New Jersey
Delivery System Reform Incentive Payment (DSRIP) Program

DSRIP Performance Measurement Databook

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I. General Overview

A. Background

The Delivery System Reform Incentive Payment (DSRIP) program is one component of the New Jersey's Comprehensive 1115 Waiver as approved by the Centers for Medicare & Medicaid Services (CMS). DSRIP is a demonstration program designed to address the three part aim for better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower costs through the achievement of health improvement goals. Incentive payment awards are available to hospitals contingent on hospitals' fully meeting performance and outcome metrics.

This New Jersey DSRIP Performance Measurement Databook (otherwise referred to as the "databook") provides the specifications for the DSRIP clinical performance measure set. This includes the measures' numerator, denominator, associated Current Procedural Terminology (CPT) codes, International Classification of Diseases, Clinical Modification (ICD-09-CM and ICD-10-CM) diagnoses codes and All Patients Diagnoses Related Groups (AP-DRG) along with the measures' reporting requirements and incentive payment impact.

A broad measure set is represented in order to monitor the influence of project-specific clinical interventions along with the general population health of the DSRIP population. Specifically, the DSRIP program will measure the health of the New Jersey Medicaid, Children's Health Insurance Program (CHIP) and Charity Care populations, collectively referred to as the "New Jersey Low Income population." This includes the fee-for-service, managed care and dually eligible sub-populations. The DSRIP measure set assesses clinical performance in the outpatient setting, inpatient setting, and across settings of care.

This databook includes eighty-one DSRIP measures and is divided between measures collected using Medicaid Management Information System (MMIS) administrative claims data and those that use the chart/ electronic health record (EHR) data collection procedures.

1. MMIS Measures – Administrative claims data

One primary method to measure performance is through the collection of relevant administrative claims data which is submitted for payment to the New Jersey Department of Medical Assistance and Human Services (DMAHS). In order to measure clinical performance across settings of care for the New Jersey Low Income population, the Department, with CMS approval, agreed to calculate certain DSRIP measures on the behalf of DSRIP participating hospitals. This administrative claims data is collected and adjudicated in the

New Jersey Medicaid Management Information System (MMIS). The data is copied and transferred for data storage to a data warehouse managed by a DMAHS vendor.

The administrative claims data captures patient utilization that can be used to measure quality performance. It relies heavily on measuring the occurrence of a service (or lack of occurrence). This includes information for ***all*** services received and submitted for payment for all provider types. This claim adjudication information is then provided to the Centers for Medicare & Medicaid Services (CMS) and retained in the federal Medicaid Statistical Information System (MSIS) data warehouse.

Collection of administrative claims data alone can be incomplete for performance measurement if pertinent clinical information is missing. If the clinical information is not required for processing the payment of the service, the data may not be submitted on the claim or the information may not be captured during the claims adjudication process. For that reason, a collection method that includes the review of patient medical record charts is very valuable in quality measurement and is included in the DSRIP program.

2. Chart/ EHR Measures – Medical record data

Patient medical records may be either in the form of a paper record, or an electronic health record (EHR). Medical record abstraction is a collection method that requires the retrospective gathering of information through either a direct review of a patient's chart, or by running a data query of an EHR system. The collection of data through the review of patient charts can be resource intensive. To minimize this concern, using statistically valid sampling procedures to find representative patient cases will be accepted for the DSRIP measurement process.

EHR systems are reducing the burden of retrospective reviews. DSRIP providers may find that performing a data query of their EHR system will more efficiently identify patients that meet measure criteria. However, EHR systems may also be incomplete if measure data points are not required data entry elements and remain unavailable. In order to reduce the population selection, a hospital may rely on both methods: a systems solution in combination with a chart review. A data query can first be run to identify whether patients meet specific measure criteria, and then a manual method can be used to further locate additional data points documented in the chart.

B. DSRIP Incentive Impact

Each Stage 3 and Stage 4 measure has an impact to hospital payment award valuation. Award is based on either a pay for reporting (P4R) basis, or a pay for performance (P4P) basis. As hospitals complete infrastructure activities over the course of the waiver, a greater portion of the DSRIP monies transition to payment based on performance measurement.

Table I. STAGE 3 and 4 DEMONSTRATION YEAR (DY) FUNDING PERCENTAGE

Stages	DY3	DY4	DY5
3	15%	35%	50%
4	10%	15%	25%

For each of the final two demonstration years (DY), award will be based on measurable improvement in a core set of the hospitals' Stage 3 performance measures marked as P4P. A measurable improvement is considered to be a minimum of a ten percent reduction in the difference between the hospital's baseline performance and a defined improvement target goal (ITG).

Table II. DSRIP PAY FOR PERFORMANCE IMPROVEMENT CALCULATION

Line 1	Improvement Target Goal (ITG)
Line 2	Better of the Hospital Rate in the prior performance period or the Expected Improvement Target ***(Baseline)***
Line 3	Subtract the hospital's rate (line 2) from the improvement target goal (line 1). This is the gap between the hospital's prior performance period rate and the improvement target goal. ***(Gap)***
Line 4	Required annual reduction in the gap (10%)
Line 5	Multiply the gap (line 3) by the 10% required annual reduction in the gap (line 4). This results in the rate of improvement required.
Line 6	Add the hospital's baseline rate (line 2) to the rate of improvement (line 5). ***(Expected Improvement Target)***
Line 7	Compare Expected Improvement Target to Actual Performance Result; Is the Actual Performance Result at the Improvement Target Goal? Is the Actual Performance Result at the Expected Improvement Target? If either is Yes – then the Payment Incentive is Awarded.

For any measure that the Department determines, with CMS concurrence, that the above calculation cannot be computed, the Department will authorize a simple ten percent rate of improvement over the hospital's baseline performance rate per year as the Expected Improvement Target for that measure. This may occur if there is insufficient data to develop a New Jersey Low Income Improvement Target Goal, or if national benchmarking data is unavailable.

A hospital may qualify for a gap reduction incentive that adjusts the ten percent reduction to an eight percent reduction if the hospital elects to include in their DSRIP network:

1) a single, or collection of community-based reporting partners, who hold a patient roster of not less than 1,000 unique NJ Low income patients, or

2) an enhanced reporting partner.

A community-based reporting partner is defined as a partner who:

1. Is not a hospital-based clinic that bills under the hospital's provider identifier with specified revenue codes 510-519.
2. Is a Medicaid-enrolled clinic, facility, or physician practice group that can/ will comply with reporting outpatient data.
3. Agrees to support the objectives of the DSRIP program.
4. May have an existing employment relationship or ownership with the hospital/ hospital system.
5. Has/will have a Data Use Agreement, or other formal data sharing arrangement in place by October 1, 2014 (DY 3).

An enhanced reporting partner is defined as a partner who:

1. Is a Medicaid-enrolled clinic, facility, or physician practice group that can/ will comply with reporting outpatient data.
2. Agrees to support the objectives of the DSRIP program.
3. Does NOT have an existing employment relationship or ownership with the hospital/ hospital system.
4. Will have Data Use Agreement, or other formal data sharing arrangement in place by July 1, 2015 (DY4).

Hospitals should refer to the Funding and Mechanics Protocol (FMP) for further information.

1. Improvement Target Goals (ITG)

As outlined in the FMP, the improvement target goal serves as the standard level of performance that New Jersey hospitals will strive to obtain. In order to select the New Jersey Low Income Improvement Target Goal, baseline results were identified for all Stage 3 measures. For any given metric that had insufficient data to compile a New Jersey Low Income Improvement Target Goal, it was determined whether publically available data was available (e.g. national, Medicare-only, or commercial) that could be used as a substitution. In order to set measure-specific ITGs, New Jersey set goals using the following benchmark hierarchy for each measure.:

1. Utilize the 90th or 75th percentile of DSRIP-participating hospitals, if 10 or more hospital results, if available.
2. Utilize the 95th percentile of national New Jersey statewide data, if available.
3. Utilize the 95th percentile of national data, if available.
4. Utilize a 90% compliance benchmark for process measures.

The approved improvement target goal and the calculated expected improvement target goal for each P4P measure is accessible to the hospitals via the New Jersey DSRIP web portal log in at: https://dsrip.nj.gov/.

C. Measure Stewards

The Stage 3 and Stage 4 performance measures were selected based on their endorsement by respected national health care bodies and their broad usage for comparing quality performance. The health care entity that developed the measure is referred to as the measure steward. The measure steward acts as the "owner" of the measure and is the entity that sought and received national measure endorsement.

It is important to note that the measure steward is responsible for maintaining the detailed description of the measure. Measure descriptions that are made available to the public based on national endorsement include such data elements as the numerator and denominator specifications, standard error rates, algorithms, groupers, and risk adjustment methodologies, as applicable. National endorsement allows for open replication of the measure for comparative purposes by other health care entities provided that the required citations are met (See Section ii below for such citations). The measure steward is identified for each measure within the DSRIP specification sheet, as well as the Planning Protocol Addendums 1 and 2.

The measure stewards that are represented within the DSRIP program include:

1. Agency for Healthcare Research and Quality (AHRQ)
2. American Medical Association – Physician Consortium for Performance Improvement (AMA-PCPI)
3. Centers for Disease Control and Prevention (CDC)
4. Centers for Medicare & Medicaid Services (CMS)
5. Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
6. Health Resources and Services Administration (HRSA)
7. Institute for Clinical Systems Improvement (ICSI)
8. Minnesota Community Measurement (MNCM)
9. National Committee for Quality Assurance (NCQA)
10. The Joint Commission

Generally, the measure specifications have been followed and summarized within this databook. In some instances, it has been necessary to adjust the measure stewards' specifications in order to more closely align to the population and monitoring goals of the DSRIP program. *The measure specifications within this document are those of the measure steward unless such DSRIP changes were required*.

i. Measure Steward Specification Version

As each measure steward is responsible for the maintenance of the measure(s) they develop, each steward may follow different maintenance schedules. To ensure consistent usage by DSRIP providers, the DSRIP program will utilize the most recent finalized version made publicly available prior to October 15 of each calendar year. The databook will then be updated and a new version made available.

For example, the National Committee for Quality Assurance (NCQA) freezes the updates for their HEDIS® manual as of October 1 the year prior to the year of the titled version. The

HEDIS® 2013 Volume 2, Technical Specifications for Health Plans was made available as of October 1, 2012. The standard specifications apply to the previous calendar year and results must be submitted to NCQA by June 2013 in order to be available for public reporting.

Within the DSRIP specification sections, the measure steward specification version is identified for each measure for reference.

Note: When an update from a measure steward would significantly change the results of a measure for which baselines were set, the original version of the measure specification will be maintained for the duration of the DSRIP project.

ii. Measure Steward Citations –

The following citation applies to every measure associated with the named measure steward:

American Medical Association

Used with permission.

Center for Quality Assessment and Improvement in Mental Health (CQAIMH)

This measure is being used following the 2007 copyright specifications of the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) and in accordance with the endorsement by the National Quality Forum (NQF).

Institute for Clinical Systems Improvement (ICSI)

Copyright 2013 by Institute for Clinical Systems Improvement. Used with permission.

National Committee for Quality Assurance (NCQA)

Measure content has been sourced from the *HEDIS, Volume 2, Technical Specifications for Health Plans* by the National Committee for Quality Assurance (NCQA) and modified by New Jersey Department of Health Delivery System Reform Incentive Payment (DSRIP) program. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA has neither reviewed nor approved these modified measures.

The Joint Commission

The *Specifications Manual for National Inpatient Quality Measures* [] is the collaborative work of the Centers for Medicare & Medicaid Services and The Joint Commission. The *Specifications Manual* is periodically updated by the Centers for Medicare & Medicaid Services and The Joint Commission. Users of the *Specifications Manual for National Hospital Inpatient Quality Measures* must update their software and associated documentation based on the published manual production timelines.

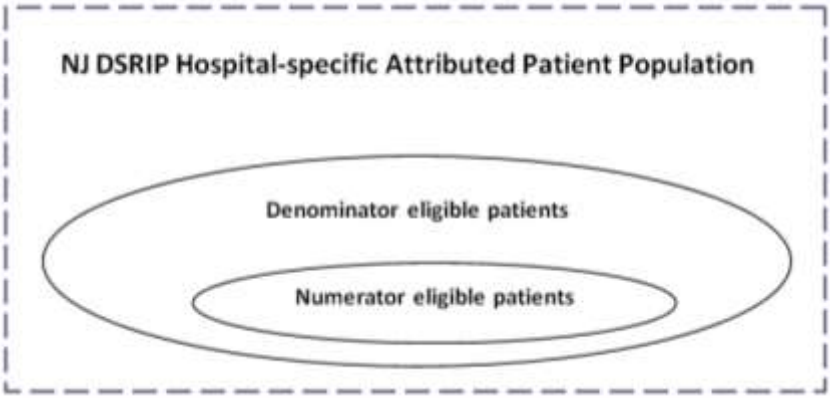
D. Data Reporting and Calculation Methods:

As discussed in Section A. above, the DSRIP program allows for multiple data collection methods to ensure broad and deep performance measurement. This section describes each calculation methodology as it applies to DSRIP and the anticipated collection steps by the DSRIP hospital and the hospital's project partners. These providers are collectively referred to as the "DSRIP Network." New Jersey Low Income population patients will be assigned to a hospital based on an attribution algorithm which includes the DSRIP Network as described in Section IV.

As a quick reference to locate the data source, hospitals may refer to the Planning Protocol addendums, "Addendum 1 – Stage 3 Measures Catalogue" and "Addendum 2 – Stage 4 Measures Catalogue" under the heading "NJ Data Source" where each measure is noted as "MMIS" (administrative claim collection methodology) or "Chart/EHR" (medical record collection methodology).

i. MMIS Measures:

The steps that follow describe the process that the ***Department*** will take on the behalf of hospitals in order to calculate measures that utilize MMIS data.



Step 1: The Department identifies the hospital-specific attributed patient population.

For each MMIS-calculated measure the first step is to capture the attributed patients for the hospital for which the measure is being run. The attribution section describes how the NJ Low Income population is linked to a hospital.

Step 2: Of those attributed patients, the Department identifies the patients that meet the ***denominator*** (D) criteria.

Step 3: Of those denominator patients, the Department identifies the patients that meet the ***numerator*** (N) criteria.

Step 4: The Department computes the result.

$$\text{Result} = \frac{\text{Numerator}}{\text{Denominator}}$$

Performance measures from a variety of care settings are represented in the DSRIP measure set. Examples are provided below. The setting of care for each measure is indicated on the DSRIP specification sheet.

a. *Inpatient or Emergency Department Setting* – refers to any MMIS measure that ***only*** considers care that was provided within the inpatient or emergency department setting. This could be monitoring a single episode of care or comparing care across inpatient or emergency department events.
   1. DSRIP # 1: 30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization
   2. DSRIP # 6: Adult Asthma Admission Rate

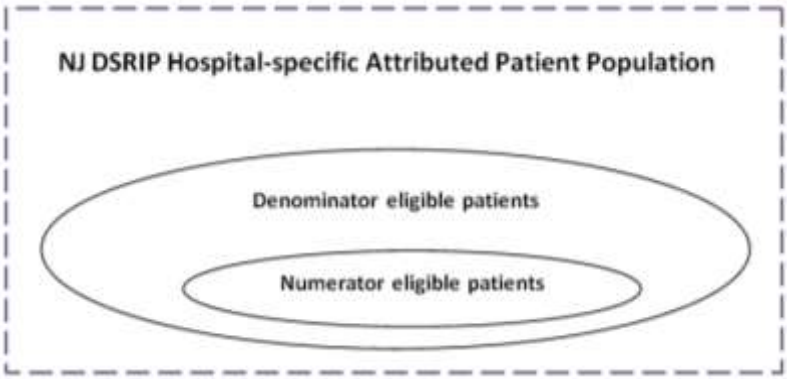
b. *Outpatient Setting* – refers to any MMIS measure that ***only*** considers care that was provided in an outpatient setting (e.g. hospital-based clinic, primary care office, Federally Qualified Health Center (FQHC), behavioral health clinic). This could be monitoring care for a single date of service or comparing care across multiple outpatient visits.
   1. DSRIP # 5: Adolescent Well-Care Visit
   2. DSRIP # 88: Well-Child Visits in the First 15 Months of Life

c. *Multi-Setting* – refers to any MMIS measure that considers care received in multiple settings of care. This may compare care across multiple service events, or to capture diagnosis and/or procedure codes to reflect patient treatment history. Comparing care across settings can determine if the expected coordination or follow-up care took place between settings.
   1. DSRIP #41: Follow-up After Hospitalization for Mental Illness
   2. DSRIP #29: Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing
   3. DSRIP # 16: Breast Cancer Screening

ii. Chart/ EHR Measures – Inpatient or Emergency Department Setting:

In this section, the steps that follow describe the process that the ***hospital*** will take in order to sample, abstract and calculate measures that utilize chart/ EHR collected data.

The following graphic represents data that is limited to the hospital's data only.



Step 1: The hospital receives the final retrospective attributed patient population list from the Department.

Step 2: The hospital runs a query of their EHR system limited to searching for information about the attributed patient population only. This query always first includes looking for the measure-specific denominator (D) criteria as outlined in the DSRIP specification sheet and detailed by the measure steward specifications. The result is referred to as the initial patient total.

Step 3: The hospital compares the initial patient total to the sampling tables to determine the number of patient records that must be abstracted (refer to Section III for sampling table information).

Step 4: The hospital runs a standard random sampling query to select the specific patient records for abstraction.

Step 5: The hospital staff reviews the sampled patient records to determine if the numerator (N) criteria have been met.

Step 6: The hospital enters the initial patient total, numerator and denominator values into the NJ DSRIP Standard Reporting Workbook. Formulas within the workbook will automatically calculate the result. The NJ DSRIP Standard Reporting Workbook is accessible via the the New Jersey DSRIP web portal log in at: https://dsrip.nj.gov/.

Examples of inpatient or emergency department setting chart/EHR measures that would follow these steps are provided.

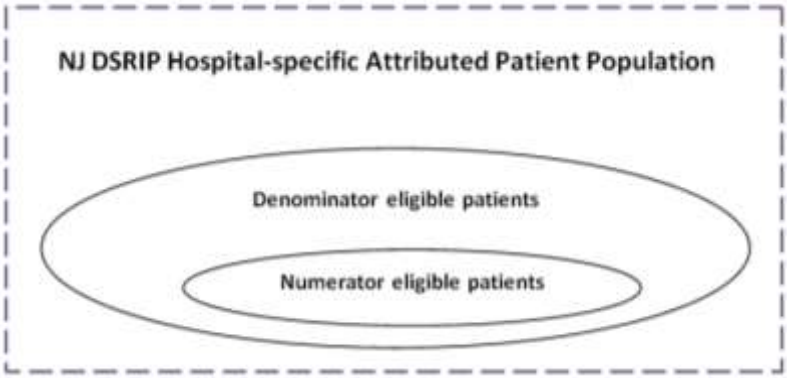
a. *Inpatient or Emergency Department Setting* – this refers to any chart/ EHR measure that only considers care that was provided within the inpatient setting. This could be a single episode of care or comparing the delivery of care across inpatient or emergency department events.
    1. DSRIP #6: Adult Asthma Admission Rate
    2. DSRIP #73: Post-Discharge Appointment for Heart Failure Patients

iii. Chart/ EHR Measure – Outpatient Setting Only – Single Reporting Provider:

In this section, the steps that follow describe the process that a ***single outpatient provider*** will take in order to sample, abstract and report measures to the hospital, which will then be reported to the Department.

The outpatient provider may be a hospital-based clinic or an outpatient community-based provider.

The following graphic represents data that is limited to the clinic's data only.



Step 1: The outpatient provider receives the final retrospective attributed patient population list from the Department.

Step 2: The outpatient provider runs a query of their EHR system limited to searching for information about the attributed patient population only. This query always first includes looking for the measure-specific denominator (D) criteria as outlined in the DSRIP specification sheet and detailed by the measure steward specifications. The result is referred to as the initial patient total.

Step 3: The outpatient provider compares the initial patient total to the sampling tables to determine the number of patient records that must be abstracted (refer to Section III for sampling table information).

