NOF & NBHA Quality Improvement Registry in collaboration with CECity (NOF)

Number of Non-PQRS Measures submitted by QCDR: **15**

NON -PQRS Measure	Measure Title	Measure Description	NQS Domain	NQF Number	eCQM Number	Rationale	Data Source	Steward	PQMM Analysis	Recommendation	QA	Number of Multiple Performance Rates (If Applicable)	Inverse Measurement (Yes/No)	Proportion Measure Scoring	Continuous Measure Scoring	CMS Feedback
NOF 1	Laboratory Investigation for Secondary Causes of Fracture	Percentage of patients age 50 and over with fragility fracture who have had appropriate laboratory investigation for secondary causes of fracture ordered or performed prior to discharge from inpatient status.	Effective Clinical Care	2416		Patients over 50 presenting with fragility fractures (low-trauma fractures) should have the underlying cause determined so that it can be treated, thereby preventing future fractures, readmissions, mortality, and unnecessary costs associated with treating these fractures.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	The Joint Commission	Facility			n/a	No	Yes	n/a	
NOF 2	Risk Assessment/Treatment after Fracture	Patients age 50 or over with a fragility fracture who have either a dual-energy X-Ray absorptiometry (DXA) scan ordered or performed, or a prescription for FDA-approved pharmacotherapy for osteoporosis, or who are seen by or linked to a fracture liaison service prior to discharge from inpatient status. If DXA is not available and documented as such, then any other specified fracture risk assessment method may be ordered or performed.	Communication and Care Coordination	2417		Fragility fracture presumes the existence of low bone mass. It has been shown that patients with fragility fracture often are not tested or treated for osteoporosis, and there is a significant opportunity for improvement in management of these patients. Across multiple studies, the rate of testing and treatment for osteoporosis after fragility fracture is 20% or less.	Electronic Clinical Data: Electronic Health Record, Paper Medical Records	The Joint Commission	Facility			n/a	No	Yes	n/a	
NOF 3	Discharge Instructions: Emergency Department	Proportion of patients age 50 or over with a fracture of the vertebra, pelvis, wrist, ankle, or humerus discharged from the Emergency Department to home, or their caregivers, who have received written discharge instructions regarding the need to follow up with a primary care physician, hospital outpatient department or specialist for possible osteoporosis to reduce the risk of future fracture, or who were contacted by a fracture liaison service.	Communication and Care Coordination	2418		Fragility fracture presumes the existence of low bone mass. It has been shown that patients with fragility fracture often are not tested or treated for osteoporosis, and there is a significant opportunity for improvement in management of these patients. The incidence of low bone mass among wrist fracture patients has been cited as 70-80%. However, across multiple studies, the rate of testing and treatment for osteoporosis after fragility fracture is 20% or less.	Electronic Clinical Data, Electronic Clinical Data Electronic Health Record, Paper Medical Records	The Joint Commission	Facility			n/a	No	Yes	n/a	
NOF 5	Osteoporosis Testing in Older Women	The number of women 65-85 years of age who report ever having received a bone density test to check for osteoporosis.	Effective Clinical Care	37		Osteoporosis is the most common of the bone diseases that will affect Americans. In the United States (U.S.), 10 million people are estimated to have osteoporosis; another 34 million are estimated to have low bone mass, placing them at risk for osteoporosis and related fractures. The prevalence of osteoporosis is high among older women. Published economic assessments suggest that diagnosis and treatment of women at risk for osteoporosis would be more cost-effective by targeting treatment to those with the lowest bone measurement results.	**Patient Reported Data/Survey**	**National Committee for Quality Assurance**	**Health Plan, Integrated Delivery System**			n/a	No	Yes	n/a	
NOF 6	Hip Fracture Mortality Rate (IQI 19)	In-hospital deaths per 1,000 hospital discharges with hip fracture as a principal diagnosis for patients ages 65 years and older. Excludes periprosthetic fracture discharges, obstetric discharges, and transfers to another hospital. [NOTE: The software provides the rate per hospital discharge. However, common practice reports the measure as per 1,000 discharges. The user must multiply the rate obtained from the software by 1,000 to report in-hospital deaths per 1,000 hospital discharges.]	Effective Clinical Care	354		Hip fracture occurs in frequently in the elderly population. Complications of fracture and treatments sometimes include embolism, pneumonia, and myocardial ischemia. These conditions and other comorbidities lead to a relatively high mortality rate, and there is some evidence that some of these complications are preventable. An observational study using a 20 percent sample of Medicare claims (from 1985 through 2005) found an annual hip fracture incidence of 957.3 per 100,000 women and 414.4 per 100,000 men and indicated a decline has occurred from 1995 through 2005.	Administrative claims	Agency for Healthcare Research and Quality	Facility			n/a	Yes	Yes	n/a	
