Quality Measures Inventory

User Guide and Data Dictionary

Updated October 2017

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Abbreviations

Abbrev.	Definition
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)
CMIT	CMS Measures Inventory Tool
CMS	Centers for Medicare and Medicaid Services
DHHS	Department of Health and Human Services
eCQM	Electronic Clinical Quality Measure
EH	Eligible Hospital
EP	Eligible Professional
EHR	Electronic Health Record
ESRD	End-Stage Renal Disease
ESRD QIP	End-Stage Renal Disease Quality Incentive Program
HACRP	Hospital-Acquired Condition Reduction Program
HEDIS	Healthcare Effectiveness Data and Information Set
HHQRP	Home Health Quality Reporting Program
HHVBP	Home Health Value-Based Purchasing 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
NHQI	Nursing Home Quality Initiative
PACE	Program for All-Inclusive Care for the Elderly
PCHQR	Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program
PDF	Portable Document Format
PPS	Prospective Payment System
QHP	Qualified Health Plan

Abbrev.	Definition
QRS	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

February 2017: Addition of Measures under Consideration Chapter
                Updates to programs listed in Quality Measures Inventory
                Updated Measure Specification definitions

June 2017:   Addition of Electronic Clinical Quality Measures (eCQMs) Chapter
              Updates to measure specification definitions

October 2017: Updates to programs listed in Quality Measures Inventory

INTRODUCTION

The Centers for Medicare & 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 publicly posts a full list of quality measures used within CMS programs twice a year. Measures include those that are under development, being considered through the pre-rulemaking process, and are 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. The goal of the CMS Measures Inventory is to provide a comprehensive list of measures that have ever been developed, considered, proposed, or utilized in a CMS program or initiative.

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

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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
- Dual Eligible Beneficiaries Program
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- HEDIS Quality Measure Rating System
- 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 and Child Core Measure Set
- Medicare Advantage Quality Improvement Program
- Medicare and Medicaid EHR Incentive Program: Eligible Hospitals and Critical Access Hospitals
- Medicare and Medicaid EHR Incentive Program: Eligible Professionals
- Medicare Part C Star Rating Program
- Medicare Part D Star Rating Program
- Medicare Physician Quality Reporting System (PQRS) Program
- Medicare Shared Savings Program (MSSP)
- Merit-Based Incentive Payment System (MIPS)
- Million Hearts
- Nursing Home Compare
- Nursing Home Quality Initiative

- Physician Compare
- Physician Feedback/Quality and Resource Use Reports (QRUR) Program
- Physician Value-Based Payment Modifier (VBM) Program
- Program for All-Inclusive Care for the Elderly (PACE)
- 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 on 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 Inventory Updates

CMS is always looking for innovative solutions to meet the needs of the quality measurement community. Upcoming versions of the CMS Quality Measures Inventory may include non-federally mandated programs, additional data fields to increase the information available for each measure, and new and easier ways to search for 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

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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. **Program ID:**
   This program ID is a numerical representation of which program a measure belongs to.

2. **CMIT Reference ID:**
   Unique measure identification number populated by the CMS Measures Inventory Tool (CMIT). A complete measure ID incorporates the Program ID and the CMIT Reference ID. For example, a Home Health measure may contain a CMIT Reference ID 0180, while the 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.

3. **CMS ID:**
   The CMS ID is the identifier that is unique to electronic clinical quality measures (eCQMs) and is generated by the Measure Authoring Tool (MAT).

4. **Program:**
   CMS Program as designated by legislation, rule or policy.

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

6. **Measure Title:**
   Name of the measure as listed within the Federal Register or measure specification documents.

7. **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.

8. **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.

9. **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.

10. **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.

11. **Status:**

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

• Planned	A measure that is currently under development and is being planned for use in a CMS program or initiative.
• Considered	A measure that has been submitted to the pre-rulemaking process and has been accepted for consideration by a CMS program, has been cleared through the HHS clearance process, and published on an annual Measures under Consideration (MUC) List.
• 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 to impact incentive or reimbursement payments.	
• 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.	

12. Measure Type:

Refers to the domain of quality that a measure assesses

• Access	An access measure assesses the timeliness and appropriateness of patients' healthcare delivered by a healthcare organization or clinician.
• 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 Use	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.
• Intermediate Outcome	A measure that assesses the change in physiologic state that leads to a longer-term 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.
• Patient-Centered Experience	Refers to measures that report observations of and participation in healthcare based on the patient's experience or assesses the patient's resulting change of health. These measures may consist of rates or average scores from patient surveys.

• Patient-Reported Outcome	A measure that focuses on a patient's report concerning observations of and participation in health care.	
• 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	
• Structural	A structural measure is one that assesses features of a healthcare organization or clinician relevant to its capacity to provide healthcare.	

13. National Quality Forum (NQF) ID:

Identification number assigned by the National Quality Forum.