Step 4: The outpatient provider runs a standard random sampling query to select the specific patient records for abstraction.

Step 5: The outpatient provider staff reviews the sampled patient records to determine if the numerator (N) criteria have been met.

Step 6: The outpatient provider submits the initial patient total, numerator and denominator values to the hospital along with patient-level data.

Step 7: The hospital enters the initial patient total, numerator and denominator values into the NJ DSRIP Standard Reporting Workbook. Formulas within the workbook will automatically calculate the result. The NJ DSRIP Standard Reporting Workbook is accessible via the the New Jersey DSRIP web portal log in at: https://dsrip.nj.gov/.

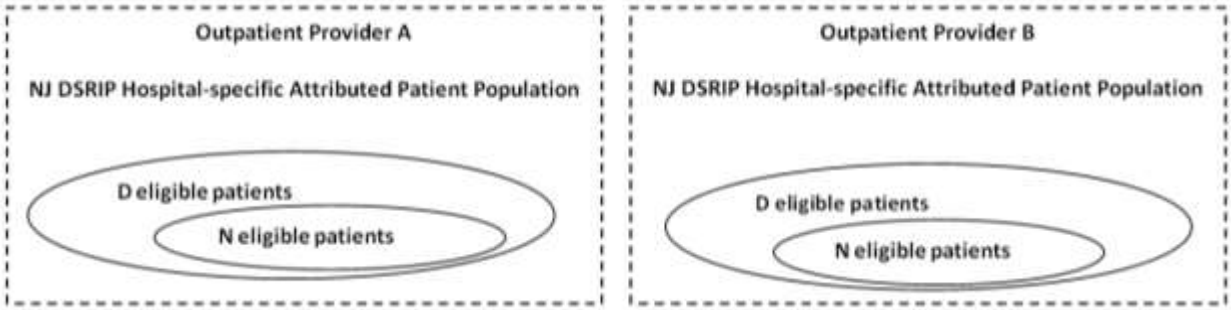
Examples of outpatient setting only, chart/ EHR measures that would follow these steps are provided.

a. *Outpatient Setting* –refers to any chart/ EHR measure that only considers care that was provided in an outpatient setting. This could be a single service event or a comparison across visits.
    1. DSRIP # 15: Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
    2. DSRIP # 65: Percent of patients evaluated for environmental triggers other than environmental tobacco smoke (dust mites, cats, dogs, molds/ fungi, cockroaches) either by history of exposure and/ or allergy testing
    3. DSRIP #79: Screening for Clinical Depression and Follow-up Plan

iv. Chart/ EHR Measure – Outpatient Setting – Multiple Reporting Providers:

If the hospital is partnering with ***multiple outpatient reporting providers,*** (e.g. multiple hospital-based clinics, multiple community-based reporting partners, a hospital-based clinic and an outpatient community-based reporting partner, a community-based reporting partner and an enhanced reporting partner) regardless of the combination that could collect the required performance data, the following sampling, abstraction and reporting steps apply.

The following graphic represents data that is limited to the clinics' data only. Provider A will only collect information available to Provider A. Provider B will only collect information available to Provider B.



Step 1: The outpatient providers receive the final retrospective attributed patient population list from the Department.

Step 2: Each outpatient provider runs a query of their EHR system limited to searching for information about the attributed patient population only. This query always first includes looking for the measure-specific denominator (D) criteria as outlined in the DSRIP specification sheet and detailed by the measure steward specifications. The result is referred to as the initial patient total.

Step 3: Each outpatient provider compares their initial patient total to the sampling tables to determine the number of patient records that must be abstracted (refer to Section III for sampling table information).

Step 4: Each outpatient provider runs a standard random sampling query to select the specific patient records for abstraction.

Step 5: Each outpatient provider staff reviews the sampled patient records to determine if the numerator (N) criteria have been met.

Step 6: Each outpatient provider submits the initial patient total, numerator and denominator values to the hospital along with patient-level data.

Step 7: The hospital compares the data received from each outpatient provider to determine if there is any patient duplication between providers. If duplication of patients exists, the hospital replaces the duplicate with an oversample record.

Step 8: The hospital enters the final initial patient total, numerator and denominator values for each provider into the NJ DSRIP Standard Reporting Workbook. The workbook will automatically calculate the applicable weighting factor and final adjusted aggregated performance result applicable for the hospital's DSRIP Network.

To obtain a hospital-level rate for a measure that is developed from the rates of multiple reporting entities, such as across multiple health clinics or physician offices, a weighted average of the individual rates will be calculated. How much any one reporting provider will contribute to the weighted average is based on the size of the provider's eligible population for the measure. This means that providers with larger eligible populations will contribute more toward the rate than those with smaller eligible populations.

Example of Reporting with Multiple Outpatient Providers:

Hospital X - "New Jersey State Hospital" is conducting Project 5 – Electronic Self-Assessment Decision Support Tool and partnering with two behavioral health clinics (Clinic A - "New Jersey State Community-based Clinic" and Clinic B – "New Jersey State Hospital-based Clinic") to implement the required interventions. From the Planning Protocol, Addendum 1 – Stage 3 Measures Catalogue, "New Jersey State Hospital" identifies that for Project 5 there are four Stage 3 measures required to be reported by their outpatient project partner: 5.2, 5.3, 5.5, and 5.9.

Specifically, for measure 5.2, "New Jersey State Hospital" identifies this measure as DSRIP #15 – Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use. The measure identifies the percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use and must be collected by a behavioral health provider. "New Jersey State Hospital" recognizes that Clinic A - "New Jersey State Community-based Clinic" and Clinic B – "New Jersey State Hospital-based Clinic" will be required to follow steps 1 through 6 described for outpatient measures with multiple partners. "New Jersey State Hospital" will complete steps 7 and 8.

Clinic A - "New Jersey State Community-based Clinic" receives the attributed patient population list and runs a query to identify patients that meet the denominator criteria (age, diagnosis and treatment history as described in the measure specification criteria for DSRIP measure #15). Clinic A's query returns 500 patients that meet all of the denominator criteria. This is their initial patient total.

Clinic B – "New Jersey State Hospital-based Clinic" follows the same procedures and their query returns 1500 patients which is their initial patient total. Although the total for both clinics is 2000, Clinic B has seventy-five (75) percent of the eligible patients and Clinic A, only twenty-five (25) percent. Each clinic's measure result will be multiplied by their associated population proportion for a weighted result.

Because the measure requires an annual measurement period, Clinic A compares their results to the annual sampling table provided in the sampling section. Clinic A determines that they must sample twenty-five (25) percent of their initial total population, for a total sample of 125 patient charts. Clinic B completes the same steps and determines that they must sample 250 charts.

Staff from Clinic A reviews each of the 125 charts to determine if the assessment for alcohol or other substance use was completed within 42 days of the initiation of treatment as required to meet the numerator criteria. 38 charts were found to be numerator compliant which results in a rate of 30 percent (.304). This percent is multiplied by the clinic's weighted factor for an adjusted rate of .076.

Of the 250 chart reviews completed by Clinic B, 63 are found to meet numerator criteria. The result is 25 percent (.252). The result is multiplied by the clinic's weighted factor for an adjusted rate of .189. The adjusted clinic rates are summed for an overall hospital rate of .265. This is rounded to the hundredth place for a final result of .265 or 26.50%.

<table>
<tr><th>BH Clinic A</th><th>BH Clinic B</th><th>Total Calculated Rate =</th></tr>
<tr><td>Query identifies = 500 patients</td><td>Query identifies = 1500 patients</td><td>2000 NJ Low Income patients</td></tr>
<tr><td>Sample required = 25% = 125</td><td>Sample required = 250</td><td>375 samples</td></tr>
<tr><td>N = 38</td><td>N = 63</td><td>N +N = 38 + 63 = 101</td></tr>
<tr><td>D = 125</td><td>D = 250</td><td>D +D = 125 + 250 = 375</td></tr>
<tr><td>% = 30% (38/125 =.304)</td><td>% = 25% (63/250 = .252)</td><td></td></tr>
<tr><th colspan="2">Clinic Adjusted Rate = (Calculated Result)(Weighted Factor)</th><th>Hospital Adjusted Total Rate</th></tr>
<tr><td>Weighted Factor for Clinic A - 500/2000 = 25%</td><td>(.304)(.25) = .076</td><td rowspan="2">.076 + .189 = .265 = 26.50%</td></tr>
<tr><td>Weighted Factor for Clinic B - 1500/2000 = 75%</td><td>(.252)(.75) = .189</td></tr>
</table>

This example can also be found in the Standard Reporting Workbook.

E. Data Specification Conditions

i. MMIS Represented Data

The data that is made available for performance measurement includes ***paid*** Medicaid and CHIP claims, ***both*** fee-for-service and managed care encounter claims and Charity Care claims.

ii. Performance Measure Calculation and Reporting Time Periods

Hospitals should adhere to the measurement periods identified in the specifications for each measure. There are several time periods that affect performance measures to be aware of and are defined below.

a. *Look-back Period* – Some measures are indexed to a specific date or event, such as a hospital discharge, where the measure requires that a certain diagnosis be present within a defined prior period to the index event for the patient to be included in the population. This prior period is referred to as the look-back period.
b. *Experience Period* –The experience period, otherwise referred to as the measurement period, indicates the specific duration of time in which the dates of service must take place in order to be considered for the measure.
c. *Reporting Period* – The time period for which the measure must be reported. New Jersey DSRIP measures must be reported annually or semi-annually. Each measure specification sheet indicates the reporting period, as well as when the report is due to be reported by, or on the behalf of, the hospital.
d. *Baseline Period* – The time period for which the first measurement will be computed. Future performance will then be compared against the baseline period. Each measure specification sheet indicates the baseline period. For MMIS measures, 2013 data will be utilized to set the measures' New Jersey improvement target goal (ITG). The baseline period for the majority of chart/EHR measures will utilize 2014 abstracted data unless otherwise noted.

iii. Eligible Population

The eligible population is referred to collectively as the New Jersey Low Income population. This includes Medicaid, CHIP and Charity Care patients. This includes fee for service, managed care and dual coverage (i.e. Medicare and Medicaid) populations. For all measures, the eligible population is assigned to a hospital based on the attribution model discussed in Section II and the denominator population is identified as a sub-set of these assigned patients based on meeting each measure's specific denominator criteria.

iv. Age Criteria

The age criterion is specific to each measure. The age can be calculated as of the last day of the measurement period or the date of the service.

a. *Age Stratifications* – Measure results can be categorized into population age ranges to drill down on clinical care outcomes for various age groups. The measure steward's age stratifications were followed unless the age ranges were considered to be too narrow or too broad to effectively capture DSRIP population health results. If the age stratification was modified, the age stratification of the Medicaid Adult or Child Core was used when appropriate. For instance, if a measure was originally captured for the Medicare population (65 years and older), it was adjusted to 18 through 64 and 65 years and older. This is documented in the measure specification sheet.

b. *Pay for Performance (P4P)* – When there are age stratifications, the age stratification that applies to P4P incentive payments will be the "Total" age group unless otherwise indicated.

v. Continuous Eligibility

This refers to the duration of time a patient must be eligible for benefits to be included in the measure denominator. The specifications provide the continuous enrollment requirement (if relevant), for each measure. Please note that although Charity Care patients do not have an established benefit period, Charity Care patients have been given a proxy twelve months of coverage if there is a single date of service within a year.

vi. Member Months

Member months are a member's contribution to the total yearly membership. Member months will be calculated based on counting members enrolled as of the last day of the month. Months in which members were enrolled retrospectively will be included in the count for total member months.

vii. Small numbers

a. *MMIS* - Regardless of the volume of patients identified in the denominator, the results will be reported on behalf of the hospital.
b. *Chart/ EHR measures* - If a measure has a denominator that is less than allowed by the applicable sampling table, the entire population is to be reported and sampling will not apply.

viii. Risk adjustment

Each 30-day readmission measure requires risk adjustment. These measures estimate the hospital-level 30-day all-cause risk-standardized readmission rate (RSRR) by using a hierarchical logistic regression model (a form of hierarchical generalized linear modeling [HGLM]). The model seeks to adjust for case differences based on the clinical status of the eligible patients. To complete this regression model, the Yale Group developed and designed a SAS program to be used with pre-processed CMS administrative data for the analysis of the Medicare population. However, these measures currently do not have a risk adjustor for the Medicaid population.

In order to use the SAS program to calculate readmission measures for New Jersey's Low Income population, the relevant Medicaid fields were identified. Medicare data elements were then cross-walked to appropriate Medicaid counterparts. The risk approach adjusts for key variables that are clinically relevant and have strong relationships with the outcome (e.g., age, gender, comorbid diseases and indicators of frailty). The risk adjustment process is discussed in more detail under each applicable measure and offers guidance to related detailed measure steward materials.

ix. Codes

a. *Code Specificity* – Appendix A has been updated to include Value Sets with the highest level specificitiy and should be utilized when determining measure results. To reduce the size of the Databook, the code tables within the measure specifications have been changed to code ranges.
b. *Code Table Versions* – National codes provided have been updated to the latest versions available. ICD-10 codes have been added alongside ICD-9 codes when provided by the measure steward. For measures that have not been updated, ICD-10 codes were mapped (forward only from ICD 9 to 10) using the AHRQ Map IT 2015 tool (http://www.qualityindicators.ahrq.gov/resources/Toolkits.aspx). Therefore, measure stewards that have utilized older versions will reflect updated codes.
c. *Adjustments* –The Medicare diagnosis related groups (MS-DRGs) are used by the Centers for Medicare & Medicaid Services (CMS) for hospital payment for Medicare beneficiaries and are utilized within the national measure specification. In order to more closely align to the DSRIP program, the specifications inclusive of the MS-DRGs have been substituted with New Jersey All Patient Diagnosis Related Groups (AP-DRG) for inpatient claims data measures. The crosswalk process does not account for payment of such groupings, but have been utilized to represent the steward's clinical specifications as closely as possible.
d. *Code Use* – Please note that the codes provided in the Databook are for quality analysis purposes only. These codes are published by the respective national measure stewards to determine measure results but may not reflect the care or billing practices of your organization.

x. Claim Types –

For both paper and electronic claim formats, the determination of what constitutes a claim is defined by National Billing Committees. Generalized guidelines are required on each claim to identify the type of service or Type of Bill represented by the submitted data. Certain bill types are designated by required data components which are utilized for the adjudication of the submitted claim, while other data components may be provided as a means of additional information only. The data elements required by the New Jersey Medicaid claim processing were identified through the use of billing supplements and training documents located within the NJMMIS website.

F. Standard Reporting Workbook Submission Procedures

The standard excel reporting workbook presented with this databook is expected to be completed by the hospital by entering the initial patient total, numerator and denominator values following the chart/EHR process previously described. The completed excel report is to be submitted via the the New Jersey DSRIP web portal at: https://dsrip.nj.gov/, the file transfer protocol (FTP) process, or other approved method, administered by the DOH's DSRIP vendor based on the reporting deadlines indicated by the measure specification.

Questions regarding the submission process may be forwarded to NJDSRIP@mslc.com.

G. MMIS Measure Acknowledgement Process

The MMIS data measure results computed on behalf of the hospitals will be made available to hospitals for viewing based on the reporting periods indicated in the measure specification.

The hospitals will be provided the opportunity to view and export the final numerator, denominator and computed results through the DSRIP webpage. Hospitals will be expected to provide acknowledgement to the Department of Health ("Department") in accordance with the DSRIP MMIS measures timelines and by following the steps below:

On the DSRIP website, the hospital will be able to log on to a secure portal with user profile information.

1. Each participating DSRIP hospital will select the applicable tab from the DSRIP website home page.
2. The selection will provide a user log-in box that will allow the user, based on the user's profile, to log directly onto the Acknowledgement page for the individual hospital.
3. From the Acknowledgement page, the user will be provided a list of those measures that are specific to their project as well as universal measures that are computed using the MMIS data source only.
4. The user page will contain the numerator, denominator and the calculated result for each measurement. The webpage will contain an option to export the information found on the acknowledgment page to the user's files by selecting the *Download* button located on the bottom left of the page.
5. The user will then select the *Acknowledgement* button located on the bottom right of the page to provide assurance to the Department that the information has been reviewed. By selecting the *Acknowledgement* button, the information will be electronically forwarded to the Department ensuring the hospital has had the opportunity to view their computed results.

II. Attribution Methodology –

A. Purpose

The fundamental objective of the attribution model is to identify the New Jersey Low Income patient population and assign patients to New Jersey hospitals to monitor the effects of the DSRIP program on population health. The intent is to do this in a way that best reflects the patient-hospital relationship and the patient's historical service utilization. In particular, this assignment will monitor a defined population and the influence of the hospital's project performance on patients' utilization of services and health care outcomes. This effect is quantified and then monitored by means of project-specific (Stage 3) and universal (Stage 4) performance measure sets.

B. Overview of Attribution

Following the requirements of Section VII.A. of the Planning Protocol, performance measurement for both Stage 3 and Stage 4 metrics will measure improvement based on a model to link the New Jersey Low Income patient population to DSRIP hospitals based on a federal attribution model (e.g. Pioneer Accountable Care Organization (ACO) or Medicare Shared Savings Program (MSSP)) or a state model (e.g. state ACO or Medicaid Managed Care Organization (MCO)).

Generally, these attribution models seek to determine which provider, or sets of providers, should be assigned responsibility for a patient's care. The goal of attribution is to capture as closely as possible the relationship between patients and providers. In order to do this, some important procedural choices are considered and these are discussed briefly below. The New Jersey DSRIP model aligns attribution features to those programs mentioned above, but when necessary, makes adjustments to more precisely meet the objectives of this unique program.

i. Prospective vs. Retrospective

Prospective attribution uses historical claims to link patients with providers prior to the start of a specified measurement (experience) period. In this method, providers know in advance those patients for whom they are responsible. If the model seeks to emphasize a longitudinal patient-provider relationship, then multiple years of data are used.

Retrospective attribution also assigns patients to providers using historical claims. However, in a retrospective model, attribution occurs at the end of the measurement period. This approach attempts to include only those patients who have actually received care from the providers to whom they are linked and for which performance measurement is based on.

For the New Jersey DSRIP program, hospitals will be able to receive a preliminary prospective attribution list to support identification, outreach and engagement of patients

in a hospital project. For computation of the measures, a final retrospective attribution will apply.

ii. Providers

Historically, attribution models have assigned patients to primary care physicians (PCP), physician groups, or accountable care organizations (ACOs) comprised of PCP's and select specialists.

For New Jersey DSRIP, the hospital setting (i.e. the hospital-based clinic and emergency department) is the emphasized provider in order to efficiently match the patient to the responsible entity leading the DSRIP project (i.e. the participating hospital). However, it will also consider services received at settings other than the hospital. It will also include the care received at the hospital's community-based reporting partner.

iii. Types of Services

Physician-based attribution models typically have used all physician claims or Evaluation and Management (E&M) physician claims to detect historical data utilization patterns to tie patients to providers.

For New Jersey DSRIP, E&M claims (across all places of service) are used to determine patients' historical patterns of care. This includes those E&M visits provided in the hospital ED. The inclusion of ED claims will help identify those patients who need to develop and enhance primary care utilization. Improper utilization of the ED can be an important signal of those patients who have the greatest need for chronic care coordination. Effective management of care for these patients will demonstrate the delivery system reform improvements anticipated for the DSRIP program.

iv. Single vs. Multiple

Another key element of patient attribution is whether the model assigns a patient only to a single provider or to multiple providers. Multiple attribution suggests that no singular provider can be assigned sole responsibility for a patient's care because no one provider has complete control over a patient's health care decisions. However, this approach makes accountability for performance measurement problematic.

In the New Jersey DSRIP model, single attribution is used. A patient is assigned a single hospital.

v. Patient vs. Episode

An additional aspect of attribution is the spectrum of health services included. One method bases attribution to a provider on an episode of clinical services. An episode of care begins from the diagnosis of symptoms until treatment is complete. The provider is not held responsible for a patient's care beyond the single episode of care. The more common approach is to consider the full range of services for a patient over a specified time period,

e.g., a measurement year. In the patient-based approach, a provider is assigned a patient for the entire time period.