NOF 7	Osteoporosis: percentage of patients, any age, with a diagnosis of osteoporosis who are either receiving both calcium & vitamin D intake, & exercise at least once within 12 months.	This measure is used to assess the percentage of patients regardless of age, with a diagnosis of osteoporosis who are either receiving both calcium and vitamin D or had documented counseling regarding both calcium and vitamin D intake, and exercise at least once within 12 months.	Effective Clinical Care			Vitamin D and calcium and exercise are important in the treatment of osteoporosis.	Administrative clinical data Electronic health/medical record Paper medical record	National Committee for Quality Assurance				n/a	No	Yes	n/a	
NOF 8	Osteoporosis: percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months.	This measure is used to assess the percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months.	Effective Clinical Care	49		Pharmacologic therapy is an evidence-based recommendation for the treatment of osteoporosis.	Administrative clinical data Electronic health/medical record Paper medical record	National Committee for Quality Assurance				n/a	No	Yes	n/a	

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NQF if endorsed - 45	Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older	Percentage of adults 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.	Effective Clinical Care	45		The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis.The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. Use of risk factors, particularly increasing age, low weight, and non-use of estrogen replacement, to screen younger women may identify high-risk women.BMD measurement should be performed in all women beyond 65 years of age. Dual x-ray absorptiometry of the lumbar spine and proximal femur provides reproducible values at important sites of osteoporosis-associated fracture. These sites are preferred for baseline and serial measurements.The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. Markers of greater osteoporosis and fracture risk include older age, hypogonadism, corticosteroid therapy, andestablished cirrhosis. The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures.	Electronic Clinical Data, Paper Medical Records	National Committee for Quality Assurance	Clinician: Group/Practice, Clinician: Individual, Clinician: Team			n/a	No	Yes	n/a	
NQF if endorsed - 326	Advance 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 an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Person and Caregiver-Centered Experience Outcomes	326			Administrative claims, Electronic Clinical Data	National Committee for Quality Assurance	Clinician: Group/Practice, Clinician: Individual			n/a	No	Yes	n/a	
NQF if endorsed - 553	Care for Older Adults (COA) – Medication Review	Percentage of adults 66 years and older who had a medication review during the measurement year; a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Effective Clinical Care	553			Administrative claims, Electronic Clinical Data, Paper Medical Records	National Committee for Quality Assurance	Health Plan, Integrated Delivery System			n/a	No	Yes	n/a	
NQF if endorsed - 662	Median Time to Pain Management for Long Bone Fracture	Median time from emergency department arrival to time of initial oral or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF).	Effective Clinical Care	662			Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy, Paper Medical Records	Centers for Medicare & Medicaid Services	Facility			n/a	Yes	n/a	Yes	
NQF if endorsed - 53	Osteoporosis Management in Women Who Had a Fracture	The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.	Effective Clinical Care	53		Partial Measure Title matches NOF 4 ...rest of content under each header does not.. No sure if they updated/changed NOF 4	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Imaging/Diagnostic Study, Electronic Clinical Data: Pharmacy, Paper Medical Records	National Committee for Quality Assurance	Clinician: Group/Practice, Clinician: Individual, Clinician: Team, Health Plan, Integrated Delivery System			n/a	No	Yes	n/a	
NQF if endorsed - 48	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Percentage of patients aged 50 years or older with fracture of the hip, spine or distal radius that had a central DXA measurement ordered or performed or pharmacologic therapy prescribed	Effective Clinical Care	48			Administrative claims	National Committee for Quality Assurance	Clinician: Group/Practice, Clinician: Individual, Clinician: Team			n/a	No	Yes	n/a	
