Affordable Care.

- Ensuring that Each Person and Family is Engaged as Partners in their Care
- Making Care Safer by Reducing Harm Caused in the Delivery of Care
- Making Quality Care More Affordable
- Promoting Effective Communication and Coordination of Care
- Promoting the Most Effective Prevention and Treatment Practices for the Leading Causes of Mortality
- Working with Communities to Promote Wide Use of Best Practices to Enable Healthy Living

## **14. Program Quality Domain:**

Program specific domains based on the National Quality Strategy domains. Examples of program specific domains include:

- Affordable Care
- Clinical Care
- Clinical Quality of Care
- Communication & Care Coordination
- Community/Population Health
- Effective Communication and Care Coordination
- Effective Clinical Care
- Efficiency and Cost Reduction
- Health and Wellbeing
- Patient Safety
- Person and Caregiver-Centered Experience Outcomes
- Patient and Caregiver-Centered Experience of Care/Care Coordination
- Person/Family Centered Care
- Safety

**15. Condition:**

A disease, illness or injury including physiologic, mental or psychological disorder (e.g., Cardiovascular Disease, Malignant Neoplasm).

**16. Sub-condition**

A specific disease, illness or injury including physiologic, mental or psychological disorder (e.g., heart failure, breast cancer). Also includes disease, illness or injury impacting a condition population (e.g., hepatitis A within patients who have hepatitis C).

**17. Target Population:**

Specific age range the measure targets. e.g., 65-85

**18. Data Source**

Type of data used within a measure specification.

- Claims
- Electronic Health Record
- Paper Medical Records
- Registry

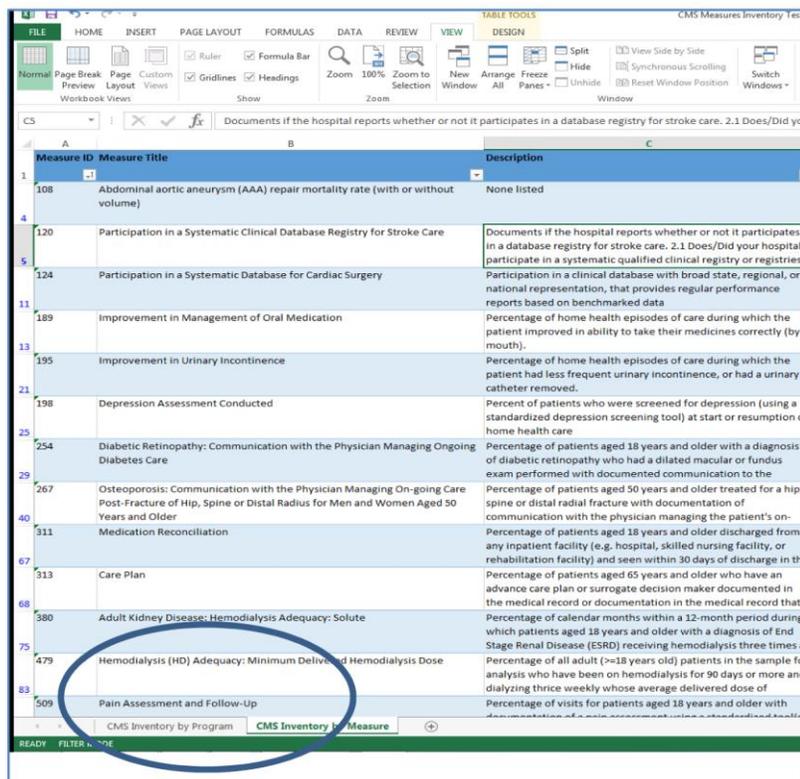
## CHAPTER 3: NAVIGATING THE INVENTORY

The CMS Quality Measures Inventory is presented as a table within an Excel spreadsheet. Each column header has been set-up with a filter function to ease navigation of the measures.

### 3.1 Inventory Tabs

The inventory has been split into two tabs:

- 1 Quality Measures Inventory by Program  
Lists each measure by program. Measures used by more than one program will be listed multiple times.
- 2 Quality Measures Inventory by Measure  
Lists each measure individually and provides a list of the programs that are either currently using the measure or have implemented the measures in the past.