In the New Jersey DSRIP model, patient attribution is used.

vi. Plurality vs. Majority

Attribution models must decide whether assignment is based on a patient receiving a majority or plurality of services from a provider. A majority is defined as more than 50% of the patient's health care services (either visits or costs). A plurality is defined more simply as the largest proportion of services (either visits or costs). A plurality-based methodology is typically adopted in attribution models because it allows for a greater assignment of patients.

In the New Jersey DSRIP model, assignment is based on a plurality (i.e. simple majority) of visits.

vii. Visits vs. Cost

The attribution method can be based on visits or some measure of provider payments. Most often, a plurality of services is based on either a count of visits or a sum of costs. Models using the cost approach typically use allowed charges which are not distorted by third-party payments. The method of using a plurality of allowed charges emphasizes the more complex services as captured by cost, whereas counting visits weights all services equally.

In the New Jersey DSRIP model, E&M visits are used. As the administrative claims include managed care data that was paid by a contracted health plan and then submitted to the state for data capture, the use of visits over payments maximizes validated adjudication procedures.

The time period of the visits are also taken into account. More recent service history receives an increased weighting value which emphasizes a patient's current utilization and provider affiliation over their historical utilization. The weighting factor applied for the New Jersey DSRIP model is 30/70.

viii. Minimum Patient Volume

In the New Jersey DSRIP model, there is no minimum patient volume as there are in the federal attribution models.

C. New Jersey DSRIP Attribution Process

All of the features mentioned above are components of the attribution design. Specifically, for the initial assignment, the New Jersey model takes into account all New Jersey Low Income patients with service utilization during the years 2012 and 2013. The most recent year receives a weighted factor of 70 percent, while the earlier year receives a 30 percent weight.

As previously discussed, the service history of each patient is based on evaluation and management (E&M) billing codes. The same E&M codes that are utilized in the Medicare models are used, plus the addition of select emergency department (ED) codes. These are provided in Appendix B -Programming Assumptions. Once the E&M codes are identified for each patient, the visit counts are multiplied by the applicable weighting factor.

Note: In DY3 and DY4, attribution was calculated once per year. Starting in DY5, attribution will be calculated twice a year for semi-annual measures.

Each patient's E&M visits are arranged in a hierarchical grouping:

- Category 1 - Visits to hospital-based clinics are grouped together– A hospital-based clinic is defined as a clinic that is allowed to bill under the hospital's provider identifier, is included on the hospital's cost report, and bills on the Universal Bill (UB) claim form with specified revenue codes (510-519). Refer to Appendix B for further detail.

- Category 2 - Visits to emergency departments are grouped together

- Category 3 - Visits to community-based reporting partners are grouped together– A community-based reporting partner is any outpatient group/ facility/ clinic affiliated to the hospital that has an agreement with the hospital to improve population health through improved care coordination, as well as one who will collect and report on Stage 3 DSRIP measures.

  A community-based reporting partner can be identified as a clinic that does not bill as a hospital-based clinic. This could be a Federally Qualified Health Center (FQHC), a physician practice group, or behavioral health facility. A community-based reporting partner will be included in the development of the Improvement Target Goals (ITGs). Enhanced reporting partners are another type of community-based reporting partner. Enhanced reporting partners are those who have to develop reporting infrastructure and will not be included in the setting of the ITGs.

- Category 4 - Visits to all other non-participating providers are grouped together

To act as further evidence of an established relationship with a provider, a minimum threshold of ten percent (10%) of utilization per category is included in the attribution approach. If a patient has received ten percent of their total visits within Category 1, the patient will be

assigned based on those visits. If the threshold is not met, the model cascades through the hierarchy to the category where the minimum threshold is met.

If a patient has visits with multiple providers ***within*** a category, the patient is then attributed to the provider with the plurality (i.e. simple majority) of visits within the category.

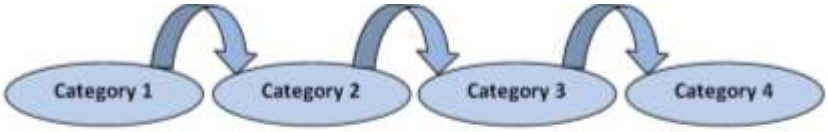
The steps for the attribution approach are as follows:

Step 1: Review Category 1

Step 2: Determine if Category 1 weighted visit total meets 10% threshold

Step 3: If the threshold is met, identify the provider with the plurality (i.e. simple majority) of visits within Category 1

Step 4: If the threshold is not met, proceed to next category and repeat steps.



Patient Smith - Attribution Example:

Provider	Visits (unweighted)	Weighted Visits	Attribution Category
Category 1: Hospital-based Clinics			
Hospital-based Clinic A	4	1.2	Hospital-based Clinic
Category Total	4	1.2	
Category %	5.19%	2.57%	Hospital-based Clinic
Category 2: Emergency Departments			
Hospital ED A	31	**19.7**	ED
Hospital ED B	31	19.3	ED
Hospital ED C	8	4.4	ED
Category Total	70	43.4	
Category %	90.91%	92.93%	ED
Category 3: Community-based Reporting Partners			
Community-based Partner	0	0	Project Partner
Category Total	0	0	
Category %	0.00%	0.00%	Project Partner
Category 4: All other providers; No attribution			
FQHC	2	1.4	Non-Hospital
Physician	1	0.7	Non-Hospital
Category Total	3	2.1	

Category %	3.90%	4.50%	Non-Hospital
Overall Total	**77**	**46.7**	

Patient Smith has had 77 total visits during the years 2012 and 2013. After taking into account the applicable weighting factor based on the year of the service, the total weighted visits is 46.7. Within Category 1, the service
visit total does not meet the required 10% threshold. Within Category 2, the threshold is met and there are three hospitals where the patient has received care. Although the patient saw both Hospital A and Hospital B a total of 31 times over the course of the two year period, Hospital A has a slightly more established relationship with the patient as identified by the weighted visit total. The patient is attributed to Hospital A.

III. Sampling Methodology

A. Sample Size for Hospital Measures

Hospitals that choose to sample in order to collect and report chart/ EHR measure results have the option of sampling semi-annually or sampling on an annual basis depending upon the experience period of the measure. The sample size requirements for each of these options are described below. Hospitals need to round to the next highest whole number when determining their required sample size. See below for rounding examples.

Hospitals selecting sample cases for measures that are not stratified must ensure that its initial total patient population and sample size meet the conditions stated in Table 1.

Once the population size has been calculated, a representative random sample can be chosen using Table 1 for annual samples or Table 2 for semi-annual samples.

Note: **Hospitals are not required to sample their data.** If sampling offers minimal benefit (i.e., a hospital has 80 cases for the quarter and must select a sample of 76 cases) the hospital may choose to use all cases.

Sample Table 1: Annual Sample Size Example

Annual Denominator Initial Patient Total *"N"*	Minimum Required Sample Size "n"
>1001	250
401 - 1000	25% of the Denominator Patient Population
151 - 400	100
76 - 150	75
46 - 75	45
1-45	No sampling; 100% of the Denominator Patient Population is required

i. Annual Examples

1. A hospital's Hypertensive Initial Patient Total is 43 patients during the year. Using the above table, no sampling is allowed – 100 percent (%) of the population is required.
2. A hospital's Heart Failure Initial Patient Total is 300 patients during the year. Using the above table, the required sample size is seen to be a minimum of 100 patients.
3. A hospital's Diabetic Initial Patient Total is 450 patients during the year. Using the above table, the required sample size is seen to be 25 percent (%) of the population, or 113 cases for the year.

Sample Table 2: Semi-Annual Sample Size

Denominator Semi-Annual Initial Patient Total *"N"*	Minimum Required Sample Size "n"
>501	150
301 - 500	25% of the Denominator Patient Population
76 - 300	75
46 - 75	45
1-45	No sampling; 100% of the Denominator Patient Population is required

i. Semi-Annual Examples

1. A hospital's Preterm Newborn Initial Patient Total is 25 patients during the six month performance period. Using the above table, no sampling is allowed – 100 percent (%) of the population is required.
2. A hospital's Asthma Initial Patient Total is 130 patients during the six month performance period. Using the above table, the required sample size is seen to be a minimum of 75 patients for this month.
3. A hospital's Nulliparious Singleton Delivery Initial Patient Total is 301 patients during the semi-annual period. Using the above table, the required sample size is seen to be 25 percent (%) of the population, or 76 cases for the month (twenty percent of 301 equals 75.25 rounded to the next whole number equals 76).

ii. Steward-specific Sampling Procedures

For hospitals selecting sample cases for stratified measure sets or measure sets with sub-populations (CAC and VTE), a modified sampling procedure is required. Hospitals selecting sample cases for these sets must ensure that each individual stratum's population/sub-population and sample size meets the conditions stated in the measure steward's Sample Size Requirements. (See VTE and CAC sample requirements from the Joint Commission as indicated within the DSRIP measure specification.)

IV. Specification Sheet Description and Definitions

Each measure specification sheet is divided into four sections.

- The opening section provides high level references including the measure title, DSRIP number, measure description, data source, National Quality Forum (NQF) number, the measure steward and measure steward version.
- The second section is labeled the "**Measure Calculation Description**." This section provides the primary information required to calculate the measure including the numerator, denominator, result information and any qualifications to the criteria that provide additional information.
- The third section is labeled "**Measure Collection Description**" and provides fields related to the collection process for example the setting of care, reporting parameters and whether sampling, continuous eligibility or risk adjustment applies to the measure. This section will also include the improvement target goal details.
- The final section is labeled "**DSRIP Incentive Impact**" and identifies the Stage 3 projects that the measure applies to, whether the measure applies to Stage 4/ Universal reporting by hospitals and the financial incentive award as either pay for reporting or pay for performance (P4P).

The following fields, as defined here, are included in the measure specifications sheets. The possible field entries are indicated.

1. **Measure** – provides the name of the measure.

2. **DSRIP #** – provides the overall DSRIP program number. As there are some measures that are represented in both Stage 3 and Stage 4 Catalogues, this is a unique number that can quickly identify the measure for tracking purposes.

3. **Measure Description** – provides a short explanation of the purpose of the measure.

4. **Data Source** – indicates the method of the data collection.
    a. Chart/ EHR
    b. MMIS

5. **NQF#** – the National Quality Forum (NQF) is a non-profit organization that endorses and publicly reports health care quality measure specifications. If the NQF has endorsed a measure, the NQF is provided to assist the hospital in determining whether the hospital currently collects and reports the measure for other programs.

6. **Measure Steward** – the measure steward is the health care entity that developed and maintains the original measure specifications. This information is provided to assist the hospital in determining whether the hospital currently collects and reports the measure for

other programs. The measure steward provides the detailed specification information regarding the measure that should be reviewed to support the hospital's measurement processes.

7. **Measure Steward Version** – through the measure maintenance process, measure specifications are adjusted and refined based on the most currently available clinical and technical information. This results in different specification versions in use for the same measure. To ensure that hospitals can compare the DSRIP measure specification to the measure steward's version, the version number is provided. When codes were referenced from multiple versions of the measure, the source for each code type is noted.

8. **Numerator** – defines the specific criteria that identifies the portion of the patient population that meet the specific performance measurement.

9. **Denominator** – defines the general criteria which identifies the patient population eligible for measurement.

10. **Result** – the calculated performance. This can be expressed as either a rate or percentage.
    a. *Percentage* – this is the most commonly used indicator of healthcare to monitor measure compliance. A percentage measures the number of a certain set of events that are proportional to one another. The numerator and denominator are the same unit of measurement and the numerator is a subset of the denominator.
    b. *Rate* – this is a specific kind of ratio, in which two measurements are related to each other but do not utilize the same unit of measurement. The numerator is not a subset of the denominator when a rate is calculated. A rate measures the number of events compared to another unit of measurement, for example the utilization per member months.

11. **Setting of Care** – this field lists where the service(s) was rendered and helps identify which provider type has the information available.

    a. *Inpatient or Emergency Department Setting* – this refers to any measure that ***only*** considers care that was provided within the inpatient or emergency department setting and is information available to the hospital.
    b. *Outpatient Setting* – this refers to any measure that ***only*** considers care that was provided in an outpatient setting. This information may be available at the hospital-based clinic if the service is offered, or the community-based reporting partner.
    c. *Multi-Setting* – this refers to any *MMIS* measure that considers care that was received across multiple cares settings.

12. **Measure Qualifications** – this field allows for additional information to be included in the measure specification. This may include such information as links to the measure steward, references to usage of the measure in other data sets, or it may indicate where the original

specification was adjusted to more accurately follow the objectives of the DSRIP program (e.g. changes to measure stratifications).

13. **Experience Period** – this field, otherwise known as the measurement or performance period, indicates the specific interval of time that a service must take place within in order to be considered o meet the measure criteria.
    a. *Calendar year* – Annual DSRIP measurement will be based on the calendar year as compared to the federal fiscal year or state fiscal year as some measure sets allow.
    b. *Six (6) months* – Semi-annual DSRIP measurement will be based on six months of calendar year data.

14. **Baseline Period** – this is the time period for which the first measurement will be reported and subsequent performance measured against. Each measure's data source and experience period will impact the baseline period. The MMIS baseline period will initially be 2013 to set the overall measure improvement target goal (ITG).

15. **Improvement Target Goal (ITG)** – the improvement target goal serves as the standard level of performance that New Jersey hospitals will strive to obtain. Note: ITG's have been removed from this document and can been viewed on the New Jersey DSRIP website: (https://dsrip.nj.gov/) > DSRIP Program Management > Measure Results (after logging in).

16. **Absolute ITG Value** – this field represents the absolute numeric value represented for the improvement target goal. Note: Absolute ITG Values have been removed from this document and can been viewed on the New Jersey DSRIP website.

17. **Attribution Date** – this field indicates whether attribution applies to the measure, and if so, will indicate that the attribution date that impacts the performance measure can be no earlier than the last day of the experience period. Note: The attribution date has been removed from this document and can been viewed on the New Jersey DSRIP website.

18. **Anchor Date** – indicates whether a measure requires a patient to be eligible on a particular date in order to be included in the denominator population. Note: The anchor date has been removed from this document.

19. **Claim Type(s)** – the claim type represents required data components utilized for the adjudication of a claim for payment. The New Jersey claim type values that were used for programming the MMIS measures are identified for each MMIS measure.

20. **Continuous Eligibility** – this field indicates whether continuous eligibility applies to the measure. If it does not, NA will be marked.

21. **Risk Adjustment** – this field indicates whether risk adjustment applies to the measure. If it does not, NA will be marked.

22. **Sampling** – this field indicates whether sampling applies to the measure. If it does not, NA will be marked.

23. **Continuous Eligibility/ Risk Adjustment/ Sampling Methodology** – this field provides instructions if any of these elements apply to the measure.

24. **Project Title** – if the measure applies to a Stage 3 project, this field denotes the applicable project(s).

25. **Project Code** – if the measure applies to a Stage 3 project, this field denotes the project code referred to within the Stage 3 measure catalogue.

26. **Payment Method** – if the measure applies to a Stage 3 project, this field denotes whether the incentive award is based on pay for reporting, or pay for performance (P4P).

27. **Universal Measure** – this field indicates whether the measure applies to Stage 4 reporting. If it does not, NA will be marked.

28. **Universal Code** – if the measure applies to Stage 4 reporting, this field denotes the project code referred to within the Stage 4 measure catalogue.

29. **Payment Method** – if the measure applies to Stage 4 reporting, this field denotes whether the incentive award is based on pay for reporting, or applies to the universal performance pool (UPP).

30. **Data Elements** – The Data Elements section of some of the chart-based measures is designed to be a starting point for data collection from the medical chart and/or electronic health record (EHR). As it may not be inclusive of every item needed to report the measure accurately and completely, a thorough study of the measure's numerator and denominator, inclusion and exclusion criteria and collection procedures will be required to determine all of the data elements needed from the medical chart or the EHR.

***IMPORTANT NOTE FOR MEASURE SPECIFICATIONS:**

The measure steward should be referred to for detailed analysis, flow charts and specifications. The DSRIP specification sheet provides the high level requirements for collection and reporting for DSRIP. The measure steward offers further details and rationale that may be important for the hospital to review.

Measure:

DSRIP #: 10

Antenatal Steroids

Measure Description:
This measure assesses patients at risk of preterm delivery at ≥ 24 and < 34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns.

Data Source:
Chart/ EHR

NQF #:
0476

Measure Steward:
Joint Commission

Measure Steward Version:
~~2015A1 (ICD 9)~~
~~2015B1 (ICD 10)~~
2016 A1

Measure Calculation Description

Numerator:
Patients with antenatal steroid therapy initiated prior to delivering preterm newborns.

Antenatal steroid therapy initiated - Initial antenatal steroid therapy is 12mg betamethasone IM or 6mg dexamethasone IM.

Table 10.1: Medications indicating antenatal steroid therapy: (Appendix A-25)

Medication	Generic
Betamethasone	Betamethasone
Betamethasone Sodium Phosphate	Betamethasone Sodium Phosphate
Betamethasone Sodium Phosphate and Betamethasone Acetate	Betamethasone Sodium Phosphate and Betamethasone Acetate
Celestone	Betamethasone
Celestone Phosphate	Betamethasone Sodium Phosphate
Celestone Soluspan	Betamethasone Sodium Phosphate and Betamethasone Acetate
Cortastat	Dexamethasone Sodium Phosphate
Dalalone	Dexamethasone Sodium Phosphate
Dalalone DP	Dexamethasone Acetate
Dalalone LA	Dexamethasone Acetate
Decadron	Dexamethasone
Decadron LA	Dexamethasone Acetate
Decadron Phosphate	Dexamethasone Sodium Phosphate
Decadron w/Xylocaine	Dexamethasone Sodium Phosphate with Lidocaine HCL
Decaject	Dexamethasone Sodium Phosphate
Decaject LA	Dexamethasone Sodium Phosphate
Dexamethasone	Dexamethasone
Dexamethasone Acetate	Dexamethasone Acetate
Dexamethasone Intensol	Dexamethasone

Dexamethasone Sodium Phosphate	Dexamethasone Sodium Phosphate
Dexamethasone Sodium Phosphate with Lidocaine	Dexamethasone Sodium Phosphate with Lidocaine
Dexamethasone Sodium Phosphate with Lidocaine HCL	Dexamethasone Sodium Phosphate with Lidocaine HCL
Dexasone	Dexamethasone Sodium Phosphate
Dexasone LA	Dexamethasone Acetate
Dexone	Dexamethasone
Dexone LA	Dexamethasone Acetate
Hexadrol	Dexamethasone
Hexadrol Phosphate	Dexamethasone Sodium Phosphate
Solurex	Dexamethasone Sodium Phosphate
Solurex LA	Dexamethasone Acetate

Denominator:
Of the New Jersey Low Income attributed population, those patients who are 8 to 64 years of age delivering live preterm newborns (Appendix A-22) with >=24 and <34 weeks gestation completed (Appendix A-23).

Exclusion(s):
1. Less than 8 years of age.
2. Greater than or equal to 65 years of age.
3. Length of Stay >120 days.
4. Enrolled in clinical trials.
5. Documented Reason for Not Initiating Antenatal Steroid Therapy.
6. ICD-9-CM/ICD-10-CM Principal Diagnosis Code or ICD-9-CM/ICD-10-CM Other Diagnosis Codes for fetal demise as defined as follows (Appendix A-24):
    a. ICD-9: 656.40 Intrauterine death-unsp,
    b. ICD-9: 656.41 Intrauter death-deliver
    c. ICD-10: O36.4XX0 Maternal care for intrauterine death, not applicable or unspecified
7. Gestational Age < 24 or >= 34 weeks or unable to determine (UTD) (Appendix A-23).

Result:
The result is expressed as a percentage

Improvement Direction:
Higher

Measure Qualifications:
This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-03: Antenatal Steroids).

Data Elements:

Numerator:

- *Antenatal steroids initiated*

Denominator:

- *Admission Date*
- *Birth Date*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *ICD-9-CM/ICD-10-CM Other Diagnosis Codes*
- *ICD-9-CM/ ICD-10-CM Principal Diagnosis Code*
- *Reason for Not Initiating Antenatal Steroid Therapy*

Notes for Abstraction:

If there is documentation that antenatal steroid therapy was initiated prior to current hospitalization in another setting of care, i.e., doctor's office, clinic, birthing center, hospital before delivery, select allowable value "yes".