NQF if endorsed - 46	Screening for Osteoporosis for Women 65-85 Years of Age	Percentage of women 65-85 years of age who ever had a central dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis.	Effective Clinical Care	46		Patients with a history of fracture should have a baseline bone mass measurement and/or receive treatment for osteoporosis. Given that the majority of osteoporotic fractures occur in patients with a diagnosis of osteoporosis by bone mass measurement, exclusion of osteoporosis by bone mass testing does not preclude treatment of osteoporosis in a patient with a history of fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis.	Electronic Clinical Data, Paper Medical Records	National Committee for Quality Assurance	Clinician: Group/Practice, Clinician: Individual, Clinician: Team			n/a	No	Yes	n/a	
	Glucocorticosteroids and Other Secondary Causes ("ACR5")	Percentage of patients aged 18 years and older with one of the following conditions or therapies: receiving oral glucocorticosteroid therapy for greater than 3 months OR hypogonadism OR fracture history OR transplant history OR obesity surgery OR malabsorption disease OR receiving aromatase therapy for breast cancer who had a central DXA ordered or performed or pharmacologic therapy prescribed within 12 months	Effective Clinical Care			The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and support the rationale: •DXA scans should be done in patients with the GI disorders reviewed earlier who have experienced a vertebral fracture, are postmenopausal, or have been on chronic corticosteroid therapy (>3months). (AGA) •Physicians should obtain a baseline BMD measurement at the lumbar spine and/or hip when initiating long-term (i.e., >6 months) glucocorticoid therapy. (ACR7) •The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH) •The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH) •Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while	Electronic Health Record/Registry	American College of Rheumatology				n/a	No	Yes	n/a	

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21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis.	Patient Safety	Process	0268	N/A	Presence of antibiotics in the blood and tissue during and after surgery can prevent infection. Cephalosporins are currently the drug of choice for antimicrobial prophylaxis due to their broad-spectrum effect and low occurrence of adverse reactions.	Medical Record	AMA-PCPI, NCQA					No			
22	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time.	Patient Safety	Process	0271	N/A	There is no evidence there is added benefit of prolonged prophylactic parenteral antibiotic use. Prolonged use may increase antibiotic resistant organisms.	Medical Record	AMA-PCPI, NCQA					No			
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	Patient Safety	Process	0239	N/A	This measure addresses VTE risk based on surgical procedure. VTE prophylaxis is appropriate for all patients undergoing these procedures regardless of individual patient thromboembolic risk factors. Duration of VTE prophylaxis is not specified in the measure due to varying guideline recommendations for different patient populations.	Medical Record	AMA-PCPI, NCQA					No			
24	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 fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.	Communication and Care Coordination	Process	0045	N/A	This measure aims to improve the communication and coordination from the physician treating the fracture in the acute care setting to the physician or clinician who is responsible for follow-up care for osteoporosis. Patients who experience a fragility fracture should either be treated or screened for the presence of osteoporosis. Although the fracture may be treated by the orthopedic surgeon, the testing and/or treatment is likely to be under the responsibility of the physician providing on-going care. It is important the physician or other clinician providing on-going care for the patient be made aware the patient has sustained a fracture so that the proper care and treatment plan can be put in place to prevent a secondary fracture from occurring. This measure holds the physician who treated the fracture accountable for this communication to the on-going care provider.	Medical Record	AMA-PCPI, NCQA					No			
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.	Effective Clinical Care	Process	0046	N/A	This measure assesses the number of women 65-85 who have ever received a dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis. There is convincing evidence that bone mineral density tests predict short-term risk for osteoporotic fractures. There is also evidence osteoporosis treatment reduces the incidence of fracture in women who are identified to be at risk of an osteoporotic fracture. Fractures, especially in the older population, can cause significant health issues, decline in function, and, in some cases lead to mortality.	Medical Record	AMA-PCPI, NCQA					No			
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Percentage of patients aged 50 years and older with fracture of the hip, spine, or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed.	Effective Clinical Care	Process	0048	N/A	Patients with a history of fracture should have a baseline bone mass measurement and/or receive treatment for osteoporosis. Given that the majority of osteoporotic fractures occur in patients with a diagnosis of osteoporosis by bone mass measurement, exclusion of osteoporosis by bone mass testing does not preclude treatment of osteoporosis in a patient with a history of fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.	Medical Record	NCQA, AMA-PCPI					No			