Measure ID	Measure Title	Description
108	Abdominal aortic aneurysm (AAA) repair mortality rate (with or without volume)	None listed
120	Participation in a Systematic Clinical Database Registry for Stroke Care	Documents if the hospital reports whether or not it participates in a database registry for stroke care. 2.1 Does/Did your hospital participate in a systematic qualified clinical registry or registries
124	Participation in a Systematic Database for Cardiac Surgery	Participation in a clinical database with broad state, regional, or national representation, that provides regular performance reports based on benchmarked data
189	Improvement in Management of Oral Medication	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly (by mouth).
195	Improvement in Urinary Incontinence	Percentage of home health episodes of care during which the patient had less frequent urinary incontinence, or had a urinary catheter removed.
198	Depression Assessment Conducted	Percent of patients who were screened for depression (using a standardized depression screening tool) at start or resumption of home health care
254	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the
267	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's on-
311	Medication Reconciliation	Percentage of patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days of discharge in the
313	Care Plan	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
380	Adult Kidney Disease: Hemodialysis Adequacy: Solute	Percentage of calendar months within a 12-month period during which patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis three times a
479	Hemodialysis (HD) Adequacy: Minimum Delivered Hemodialysis Dose	Percentage of all adult (>=18 years old) patients in the sample for analysis who have been on hemodialysis for 90 days or more and dialyzing thrice weekly whose average delivered dose of
509	Pain Assessment and Follow-Up	Percentage of visits for patients aged 18 years and older with

Figure 1: CMS Quality Measures Inventory Measures File Tabs

### 3.2 Filtering by Program

- 1 Under the column 'Program' select the down arrow to show all of the programs listed in the inventory

Program ID	Measure ID	Program	Measure Title	Description	Numerator	Denominator	Exclusions
14	2	Hospital Inpatient Quality Reporting	Aspirin at arrival for acute myocardial infarction (AMI)	Percentage of acute myocardial infarction (AMI) patients who received aspirin within 24 hours before or after hospital arrival	AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM])	AMI patients	Patients less than 18 years of age; Patients who have a Length of Stay greater than 120 days; Patients with
14	4	Hospital Inpatient Quality Reporting	Aspirin prescribed at discharge for AMI	Percentage of acute myocardial infarction (AMI) patients who are prescribed aspirin at hospital discharge	AMI patients who are prescribed aspirin at hospital discharge	AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM])	Excluded Populations: <18 years of age; Patients who have a length of stay greater than 120 days; Patients
14	6	Hospital Inpatient Quality Reporting	ACE/ARB for LVSD	Acute myocardial infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) who are prescribed an	AMI patients who are prescribed an ACEI or ARB at hospital discharge.	AMI patients with LVSD	Patients enrolled in clinical trials
14	7	Hospital Inpatient Quality Reporting	Adult smoking cessation advice/counseling	Acute myocardial infarction (AMI) patients with a history of smoking cigarettes, who are given smoking cessation advice	NONE in CMS UPDATE	NONE in CMS UPDATE	Discharged to another hospital
14	10	Hospital Inpatient Quality Reporting	Beta-blocker prescribed at discharge for AMI	Percentage of acute myocardial infarction (AMI) patients who are prescribed a beta-blocker at hospital discharge	AMI patients who are prescribed a beta-blocker at hospital discharge	AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM])	Discharged to home for hospice care
14	13	Hospital Inpatient Quality Reporting	Fibrinolytic Therapy received within 30 minutes of hospital arrival	Percentage of acute myocardial infarction (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving fibrinolytic	AMI patients whose time from hospital arrival to fibrinolytic is 30 minutes or	Principal diagnosis of AMI (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM])	Exclusions: <18 years of age; Patients who have a length of stay greater than 120 days

Figure 2: CMS Quality Measures Inventory Program Column

- 2 Select the desired program and press 'ok' – Only measures associated with the selected program(s) will be shown.