If antenatal steroid therapy was initiated in the hospital, the name of the medication must be documented in the medical record in order to select allowable value "yes".

The following link(s) may be used to obtain additional information regarding the specific instructions on the measurement qualifications and data collection. This is provided without assurances:

http://www.jointcommission.org/core_measure_sets.aspx

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 29	Payment Method: Pay for Reporting

Measure:

DSRIP #: 89

Asthma: Pharmacologic Therapy for Persistent Asthma

Measure Description:
Percentage of patients with mild, moderate, or severe *persistent* asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid)* or an acceptable alternative treatment.

*In patients with moderate or severe persistent asthma, strong evidence indicates that use of long-acting inhaled beta2-agonists (LABA) *in combination with* inhaled corticosteroids (ICS) leads to improvements in lung function and symptoms, and reduced supplemental bronchodilator use. LABA is not recommended for use as monotherapy.

Data Source:	NQF #:
Chart/ EHR	**0047**
Measure Steward:	Measure Steward Version:
AMA-PCPI	**2005**

Measure Calculation Description

Numerator:

Patients who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.

Long Term Control Medication Includes:
Patients prescribed inhaled corticosteroids (the preferred long-term control medication at any step of asthma pharmacological therapy)
OR
Patients prescribed alternative long-term control medications (inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, methylxanthines)

Prescribed – May include prescription given to the patient for inhaled corticosteroid OR an acceptable alternative long-term control medication at one or more visits in the 12-month period OR patient already taking inhaled corticosteroid OR an acceptable alternative long-term control medication as documented in current medication list.

Denominator:
Of the New Jersey Low Income attributed population, those patients aged 5-40 years with mild, moderate, or severe *persistent* asthma.

The primary care office or FQHC should refer to the measure steward for detail, rationale and instruction regarding proposed methods to collect the required clinical data for reporting.

Table 89.1 Classification of Asthma Severity

	Symptoms[b]	Nighttime Symptoms	Lung Function	Recommended Treatment
Step 4: Severe Persistent[c]	Continual symptoms Limited physical activity Frequent exacerbations	Frequent	FEV_1 or PEF ≤60% predicted PEF variability >30%	**Preferred treatment:** • High-dose inhaled corticosteroids **and** • Long-acting inhaled beta2-agonists **And**, if needed, • Corticosteroid tablets or syrup long term (2 mg/kg/day; generally do not exceed 60 mg per day). (Make repeated attempts to reduce systemic corticosteroids and maintain control with high-dose inhaled corticosteroids.)
Moderate Persistent	Daily symptoms Daily use of inhaled short-acting beta2-agonist Exacerbations affect activity Exacerbations ^{3}2 times a week; may last days	>1 time a week	FEV1 or PEF >60%-<80% predicted PEF variability >30%	**Preferred treatment:** • Low-to-medium dose inhaled corticosteroids and long-acting inhaled beta2-agonists **Alternative treatment** (listed alphabetically): • Increase inhaled corticosteroids within medium-dose range **or** • Low-to-medium dose inhaled corticosteroids and either leukotriene modifier or theophylline If needed (particularly in patients with recurring severe exacerbations): **Preferred treatment:** • Increase inhaled corticosteroids within medium-dose range, and add long-acting inhaled beta2-agonists **Alternative treatment** (listed alphabetically): • Increase inhaled corticosteroids in medium-dose range, and add either leukotriene modifier or theophylline
Mild Persistent	Symptoms >2 times a week but <1 time a day Exacerbations may affect activity	>2 times a month	FEV or PEF ≥80% predicted PEF variability 20-30%	**Preferred treatment:** • Low-dose inhaled corticosteroids **Alternative treatment** (listed alphabetically): cromolyn, leukotriene modifier, nedocromil, **or** sustained release theophylline to serum concentrations of 5-15 mcg/mL

[b]Patients at any level of severity can have mild, moderate, or severe exacerbations. Some patients with intermittent asthma experience severe and life-threatening exacerbations separated by long periods of normal lung function and no symptoms.
[c] Referral to an asthma specialist is recommended if there are difficulties achieving or maintaining control of asthma or if the patient requires step 4 care. Referral may be considered if the patient requires step 3 care.

Exclusion(s):

1. Documentation of patient reason(s) for not prescribing either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment, economic, social, and/or religious, etc.
2. Asthma Severity - Mild Intermittent as defined in table below

Table 89.2 Mild Intermittent Exclusion

	Symptoms[b]	**Nighttime Symptoms**	**Lung Function**	**Recommended Treatment**
Step 1: Mild Intermittent	Symptoms ≤2 times a week Asymptomatic and normal PEF between exacerbations Exacerbations brief (from a few hours to a few days); intensity may vary	≤2 times a month	FEV1 or PEF ≥80% predicted PEF variability <20%	No daily medication needed Severe exacerbations may occur, separated by long periods of normal lung function and no symptoms. A course of systemic corticosteroids is recommended

[b]Patients at any level of severity can have mild, moderate, or severe exacerbations. Some patients with intermittent asthma experience severe and life-threatening exacerbations separated by long periods of normal lung function and no symptoms.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the specific instructions on the measurement qualifications and data collection. This is provided without assurances:

This measure is no longer available on the AMA-PCPI website.

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **6 month period**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**
Sampling or Risk Adjustment Methodology This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.	

DSRIP Incentive Impact		
Project Title: Project 1 – Hospital-Based Educators Teach Optimal Asthma Care	Project Code: Substitution measure	Payment Method: P4P
Project Title: Project 2 – Pediatric Asthma Case Management and Home Evaluations	Project Code: Substitution measure	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 15**

Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use

Measure Description:
Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use

Data Source:	NQF # (No longer endorsed):
Chart/EHR	**0110**
Measure Steward:	Measure Steward Version:
CQAIHM	**2007**

Measure Calculation Description

Numerator:
Patients with evidence of an assessment for alcohol or other substance use following or concurrent with the new diagnosis and prior to or current with the initiation of treatment for that diagnosis.

Numerator Inclusion Criteria:
Documented assessment for use of alcohol and chemical substance use; to include at least one of the following:

1. Clinician documentation regarding presence or absence of alcohol and chemical substance use.
2. Patient completed history/ assessment form that addresses alcohol and chemical substance use that is documented as being noted/ acknowledged by clinician performing the assessment.
3. Use of screening tools that address alcohol and chemical substance use.

AND

Timeframe: Documentation of the assessment for alcohol and chemical substance use **must be present prior to, or concurrent with, the visit where the diagnosis and/ or treatment plan is first documented.**

Denominator:
Of the New Jersey Low Income attributed population, those patients 18 years of age or older at the start of the measurement period with a new diagnosis of unipolar depression or bipolar disorder during the first 323 days of the measurement period, and evidence of treatment for unipolar or bipolar disorder within 42 days of diagnosis.

The existence of a 'new diagnosis' is established by the absence of diagnoses and treatments of unipolar depression or bipolar during the 180 days prior to the diagnosis.

Denominator Inclusion Criteria:

1. Documentation of a diagnosis involving unipolar depression or bipolar disorder to include at least one of the following:
   a. Documentation of a diagnosis or impression involving unipolar depression (Table 15.1) or bipolar disorder (Table 15.2); documented in the body of a chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/form

b. Use of a screening/assessment tool for unipolar depression or bipolar disorder with a score or conclusion that patient has unipolar depression or bipolar disorder and indication that this information is used to establish or substantiate the diagnosis

Table 15.1: Codes to Identify Unipolar Depression (Appendix A-26)

Description	Code Type	Code
Unipolar Depression	ICD-9-CM	- 296.20-296.26, 296.30-296.36, 300.4, 311
	ICD-10-CM	F32.0-F32.9, F33.0-F33.3, F33.9, F33.41, F33.42, F34.1

Table 15.2: Codes to Identify Bipolar Disorder (Appendix A-27)

Description	Code Type	Code
Bipolar Disorder	ICD-9-CM	296.00-296.06, 296.10-296.16, 296.40-296.46, 296.50-296.56, 296.60-296.66, 296.7, 296.80-296.82296.89, 301.13
	ICD-10-CM	F30.10-F30.13, F30.2-F30.4, F30.8, F31.10-F31.13, F31.2, F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.73-F31.78, F31.81, F31.9, F32.8, F34.0

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Data Elements:

Numerator

- *Alcohol and Chemical Substance Use Assessment*

Denominator

- *Birth Date*
- *ICD-9-CM/ICD-10-CM Principal Diagnosis Code*
- *Date of ICD-9-CM/ICD-10-CM Principal Diagnosis Code*
- *ICD-9-CM/ICD-10-CM Other Diagnosis Code*
- *Date of ICD-9-CM/ICD-10-CM Other Diagnosis Code*
- *Documentation Source*

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications and data collection. This is provided without assurances:

http://www.cqaimh.org/measure_SU.html

Measure Collection Description

Setting of Care: **Outpatient Setting**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 3 - Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: 3.8	Payment Method: P4P
Project Title: Project 5 - Electronic Self-Assessment Decision Support Tool	Project Code: 5.2	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 17**

CAC-1: Relievers for Inpatient Asthma

Measure Description:
Children's Asthma Care (CAC) measurement of the use of relievers in pediatric patients admitted for inpatient treatment of asthma.

Data Source: **Chart/EHR**

NQF # (no longer endorsed): **0143**

Measure Steward: **Joint Commission**

Measure Steward Version: **Version 4.3b**

Measure Calculation Description

Numerator:
Pediatric asthma inpatient patients who received relievers (Table 17.1) during hospitalization.

Table 17.1: Reliever Medications (Appendix A-44)

Medication	Generic
Accuneb	Albuterol Sulfate
Adrenaclick	Epinephrine
Adrenaline	Epinephrine
Albuterol/Ipratropium	Albuterol/Ipratropium
Albuterol Sulfate	Albuterol Sulfate
Atrovent HFA	Ipratropium Bromide
Combivent	Albuterol/Ipratropium
DuoNeb	Albuterol/Ipratropium
Epinephrine	Epinephrine
Epipen	Epinephrine
Epipen JR	Epinephrine
Ipratropium Bromide	Ipratropium Bromide
Isoproterenol	Isoproterenol
Isuprel	Isoproterenol
Levalbuterol Hydrochloride	Levalbuterol Hydrochloride
Maxair Autohaler	Pirbuterol Acetate
Maxair	Pirbuterol Acetate
Metaproterenol	Metaproterenol
Pirbuterol Acetate	Pirbuterol Acetate
ProAir HFA	Albuterol Sulfate
Proventil HFA	Albuterol Sulfate

Reliever Not Otherwise Specified (NOS)	None
Terbutaline	Terbutaline
Twinject	Epinephrine
Ventolin HFA	Albuterol Sulfate
Xopenex	Levalbuterol Hydrochloride
Xopenex HFA	Levalbuterol Hydrochloride

The results are stratified by:
1. Overall rate (Age 2 years through 17 years)
2. Age 2 years through 4 years
3. Age 5 years through 12 years
4. Age 13 years through 17 years

Denominator:
Of the New Jersey Low Income attributed population, those pediatric patients aged 2 through 17 years of age who were discharged with a principal diagnosis of asthma. (Table 17.2)

Table 17.2: Codes to Identify Asthma (Appendix A-45)

Description	Code Type	Codes
Asthma	ICD-9-CM	493.00-493.02, 493.10-493.12, 493.81, 493.82, 493.90-493.92
	ICD-10-CM	J4520-J4522, J4530-J4532, J4540-J4542, J4550-J4552, J45901, J45902, J45909, J45990, J45990, J45991, J45998

Exclusion(s):
1. Patients with a documented *Reason For Not Administering Relievers.*
2. Patients enrolled in clinical trials.
3. Patients with a length of stay greater than 120 days.
4. Patients with age less than 2 years or 18 years or greater.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

For the purposes of the CAC measures, inpatient hospitalization includes the time of arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

Data Elements

Numerator:
- *Relievers Administered*

Denominator:

- *Admission Date*
- *Birth Date*
- *Clinical Trial*
- *Reason for Not Administering Relievers*
- *Discharge Date*
- *ICD-9-CM/ICD-10-CM Principal Diagnosis Code*

Patient age is calculated by Admission Date – Birth Date as part of the ICD population logic" from page 8 of the steward document.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances.

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **Quarterly**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

For hospitals selecting sample cases for stratified measure sets or measure sets with sub-populations (CAC and VTE), a modified sampling procedure is required. Hospitals selecting sample cases for these sets must ensure that each individual stratum's population/sub-population and sample size meets the conditions stated in the measure set's Sample Size Requirements. (See VTE and CAC sample requirements from the Joint Commission. Once electronic manual is open, methodology can be found on the following document : 2zc_CAC_List)

Hospitals will follow the quarterly sampling guidelines then collect and report the data on a semi-annual basis. The two quarters will be summed for the final result.

DSRIP Incentive Impact		
Project Title: Project 1 – Hospital-Based Educators Teach Optimal Asthma Care	Project Code: 1.1	Payment Method: Pay for Reporting
Project Title: Project 2 – Pediatric Asthma Case Management and Home Evaluations	Project Code: 2.1	Payment Method: Pay for Reporting
Universal Measure: NA	Universal Code: NA	Payment Method: NA

Measure Name

DSRIP # 18

CAC-2: Systemic Corticosteroids for Inpatient Asthma

Measure Description:
Use of systemic corticosteroids in pediatric patients admitted for inpatient treatment of asthma.

Data Source:
Chart/EHR

NQF # (no longer endorsed):
0144

Measure Steward:
Joint Commission

Measure Steward Version:
Version 4.3b

Measure Calculation Description

Numerator:
Pediatric asthma patients who received systemic corticosteroids during hospitalization.

Patients who were administered systemic corticosteroids (Table 18.1) during this hospitalization.

Table 18.1 Systemic Corticosteroid Medications (Appendix A-46)

Medication	Generic
Flo-pred	Prednisolone Acetate
Hydrocortisone	Hydrocortisone
Hydrocortisone Sodium Succinate	Hydrocortisone Sodium Succinate
Kenalog	Triamcinolone Acetonide
Medrol	Methylprednisolone
Medrol Dosepak	Methylprednisolone
Methylprednisolone	Methylprednisolone
Methylprednisolone Acetate	Methylprednisolone Acetate
Methylprednisolone Sodium Succinate	Methylprednisolone Sodium Succinate
Millipred	Prednisolone
Orapred	Prednisolone
Orapred ODT	Prednisolone
Pediapred	Prednisolone
Prednisolone	Prednisolone
Prednisolone Acetate	Prednisolone Acetate
Prednisone Intensol	Prednisone
Prednisolone Sodium Phosphate	Prednisolone Sodium Phosphate
Prednisone	Prednisone
Prelone	Prednisolone
Solu-Cortef	Hydrocortisone Sodium Succinate
Sterapred	Prednisone
Systemic Corticosteroid Not Otherwise Specified (NOS)	None
Triamcinolone Acetonide	Triamcinolone Acetonide
Veripred 20	Prednisolone

Hospitals results will be stratified by:
1. Overall rate (2 through 17 years)
2. Age 2 years through 4 years
3. Age 5 years through 12 years

4. Age 13 years through 17 years

Denominator:
Of the New Jersey Low Income attributed population, pediatric patients aged 2 through 17 years of age who were discharged with a principal diagnosis of asthma. (Table 18.2)

Table 18.2: Codes to Identify Asthma (Appendix A-45)

Description	Code Type	Codes
Asthma	ICD-9-CM	493.00-493.02, 493.10-493.12, 493.81, 493.82, 493.90-493.92
	ICD-10-CM	J4520-J4522, J4530-J4532, J4540-J4542, J4550-J4552, J45901, J45902, J45909, J45990, J45990, J45991, J45998

Denominator Exclusion(s):
1. Patients with a documented *Reason for Not Administering Systemic Corticosteriods.*
2. Patients with a length of stay greater than 120 days.
3. Patients enrolled in clinical trials.
4. Patients with age less than 2 years or 18 years or greater.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

<u>Data Elements:</u>

Numerator:
- *Systemic Corticosteroids Administered (Table 18.1)*

Denominator:
- *Admission Date*
- *Birth Date*
- *ICD-9-CM Principal Diagnosis Code*
- *Clinical Trials*
- *Discharge Date*
- *Reason for not Administering Systemic Corticosteroids*

Patient age is calculated by Admission Date – Birth Date as part of the ICD population logic" from page 8 of the steward document.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances.

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **Quarterly**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

For hospitals selecting sample cases for stratified measure sets or measure sets with sub-populations (CAC and VTE), a modified sampling procedure is required. Hospitals selecting sample cases for these sets must ensure that each individual stratum's population/sub-population and sample size meets the conditions stated in the measure set's Sample Size Requirements. (See VTE and CAC sample requirements from the Joint Commission. Once electronic manual is open, methodology can be found on the following document : 2zc_CAC_List)

Hospitals will follow the quarterly sampling guidelines then collect and report the data on a semi-annual basis. The two quarters will be summed for the final result.

DSRIP Incentive Impact		
Project Title: Project 1 – Hospital-Based Educators Teach Optimal Asthma Care	Project Code: 1.2	Payment Method: Pay for Reporting
Project 2 – Pediatric Asthma Case Management and Home Evaluations	2.2	Pay for Reporting
Universal Measure: NA	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 94

Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medicines

Measure Description:
The percentage of patients 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.

Data Source:	NQF #:
Chart/ EHR	**1927**
Measure Steward:	Measure Steward Version:
NCQA	**2014**

Measure Calculation Description

Numerator:
Individuals who had one or more LDL-C screenings performed during the measurement year. (Appendix A-51)

Denominator:
Of the New Jersey Low Income attributed population, patients 25 to 64 years of age by the end of the measurement year with a diagnosis of schizophrenia (Appendix A-109) or bipolar disorder (Appendix A-110) who were prescribed any antipsychotic medication during the measurement year. (Appendix A-111)

Exclusion(s):
1. Patients are excluded from the denominator if they were discharged alive for a coronary artery bypass graft (CABG) (Appendix A-112) or percutaneous coronary intervention (PCI) (Appendix A-113) (these events may occur in the measurement year or the year prior to the measurement year).
2. Patients diagnosed with ischemic vascular disease (IVD) (Appendix A-114) (this diagnosis must appear in both the measurement year and the year prior to the measurement year)
3. Patient diagnosed with chronic heart failure (Appendix A-115), or had a prior myocardial infarction (Appendix A-116) (identified in the measurement year or as far back as possible).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:
The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications and data collection. This is provided without assurances:

http://www.qualityforum.org/QPS/1927

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 3 – Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: Substitution measure	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 21

Central Line-Associated Bloodstream Infection (CLABSI) Event

Measure Description:
CLABSI rate, expressed per 1,000 central line days.

Data Source:	NQF #:
Chart/ EHR	**Based on 0139**
Measure Steward:	Measure Steward Version:
CDC	**2015**

Measure Calculation Description

Numerator:
Total number of observed healthcare-associated central line-associated bloodstream infections (CLABSI) among patients in all reportable locations including ICUs, NICUs, SCAs and other acute care hospital locations where patients reside overnight.

A bloodstream infection must first be determined to be a healthcare-associated infection (HAI) before it can be identified as a CLABSI. Only HAIs can be CLABSIs. An HAI is a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that was not present or incubating on admission to the acute care facility.

Numerator Inclusion Criteria:
A laboratory-confirmed bloodstream infection (LCBI) where a central line (CL) or umbilical catheter (UC) was in place >2 calendar days on the date of event, with device placement being Day 1,
AND a central line (CL) or umbilical catheter (UC) was in place on the date of event or the day before.

If a CL or UC was in place for >2 calendar days and then removed, the LCBI criteria must be fully met on the day of discontinuation or the next day.

If the patient is admitted or transferred into a facility with central line in place (e.g. tunneled or implanted central line), day of first access is considered Day 1.

Denominator:
Of the New Jersey Low Income attributed population, the total number of central line device days for all locations under surveillance for CLABSI.