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months.	Effective Clinical Care	Process	N/A	N/A	Pharmacologic therapy is an evidence-based recommendation for the treatment of osteoporosis.	Medical Record	AMA-PCPI, NCQA					No			
46	Medication Reconciliation	The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: - Reporting Criteria 1: 18-64 years of age - Reporting Criteria 2: 65 years and older - Total Rate: All patients 18 years of age and older	Communication and Care Coordination	Process	0097	N/A	Medications are often changed while a patient is hospitalized. Continuity between inpatient and on-going care is essential.	Medical Record	AMA-PCPI, NCQA				3	No			
47	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 an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Communication and Care Coordination	Process	0326	N/A	It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno, 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.	Medical Record	AMA-PCPI, NCQA					No			
109	Osteoarthritis (OA): Function and Pain Assessment	Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.	Person and Caregiver-Centered Experience and Outcomes	Process	N/A	N/A	Osteoarthritis can be a debilitating condition. An assessment of patient symptoms and functional status is important as it serves as the basis for making treatment modifications, which in turn, assists in improving the patient's quality of life.	Medical Record	AMA-PCPI, NCQA, AAOS					No			
110	Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Community/Population Health	Process	0041	CMS147v4	Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza vaccine is recommended for all persons aged ≥ 6 months who do not have contraindications to vaccination.	Medical Record	AMA-PCPI					No			
111	Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	Community/Population Health	Process	0043	CMS127v3	Pneumonia is a common cause of illness and death in the elderly and persons with certain underlying conditions such as heart failure, diabetes, cystic fibrosis, asthma, sickle cell anemia, or chronic obstructive pulmonary disease (NHLBI, 2011). In 1998, an estimated 3,400 adults aged > 65 years died as a result of invasive pneumococcal disease (IPD) (CDC, 2003). Among the 91.5 million US adults aged > 50 years, 29,500 cases of IPD, 502,600 cases of nonbacteremic pneumococcal pneumonia and 25,400 pneumococcal-related deaths are estimated to occur yearly; annual direct and indirect costs are estimated to total $3.7 billion and $1.8 billion, respectively. Pneumococcal disease remains a substantial burden among older US adults, despite increased coverage with 23-valent pneumococcal polysaccharide vaccine, (PPV23) and indirect benefits afforded by PCV7 vaccination of young children (Weycker, et al., 2011). Vaccination has been found to be effective against bacteremic cases (OR: 0.34; 95% CI: 0.27–0.66) as well as nonbacteremic cases (OR: 0.58; 95% CI: 0.39–0.86). Vaccine effectiveness was highest against bacteremic infections caused by vaccine types (OR: 0.24; 95% CI: 0.09–0.66) (Vila-Corcoles, et al., 2009).	Medical Record	NCQA					No			
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 kg/m2; Age 18 – 64 years BMI ≥ 18.5 and < 25 kg/m2	Community/Population Health	Process	0421	CMS69v3	Normal Parameters for Age 65 Years and Older Winter et al. (2014) performed a meta-analysis looking at the relationship between BMI and all-cause mortality among adults 65 and older. They identified a higher risk of mortality among those with a BMI <23 kg/m2 and recommended monitoring weight status in this group to address any modifiable causes of weight loss promptly with due consideration of individual comorbidities. Dahl et al. (2013) reported that old persons (70-79) who were overweight had a lower mortality risk than old persons who were of normal weight, even after controlling for weight change and multimorbidity. The study also shows that persons who increased or decreased in BMI had a greater mortality risk than those who had a stable BMI, particularly those aged 70 to 79… NOTE: To see the full Rationale, see this Measure's specification in the Physician Quality Reporting System Measure Specifications Manual from CMS for the current reporting year.	Medical Record	CMS, QIO					No			

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130	Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Patient Safety	Process	0419	CMS68v4	In the American Medical Association's (AMA) Physician's Role in Medication Reconciliation (2007), critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.... NOTE: To see the full Rationale, see this Measure's specification in the Physician Quality Reporting System Measure Specifications Manual from CMS for the current reporting year.	Medical Record	CMS, QIO					No			