Program ID	Measure ID	Program	Measure Title	Description	Numerator	Denominator	Exclusions
14	2	Hospital Inpatient Quality Reporting	Aspirin at arrival for acute myocardial infarction (AMI)	Percentage of acute myocardial infarction (AMI) patients who received aspirin within 24 hours before or after hospital arrival	AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM])	AMI patients	Patients less than 18 years of age; Patients who have a Length of Stay greater than 120 days; Patients with
14	4	Hospital Inpatient Quality Reporting	Aspirin prescribed at discharge for AMI	Percentage of acute myocardial infarction (AMI) patients who are prescribed aspirin at hospital discharge	AMI patients who are prescribed aspirin at hospital discharge	AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM])	Excluded Populations: <18 years of age; Patients who have a length of stay greater than 120 days; Patients
14	6	Hospital Inpatient Quality Reporting	ACE/ARB for LVSD	Acute myocardial infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) who are prescribed an	AMI patients who are prescribed an ACEI or ARB at hospital discharge.	AMI patients with LVSD	Patients enrolled in clinical trials
14	7	Hospital Inpatient Quality Reporting	Adult smoking cessation advice/counseling	Acute myocardial infarction (AMI) patients with a history of smoking cigarettes, who are given smoking cessation advice	NONE in CMS UPDATE	NONE in CMS UPDATE	Discharged to another hospital
14	10	Hospital Inpatient Quality Reporting	Beta-blocker prescribed at discharge for AMI	Percentage of acute myocardial infarction (AMI) patients who are prescribed a beta-blocker at hospital discharge	AMI patients who are prescribed a beta-blocker at hospital discharge	AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM])	Discharged to home for hospice care
14	13	Hospital Inpatient Quality Reporting	Fibrinolytic Therapy received within 30 minutes of hospital arrival	Percentage of acute myocardial infarction (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving fibrinolytic	AMI patients whose time from hospital arrival to fibrinolytic is 30 minutes or	Principal diagnosis of AMI (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM])	Exclusions: <18 years of age; Patients who have a length of stay greater than 120 days

Figure 3: CMS Quality Measures Inventory Filtered by Program

### 3.3 Filtering by Program and Status

Users can filter by any column listed within the inventory. It is also possible to filter by more than one column at a time. For example, a user may wish to see only the finalized measures within the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. So, once the inventory has been filtered to show only the IPFQR measures:

1. Scroll over to the 'Status' column, and filter by 'Finalized'

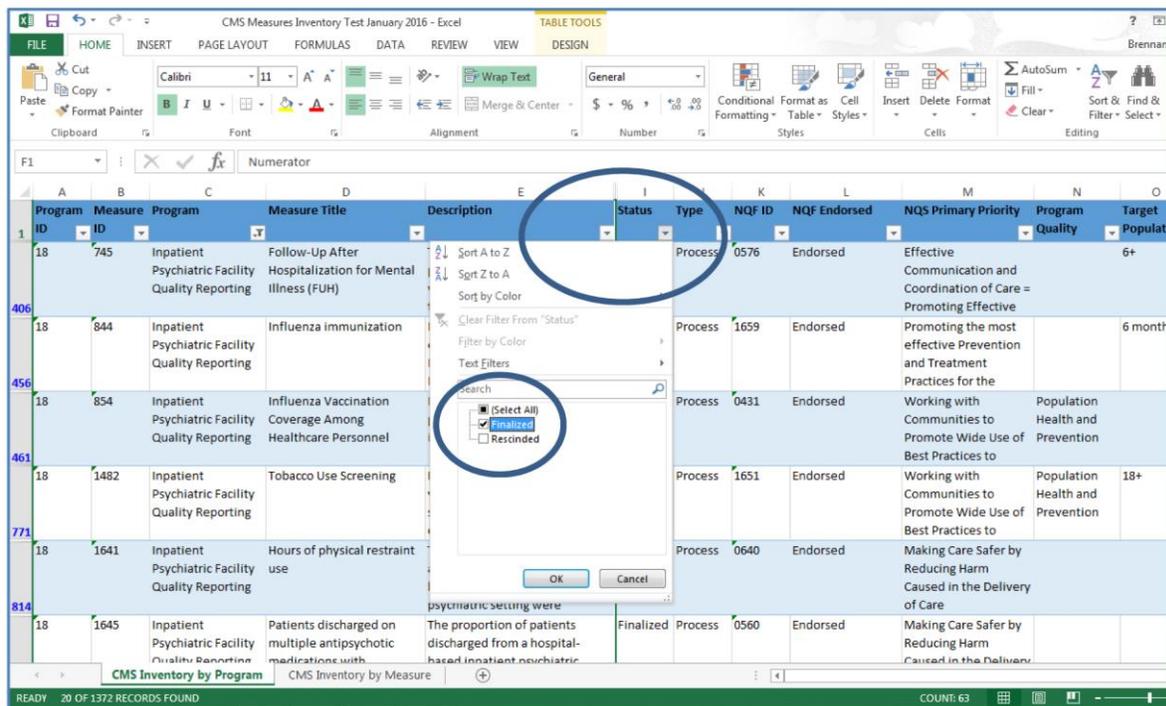


Figure 4: CMS Quality Measures Inventory Filtered by Status

Users can use the filters to narrow down the list of measures by many columns at once. For example, a user who wanted to only see finalized, outcome measures, which were also NQF endorsed would:

- 1 Select 'Finalized' within the 'Status' column
- 2 Select 'Outcome' under the 'Type' Column
- 3 Select 'Endorsed' under 'NQF Status'

### 3.4 Clearing Filters

Users can easily reset the inventory to show all of the measures after filtering.