Result:
The result is expressed as a rate.

The rate is calculated as the number of identified CLABSI events over the number of central line device days multiplied by 1000.

Improvement Direction:
Lower

Measure Qualifications:

See measure steward specification for more details on how to identify CLABSI events.

Definition of device days: a daily count of the number of patients with a specific device (i.e. central line) in place in a patient care location. Device days are used for denominators in CLABSI rates. Device day denominator data that are collected differ according to the location of the patients being monitored.

a. For ICUs, the number of patients with one or more central lines of any type is collected daily, at the same time each day during the month. The totals for the month are entered.
b. In NICUs, the number of patients with one or more central lines (including umbilical catheters) is stratified by birth weight in five categories since risk of BSI varies by birth weight.

Intensive Care Unit – A nursing care area in which at least 80 percent of the patients match definitions of critical care locations found in chapter 15, Master CDC Locations and Descriptions, of the NHSN Patient Safety Component Manual.
http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf

Central Line – An intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting CLABSI and counting central-line days:

- Aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, common iliac veins, femoral veins and in neonates, the umbilical artery/ vein. Note: Neither the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of the great vessels or in or near the heart and be used for one of the purposes outlined above to qualify as a central line.

Infusion – The introduction of a solution through a blood vessel via a catheter lumen. This may include continuous infusions such as nutritional fluids or medications, or it may include intermittent infusions such as flushes or IV antimicrobial administration, or blood, in the case of transfusion or hemodialysis.

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications and data collection. This is provided without assurances:
http://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 36	Payment Method: UPP

Measure:

DSRIP #: 23

Cesarean Rate for Nulliparious Singleton Visits

Measure Description:
Nulliparous women with a term, singleton baby in a bertex position delivered by cesarean section.

Data Source:
Chart/ EHR

NQF #:
0471

Measure Steward:
Joint Commission

Measure Steward Version:
V2015A1 (ICD 9)
v2015B1 (ICD 10)

Measure Calculation Description

Numerator:
Patients with cesarean sections. (Table 23.1)

Table 23.1: Codes to Identify Cesarean Section (Appendix A-47)

Code Type	Codes
ICD-9-CM	74.0, 74.1, 74.2, 74.4, 74.99
ICD-10-CM	10D00Z0, 10D00Z1, 10D00Z2

Denominator:

Of the New Jersey Low Income attributed population, nulliparous patients delivered of a live term singleton newborn in vertex presentation.

Include nulliparous patients with codes for outcome of delivery (Table 23.2) with a delivery of a newborn with 37 weeks or more of gestation completed (Appendix A-23).

Table 23.2: Codes to Identify Outcome of Delivery (Appendix A-48)

Code Type	Codes
ICD-9-CM	V27.0
ICD-10-CM	Z370

Exclusion(s):
1. Patients less than 8 years of age
2. Patients greater than or equal to 65 years of age
3. Length of Stay > 120 days
4. Patients enrolled in clinical trials
5. Gestational age < 37 weeks or unable to determine (UTD) (Appendix A-23)
6. Patients with codes for multiple gestations and other presentations (Appendix A-49)

Result:
The result is expressed as a percentage.

Improvement direction:
Lower

Measure Qualifications/ Definitions:

Data Elements:

- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *ICD-9-CM/ICD-10-CM Other Diagnosis Codes*
- *ICD-9-CM/ICD-10-CM Other Procedure Codes*
- *ICD-9-CM/ICD-10-CM Principal Diagnosis Codes*
- *ICD-9-CM/ICD-10-CM Principal Procedure Codes*
- *Parity*

This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances.:

http://manual.jointcommission.org/releases/TJC2013B/MIF0167.html

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Risk Adjustment/ Sampling Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 40	Payment Method: UPP

Measure:

DSRIP #: 26

Children Age 6 – 17 Years who Engage in Weekly Physical Activity

Measure Description:
Percentage of patients 6-17 years of age that participate in at least 60 minutes of physical activity at least 3 times a week.

Data Source: **Chart/ EHR**	NQF #: **1348**
Measure Steward: **CDC**	Measure Steward Version: **2008**

Measure Calculation Description

Numerator:
Number of patients that participate in at least 60 minutes of physical activity at least 3 times a week.

Denominator:
Of the New Jersey Low Income attributed population, children 6-17 years of age as of the end of the measurement period.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

http://www.cdc.gov/healthyschools/physicalactivity/guidelines.htm

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **6 month period**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **No**

Sampling or Risk Adjustment Methodology

NA

DSRIP Incentive Impact		
Project Title: Project 15 - After-School Obesity Program	Project Code: 15.4	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 30

Comprehensive Diabetes Care: LDL-C Control <100mg/DL

Measure Description:
Percentage of patients 18 to 75 years of age with diabetes (type 1 and type 2) whose low density lipoprotein cholesterol (LDL-C) level is controlled (less than 100 mg/dL).

Data Source: **Chart/ EHR**

NQF #: **Based on 0064**

Measure Steward: **NCQA**

Measure Steward Version: **2014**

Measure Calculation Description

Numerator:
Patients whose most recent LDL-C screening, performed during the measurement year, is less than 100 mg/dL.

Table 30.1: Codes to Identify LDL-C Screening (Appendix A-51)

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2, 6919-0

Numerator Exclusions Criteria

- The result of the most recent LDL-C screening is ≥100 mg/dL
- The result of the most recent LDL-C screening is missing
- An LDL-C screening was not performed

Table 30.2: Codes to Identify LDL-C Levels

Description	CPT Category II
Numerator compliant (LDL-C <100 mg/dL)	3048F
Not numerator compliant (LDL-C ≥100 mg/dL)LDL-C ≥	3049F, 3050F

Denominator:
Of the New Jersey Low Income attributed population, patients 18 to 75 years of age with diabetes (type 1 and type 2) as of the end of the measurement year. (Appendix A-28)

Patients with diabetes mellitus are identified using diagnosis codes and/or pharmacy data within the inpatient or outpatient claims data. Only one method to identify patients is needed to be included in the denominator.

1. Claims data.
    a. Patients with at least two face-to-face encounters with a principal or secondary diagnosis of diabetes (Appendix A-28) with different dates of service in an outpatient setting or non-acute inpatient setting during the measurement year.
    b. Patients with at least one face-to-face encounter with a principal or secondary diagnosis of diabetes (Appendix A-28) in an acute inpatient or emergency department setting during the measurement year.

2. Pharmacy data. Patients who were dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year. (Appendix A-9)

Prescriptions to Identify Members With Diabetes

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlinitide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin	• Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin	• Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Exenatide	• Liraglutide	• Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA will post a complete list of medications and NDC codes to www.ncqa.org by November 2, 2015.*

Exclusion(s):

1. Diagnosis of active gestational diabetes and active steroid induced diabetes. (Appendix A-91)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.

- (LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5)
- If lipoprotein (a) is measured, use the following calculation.
  (LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5) – 0.3 [lipoprotein (a)]

These formulae are used when all levels are expressed in mg/dL and cannot be used if triglycerides >400 mg/dL. The Friedewald equation may not be used if a direct or calculated result is present in the medical record for the most recent LDL-C test.

Please note: NCQA allows for collection of this measure in multiple settings (inpatient and outpatient). For the NJ DSRIP program, this measure will be collected in an outpatient setting only.

The following links may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

http://www.qualitymeasures.ahrq.gov/content.aspx?id=38877&search=ldl-c+control

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2015**
Risk Adjustment: **No**	Sampling: **Yes**
Sampling or Risk Adjustment Methodology	

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 17	Payment Method: Pay for Reporting

Measure: Controlling High Blood Pressure (CBP)

DSRIP #: 31

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

Data Source:	NQF #:
Chart/ EHR	**0018**
Measure Steward:	Measure Steward Version:
NCQA	**2014**

Measure Calculation Description

Numerator:
The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled during the measurement year.

Adequate Control For the patient's BP to be controlled, *both* the systolic and diastolic BP *must be* <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.
Follow the steps below to determine representative BP:

Step 1: Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was made or confirmed.

Do not include BP readings that meet the following criteria:

a. Taken during an acute inpatient stay or an ED visit.
b. Taken during an outpatient visit which was for the sole purpose of having a diagnosis diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
c. Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).
d. Reported or taken by the patient.

Step 2: Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

Denominator:
Of the New Jersey Low Income attributed population, those patients aged 18-85 years of age with a diagnosis of hypertension.

Patients are identified as hypertensive (Table 31.1) if there is at least one outpatient visit (Table 31.2) (Appendix A-55) (Appendix A-32) with a diagnosis of hypertension during the first six months of the measurement year.

Table 31.1: Codes to Identify Hypertension (Appendix A-55)

Code Type	Codes
ICD-9-CM	401.0, 401.1, 401.9
ICD-10-CM	I10

Table 31.2: Codes to Identify Outpatient Visits (Appendix A-32)

Description	CPT
Outpatient visits	99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397, G0402, G0438, G0439, G0463, T1015

To confirm the diagnosis of hypertension, the provider must find notation of one of the following in the medical record on or before June 30 of the measurement year:

HTN.

High BP (HBP).

Elevated BP (↑BP).

Borderline HTN.

Intermittent HTN.

- History of HTN.
- Hypertensive vascular disease (HVD).
- Hyperpiesia.
- Hyperpiesis.

The notation of hypertension may appear on or before June 30 of the measurement year, including prior to the measurement year. It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis; see **Note** at the end of this section).
- Office note.
- Subjective, Objective, Assessment, Plan (SOAP) note.
- Encounter form.
- Telephone call record.
- Diagnostic report.
- Hospital discharge summary.

Statements such as “rule out HTN,” “possible HTN,” “white-coat HTN,” “questionable HTN” and “consistent with HTN” are not sufficient to confirm the diagnosis if such statements are the *only* notations of hypertension in the medical record.

Exclusion(s):

1. Exclude from the eligible population all patients with evidence of end-stage renal disease (ESRD) (Appendix A-56) or kidney transplant on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.

2. Exclude from the eligible population all patients with a diagnosis of pregnancy (Appendix A-50) during the measurement year.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications and data collection. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **Stage 3= CY 2014** **Stage 4= CY 2015**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 6 - Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	Project Code: 6.2	Payment Method: Pay for Reporting
Project Title: Project 7 - Extensive Patient CHF-Focused Multi-Therapeutic Model	Project Code: 7.3	Payment Method: Pay for Reporting
Project Title: Project 8 - The Congestive Heart Failure Program (CHF-TP)	Project Code: 8.3	Payment Method: Pay for Reporting
Project Title: Project 11 - Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: 11.8	Payment Method: P4P
Project Title: Project 12 - Diabetes Group Visits for Patients and Community Education	Project Code: 12.6	Payment Method: P4P
Universal Measure: Yes	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 33**

Depression Remission at 12 Months

Measure Description:
Patients age 18 years of age or older with major depression or dysthymia and an initial PHQ-9 score greater than (>) nine (9) who demonstrate remission at twelve (12) months defined as a PHQ-9 score less than (<) five (5).

Data Source:	NQF #:
Chart/ EHR	**0710**
Measure Steward:	Measure Steward Version:
Minnesota Community Measurement (MNCM)	**2016**

Measure Calculation Description

Numerator:
Depression patients with an initial PHQ-9 score > nine whose PHQ-9 score at 12 months (+/- 30 days) is less than five.

Denominator:
Of the New Jersey Low Income attributed population, patients 18 years of age or older as of December 31 of the measurement year with an active diagnosis of major depression or dysthymia (Appendix A-74) and an initial PHQ-9 score > 9 who had a visit or contact with an eligible provider in an eligible specialty during the measurement year.

Note: For behavioral health providers: The diagnosis of Major Depression or Dysthymia must be the primary diagnosis.

This measure contains a fourteen month measurement period due to the +/- 30 day period on the front and back of the twelve month experience period.

Eligible providers: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Advanced Practice Registered Nurses (APRN). If a physician is on site, these providers are also eligible: Licensed Psychologist (LP), Licensed Independent Clinical Social Worker (LICSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage & Family Therapist (LMFT).

Eligible specialties: Family Medicine, Internal Medicine, Geriatric Medicine, Psychiatry, and Behavioral Health.

The measurement period is a fixed twelve (12) month period. In order to collect data to calculate remission at twelve (12) months, patient visits will need to be tracked the year prior to the measurement period.

Exclusion(s):
1. Patient was a permanent nursing home resident during the measurement period.
2. Patient was in hospice or receiving palliative care at any time during the measurement period.
3. Patient died prior to the end of the measurement period.
4. Patient has diagnosis of bipolar (Appendix A-75) or personality disorder (Appendix A-76).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

The following link(s) may be used to obtain additional information regarding the specific instructions on the measurement qualifications and data collection. This is provided without assurances:

http://mncm.org/wp-content/uploads/2015/12/Depression-Care-Measures-2016-Data-Collection-Guide-FINAL-v1.pdf

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 3 - Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: 3.9	Payment Method: P4P
Project Title: Project 5 - Electronic Self-Assessment Decision Support Tool	Project Code: 5.9	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 100

Diabetes Mellitus: Daily Aspirin or Anti-platelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease

Measure Description:
Percentage of patients 18 to 75 years of age with diabetes mellitus and ischemic vascular disease with documented daily aspirin or anti-platelet medication use during the measurement year unless contraindicated.

Data Source:	NQF #:
Chart/EHR	**0729**
Measure Steward:	Measure Steward Version:
Minnesota Community Measurement (MNCM)	~~2016~~ 2017

Measure Calculation Description

Numerator:

Patients with a diagnosis of diabetes and ischemic vascular disease with documentation of taking daily aspirin or anti-platelet medication or have a documented contraindication in the measurement year.

Accepted Contraindications:
1. Prescribed anticoagulant use, Lovenox (enoxaparin) or Coumadin (warfarin)
2. History of gastrointestinal (GI)*
3. History of intracranial bleeding
4. Bleeding disorder
5. Other documented reason: allergy to aspirin (ASA) or anti-platelets
6. Other documented reason: use of non-sterodial anti-inflammatory measures
7. Other documented reason: documented risk for drug interaction
8. Other documented reason: uncontrolled hypertension (systolic blood pressure greater than 180 mm/Hg and/or diastolic blood pressure greater than 110mmHg)
9. Other documented reason: gastroesophageal reflux disease (GERD)

Denominator:
Of the New Jersey Low Income attributed population, patients 18 to 75 years of age with a diagnosis of diabetes mellitus with two or more face-to-face visits for diabetes in the last two years and at least one visit for any reason in the last 12 months and a diagnosis of ischemic vascular disease.

A complete list of diagnosis codes identifying diabetes mellitus and ischemic vascular disease (IVD) can be found in Appendix A-59 and Appendix A-60.

Exclusions:
1. Patient was a permanent nursing home resident at any time during the measurement period
2. Patient was in hospice or receiving palliative care at any time during the measurement period
3. Patient died prior to the end of the measurement period
4. Patient was pregnant at any time during the measurement period
5. Documentation that diagnosis was coded in error

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Data Elements:

- *Date of Birth*
- *Diagnosis Code(s)*
- *Procedure Code(s)*
- *Daily Aspirin order instructions*
- *Patient Status*

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf

http://www.health.state.mn.us/healthreform/measurement/msr812prp01odc.pdf

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**
Sampling or Risk Adjustment Methodology	

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 11 – Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: Substitution measure	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 37

Elective Delivery

Measure Description:
This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.

Data Source:
Chart/ EHR

NQF #:
0469

Measure Steward:
Joint Commission

Measure Steward Version:
2015A1 (ICD 9)
2015B1 (ICD 10)

Measure Calculation Description

Numerator:

Patients with elective deliveries.

1. Medical induction of labor (Table 37.1) while not in *Labor* prior to the procedure.

Table 37.1: Codes to Identify Medical Induction of Labor (Appendix A-52)

Code Type	Codes
ICD-9-CM	73.01, 73.1, 73.4
ICD-10-CM	0U7C7DZ, 0U7C7ZZ, 10900ZC, 10903ZC, 10904ZC, 10907ZC, 10908ZC, 3E033VJ

Table 37.2: Codes to Identify Cesarean Section (Appendix A-47)

Code Type	Codes
ICD-9-CM	74.0, 74.1, 74.2, 74.4, 74.99
ICD-10-CM	10D00Z0, 10D00Z1, 10D00Z2

Denominator:

Of the New Jersey Low Income attributed population, those patients ages 8 through 64 years of age delivering newborns with >= 37 and < 39 weeks of gestation completed. (Table 37.3) or Appendix A-22.

Table 37.3: Codes to Identify Planned Cesarean Section in Labor (Appendix A-53)

Code Type	Codes
ICD-9-CM	649.81, 649.82
ICD-10-CM	O7582

Exclusion(s):

1. ICD-9-CM/ICD-10-CM Principal Diagnosis Code or ICD-9-CM/ICD-10-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation (See Appendix A-10).
2. Patients less than 8 years of age.
3. Patients greater than or equal to 65 years of age.
4. Patients with a length of stay > 120 days.
5. Patients enrolled in clinical trials.
6. Patients with prior uterine surgery.
7. Gestational Age < 37 or >= 39 weeks or Unable to Determine (UTD)

Result:
The result is expressed as a percentage.

Improvement direction:
Lower

Measure Qualifications:

Data Elements:

Numerator

- *ICD-9-PCS /ICD-10-PCS Other Procedure Codes*
- *ICD-9-PCS /ICD-10-PCS Principal Procedure Code*
- *Labor*
- *Prior Uterine Surgery*

Denominator

- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *ICD-9-CM/ICD-10-CM Other Diagnosis Codes*
- *ICD-9-CM/ICD-10-CM Principal Diagnosis Code*
- *Prior Uterine Surgery*

This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).

The following link may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

https://manual.jointcommission.org/releases/TJC2015B1/

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Risk Adjustment/ Sampling Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 41	Payment Method: UPP

Measure:

DSRIP #: 69

Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status

Measure Description:
This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of community-acquired pneumonia with mental status assessed.

Data Source:	NQF #:
Chart/EHR	**Not Found**
Measure Steward:	Measure Steward Version:
AMA-PCPI	**2010**

Measure Calculation Description

Numerator:
All patients for whom mental status was assessed.

Assessed: May include: Documentation by clinician that patient's mental status was noted (e.g., patient is oriented or disoriented). (Appendix A-99)

Denominator:
Of the New Jersey Low Income attributed population, all patients aged greater than or equal to 18 years with community-acquired bacterial pneumonia. Patients qualify for denominator using either Option 1 or 2 below.

Option 1:
Diagnosis codes (Appendix A-100)
AND
Service codes (Appendix A-101)

Option 2:
Diagnosis codes (Appendix A-100)
AND
Service codes (Appendix A-102)
AND
Place of service (Appendix A-103)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the specific instructions on the measurement qualifications and data collection. This is provided without assurances:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2012_Physician_Quality_Reporting_System.html

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **6 month period**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 17 – Patients Receive Recommended Care for Community-Acquired Pneumonia	Project Code: 17.2	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: Eye Examination

DSRIP #: 39

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

Data Source:	NQF #:
Chart/ EHR	**0055**
Measure Steward:	Measure Steward Version:
NCQA	**2016**

Measure Calculation Description

Numerator:
Patients who received a retinal eye exam.

Includes:

1. A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
2. A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Or any of the following criteria:

1. A retinal screening code (Appendix A-63) billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.

Denominator:
Of the New Jersey Low Income attributed population, patients who are 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). (Appendix A-28)

Patients with diabetes mellitus are identified using diagnosis codes and/or pharmacy data within the inpatient or outpatient claims data. Only one method to identify patients is needed to be included in the denominator.

3. Claims data.
   a. Patients with at least two face-to-face encounters with a principal or secondary diagnosis of diabetes (Appendix A-28) with different dates of service in an outpatient setting or non-acute inpatient setting during the measurement year.
   b. Patients with at least one face-to-face encounter with a principal or secondary diagnosis of diabetes (Appendix A-28) in an acute inpatient or emergency department setting during the measurement year.