14. NQF Endorsement Status:

Status provided by the National Quality Forum
http://www.qualityforum.org/Field_Guide/
- Endorsed
- Endorsement Removed
- Endorsed-Time Limited
- Endorsed-Reserved
- Not Endorsed

15. National Quality Strategy (NQS) Domain:

The six priorities supporting the National Quality Strategy have 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

16. **Condition:**
A disease, illness or injury including physiologic, mental or psychological disorder (e.g., Cardiovascular Disease, Malignant Neoplasm) specific to the measure concept addressed in the quality measure.

17. **Sub-condition**
A specific disease, illness or injury including physiologic, mental or psychological disorder (e.g., heart failure, breast cancer). The sub-condition also includes how a disease, illness or injury impacts the condition that the measure concept addresses. (e.g., hepatitis A within patients who have hepatitis C).

18. **Target Population Age:**
A specific age range the measure targets. e.g., 65-85.

19. **Data Source**
Type of data used within a measure specification. Data sources can be specific to programs (i.e. MDS 3.0 for Skilled Nursing Facility Quality Reporting Program or OASIS for Home Health Quality Reporting Program). Some examples of data sources are:
- Claims
- Electronic Health Record
- Paper Medical Records
- Registry
- Patient-Reported Data/Survey
- CMS Web Interface
- Chart-Abstracted Data

20. **Current Status Effective Date**
This date reflects the effective date of the status of a quality measure in relation to its use in payment determination in the respective CMS Program.

21. **MUC ID**
The MUC ID is the identifier that is provided for measures that have been published on a Measures under Consideration List, from 2013 through 2016.

22. **MUC Year**
MUC Year is the year that the measure had been published on the Measures under Consideration List.

CHAPTER 3: NAVIGATING THE INVENTORY

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

3.1 Inventory Tabs

The inventory is split into four 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.

3. **Medicare and Medicaid Core Measures**
   Lists the measure that are part of the Medicaid Adult and Child measure sets, and the measures identified in the Core Quality Measure Collaborative. The core measures consist of the following seven sets:
   - Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH), and Primary Care
   - Cardiology
   - Gastroenterology
   - HIV and Hepatitis C
   - Medical Oncology
   - Obstetrics and Gynecology
   - Orthopedics

4. **eCQMs**
   Lists each eCQM by program. eCQMs that are used by more than one program will be listed multiple times.

	A	B	C	D	E	F
1	Program ID	CMIT Reference ID	CMS ID (for eCQMs)	Measure Groups	Program	Measure Title
2	14	2	n/a	AMI: 01	Hospital Inpatient Quality Reporting	Aspirin at arrival for a(myocardial infarction (
3	14	4	n/a	AMI: 02	Hospital Inpatient Quality Reporting	Aspirin prescribed at discharge for AMI (Cha
4	13	4	n/a	AMI: 02	Hospital Compare	Aspirin prescribed at discharge for AMI (Cha
5	14	6	n/a	AMI: 03	Hospital Inpatient Quality Reporting	ACE/ARB for LVSD
6	22	6	n/a	AMI: 03	Medicare and Medicaid Electronic	ACE/ARB for LVSD
7	14	7	n/a	AMI: 04	Hospital Inpatient Quality Reporting	Adult smoking cessatic advice/counseling
8	14	10	n/a	AMI: 05	Hospital Inpatient Quality Reporting	Beta-blocker prescribe discharge for AMI
9	22	10	n/a	AMI: 05	Medicare and Medicaid Electronic	Beta-blocker prescribe discharge for AMI
	14	13	n/a	AMI: 07a	Hospital Inpatient Quality Reporting	Fibrinolytic Therapy re within 30 minutes of h

InventorybyProgram   InventorybyTitle   MedicareandMedicaidCoreMeasures   eCQMs

Ready

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 the programs listed in the inventory

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.

Figure 3: CMS Quality Measures Inventory Filtered by Program

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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 implemented 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 'Implemented'