- 1 Select the 'HOME' tab along the bar at the top of the Excel page,
- 2 Select 'Filter and Sort'
- 3 Select 'Clear'

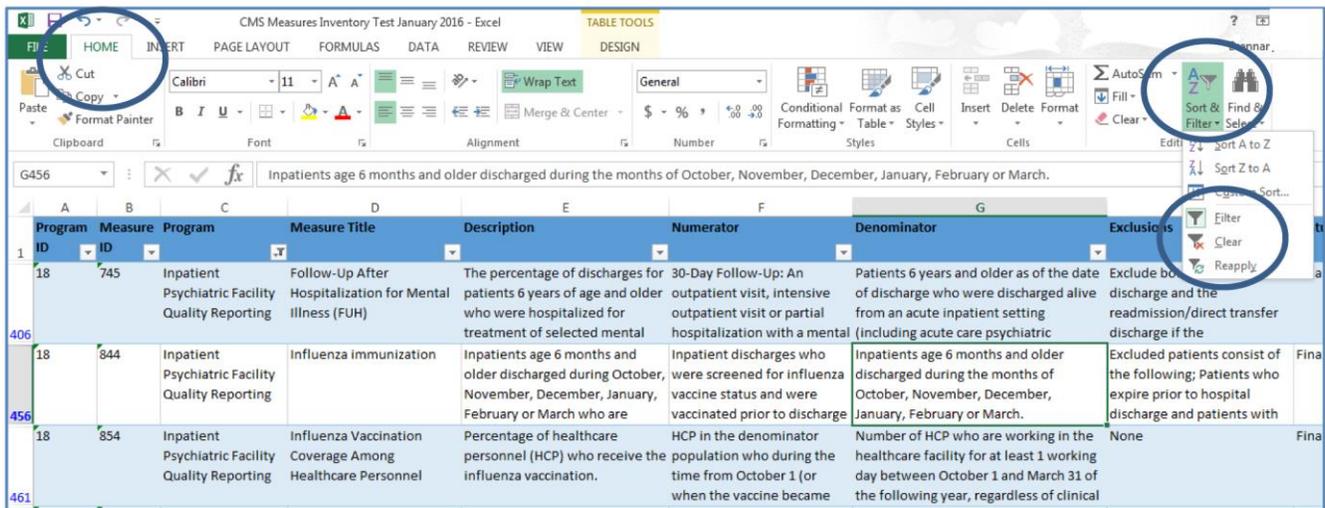


Figure 5: CMS Quality Measures Inventory Filters Cleared

#### Helpful Hints:

Creating a filter is as easy as clearing them. Instead of selecting 'Clear' select 'Filter'

## **CHAPTER 4. MEASURES UNDER DEVELOPMENT**

The Measures under Development (MUD) List is meant to serve as a resource for CMS Program and Measure Leads, contractors, and measure developers to ensure awareness of measures that are being developed for CMS programs. The MUD list is not the same as the Measures under Consideration (MUC) list. CMS has not made a final determination of any kind with respect to any specific measure on the MUD list. The MUD list is provided for the purposes of transparency, promoting harmonization, and alignment of quality improvement efforts. If CMS decides to include a measure for consideration in the Medicare programs covered under ACA 3014, the measure will be published on the MUC list and clear CMS's pre-rulemaking and rulemaking processes.

### ***4.1 Data Sources***

The Measures under Development (MUD) List is currently compiled from two sources. These sources include measure information that measure developers submitted to the MIDS Resource Library and measures that were submitted as part of pre-rulemaking in 2014 or 2015. Any measure that was submitted to the MUC List, but was not approved by the CMS program, is retained on the MUD List. The MUD List is reviewed by CMS program leads to validate the accuracy of the measure information, as well as to designate any confidential measures so that those measures are not publicly posted.