4. Pharmacy data. Patients who were dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year. (Appendix A-9)

Prescriptions to Identify Members with Diabetes

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlinitide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin	• Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin	• Metformin-sitagliptin • Sitagliptin-simvastatin • Empagliflozin-linagliptin (Glyxambi) • Empagliflozin-metformin (Synjardy)
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled (Afrezza)	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Exenatide • Dulaglutide (Trulicity)	• Liraglutide	• Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA will post a complete list of medications and NDC codes to www.ncqa.org by November 2, 2015.*

Exclusion(s):

1. Diagnosis of active gestational diabetes and active steroid induced diabetes. (Appendix A-91)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications/ Definitions:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances.:

http://www.qualityforum.org/QPS/0055
http://www.ncqa.org/HEDISQualityMeasurement.aspx

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Risk Adjustment/ Sampling Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 11 – Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: 11.3	Payment Method: Pay for Reporting
Project Title: Project 12 – Diabetes Group Visits for Patients and Community Education	Project Code: 12.3	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 43

Foot Examination

Measure Description:
Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).

Data Source:	NQF #:
Chart/EHR	**Not Found**
Measure Steward:	Measure Steward Version:
NCQA	**2003**

Measure Calculation Description

Numerator:
Patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).

Denominator:
Of the New Jersey Low Income attributed population, patients who are 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

Exclusion(s):
1. Patients with bilateral foot amputation.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications/ Definitions:

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

This measure is no longer included in the AMA Diabetes Set.

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 11 - Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: 11.2	Payment Method: Pay for Reporting
Project Title: Project 12 - Diabetes Group Visits for Patients and Community Education	Project Code: 12.2	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 9**

Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (inpatient setting)

Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF <40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen at hospital discharge.

Data Source:	NQF #:
Chart/EHR	**0081**
Measure Steward:	Measure Steward Version:
AMA-PCPI	~~May 15, 2012~~ April 2016

Measure Calculation Description

Numerator:
Patients who were prescribed an Angiotensin-Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy at hospital discharge.

Prescribed - Inpatient setting – a prescription given to the patient for ACE inhibitor or ARB therapy at discharge.

Medication must be present on the discharge medication list. The following list of medications/drug names is based on clinical guidelines and other evidence and may not be all-inclusive or current. Physicians and other health care professionals should refer to the FDA's web site page entitled "Drug Safety Communications" for up-to-date drug recall and alert information when prescribing medications.

ACE Inhibitor Medications

- Captopril
- Enalapril
- Fosinopril
- Lisinopril
- Perindopril
- Quinapril
- Ramipril
- Trandolapril

Angiotensin Receptor Blockers

- Candesartan
- Losartan
- Valsartan

Denominator:

Of the New Jersey Low Income attributed population, all patients aged 18 years and older with a principal diagnosis of heart failure with a current or
prior Left Ventricular (LVEF) < 40%.

LVEF < 40% - *corresponds to qualitative documentation of moderate dysfunction or severe dysfunction.*

Table 9.1: Codes to Identify Heart Failure (Appendix A-30)

Code Type	Code
CPT	99201-99203, 99205, 99212-99215 99241-99245,99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350
ICD-9	402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9
ICD-10	I50.20-23, I50.30-33, I50.40-43, I50.9, I50.1, I50.20-I50.23, I50.30-I50.33, I50.40-I50.43, I50.9

Exclusion(s):

1. Patients who expired.
2. Patients who left against medical advice (AMA).
3. Patients discharged to hospice.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

This measure follows the ***inpatient*** criteria set out by the measure steward.

The following link(s) may be used to obtain additional information regarding the specific instructions on the measurement qualifications and data collection. This is provided without assurances:

http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Risk Adjustment/ Sampling Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 6 - Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	Project Code: 6.1	Payment Method: Pay for Reporting
Project Title: Project 7 - Extensive Patient CHF-Focused Multi-Therapeutic Model	Project Code: 7.2	Payment Method: Pay for Reporting
Project Title: Project 8 - The Congestive Heart Failure Program (CHF-TP)	Project Code: 8.2	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 47**

Hospital Acquired Potentially Preventable Venous Thromboembolism

Measure Description:
The number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date. (VTE-6)

Data Source:	NQF #:
Chart/ EHR	**Not Found**
Measure Steward:	Measure Steward Version:
Joint Commission	~~**Version 4.4 (ICD 9)**~~ ~~**Version 5.0 (ICD 10)**~~ **2017 v 5.2a**

Measure Calculation Description

Numerator:

Patients who received no venous thromboembolism (VTE) prophylaxis prior to the VTE diagnosis test order date.

Denominator:

Of the New Jersey Low Income attributed population, patients age 18 years and older who developed confirmed VTE during hospitalization.

Denominator Inclusion Criteria:

Discharges with an *ICD-9-CM/ICD-10-CM Other Diagnosis Codes* of VTE as defined in Appendix A-20 or Appendix A-54.

Exclusion(s):
1. Patients less than 18 years of age
2. Patients who have a hospital length of stay (LOS) greater than 120 days
3. Patients with *Comfort Measures Only* documented.
4. Patients enrolled in clinical trials
5. Patients with an *ICD-9-CM/ICD-10-CM Principal Diagnosis Codes* of VTE as defined in Appendix A-20 or Appendix A-54.
6. Patients with *VTE Present at Admission*
7. Patients with reasons for not administering mechanical and pharmacologic prophylaxis
8. Patients without VTE confirmed by diagnostic testing

Result:
The result is expressed as a percentage.

Improvement Direction:

Lower

Measure Qualifications:

Data Elements:

Numerator:

1. *VTE Prophylaxis Status*

Denominator:

1. *Admission Date*
2. *Birthdate*
3. *Clinical Trial*
4. *Comfort Measures Only*
5. *Discharge Date*
6. *ICD–10 or ICD-9 Diagnosis Codes*
7. *ICD-10 or ICD-9 Diagnosis Code*
8. *VTE Confirmed*
9. *VTE Diagnostic Test*
10. *VTE Present at Admission*
11. *Reason for No Administration of VTE Prophylaxis*

The following link may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **Quarterly**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**
Sampling or Risk Adjustment Methodology For hospitals selecting sample cases for stratified measure sets or measure sets with sub-populations (CAC and VTE), a modified sampling procedure is required. Hospitals selecting sample cases for these sets must ensure that each individual stratum's population/sub-population and sample size meets the conditions stated in the measure set's Sample Size Requirements. (See VTE and CAC sample requirements from the Joint Commission. Once the electronic manual is open, the sampling tables and methodology can be found on the following document: "2zg.VTE_List.pdf") Quarterly data will be required to be reported semi-annually. Each quarter data will be aggregated by the hospital in the Standardized Reporting Workbook for a semi-annual reported rate.	

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 30	Payment Method: UPP

Measure:

DSRIP #: 51

Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patient

Measure Description:
This measure is used to assess pneumonia patients who received an initial antibiotic regimen consistent with current guidelines during the first 24 hours of their hospitalization.

Data Source:	NQF #:
Chart/ EHR	**0147**
Measure Steward:	Measure Steward Version:
Joint Commission	**Version 4.4a**

Measure Calculation Description

Numerator:
Pneumonia patients who received an initial antibiotic regimen consistent with current guidelines during the first 24 hours of their hospitalization.

Antibiotic guidelines by patient type:
Non – ICU Patient
Antipneumococcal Quinolone monotherapy (IV or PO) Appendix A-90
– Regimen 1a
Or
Tigecycline monotherapy (IV) Appendix A-86
– Regimen 2a
Or
β-lactam (IV or IM) Table 2.3 + Macrolide (IV or PO) Appendix A-80
– Regimen 3a
Or
β-lactam (IV or IM) Table 2.3 + Doxycycline (IV or PO) Table 2.10
– Regimen 3a

Non-ICU patient with Pseudomonal Risk
These regimens are acceptable for Non-ICU patients with Pseudomonal Risk ONLY:
Antipneumococcal/Antipseudomonal β-lactam (IV) Appendix A-79 + Antipseudomonal Quinolone (IV or PO) Appendix A-83
– Regimen 4a
Or
Antipneumococcal/Antipseudomonal β-lactam (IV) Appendix A-79 + Aminoglycoside (IV) Appendix A-85 + either Antipneumococcal Quinolone (IV or PO) Appendix A-90 Or Macrolide (IV or PO) Appendix A-80
– Regimen 5a

Non-ICU patients with β-lactam allergy and Pseudomonal Risk ONLY
These regimens are acceptable for Non-ICU patients with β-lactam allergy and Pseudomonal Risk ONLY:
Aztreonam (IV or IM) Appendix A-82 + Antipneumococcal Quinolone (IV or PO) Appendix A-90 + Aminoglycoside (IV) Appendix A-85
– Regimen 6a
Or
Aztreonam2 (IV or IM) Appendix A-82 + Levofloxacin1 (IV or PO) Appendix A-89
– Regimen 7a
1 Levofloxacin should be used in 750mg dosage when used in the management of patients with pneumonia.
2 For patients with renal insufficiency.

ICU Patient
Macrolide (IV) Appendix A-81 + either β-lactam (IV) Appendix A-88 OR Antipneumococcal/Antipseudomonal β-lactam (IV) Appendix A-79
– Regimen 1b
Or
Antipseudomonal Quinolone (IV) Appendix A-83 + either β-lactam (IV) Appendix A-88 OR Antipneumococcal/Antipseudomonal β-lactam (IV) Appendix A-79
– Regimen 2b
Or
Antipneumococcal Quinolone (IV) Appendix A-87 + either β-lactam (IV) Appendix A-88 OR Antipneumococcal/Antipseudomonal β-lactam (IV) Appendix A-79
–Regimen 2b
Or
Antipneumococcal/Antipseudomonal β-lactam (IV) Appendix A-79 + Aminoglycoside (IV) Appendix A-85 + either Antipneumococcal Quinolone (IV) Appendix A-87 OR Macrolide (IV) Appendix A-81
– Regimen 3b

ICU Patient with Francisella tularensis or Yersinia pestis risk
If the patient has Francisella tularensis or Yersinia pestis risk as determined by Another Source of Infection (see data element) the following is another acceptable regimen:
Doxycycline (IV) Appendix A-84 + either B-lactam (IV) Appendix A-88 OR Antipneumococcal/Antipseudomonal β-lactam (IV) Appendix A-79
– Regimen 4b

Denominator:
Of the New Jersey Low Income attributed population, those ICU pneumonia patients 18 years of age and older with a principal diagnosis of pneumonia (Appendix A-69), or a principal diagnosis code of septicemia (Appendix A-70), or respiratory failure (acute or chronic) (Appendix A-71) with an ICD-9-CM Other Diagnosis Code of pneumonia (Appendix A-69).

Exclusion(s):

1. Patients less than 18 years of age.
2. Patients who have a length of stay greater than 120 days.
3. Patients with Cystic Fibrosis. (Appendix A-72)

4. Patients who had no chest x-ray or CT scan that indicated abnormal findings within 24 hours prior to hospital arrival or anytime during this hospitalization.
5. Patients with *Comfort Measures Only* documented day of or day after arrival.
6. Patients enrolled in clinical trials.
7. Patients received as a transfer from the emergency/ observation department of another hospital.
8. Patients received as a transfer from an inpatient or outpatient department of another hospital.
9. Patients received as a transfer from an ambulatory surgery center.
10. Patients who have no diagnosis of pneumonia either as the ED final diagnosis/ impression or direct admission diagnosis/ impression.
11. Patients transferred/ admitted to the ICU within 24 hours after arrival to this hospital, with a beta-lactam allergy.
12. Patients who have duration of stay less than or equal to one day.
13. Pneumonia patients with *Another Source of Infection* who did not receive an antibiotic regimen recommended for pneumonia, but did receive antibiotics within the first 24 hours of hospitalization.
14. Patients with a reason for *Alternative Empiric Antiobiotic Therapy*

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

This measure is based on the Joint Commission Pneumonia set, i.e. PN-6.

Data Elements:

Numerator:

- *Antibiotic Administration Date*
- *Antibiotic Administration Route*
- *Antibiotic Administration Time*
- *Antibiotic Allergy*
- *Antibiotic Name*
- *Arrival Date*
- *Arrival Time*
- *Pseudomonas Risk*

Denominator:

- *Admission Date*

- *Another Source of Infection*
- *Antibiotic Administration Date*
- *Antibiotic Administration Time*
- *Antibiotic Name*
- *Antibiotic Received*
- *Birthdate*
- *Chest X-Ray*
- *Clinical Trial*
- *Comfort Measures Only*
- *Discharge Date*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Principal Diagnosis Code*
- *ICU Admission or Transfer*
- *Pneumonia Diagnosis: ED/Direct Admit*
- *Pseudomonas Risk*
- *Reason for Alternative Empiric Antibiotic Therapy*
- *Transfer From Another Hospital or ASC*

Retrospective, data sources for required data elements include administrative data and medical record documents.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances.

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**
Sampling or Risk Adjustment Methodology	

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 17 – Patients Receive Recommended Care for Community-Acquired Pneumonia	Project Code: 17.5	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 55

Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100mg/dL

Measure Description:

The percentage of members 18 to 75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had LDL-C control (<100 mg/dL) during the measurement year.

Data Source:
Chart/EHR

NQF # (no longer endorsed):
Based on 0075

Measure Steward:
NCQA

Measure Steward Version:
2014

Measure Calculation Description

Numerator:
Patients whose most recent LDL-C screening (Table 55.1), performed during the measurement year, is less than 100 mg/dL

Table 55.1: Codes to Identify LDL-C Screening (Appendix A-51)

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2, 69419-0

Table 55.2: Codes to Identify LDL-C Levels

Description	CPT Category II
LDL-C <100 mg/dL	3048F
LDL-C ≥ 100 mg/dL	3049F, 3050F

Exclusion(s):

1. The result of the most recent LDL-C screening is ≥100 mg/dL.
2. The result of the most recent LDL-C screening is missing.
3. An LDL-C screening was not performed.

Denominator:
Of the New Jersey Low Income attributed population, patients who are 18 to75 years of age discharged alive for AMI (Appendix A-64), CABG (Appendix A-65) or PCI (Appendix A-66) during the 12 months prior to the measurement year or who had at least one outpatient visit or acute inpatient encounter with a diagnosis of IVD (Appendix A-67) during both the measurement year and the year prior to the measurement year (criteria do not need to be same for both years).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Data Elements:

- *Date of Birth*
- *Diagnosis Code(s)*
- *Procedure Code(s)*
- *Date when LDL test was performed*
- *Results of LDL test*

LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.

- (LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5)
- If lipoprotein (a) is measured, use the following calculation.
  (LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5) – 0.3 [lipoprotein (a)]

These formulae are used when all levels are expressed in mg/dL and cannot be used if triglycerides >400 mg/dL. The Friedewald equation may not be used if a direct or calculated result is present in the medical record for the most recent LDL-C test.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances.

http://www.ncqa.org/HEDISQualityMeasurement.aspx

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2015**
Risk Adjustment: **No**	Sampling: **Yes**
Sampling or Risk Adjustment Methodology	

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 6 – Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Care Conditions	Project Code: Substitution measure	Payment Method: P4P
Project Title: Project 7 – Extensive Patient CHF-Focused Multi-Therapeutic Model	Project Code: Substitution measure	Payment Method: P4P
Project Title: Project 8 – The Congestive Heart Failure Transition Program (CHF-TP)	Project Code: Substitution measure	Payment Method: P4P
Universal Measure: Yes	Universal Code: 18	Payment Method: Pay for Reporting

Measure:

DSRIP #: 57

Left Ventricular Ejection Fraction (LVEF) Assessment

Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of heart failure for whom the quantitative or qualitative results of a recent or prior (any time in the past) LVEF assessment is documented within a 12 month period.

Data Source:	NQF #:
Chart/EHR	**0079**
Measure Steward:	Measure Steward Version:
AMA-PCPI	**May 15, 2012**

Measure Calculation Description

Numerator:
Patients for whom the quantitative or qualitative** results of a recent or prior (any time in the past) LVEF assessment is documented within a 12 month period.

Documentation - must include documentation in a progress note of the results of an LVEF assessment, regardless of when the evaluation of ejection fraction was performed.

**Qualitative results correspond to numeric equivalents as follows:
- Hyperdynamic: corresponds to LVEF greater than 70%
- Normal: corresponds to LVEF 50% to 70% (midpoint 60%)
- Mild dysfunction: corresponds to LVEF 40% to 49% (midpoint 45%)
- Moderate dysfunction: corresponds to LVEF 30% to 39% (midpoint 35%)
- Severe dysfunction: corresponds to LVEF less than 30%

Numerator Inclusion Criteria:
Patients for whom the quantitative or qualitative results of a recent or prior (any time in the past) LVEF assessment is documented within a 12 month period.

CPT Category II Code
- **3021F**- Left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function
- **3022F**- Left ventricular ejection fraction (LVEF) greater than or equal to 40% or documentation as normal or mildly depressed left ventricular systolic function

Denominator:
Of the New Jersey Low Income attributed population, all patients aged 18 years and older with a diagnosis of heart failure. (Appendix A-68)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the specific instructions on the measurement qualifications and data collection. This is provided without assurances:

http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 7 - Extensive Patient CHF-Focused Multi-Therapeutic Model	Project Code: 7.1	Payment Method: Pay for Reporting
Project Title: Project 8 - The Congestive Heart Failure Transition Program (CHF-TP)	Project Code: 8.1	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 58

Lipid Management

Measure Description:
The percentage of patients 18-75 with diabetes (type 1 or type 2) who had at least one lipid profile (or all component tests).

Data Source:
Chart/EHR

NQF #:
Not Found

Measure Steward:
NCQA

Measure Steward Version:
2003

Measure Calculation Description

Numerator:
Patients who received at least one lipid profile (or ALL component tests).

Table 58.1: CPT Category I codes

Code	Description
80061	Lipid Panel
82465*	Cholesterol, serum, total
83718*	Lipoprotein, direct measurement, high density cholesterol (HDL)
84478*	Triglycerides
83721	Lipoprotein, direct measurement, low density cholesterol (LDL)

*Must be included to bill panel code 80061.

Denominator:
Of the New Jersey Low Income attributed population, patients aged 18-75 diagnosed with diabetes (type 1 or type 2).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Data Elements:

- *Date of Birth*
- *Diagnosis Code(s)*
- *Procedure Code(s)*

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances.

http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/diabetesset.pdf

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Improvement Target Goal (ITG): **NA**	Absolute ITG Value: **NA**
Attribution Date: **Last day of measurement period**	Anchor Date: **NA**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 11: Improve Overall Quality of Care for Patients with Diabetes Mellitis and Hypertension	Project Code: 11.1	Payment Method: Pay for Reporting
Project Title: Project 12: Diabetes Group Visits for Patients and Community Education	Project Code: 12.1	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 59**

Major Depressive Disorder (MDD): Suicide Risk Assessment

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

Data Source:	NQF #:
Chart/EHR	**0104**
Measure Steward:	Measure Steward Version:
AMA-PCPI	**2012**

Measure Calculation Description

Numerator:
Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

Suicide risk assessment must include questions about the following:

1. Suicidal ideation
2. Patient's intent of initiating a suicide attempt AND, if either is present,
   a. Patient plans for a suicide attempt
   b. Whether the patient has means for completing suicide

Denominator:
Of the New Jersey Low Income attributed population, patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD). (Tables 59.1 and 59.2)

Table 59.1: Codes to Identify Major Depressive Disorder – Single Episode (Appendix A-61)

Code Type	Codes
ICD-9-CM	296.20, 296.21, 296.22, 296.23, 296.24
ICD-10-CM	F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1

Table 59.2: Codes to Identify Major Depressive Disorder – Recurrent (Appendix A-62)

Code Type	Codes
ICD-9-CM	296.30, 296.31, 296.32, 296.33, 296.34
ICD-10-CM	F33.2, F33.3, F33.9

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Data Elements:

- *Date of Birth*
- *Date of MDD diagnosis, if recurrent*
- *Suicide Assessment Date*
- *ICD-9-CM/ICD-10-CM Diagnosis codes*

The following link may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/major-depressive-disorder-adult-worksheets.pdf

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **6 month period**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 3 – Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: 3.4	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #:**

Medical attention for nephropathy

98

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

Data Source:	NQF #:
Chart/EHR	**0062**
Measure Steward:	Measure Steward Version:
NCQA	**~~2016~~2017**

Measure Calculation Description

Numerator:
Patients with a nephropathy screening during the measurement year or evidence of nephropathy during the measurement year.