Figure 4: CMS Quality Measures Inventory Filtered by Status

2. Users can use the filters to narrow down the list of measures by many columns at once. For example, a user who only wants to 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 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'
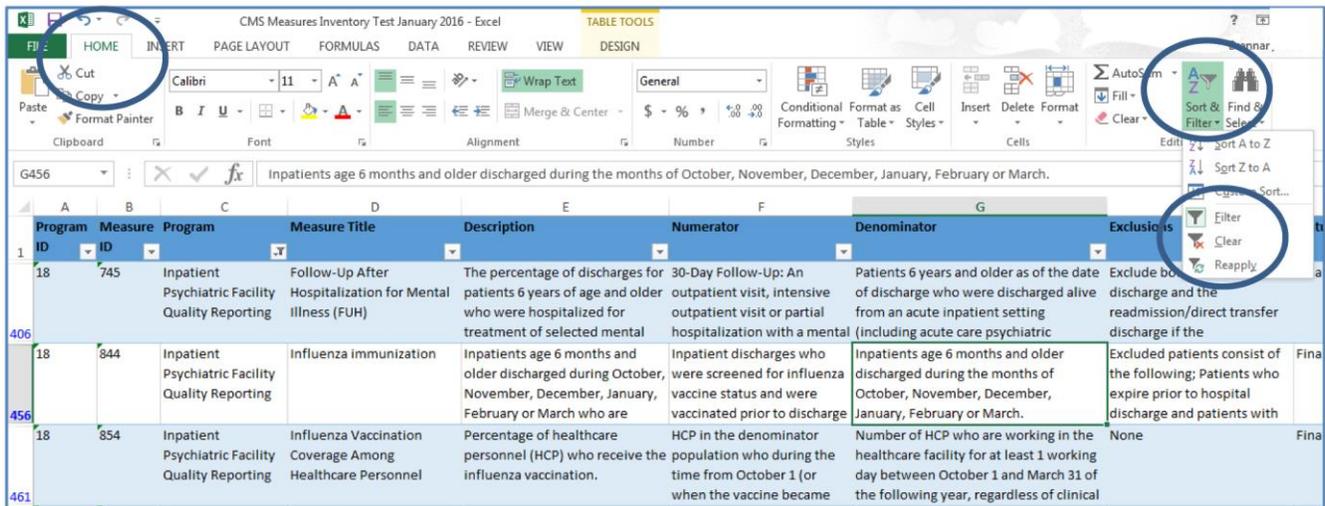
Figure 5: CMS Quality Measures Inventory Filters Cleared

Helpful Hints:

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

CHAPTER 4. MEASURES UNDER CONSIDERATION

The Measures under Consideration (MUC) are federally mandated through the pre-rulemaking process to be submitted for CMS approval, HHS clearance, and to be publicly posted annually. With the recent implementation of the Merit-Based Incentive Payment System (MIPS), there are a total of 18 programs that are required to go through the pre-rulemaking process. CMS seeks to be inclusive with respect to new measures for consideration by convening meetings to obtain input and consensus on the measures submitted, and invites non-federal stakeholders to submit quality measures. Measures that are published onto the annual MUC List can be proposed into a CMS program through the Federal Rulemaking process.

If measures on the MUC List are not selected for a CMS program in the current rulemaking cycle, the measure remains under consideration by the Secretary and may be proposed and adopted in subsequent rulemaking cycles. Measures that are included on the MUC List are not required to be adopted into a CMS program. The MUC Lists from 2013, 2014, 2015, and 2016 have been compiled and are included as a part of the Measures Inventory.

4.1 Data Sources

The MUC measures in the Measures Inventory were populated from the published MUC Lists available on the CMS pre-rulemaking website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html.

4.2 Measure Specifications

The measure specifications for the MUC measures align with the measure specifications from the in the CMS Measures Inventory.

4.2.1 Data Fields Consistent with the CMS Measures Inventory

1. CMS Program
2. Measure Title
3. Description
4. Numerator
5. Denominator
6. Exclusions
7. Measure Type
8. Measure Status
9. NQF ID
10. Data Source
11. NQS Priority/Domain(s)

4.3 Navigating the MUC List

The MUC List is included in the CMS Quality Measures Inventory, and therefore, 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. 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. 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.

5.1 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, 2015, and 2016. 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.

5.2 Measure Specifications

To maintain consistency with the data fields used in the CMS Measures Inventory, the following is a list of data fields and their definitions that 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 could 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.

5.2.1 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 "Planned" 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)

5.2.2 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 not be supported and ultimately removed from consideration, this column contains the year that the MAP review was published.

5.3 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. 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 6. ELECTRONIC CLINICAL QUALITY MEASURES

Electronic Clinical Quality Measures (eCQMs) are clinical quality measures that use data from electronic health records (EHR) and/or health information technology systems. While an eCQM may have a regular quality measure counterpart, not all measures in the Inventory have an eCQM version. For this reason, eCQMs have a separate tab in the measures inventory to distinguish between traditional reporting methods and eCQMs.

6.1 Data Sources

The eCQM measures are currently populated using the eCQI Resource Center, the authoritative source for information related to eCQMs. The website provides a list of current eCQMs, measure technical specifications, and reporting year history. For complete information regarding eCQMs, including measure version history, please visit the eCQI Resource Center.

6.2 Measure Specifications

To maintain consistency with the data fields used in the CMS Measures Inventory, eCQM specifications align with those listed in Chapter 2. As noted, the CMS ID is a unique identifier specific to eCQMs that is generated by the Measure Authoring Tool (MAT). The following programs are currently utilizing eCQMs as a part of their payment program:

1. Merit-Based Incentive Payment System (MIPS) Program
2. Hospital Inpatient Quality Reporting Program
3. Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals
4. Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals

6.3 Navigating the eCQM Inventory

The eCQM Inventory is included in the CMS Quality Measures Inventory, and therefore, 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. 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 7. UPDATES

The CMS Quality Measures Inventory will be updated three times per year to align with the Federal rulemaking process, so updates will be posted in February, July, and November. In addition to the CMS Quality Measures Inventory, the MUD and MUC measures, 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 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.

Electronic Clinical Quality Measure

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 heath 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 while 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.