### ***4.2 Measure Specifications***

In order to maintain consistency with the data fields used in the CMS Measures Inventory, the following is a list of data fields and their definitions are included in the MUD List. Additional fields that are not applicable to the CMS Measures Inventory, but are relevant to the MUD List are also defined below. The measures specifications included in the MUD List are as complete as the data that was able to be abstracted from the data sources. As these measures are varying in level of development, not all measures will have final or thorough specifications available.

#### ***4.2.1 Data Fields Consistent with the CMS Measures Inventory***

1. CMS Program
2. Program Domain (if applicable)
3. Measure Title
4. Description
5. Numerator
6. Denominator
7. Exclusions
8. Measure Type
9. Measure Status

All measures have the status of “Under Development” meaning: A measure in the conceptualization, development, or testing phase. The measure has not been designated as under Consideration for incorporation within a CMS program.

10. NQF ID
11. Data Source
12. NQS Priority/Domain(s)

#### ***4.2.2 Data Fields Unique to the MUD List***

##### **13. Measure Steward**

Refers to the primary (and secondary, if applicable) party responsible for updating and maintaining a measure

##### **14. Measure Developer**

Refers to the organization, contractor, or partnering agencies responsible for conceptualizing, developing, and testing a measure in preparation for consideration for a CMS program.

##### **15. MUC Year (if applicable)**

If a measure was submitted to the pre-rulemaking process, but ultimately declined by a CMS program, this column contains the year the measure was submitted for consideration.

##### **16. MAP Year (if applicable)**

If a measure was submitted to the pre-rulemaking process, was accepted by a program, but then during the MAP review process was found to be not supported and ultimately removed from consideration, this column contains the year that the MAP review was published.

#### ***4.3 Navigating the MUD List***

The MUD List, similarly to the CMS Quality Measures Inventory, is presented as a table within an Excel spreadsheet. Each column header has been set-up with a filter function to ease navigation of the measures. In order to search for measures of interest, the filtering instructions from [Chapter 3](#) apply. You can apply a filter on multiple columns at a time to help narrow the search for measures.

## **CHAPTER 5. UPDATES**

The CMS Quality Measures Inventory and MUD list will be updated on the CMS Inventory Website twice a year, in February and July. The User Guide will be updated as needed to reflect changes in the Quality Measures Inventory content or structure.

## **APPENDIX A: GLOSSARY**

CMS has included a list of terms for clarity and consistency. For a more detailed list of common properties used in health care measure development, go to:

<http://www.qualitymeasures.ahrq.gov/about/glossary.aspx>

### **Accountable Care Organizations**

Umbrella organizations that provide coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organizations are paid for an episode of care and distribute funds to the providers who participate in that care. The organizations' payments are tied to achieving health care quality goals and outcomes that result in cost savings.

### **Administrative clinical data**

Data such as enrollment or eligibility information, claims information, and managed care encounters. The claims and encounters may be for hospital and other facility services, professional services, prescription drug services, laboratory services, and so on, gathered from billing codes or other coding systems. This refers to information that is collected, processed, and stored in automated information systems.

### **Administrative management data**

Data that describe attributes of delivery organizations, staff, equipment, non-clinical operations, and financing.

### **Ambulatory/Office-based Care**

Health care services provided to patients on an ambulatory basis rather than by admission to a hospital or other health care facility. The services may be provided by a hospital augmenting its inpatient services or may be provided at a free-standing facility.

### **Ambulatory Procedure/Imaging Center**

Health care facilities where diagnostic imaging services and/or surgical procedures not requiring an overnight hospital stay are performed. Comprehensive care including pre-screening, pain management and post-operative nursing care is provided. Services include acupuncture, angiography, biopsy, chemotherapy, computed tomography, lab tests, laser medicine, magnetic resonance imaging (MRI), radiography, electrocardiography (ECG), endoscopy, hemodialysis, palliative care, physical therapy, radiation therapy, ultrasonography, and various outpatient surgeries.

### **Ancillary Services**

Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy, which are provided in conjunction with medical or hospital care.

### **Assisted Living Facilities**

Long-term care facilities that typically permit residents to live in their own apartments or rooms. They provide services such as meals, housekeeping, 24-hour security, on site staff for

emergencies, and social programs. Assisted living facilities may also offer assistance with personal care, medications, and other activities of daily living.