Numerator Inclusion Criteria:

Evidence of nephropathy includes any of the following:

1. An encounter with a code to indicate evidence of nephropathy screening () or nephropathy as indicated by the following () during the measurement year.
    - A nephropathy screening or monitoring test (Appendix A-104).
    - Evidence of treatment for nephropathy or ACE/ARB therapy (Appendix A-105).
    - Evidence of stage 4 chronic kidney disease (Appendix A-106).
    - Evidence of ESRD (Appendix A-107).
    - Evidence of kidney transplant (Appendix A-108).
    - At least one ACE inhibitor or ARB dispensing event (Appendix A-1).
2. Documentation that a urine microalbumin test was performed. Documentation must include a note indicating the date when a urine microalbumin test was performed, and the result. Any of the following meet the criteria for a urine microalbumin test:
    - 24-hour urine for microalbumin
    - Timed urine for microalbumin
    - Spot urine for microalbumin
    - Urine for microalbumin/creatinine ratio
    - 24-hour urine for total protein
    - Random urine for protein/creatinine ratio
3. A nephrologist visit during the measurement year (no restriction on the diagnosis or procedure code submitted).
4. Documentation of a renal transplant.
5. Documentation of medical attention for any of the following (no restriction on provider type):

- Diabetic nephropathy
- ESRD
- Chronic renal failure (CRF)
- Chronic kidney disease (CKD)
- Renal insufficiency
- Proteinuria
- Albuminuria
- Renal dysfunction
- Acute renal failure (ARF)
- Dialysis, hemodialysis or peritoneal dialysis

6. Evidence of ACE inhibitor/ARB therapy during the measurement year. Patients who had an encounter with a code indicating therapy (Table 98.3) or received an ambulatory prescription or were dispensed an ambulatory prescription for ACE inhibitors or ARBs during the measurement year. A comprehensive medication list can be found in Appendix A-1.

Table 98.3: ACE Inhibitors/ARBs (Appendix A-1)

Description	Prescription				
Angiotensin converting enzyme inhibitors	Benazepril Captopril	Enalapril Fosinopril	Lisinopril Moexipril	Perindopril Quinapril	Ramipril Trandolapril
Angiotensin II inhibitors	Azilsartan Candesartan	Eprosartan Irbesartan	Losartan Olmesartan	Telmisartan Valsartan	
Antihypertensive combinations	Aliskiren-valsartan Amlodipine-benazepril Amlodipine-hydrochlorothiazide-valsartan Amlodipine-hydrochlorothiazide-olmesartan Amlodipine-olmesartan Amlodipine-telmisartan Amlodipine-valsartan		Azilsartan-chlorthalidone Benazepril-hydrochlorothiazide Candesartan-hydrochlorothiazide Captopril-hydrochlorothiazide Enalapril-hydrochlorothiazide Eprosartan-hydrochlorothiazide Fosinopril-hydrochlorothiazide Hydrochlorothiazide-irbesartan Hydrochlorothiazide-lisinopril		Hydrochlorothiazide-losartan Hydrochlorothiazide-moexipril Hydrochlorothiazide-olmesartan Hydrochlorothiazide-quinapril Hydrochlorothiazide-telmisartan Hydrochlorothiazide-valsartan Trandolapril-verapamil

Denominator:
Of the New Jersey Low Income attributed population, patients 18 to 75 years of age with diabetes (type 1 and type 2). (Appendix A-28)

Patients with diabetes mellitus are identified using diagnosis codes and/or pharmacy data within the inpatient or outpatient claims data. Only one method to identify patients is needed to be included in the denominator.

1. Claims data.
    a. Patients with at least two face-to-face encounters with a principal or secondary diagnosis of diabetes (Appendix A-28) with different dates of service in an outpatient setting or non-acute inpatient setting during the measurement year.
    b. Patients with at least one face-to-face encounter with a principal or secondary diagnosis of diabetes (Appendix A-28) in an acute inpatient or emergency department setting during the measurement year.

2. Pharmacy data. Patients who were dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year. (Appendix A-9)

Prescriptions to Identify Members With Diabetes (Appendix A-9)

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlinitide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin	• Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin	• Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Exenatide	• Liraglutide	• Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA will post a complete list of medications and NDC codes to www.ncqa.org by November 2, 2015.*

Exclusion(s):

1. Diagnosis of active gestational diabetes and active steroid induced diabetes. (Appendix A-91)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**
Sampling or Risk Adjustment Methodology	

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 11 – Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: Substitution measure	Payment Method: P4P
Project Title: Project 12 – Diabetes Group Visits for Patients and Community Education	Project Code: Substitution measure	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: Medication Reconciliation

DSRIP #: 61

Measure Description:
Percentage of patients aged 18 years and older discharged from any inpatient facility (i.e. hospital) and seen within 31 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist who had reconciliation of the discharge medications with the current medication list in the outpatient record documented.

Data Source: **Chart/EHR**

NQF #: **Based on 0097**

Measure Steward: **NCQA**

Measure Steward Version: ~~2016~~ 2017

Measure Calculation Description

Numerator:
Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.

Table 61.1: Codes to Identify Medication Reconciliation

Description	CPT Codes
Medication reconciliation	1111F, 99495, 99496

Denominator:
Of the New Jersey Low Income attributed population, all patients aged 18 years and older discharged from any inpatient facility (i.e. hospital) between January 1 and December 1 of the measurement year and seen within 31 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care.

The denominator for this measure is based on discharges, not patients. If a patient has more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. (Appendeix A - 33)

If the discharge is followed by a readmission or direct transfer to an acute facility within the 30-day follow-up period, only count the readmission discharge or the discharge from which the patient was transferred.

This measure is reported as **two** rates stratified by age group:
1. 18 through 64 years
2. 65 years and above

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

http://www.qualityforum.org/QPS/0097

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 6 – Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	Project Code: 6.4	Payment Method: Pay for Reporting
Project Title: Project 7 – Extensive Patient CHF-Focused Multi-Therapeutic Model	Project Code: 7.5	Payment Method: Pay for Reporting
Project Title: Project 8 – The Congestive Heart Failure Program (CHF-TP)	Project Code: 8.5	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 63

Pediatric Central-Line Associated Bloodstream Infections (CLABSI)- Neonatal Intensive-Care Unit and Pediatric Intensive Care Unit

Measure Description:
The Central line-associated blood stream infections (CLABSI) rate in pediatric and neonatal intensive care units, reported per 1,000 device days.

Data Source:	NQF #:
Chart/ EHR	**Not Found**
Measure Steward:	Measure Steward Version:
CDC	**2015**

Measure Calculation Description

Numerator:
Total number of CLABSI events among patients in PICUs and NICUs.

A bloodstream infection must first be determined to be a healthcare-associated infection (HAI) before it can be identified as a CLABSI. Only HAIs can be CLABSIs. An HAI is a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that was not present or incubating on admission to the acute care facility.

Once identified as an HAI, a laboratory-confirmed bloodstream infection (LCBI) is further identified as a CLABSI if a central line (CL) or umbilical catheter

Denominator:
Of the hospital's attributable New Jersey Low Income population, the total central line device-days among patients in PICUs and NICUs for the measurement period.

Result:
The result is expressed as a rate.

The rate is calculated as the number of identified CLABSI events over the number of central line device days multiplied by 1000.

Improvement Direction:
Lower

Measure Qualifications:

See measure steward specification for more details on how to identify CLABSI events.

Definition of device days: a daily count of the number of patients with a specific device (i.e. central line) in place in a patient care location. Device days are used for denominators in CLABSI rates. Device day denominator data that are collected differ according to the location of the patients being monitored.

a. For ICUs, the number of patients with one or more central lines of any type is collected daily, at the same time each day during the month. The totals for the month are entered.

b. In NICUs, the number of patients with one or more central lines (including umbilical catheters) is stratified by birth weight in five categories since risk of BSI varies by birth weight.

Intensive Care Unit – A nursing care area in which at least 80 percent of the patients match definitions of critical care locations found in chapter 15, Master CDC Locations and Descriptions, of the NHSN Patient Safety Component Manual.
http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current. pdf

Central Line – An intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting CLABSI and counting central-line days:

- Aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, common iliac veins, femoral veins and in neonates, the umbilical artery/ vein. Note: Neither the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of the great vessels or in or near the heart and be used for one of the purposes outlined above to qualify as a central line.

Infusion – The introduction of a solution through a blood vessel via a catheter lumen. This may include continuous infusions such as nutritional fluids or medications, or it may include intermittent infusions such as flushes or IV antimicrobial administration, or blood, in the case of transfusion or hemodialysis.

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Improvement Target Goal (ITG): **NA**	Absolute ITG Value: **NA**
Attribution Date: **Last day of measurement period**	Anchor Date: **NA**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 38	Payment Method: UPP

Measure: **DSRIP #: 64**

Percent of hospitalized patients who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use

Measure Description:
Percentage of hospitalized patients who are screened within the first three days during the hospital stay using a validated screening questionnaire for unhealthy alcohol use.

Data Source:	NQF #:
Chart/EHR	**1661**
Measure Steward:	Measure Steward Version:
Joint Commission	**~~2015 v 5.0~~ 2017 v5.2a**

Measure Calculation Description

Numerator:
The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first three days of admission.

Numerator Inclusion(s):
1. Patients with a blood alcohol test indicative of acute intoxication
2. Patients who refused screening

Denominator:
Of the New Jersey Low Income attributed population, those who are hospitalized inpatients 18 years of age and older.

Exclusion(s):
1. Patients less than 18 years of age.
2. Patients who are cognitively impaired.
3. Patients who have a duration of stay less than or equal to three days or greater than 120 days.
4. Patients with Comfort Measures Only documented.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Data Elements:

Numerator:
- *Alcohol Use Status*

Denominator:

- *Admission Date*
- *Birth Date*
- *Comfort Measures Only*
- *Discharge Date*

The following link may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

Please Note: Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiuritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as "comfort care" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do No Resuscitate (DNR).

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **6 month period**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 9 - Hospital-Wide Screening for Substance Use Disorder	Project Code: 9.1	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 65

Percent of patients evaluated for environmental triggers other than environmental tobacco smoke (dust mites, cats, dogs, molds/fungi)

Measure Description:
Percentage of patients evaluated for environmental triggers other than environmental tobacco smoke (dust mites, cats, dogs, molds/fungi, cockroaches) either by history of exposure and/or by allergy testing.

Data Source:
Chart/EHR

NQF #:
Not Found

Measure Steward:
HRSA

Measure Steward Version:
October ~~2013~~2015

Measure Calculation Description

Numerator:
The number of patients evaluated for environmental triggers other than environmental tobacco smoke (e.g. dust mites, cats, dogs, molds/fungi, cockroaches) either by history of exposure and/or by allergy testing.

Note: The "indoor" environmental triggers here are those having the strongest evidence of causal relationship to asthma.

Denominator:
Of the New Jersey Low Income attributed population, patients under 18 years of age with a diagnosis of asthma.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:
This measure is one of 11 measures that participants track in the HRSA Health Disparities Collaborative for Asthma.

Please note: The age range follows the youngest age group for the Medicaid Adult Core measure Set.

The following link may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://www.qualitymeasures.ahrq.gov/content.aspx?id=27598

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **6 month period**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 2 - Pediatric Asthma Case Management and Home Evaluations	Project Code: 2.6	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 70**

Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia who had a chest x-ray

Measure Description:
Percentage of patients age 18 years and older diagnosed with community-acquired bacterial pneumonia who had a chest x-ray performed.

Data Source:	NQF #:
Chart/EHR	**Not Found**
Measure Steward:	Measure Steward Version:
AMA-PCPI	**2011**

Measure Calculation Description

Numerator:
Patients with a chest x-ray performed.

Denominator:
Of the New Jersey Low Income attributed population, patients aged 18 years and older with community-acquired bacterial pneumonia.

Exclusion(s):
1. Documentation of medical reason(s) for not performing a chest x-ray.
2. Documentation of patient reason(s) for not performing a chest x-ray (e.g., economic, social, religious, other patient reasons).
3. Documentation of system reason(s) for not performing a chest x-ray (e.g., equipment not available).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

https://download.ama-assn.org/resources/doc/pcpi/capminiset062007.pdf

Measure Collection Description

Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **6 month period**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 17 - Patients Receive Recommended Care for Community-Acquired Pneumonia	Project Code: 17.1	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 71**

Percentage of patients with BMI >= 25 who set an individualized goal along with target date for reduction in body mass index

Measure Description:
Percentage of patients aged 18 years and younger with a documented body mass index (BMI) during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.

Data Source:	NQF #:
Chart/ EHR	**Based on 0421**
Measure Steward:	Measure Steward Version:
~~CMS~~ **ICSI**	~~2012~~ **May 2013**

Measure Calculation Description

Numerator:
Patients with BMI calculated within the past six months or during the current visit, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters.

Denominator:
Of the hospital's attributable New Jersey Low Income population, all patients aged 18 years and younger.

Exclusion(s):
1. Patient is pregnant
2. Patient refuses BMI measurement
3. If there is any other reason documented in the medical record by the provider explaining why BMI measurement of follow-up plan was not appropriate
4. Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Numerator Note:
Calculated BMI or follow-up plan for BMI outside of normal parameters that is documented in the medical record may be reported if done in the provider's office/facility or if obtained by the provider from outside medical records within the past six months. The documented follow-up interventions must be related to the BMI outside of normal parameters (i.e., patient referred to nutrition counseling for BMI above normal parameters).

BMI – Body mass index (BMI) is expressed as weight/height (BMI; kg/m2) and is commonly used to classify weight categories.

Calculated BMI – Requires an eligible professional or their staff to measure both the height and weight. Self-reported values cannot be used. BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared.

Follow-up Plan – Proposed outline of treatment to be conducted as a result of a BMI measurement out of normal parameters. Such follow-up may include but is not limited to:

- Documentation of a future appointment
- Education
- Referral (such as, a registered dietician, nutritionist, occupational therapist, physical therapist, primary care physician, exercise physiologist, mental health professional, surgeon)
- Pharmacological interventions
- Dietary supplements
- Exercise counseling
- Nutrition counseling

Please note: The measure steward age stratification age groupings have been adjusted to follow the Medicaid Adult Core measure set age category 18 years and younger.

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

http://www.qualityforum.org/QPS/0421

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**
Sampling or Risk Adjustment Methodology This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.	

DSRIP Incentive Impact		
Project Title: Project 15 – After-School Obesity Program	Project Code: 15.1	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 73

Post-Discharge Appointment for Heart Failure Patients

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

Data Source:
Chart/EHR

NQF #:
Not Found

Measure Steward:
AMA-PCPI

Measure Steward Version:
May 2012

Measure Calculation Description

Numerator:

Patients for whom a follow up appointment was scheduled and documented prior to discharge including either:

1. An office visit (including location, date and time) for management of heart failure with a physician, advanced practice nurse, physician assistant. (Appendix A-32)
2. A home health visit (including location and date) for management of heart failure

Due to the nature of scheduling home health visits, the location and date of the follow-up appointment is sufficient for meeting the measure.

Denominator:
Of the New Jersey Low Income attributed population, all patients, regardless of age, discharged from an inpatient facility (i.e. hospital inpatient or observation) to ambulatory care (home/self care) or home health care with a principal discharge diagnosis of heart failure (Table 73.1)(Appendix A-30).

Table 73.1 Codes to Identify Heart Failure (Appendix A- 30), (Appendix A - 32)

Code Type	Code
CPT	99201-99203, 99205, 99212-99215 99241-99245,99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350
ICD-9	402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9
ICD-10	I11.0, I13.0, I13.2, I50.20-23, I50.30-33, I50.40-43, I50.9, I50.1, I50.20-I50.23, I50.30-I50.33, I50.40-I50.43, I50.9

AND

UB-04 (Form Locator 04- Type of Bill)	
0111	Hospital, Inpatient, Admit through Discharge Claim
0121	Hospital, Inpatient – Medicare Part B only, Admit through Discharge Claim
0114	Hospital, Inpatient, Last Claim
0124	Hospital, Inpatient – Medicare Part B only, Interim-Last Claim

AND

Discharge Disposition—on day of discharge only	
1	Home
Includes assisted living facilities, court/law enforcement (detention facilities, jails, and prison), foster or residential care, group or personal care homes, and homeless shelters, home with home health services, outpatient services including outpatient procedures at another hospital, outpatient chemical dependency programs, and partial hospitalization.	

Exclusion(s):

1. Documentation of medical reason(s) for not documenting that a follow up appointment was scheduled.
2. Patients who expired.
3. Patients who left against medical advice (AMA) or discontinued care.
4. Patients discharged to hospice.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Data Elements:

- *Birth Date*
- *Diagnosis Code(s)*
- *Procedure Code(s)*
- *Documentation of medical reason for not documenting a follow up appointment was scheduled*
- *Discharge Status*

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances.

http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/hfset-12-5.pdf

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **6 month period**	Baseline Period**:** **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 6 - Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	Project Code: 6.3	Payment Method: Pay for Reporting
Project Title: Project 7 - Extensive Patient CHF-Focused Multi-Therapeutic Model	Project Code: 7.4	Payment Method: Pay for Reporting
Project Title: Project 8 - The Congestive Heart Failure Program (CHF-TP)	Project Code: 8.4	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: Postoperative Sepsis

DSRIP #: 74

Measure Description:
Percentage of ostoperative sepsis cases (secondary diagnosis) per 1,000 elective surgical discharges for patients ages 18 years and older.

Data Source: **Chart/EHR**

NQF #: **Not Found**

Measure Steward: **AHRQ**

Measure Steward Version: ~~2015~~ 2016

Measure Calculation Description

Numerator:
Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-9-CM/ICD-10-CM diagnosis codes for sepsis.

Table 74.1: Codes to Identify Sepsis codes (Appendix A- 29)

Code Type	Codes
ICD-9-CM	038.0, 038.10-12, 038.19, 038.2-038.3, 038.3, 038.40-038.44, 038.49, 038.8-9, 785.52, 995.91-995.92, 998.02, 003.1, 022.3, 027.0-027.1, 098.89, 112.5
ICD-10-CM	A02.1, A22.7, A26.0, A26.7, A26.8-A26.9, A32.0, A32.7, A32.11-A32.12, A32.81-A32.82, A32.89, A32.9, A40.0-A40.3, A40.8-9, A41.01-A41.02, A41.1-A41.4, A41.50-A41.53, A41.59, A41.81, A41.89, A54.82, A54.84, A41.9, A42.7, A54.86, A54.89,A54.9, B37.7, R65.20-R65.21, T81.12XA

Exclusion(s):

1. Patients with a principal ICD-9-CM/ICD-10-CM diagnosis code (or secondary diagnosis present on admission) for sepsis (see above)
2. Patients with a principal ICD-9-CM/ICD-10-CM diagnosis code (or secondary diagnosis present on admission) for infection or pressure ulcer (Appendix A- 36)
3. Patients with any-listed ICD-9-CM/ICD-10-CM diagnosis codes or any-listed ICD-9-CM/ICD-10-CM procedure codes for immunocompromised state (Appendix A- 37)
4. Patients with any-listed ICD-9-CM/ICD-10-CM diagnosis codes for cancer (Appencix A-38)
5. Patients with length of stay of less than 4 days
6. Patients with an MDC 14 (pregnancy, childbirth, and puerperium) (Appendix A-92)
7. Patients with missing gender, age, quarter, year, or principal diagnosis

Denominator:
Of the hospital's attributable New Jersey Low Income population, those with elective surgical discharges, for patients ages 18 years and older, with any-listed ICD-9-CM/ICD-10-CM procedure codes for an operating room procedure. (Appendix A-93 and Appendix A-94)

Elective surgical discharges are defined by specific DRG or MS-DRG codes with admission type recorded as elective (SID ATYPE=3).

Result:
The result is expressed as a rate per 1,000.