131	Pain Assessment and Follow-Up	Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Communication and Care Coordination	Process	0420	N/A	Chronic pain is defined as pain without biological values that has persisted beyond the normal time and despite the usual customary efforts to diagnose and treat the original condition and injury. If a patient's pain has persisted for six weeks (or longer than the anticipated healing time), a thorough evaluation for the course of the chronic pain is warranted (ICSI, 2013). Chronic pain affects approximately 100 million adults in the USA. (Gaskin, 2012). It is clear the enormous pain- related costs represent both a great challenge and an opportunity in terms of improving the quality and cost- effectiveness of care (Mayday Fund, 2009). NOTE: To see the full Rationale, see this Measure's specification in the Physician Quality Reporting System Measure Specifications Manual from CMS for the current reporting year.	Medical Record	CMS, QIO					No			
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Community/Population Health	Process	0418	CMS2v4	The World Health Organization (WHO), as seen in Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Persons 40-59 years of age had higher rates of depression than any other age group. Persons 12-17, 18-39 and 60 years of age and older had similar rates of depression... NOTE: To see the full Rationale, see this Measure's specification in the Physician Quality Reporting System Measure Specifications Manual from CMS for the current reporting year.	Medical Record	CMS, QIO					No			
154	Falls: Risk Assessment	This is a two-part measure which is paired with Measure #155: Falls: Plan of Care. If the falls risk assessment indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year (CPT II code 1100F is submitted), #155 should also be reported.	Patient Safety	Process	0101	N/A	Screening for specific medical conditions may direct the therapy. Although the clinical guidelines and supporting evidence calls for an evaluation of many factors, it was felt that for the purposes of measuring performance and facilitating implementation this initial measure must be limited in scope. For this reason, the work group defined an evaluation of balance and gait as a core component that must be completed on all patients with a history of falls as well as four additional evaluations – at least one of which must be completed within the 12 month period. Data elements required for the measure can be captured and the measure is actionable by the physician.	Medical Record	AMA-PCPI, NCQA					No			
155	Falls: Plan of Care	Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	Communication and Care Coordination	Process	0101	N/A	Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls.	Medical Record	AMA-PCPI, NCQA					No			
181	Elder Maltreatment Screen and Follow-Up Plan	Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Patient Safety	Process	N/A	N/A	The Institute of Medicine and the National Research Council of the National Academies: Elder abuse and its prevention: Workshop summary (2013) reports "The association of elder maltreatment with hospitalizations, hospital admissions, and mortality emphasizes the need to explore and expand appropriate measurement and assessment of maltreatment—across multiple settings and provider types" (Mosqueda & Dong, 2011; Dong et al., 2011d, 2012d; Dong, 2012). Research conducted by Bond and Butler (2013) reports "Elder abuse and neglect is estimated to affect approximately 700,000 to 1.2 million elderly people a year with an estimated annual cost of tens of billions of dollars".. NOTE: To see the full Rationale, see this Measure's specification in the Physician Quality Reporting System Measure Specifications Manual from CMS for the current reporting year.	Medical Record	CMS, QIO					No			
182	Functional Outcome Assessment	Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Communication and Care Coordination	Process	2624	N/A	Standardized outcome assessments, questionnaires or tools are a vital part of evidence-based practice. Despite the recognition of the importance of outcomes assessments, questionnaires and tools, recent evidence suggests their use in clinical practice is limited. Selecting the most appropriate outcomes assessment, questionnaire or tool enhances clinical practice by (1) identifying and quantifying body function and structure limitations; (2) formulating the evaluation, diagnosis, and prognosis; (3) informing the plan of care; and (4) helping to evaluate the success of physical therapy interventions (Potter et al., 2011)... NOTE: To see the full Rationale, see this Measure's specification in the Physician Quality Reporting System Measure Specifications Manual from CMS for the current reporting year.	Medical Record	CMS, QIO					No			
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Community/Population Health	Process	0028	CMS138v3	This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.	Medical Record	AMA-PCPI					No			