**Behavioral Health Care**

Health care services organized to provide mental health care, which may include diagnostic, therapeutic, and preventive mental health services; therapy and/or rehabilitation for substance-dependent individuals; and the use of community resources, individual case work, or group work to promote the adaptive capacities of individuals in relation to their social and economic environments.

**Clinical Practice Guideline**

Gives users an identifier to refer to a measure. Clinical practice guidelines are statement that include recommendations intended to optimize patient care that are informed by systematic review of evidence and an assessment of the benefits and harm of alternative care options.

**Clinical training documentation**

The recording of the details of educational and related activities intended to augment the skills and knowledge of clinical personnel.

**CMS Program(s)**

Refers to the applicable Medicare program(s) that may adopt the measure through rulemaking in the future.

**Community Health Care**

Diagnostic, therapeutic, and preventive health care services provided for individuals or families in the community for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability. Community health care takes a public health perspective of addressing the health of all residents in a community and undertaking health education and other public health measures as well as delivery of personal health care. Classic examples of community health care are the federally funded community health centers, most of which are in towns and cities.

**Composite**

A combination of two or more component measures, each of which individually reflects quality of care, into a single performance measure with a single score.

**Composite Measure**

A combination of two or more component measures, each of which individually reflects quality of care, into a single performance measure with a single score.

**Cost/Resource Use**

Counting the frequency of units of defined health system services or resources; some may further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource use (i.e., monetize the health service or resource use units).

**Data Source**

Identifies the data source(s) necessary to implement the measure.

**Denominator**

The lower part of a fraction used to calculate a rate, proportion, or ratio. The denominator is associated with a given patient population that may be counted as eligible to meet a measure's inclusion requirements.

**Description**

Gives users more detailed information about the measure, such as medical conditions to be measured, particular outcomes or results that could or should/should not result from the care and patient populations.

**Documentation of organizational self-assessment**

An organization's record keeping of its identifiable strengths and noticeable gaps in agency performance. The assessment serves to provide agencies with the means to evaluate and understand their own systems and program operations in order to strengthen the services delivered to the community and gain accreditation.

**Efficiency**

Refers to a relationship between a specific level of quality of health care provided and the resources used to provide that care.

**Electronic health/medical record**

In health informatics, an electronic medical record (EMR) is considered to be one of several types of electronic health records (EHRs), but EMR and EHR are also used interchangeably. EHRs are sometimes defined as including other systems that keep track of medical information, such as practice management software that facilitates the day-to-day operations of a medical practice. Such software frequently allows users to capture patient demographics, schedule appointments, maintain lists of insurance payers, perform billing tasks, and generate reports.

**eMeasure**

Performance measures that have been specified such that they can be implemented using data directly from electronic health records (EHR) or other electronic data sources, without manual coding or abstraction from paper records.

**Emergency Department**

A section of an institution that is staffed and equipped to provide rapid and varied emergency care, especially for those who are stricken with sudden and acute illness or who are the victims of severe trauma.

**Emergency Medical Services**

Services specifically designed, staffed, and equipped for the emergency care of patients.

**Exclusion Criteria**

Specifications of those characteristics that would cause groups of individuals to be removed from the numerator and/or denominator of a measure although they experience the

denominator index event. For instance, the denominator index event may specify a discharge diagnosis, but patients with certain co-morbidities may be excluded.

**Exclusions**

Exclusions are patients included in an initial population for whom there are valid reasons a process or outcome of care has not occurred. These cases are removed from the denominator. When clinical judgment is allowed, these are referred to as “exceptions”. Denominator exceptions fall into three general categories: medical reasons, patients’ reasons, and system reasons. Exceptions must be captured in a way that they could be reported separately.

**Exclusions/Exceptions**

Characteristics defined during the delivery of care that would mean that care specified in the numerator was contraindicated, refused by the patient, or not possible for some other compelling and particular circumstance of this case.

**External audit**

A review of a health care organization by a separate organizational entity that examines structures in the health care setting (e.g., facilities, staffing, or the availability of drugs and equipment) or the management of particular clinical or administrative processes.

**Health professional survey**

An investigation aimed at gathering information from health professionals to search and disseminate information relating to their professions.

**Home Care**

Community health and nursing services providing coordinated multiple service home care to the patient. It includes home-offered services provided by visiting nurses, home health agencies, hospitals, or organized community groups using professional staff for care delivery.

**Hospices**

Facilities or services that are specifically devoted to providing palliative and supportive care to the patient with a terminal illness and to the patient's family.

**Hospital Inpatient**

A hospital setting in which patients are admitted for diagnosis or treatment that requires at least one overnight stay.

**Hospital Outpatient**

A hospital setting in which patients are admitted for diagnosis or treatment that does not require at least one overnight stay.

**Hospital - Other**

A hospital setting that cannot be characterized as "hospital inpatient," "hospital outpatient," "intensive care units," or "emergency room."

**Imaging data**

Data derived from the use of radiographic, sonographic, and other technologies.

**Inclusion Criteria**

Specifications of the characteristics that define membership in a group. (a) Denominator inclusion criteria define those individuals or events that are included in the denominator of a measure. (b) Numerator inclusion criteria define those individuals or events, already defined as belonging to the denominator, that are also included in the numerator of a measure. (c) NQMC Inclusion Criteria are used to define those among submitted measures that can be included in NQMC.

**Inspections/Site visits**

A formal visit to a hospital or health care facility by representatives from an accrediting organization (e.g., The Joint Commission [TJC], Centers for Medicare & Medicaid Services [CMS]) to assess the quality of care provided in the institution, as reflected by the facility's adherence to guidelines for providing such care.

**Intensive Care Units**

A hospital unit in which is concentrated special equipment and specially trained personnel for the care of seriously ill patients requiring immediate and continuous attention.

**Intermediate Outcome**

Refers to a change produced by a health care intervention that leads to a longer term outcome (e.g., a reduction in blood pressure is an intermediate outcome that leads to a reduction in the risk of longer term outcomes such as cardiac infarction or stroke).

**Laboratory data**

Data collected from a site equipped for experimentation, observation, testing and analysis, or practice in a field of study. In regards to clinical practice, laboratory data may provide information on diagnosis, prognosis, prevention, or treatment of disease based on close examination of the human body.

**Long-term Care Facilities — Other**

Long-term care facilities that cannot be characterized as "assisted living facilities" or "skilled nursing facilities/nursing homes."

**Managed Care Plans**

Health insurance plans intended to reduce unnecessary health care costs through a variety of mechanisms, including economic incentives for physicians and patients to select less costly forms of care, programs for reviewing the medical necessity of specific services, increased beneficiary cost sharing, controls on inpatient admissions and lengths of stay, the establishment of cost-sharing incentives for outpatient surgery, selective contracting with health care providers, and the intensive management of high-cost health care cases. The programs may be provided in a variety of settings, such as health maintenance organizations (HMO), independent practice associations (IPA), and preferred provider organizations (PPO), etc.

**Measure Steward**

Refers to the primary (and secondary, if applicable) party responsible for updating and maintaining a measure

**Measure Title**

Refers to the title of the measure.

**Measure Type**

Refers to the domain of quality that a measure assesses

**Measurement Setting**

The setting for which the measure was developed.

**National public health data**

Public health data include national health status (gathered through birth and death certificates, hospital discharge diagnoses, other epidemiologic sources), communicable disease (food/water/air/waste/vector borne), environmental health risks, presence of and use of health care facilities and providers, preventive services, and other information identified by the nation as helpful for planning.

**National Public Health Programs**

An officially authorized entity concerned with the prevention and control of disease and disability and the promotion of physical and mental health of the population on the national level.

**Numerator**

The numerator reflects the subset of patients in the denominator for whom a particular service has been provided or for whom a particular outcome has been achieved.

**Organizational policies and procedures**

Refers to the principles and methods, whether formalized, authorized, or documented, that enable people affiliated with an organization to perform in a predictable, repeatable, and consistent way.

**Outcome**

The health state of a patient (or change in health status) resulting from healthcare- desirable or adverse.

**Paper medical record**

A collection of hard-copy documents compiled and maintained by health care professionals in the course of providing care to patients.

**Patient-centered Medical Homes**

Primary care facilities that adopt a model of providing coordinated, relationship-based care with an orientation toward the whole person. Patient-centered medical homes involve changes to the way care is organized, paid for, and certified. The model is centered on partnering with patients and their families, and requires understanding of and respect for each patient's unique needs, culture, values, and preferences.

**Patient/Individual survey**

An instrument that assesses patients' perspectives on any of the following: their health and the care they receive, including the level of patients' satisfaction, or patients' understanding of their health status.

**Patient Reported Outcome**

Information about the patient, as communicated by that person.

**Patient Reported Outcome Measure**

An instrument, scale, or single-item measure that gathers the information directly from the patient.