238	Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	Patient Safety	Process	0022	CMS156v3	Seniors receiving inappropriate medications are more likely to report poorer health status at follow-up, compared to seniors who receive appropriate medications (Fu, Liu, and Christensen 2004). In 2005, rates of potentially inappropriate medication use in the elderly were as large or larger than in a 1996 national sample, highlighting the need for progress in this area (Simon et al. 2005). While some adverse drug events are not preventable, studies estimate that between 30 and 80 percent of adverse drug events in the elderly are preventable (MacKinnon and Hepler 2003). NOTE: To see the full Rationale, see this Measure's specification in the Physician Quality Reporting System Measure Specifications Manual from CMS for the current reporting year.	Medical Record	NCQA				2	Yes			
178	Rheumatoid Arthritis (RA): Functional Status Assessment	Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months.	Effective Clinical Care	Process	N/A	N/A	Functional limitations are a significant and disruptive complication for patients living with RA. Assessments of functional limitations are used to assess prognosis and guide treatment and therapy decisions. Functional status should be assessed at the baseline and each follow-up visit, using questionnaires such as the ACR's Classification of Functional Status in RA or the Health Assessment Questionnaire or an assessment of activities of daily living. Regardless of the assessment tool used, it should indicate whether a functional decline is due to inflammation, mechanical damage, or both, as treatment strategies will vary accordingly.	Medical Record	AMA-PCPI, AC Rheumatology					No			
217	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments.	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the knee in which the change in their Risk-Adjusted Functional Status is measured.	Communication and Care Coordination	Process	0422	N/A	Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1873)	Medical Record	FOTO					No			
218	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments.	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the hip in which the change in their Risk-Adjusted Functional Status is measured.	Communication and Care Coordination	Outcome	0423	N/A	Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1872)	Medical Record	FOTO					No			
219	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments.	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lower leg, foot or ankle in which the change in their Risk-Adjusted Functional Status is measured.	Communication and Care Coordination	Outcome	0424	N/A	Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1874)	Medical Record	FOTO					No			

NOF & NBHA Quality Improvement Registry in collaboration with CECity (NOF)

Number of PQRS Measures submitted by QCDR: **31**

PQRS Measure	Measure Title	Measure Description	NQS Domain	Measure Type	NQF Number	eCQM Number	Rationale	Data Source	Steward	POMM Analysis	Recommendation	QA	Number of Multiple Performance Rates (If Applicable)	Inverse Measurement (Yes/No)	Proportion Measure Scoring	Continuous Measure Scoring	CMS Feedback
220	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments.	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lumbar spine in which the change in their Risk-Adjusted Functional Status is measured.	Communication and Care Coordination	Outcome	0425	N/A	Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-2632)	Medical Record	FOTO					No			
221	Functional Deficit: Change in Risk-Adjusted Status for Patients with Shoulder Impairments.	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the shoulder in which the change in their Risk-Adjusted Functional Status is measured.	Communication and Care Coordination	Outcome	0426	N/A	Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-2633)	Medical Record	FOTO					No			
222	Functional Deficit: Change in Risk-Adjusted Status for Patients with Elbow, Wrist or Hand Impairment.	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the elbow, wrist or hand in which the change in their Risk-Adjusted Functional Status is measured.	Communication and Care Coordination	Outcome	0427	N/A	Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1874)	Medical Record	FOTO					No			
223	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs or Other General Orthopedic Impairments.	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment in which the change in their Risk-Adjusted Functional Status is measured.	Communication and Care Coordination	Outcome	0428	N/A	Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-0022)	Medical Record	FOTO					No			
418	Osteoporosis Management in Women Who Had a Fracture	The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.	Effective Clinical Care		0053	N/A	The intent of this measure is secondary prevention of fractures through the appropriate diagnosis and treatment of osteoporosis. Detecting osteoporosis and initiating treatment will help to prevent future fractures from occurring. Future fractures, especially in the older population, can cause significant health issues, decline in function, and, in some cases lead to mortality.	Medical Record	AMA-PCPI, NCQA					No			