**Patient Reported Outcome-Based Performance Measure**

A way to aggregate the information that has been shared by the patient and collected into a reliable, valid measure of health system performance.

**Pharmacy data**

A database that provides information on prescription and/or dispensing of drug and non-drug products that may be obtained from a pharmacy (retail or health care institution-based). The information provided may include clinical attributes such as the product's ingredients (e.g., ampicillin), drug classes (e.g., antibiotics, penicillins), strength (e.g., 500mg), and form (e.g., capsule). Non-clinical information provided may include manufacturer (e.g., Merck), packaging (e.g., 500 per bottle), and price (e.g., \$2 per 500).

**Population Health**

The health states of a group of individuals, including the distribution of such states within the group. There are multiple determinants of such health states, however measured. These determinants include medical care, public health interventions, aspects of the social environment (income, education, employment, social support, culture) and of the physical environment (urban design, clean air and water), genetics, and individual behavior.

**Population Health Quality**

The degree of accomplishment of desired population health objectives by a public health practitioner or organization or by the health system serving a geographically or otherwise non-clinically-identified group of people.

**Population Health Quality Measure**

A mechanism to assess the degree to which public health providers or the health system serving a population effectively and safely delivers health services that are appropriate for the population in the optimal time period.

**Process**

A healthcare service provided to, or on behalf of, a patient. This may include, but is not limited to, measures that may address adherence to recommendations for clinical practice based on evidence or consensus.

**Provider characteristics**

Specific descriptive information about the clinician provider or the facility caring for the patient.

**Rationale for the Measure**

The rationale is a brief statement describing the patients and the specific aspect of health care to which the measure applies. The rationale may also include the evidence basis for the measure and an explanation of how to interpret results.

**Region, county, or city public health data**

Public health data include community health status on a region/county/city level (gathered through birth and death certificates, hospital discharge diagnoses, local surveys, other epidemiologic sources), communicable disease (food/water/air/waste/vector borne), environmental health risks, presence of and use of health care facilities and providers, preventive services, and other information identified by the local community as helpful for planning.

**Regional, County, or City Public Health Programs**

An officially authorized entity concerned with the prevention and control of disease and disability and the promotion of physical and mental health of the population on the regional, county, or city level.

**Registry data**

Data derived from an organized system for the collection, storage, retrieval, analysis, and dissemination of information on individual persons who have a clinical condition that predisposes them to the occurrence of a health-related event, or prior exposure to substances (or circumstances) known or suspected to cause adverse health effects.

**Rehabilitation Centers**

Facilities/programs that provide interventions and support services intended for rehabilitating individuals with mental illnesses or physical disabilities.

**Residential Care Facilities**

Communal living facilities for residents who, though unrelated, live together. Includes group homes, halfway houses, and orphanages.

**Rural Health Care**

Rural health care generally refers to health care services provided to patients who live in rural areas. The services include the promotion of health and the delivery of health care. Some measures specifically address the challenges of delivering quality of care in the special circumstances of rural settings where travel distances are long and public transportation is virtually non-existent.

**Skilled Nursing Facilities/Nursing Homes**

Long-term care facilities that house chronically ill, usually elderly patients, and provide long-term nursing care, rehabilitation, and other services.

**State/Province public health data**

Public health data include community health status on a state/province level (gathered through birth and death certificates, hospital discharge diagnoses, statewide and local surveys, other epidemiologic sources), communicable disease (food/water/air/waste/vector borne), environmental health risks, presence of and use of health care facilities and providers, preventive services, and other information identified by the community as helpful for planning.

**State/Provincial Public Health Programs**

An officially authorized entity concerned with the prevention and control of disease and disability and the promotion of physical and mental health of the population on the state level.

**Structure**

Features of a healthcare organization or clinician relevant to the capacity to provide healthcare. This may include, but is not limited to, measures that address health IT infrastructure, provider capacity, systems, and other healthcare infrastructure supports.

**Substance Use Treatment Programs/Centers**

Facilities/programs providing therapy and/or rehabilitation for substance-dependent individuals. Includes inpatient programs and outpatient programs (e.g., methadone distribution centers).

**Target Population**

This refers to the entire group of individuals or objects to which researchers are interested in generalizing the conclusions. Individuals/events in the denominator of a measure are sampled from a target population whose care the measure is intended to represent.

**Transition**

The transfer of a patient or responsibility for a patient between providers, settings, or time points.