Improvement Direction:
Lower

Measure Qualifications:

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

http://www.qualityindicators.ahrq.gov/
Link to measure steward appendix procedure code and diagnosis code documentation:
http://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V50-ICD10/TechSpecs/PSI_Appendix_A.pdf
http://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V50-ICD
http://www.qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10.aspx
10/TechSpecs/PSI_Appendix_D.pdf

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	**Baseline Period: CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 37	Payment Method: UPP

Measure: **DSRIP #: 76**

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who were screened for tobacco use AND who received tobacco cessation counseling intervention if identified as a tobacco user.

Data Source:	NQF #:
Chart/EHR	**0028**
Measure Steward:	Measure Steward Version:
AMA-PCPI	**2011**

Measure Calculation Description

Numerator:
Patients who were screened for tobacco use AND who received tobacco cessation counseling intervention, if identified as a tobacco user.

All patients aged 18 years and older with a diagnosis of coronary artery disease (Appendix A-39) seen within a 12 month period should be screened for tobacco use (even life-long non-smokers). If identified as a tobacco user, tobacco cessation counseling should also be provided. (Appendix A–58)

Numerator Inclusion Criteria:
1. Patients screened for tobacco use. (Table 71.1)
2. Patients identified as tobacco users. (Table 71.1)
3. Patients who received tobacco cessation counseling intervention (Table 71.1) and/or pharmacotherapy. (Table 71.2)

Table 76.1: Codes to Identify Tobacco Screening, Use, Non-Use, Cessation Intervention (Appendix A-58)

CPT Code	Description
1000F	TOBACCO USE ASSESSED
1034F	CURRENT TOBACCO SMOKER
1035F	CURRENT SMOKELESS TOBACCO USER
1036F	CURRENT TOBACCO NON-USER
AND	
4000F	TOBACCO USE CESSATION INTERVENTION COUNSELING
4001F	TOBACCO USE CESSATION INTERVENTION, PHARMACOLOGIC THERAPY
OR	
99406	SMOKING/TOBACCO COUNSELING 3-10 MINUTES
99407	SMOKING/TOBACCO COUNSELING GREATER THAN 10 MINUTES

The following list of medications/drug names is based on clinical guidelines and other evidence and may not be all-inclusive or current. Physicians and other health care professionals should refer to the FDA's web site page entitled *Drug Safety Communications* for up-to-date recall and alert information when prescribing medication.

Table 76.2: Medications to Identify Pharmacotherapy

Description	Drug Name
Nicotine Treatment	• Transdermal Patch • Lozenge • Inhalant Solution • Nasal Spray • Chewing Gum • Sublingual Tablet
Antidepressant	• Bupropion Sustained Release
Smoking Deterrent	• Vareniciline

Denominator:
Of the New Jersey Low Income attributed population, all patients aged 18 years and older with a diagnosis of coronary artery disease (Refer to Appendix ~~A-8~~ A-39) seen within a 12 month period.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:
Data Elements:

Numerator
- *Tobacco Screening/Assessment Code*
- *Tobacco User/Non-User Code*
- *Cessation Intervention Code*
- *Pharmacotherapy Medication(s)*

Denominator
- *Birth Date*
- *ICD-9-CM/ICD-10-CM Principal Diagnosis Code*
- *ICD-9-CM/ICD-10-CM Other Diagnosis Code*
- *Date of Ambulatory Visit*

Tobacco screening includes any type of tobacco.

Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy.

The list of pharmacotherapy medications (Table 71.2) is based on clinical guidelines and other evidence and may not be all-inclusive or current. Refer to the FDA's website page entitled "*Drug Safety Communications*" for up-to date drug information.

The following link may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/cadminisetjune06.pdf

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2015**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 6 – Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	Project Code: Substitution measure	Payment Method: P4P
Project Title: Project 7 – Extensive Patient CHF-Focused Multi-Therapeutic Model	Project Code: Substitution measure	Payment Method: P4P
Project Title: Project 8 – The Congestive Heart Failure Transition Program (CHF-TP)	Project Code: Substitution measure	Payment Method: P4P
Universal Measure: Yes	Universal Code: 19	Payment Method: Pay for Reporting

Measure:

DSRIP #: 79

Screening for Clinical Depression and Follow-up Plan

Measure Description:
Percentage of patients aged 12 years and older screened for clinical depression on the date of 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.

Data Source:	NQF #:
Chart/EHR	**0418**
Measure Steward:	Measure Steward Version:
CMS	**Version 7.2**

Measure Calculation Description

Numerator:
Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. (Appendix A-349)

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. Examples of depression screening tools
include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of positive clinical depression
screening. Follow-up for a positive depression screening must include one (1) or more of the following:

- Additional evaluation
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Numerator Exclusions Criteria

A patient is not eligible if one or more of the following conditions exist:

1. Patient refuses to participate.
2. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
3. Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.
4. Patient has an active diagnosis of Depression or Bipolar Disorder.

Denominator:
Of the New Jersey Low Income attributed population, patients aged 12 years and older with one of the following encounter types: (Appendix A-73)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

If the provider is not currently utilizing a standard depression screening tool, this would have to be implemented during the pilot period.

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**
Sampling or Risk Adjustment Methodology	

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 5 - Electronic Self-Assessment Decision Support Tool	Project Code: 5.3	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 68**

Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence

Measure Description:
The percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period.

Data Source:	NQF #:
Chart/ EHR	**Not Found**
Measure Steward:	Measure Steward Version:
AMA-PCPI	**May 2008**

Measure Calculation Description

Numerator:
Patients who were screened for depression within the 12 month reporting period.
(CPT Category II code: 1220F – Patients screened for depression) (Appendix A-97)

Denominator:
Of the hospital's attributable New Jersey Low Income population, all patients 18 years and older with a diagnosis of ~~depression or~~ current substance abuse or dependence.
Diagnosis code (Appendix A-95)
AND
Service code (Appendix A-96)

Exclusion(s):
1. Documentation of medical reason(s) for not screening for depression within the 12 month reporting period. (*Append modifier to CPT Category II: 1220F-1P*) (Appendix A-98)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances.:

http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/sud_ws_final.pdf

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 9 – Hospital-wide Screening for Substance Use Disorder	Project Code: 9.2	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 80**

Timely Transmission of Transition Record

Measure Description:
Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Data Source:	NQF #:
Chart/EHR	**0648**
Measure Steward:	Measure Steward Version:
AMA-PCPI	**2009**

Measure Calculation Description

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

Transition record **-** a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.

Transmitted - transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).

Primary physician or other health care professional designated for follow-up care - may be a designated primary care physician (PCP), medical specialist, or other physician or health care professional

Denominator:
Of the New Jersey Low Income attributed population, all patients, regardless of age, discharged from an inpatient facility (i.e. hospital inpatient) to home/self care or any other site of care with a diagnosis of care or working diagnosis of Congestive Heart Failure (CHF) Appendix A-30.
See Table 80.1 for codes to identify patients discharged from an inpatient facility

Table 80.1: Codes to Identify Patients Discharged from Inpatient Facility ~~(Appendix A-30)~~

Type of Bill (Form Locator 04, UB-04)		Revenue Code (Form Locator 42, UB-04)		Discharge Status (Form Locator 17, UB-04)
0111, 0121, 0114, 0124, 0211, 0214, 0221, 0224, 0281, 0284, 0131, 0134	AND		AND	01, 02, 03, 04, 05, 06, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70,
0131, 0134	AND	0762, 0490, 0499	AND	01, 02, 03, 04, 05, 06, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70,

Exclusion(s):

- Patients who expired. (Table 80.2)
- Patients who left against medical advice or discontinued care. (Table 80.2)

Table 80.2: Codes to Identify Discharge Exclusions (Appendix A-346)

Discharge Status (Form Locator 17, UB-04)	07 – Left Against Medical Advice or Discontinued Care 20 – Expired 40 – Expired at Home 41 – Expired in a Medical Facility 42 – Expired, Place Unknown

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Data Elements:

- *Diagnosis of Care (Working Diagnosis)*
- *Patient Discharge Status Code*
- *Discharge date*
- *Patient Discharge Summary Transmission Date*

The addition of the diagnosis was included to track only CHF discharges.

The following link may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/care-transitions-ms.pdf

Measure Collection Description	
Setting of Care: **Inpatient or Emergency Department**	Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**
Experience Period: **6 month period**	Baseline Period: **SA July – December 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 6 - Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions A	Project Code: 6.9	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 87**

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure Description:
Percentage of patients 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:

1. Body Mass Index (BMI) percentile documentation*
2. Counseling for nutrition
3. Counseling for physical activity

**Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

Data Source: **Chart/ EHR**

NQF #: **0024**

Measure Steward: **NCQA**

Measure Steward Version: ~~2016~~ 2017

Measure Calculation Description

Numerator:
Patients who had an outpatient visit (Appendix A-32) with a PCP or OB/GYN and who had evidence of the following during the measurement year:

1. BMI percentile during the measurement year. (Table 87.1) (Appendix A- 42)
2. Counseling for nutrition (Table 87.1) (Appendix A- 40) or referral for nutrition education during the measurement year.
3. Counseling for physical activity (Table 87.1) (Appendix A- 41) or referral for physical activity during the measurement year.

Table 87.1: Codes to Identify BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity

Description	CPT	ICD-9-CM Diagnosis	ICD-10 CM Diagnosis	HCPCS
BMI percentile		V85.51-V85.54	Z68.51-Z68.54	
Counseling for nutrition	97802-97804	V65.3	Z71.3	G0270, G0271, S9449, S9452, S9470, G0447
Counseling for physical activity		V65.41	Z71.89	S9451, G0447

Numerator Inclusion Criteria:

BMI Percentile:
Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI must be from the same data source.

Either of the following meets criteria for BMI percentile:

- BMI percentile, ***or***
- BMI percentile plotted on age-growth chart.

Counseling for Nutrition:
Documentation must include a note indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Member received educational materials on nutrition.
- Anticipatory guidance for nutrition.
- Weight or obesity counseling.

Counseling for Physical Activity:
Documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity.
- Anticipatory guidance specific to the child's physical activity.
- Weight or obesity counseling.

Numerator Exclusions Criteria:
The following notations or examples of documentation do not count as numerator compliant:

BMI:

- No BMI or BMI percentile documented in medical record or plotted on age-growth chart.
- Notation of height and weight only.

Nutrition and Diet:

- No counseling/education on nutrition and diet.
- Counseling/education before or after the measurement year.
- Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.
- A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.

Physical Activity:

- No counseling/education on physical activity.
- Notation of "cleared for gym class" alone without documentation of a discussion.
- Counseling/education before or after the measurement year.
- Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.
- Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.

- Notation solely related to screen time (computer or television) without specific mention of physical activity.

Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. Services specific to an acute or chronic condition do not count toward the "Counseling for nutrition" and "Counseling for physical activity" indicators.

The Total sample is stratified by age to report rates:
1. 3 through 11 years of age
2. 12 through 17 years of age
3. Total 3 – 17 years of age

Denominator:
Of the New Jersey Low Income attributed population, those patients who are 3-17 years of age as of December 31 of the measurement year who had an outpatient visit (Table 87.2) with a PCP or an OB/GYN during the measurement year.

Table 87.2: Codes to Identify Outpatient Visits

CPT	UB Revenue	HCPCS
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	0510-0519, 0520-0523, 0526-0529, 0982, 0983	G0402, G0438, G0439, G0463, T1015

Exclusion(s):
Patients who have a diagnosis of pregnancy (Table 87.3) (Appendix–50) during the measurement year.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Please note: The age stratification: "Total 3-17 years of age" will be monitored and apply to the P4P incentive award for this measure.

The following link may be used to obtain additional information regarding the specific instructions on the measurement qualifications/definitions and data collection. This is provided without assurances:

http://www.qualitymeasures.ahrq.gov/content.aspx?id=48584

Measure Collection Description	
Setting of Care: **Outpatient**	Reporting Period: **Annual; April**
Experience Period: **Calendar Year**	Baseline Period: **CY 2014**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology

This measure is to be collected and reported by the hospital following the sampling guidance provided in Section III.

DSRIP Incentive Impact		
Project Title: Project 4 – Day Program and School Support Expansion	Project Code: 4.4	Payment Method: Pay for Reporting
Project Title: Project 5 – Electronic Self-Assessment Decision Support Tool	Project Code: 5.5	Payment Method: Pay for Reporting
Project Title: Project 15 - After-School Obesity Program	Project Code: 15.3	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

MMIS Measure Specification Forms

Measure: **DSRIP #: 1**

30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization

Measure Description:
The percentage of 30-day all cause readmissions following acute myocardial infarction (AMI) hospitalization.

Data Source:	NQF #:
MMIS	**Based on 0505**
Measure Steward:	Measure Steward Version:
CMS	**March 2013, Version 6.0**

Measure Calculation Description

Numerator:
The number of unplanned 30-day all-cause readmission from the date of discharge of the index acute myocardial infarction (AMI) admission. (Appendix A-340)

The measure assesses *unplanned readmissions* within a 30-day period from the date of discharge of an index admission. This standard time period is necessary so that the outcome for each patient is measured uniformly. The 30-day time frame is a clinically meaningful period for hospitals to collaborate with their communities in an effort to reduce readmissions.

Readmission Exclusions:

Admissions not counted as readmissions:
As published in the measure steward specifications, CMS follows a Planned Readmission Algorithm based on three principles (Appendix B-350):

1. A few specific, limited types of care are always considered planned (obstetric delivery, transplant surgery, maintenance chemotherapy/ radiotherapy/ immunotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The algorithm identifies admissions that are typically planned (Appendix B-350) and may occur within 30 days of discharge from the hospital. The details of the *index* admission (diagnosis or procedures) are not considered when determining whether a readmission is planned.

Denominator:
Of the hospital's attributed New Jersey Low Income population, the total number of hospital discharges with a principal diagnosis of acute myocardial infarction (AMI) for patients aged 18 years and older (Appendix A-340).

Index admission – is the hospitalization considered for the readmission outcome.

Patients with an index hospitalization within an acute care hospital are included if they have been a New Jersey Low Income population member for the 365 days prior to the Index Discharge date through

30 days following the index discharge date to ensure a full year of administrative data for risk adjustment.

Index Admission Exclusion(s):

1. Patients with an in-hospital death: Admissions for patients with an in-hospital death are excluded because they are not eligible for readmission.

2. Less Than 30 Days Post-discharge Information: Admissions for patients without at least 30 days post-discharge as a member of the New Jersey Low Income population are excluded because the 30-day readmission outcome cannot be assessed for this group.

3. Transfers: Admissions for patients having a principal diagnosis of AMI during the index hospitalization and subsequently transferred to another acute care facility are excluded because this measure applies to discharges to non-acute care settings.
    a. Admissions to another hospital within one day of discharge are considered transfers, regardless of the disposition of the previous admission.

4. Discharges Against Medical Advice (AMA): Patients who were discharged against medical advice (AMA).

5. Same Day Discharge: Patients admitted and discharged on the same day are not included because it is unlikely these are clinically significant AMIs.

6. Admissions within 30 days of discharge from an index admission will not be considered index admissions. No hospitalization will be counted as both a readmission and an index admission within the same measure. However, because cohorts for the readmission measures are determined independently of each other, a readmission in one measure (e.g. DSRIP # 1 AMI) may qualify as an index admission in another readmission measure (e.g. DSRIP # 2 COPD).

If a patient is readmitted to the same hospital on the same day of discharge for the same principal diagnosis as the index admission, the measure *combines* both stays to account for the index admission.

If a patient is readmitted to the same hospital on the same day as the index admission with a *different principal diagnosis* from the index admission, this is considered as a readmission.

Readmissions for transferred patients are attributed to the hospital that ultimately discharges the patient to a non-acute care setting (e.g., to home or a skilled nursing facility). If a patient is admitted to Hospital A, transferred to Hospital B, and ultimately discharged from Hospital B to a non-acute care setting, a readmission within 30 days of discharge to any acute care hospital is attributed to Hospital B.

If a patient has more than one unplanned admission within 30 days of discharge from the index admission, only the first one is counted as a readmission.

If the first readmission after discharge is planned, then no readmission is considered in the outcome, regardless of whether a subsequent unplanned readmission takes place because it would be unfair to attribute the unplanned readmission back to the care received during the index admission.

Result:
The result is expressed as a percentage.

Improvement Direction:
Lower

Measure Qualifications:

Please note: The measure steward age stratification is based on Medicare age groupings. This has been adjusted to follow the Medicaid Adult Code age categories. The unplanned input files used were obtained from the Yale Group's SAS program (2013 SAS) package which is made available to the public.

The following link(s) may be used to obtain additional information regarding the original measure specification and risk standardization methodology. This is provided without assurances:

http://www.jointcommission.org/core_measure_sets.aspx

http://qualitynet.org/dcs/ContentServer?cid=1219069855841&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

Continuous Eligibility –
The patient is to be continuously enrolled for the 365 days prior to the Index discharge date through 30 days with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 6 - Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	Project Code: 6.7	Payment Method: P4P

Project Title:	Project Code:	Payment Method:
Project 7 - Extensive Patient CHF-Focused Multi-Therapeutic Model	7.8	P4P
Project Title:	Project Code:	Payment Method:
Project 8 - The Congestive Heart Failure Program (CHF-TP)	8.8	P4P
Universal Measure:	Universal Code:	Payment Method:
Yes	43	UPP Substitution

Measure: **DSRIP #: 2**

30-Day All-Cause Readmission Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

Measure Description:
The percentage of 30-day all cause readmissions following Chronic Obstructive Pulmonary Disease (COPD) hospitalization.

Data Source:	NQF #:
MMIS	**Based on 1891**
Measure Steward:	Measure Steward Version:
CMS	**September 2011**

Measure Calculation Description

Numerator:
The number of patients with unplanned 30-day all-cause readmission from the date of discharge of the index having a principle diagnosis of Chronic Obstructive Pulmonary Disease (COPD) admission (Appendix A-341) or a principle diagnosis of respiratory failure (Appendix A-342) with a secondary diagnosis of acute exacerbation of COPD (AECOPD) (Appendix A-343).
The measure assesses *unplanned readmissions* within a 30-day period from the date of discharge of an index admission. This standard time period is necessary so that the outcome for each patient is measured uniformly. The 30-day time frame is a clinically meaningful period for hospitals to collaborate with their communities in an effort to reduce readmissions.

Readmission Exclusions:

Admissions not counted as readmissions:
As published in the measure steward specifications, CMS follows a Planned Readmission Algorithm based on three principles (Appendix B-350):

1. A few specific, limited types of care are always considered planned (obstetric delivery, transplant surgery, maintenance chemotherapy/ radiotherapy/ immunotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The algorithm identifies admissions that are typically planned (Appendix B-350) and may occur within 30 days of discharge from the hospital. The details of the *index* admission (diagnosis or procedures) are not considered when determining whether a readmission is planned.

Denominator:
Of the hospital's attributed New Jersey Low Income population aged 18 years and older, the total number of hospital discharges with an acute care hospital admission having a principal diagnosis of Chronic Obstructive Pulmonary Disease (COPD) (Appendix A-341) or a principal diagnosis of respiratory failure (Appendix A-342) with a secondary diagnosis of acute exacerbation of COPD (AECOPD) (Appendix A-343).

Index admission – is the hospitalization considered for the readmission outcome.

Patients with an index hospitalization within an acute care hospital are included if they have been a New Jersey Low Income population member for the 365 days prior to the Index Discharge date through 30 days following the index discharge date to ensure a full year of administrative data for risk adjustment.

Index Admission Exclusion(s):

1. Patients with an in-hospital death: Admissions for patients with an in-hospital death are excluded because they are not eligible for readmission.

2. Less Than 30 Days Post-discharge Information: Admissions for patients without at least 30 days post-discharge as a member of the New Jersey Low Income population are excluded because the 30-day readmission outcome cannot be assessed for this group.

3. Transfers: Admissions for patients having a principal diagnosis of COPD or a principal diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD (AECOPD) during the index hospitalization and subsequently transferred to another acute care facility are excluded because this measure applies to discharges to non-acute care settings.
    a. Admissions to another hospital within one day of discharge are considered transfers, regardless of the disposition of the previous admission.

4. Discharges Against Medical Advice (AMA): Patients who were discharged against medical advice (AMA).

5. Admissions within 30 days of discharge from an index admission will not be considered index admissions. No hospitalization will be counted as both a readmission and an index admission within the same measure. However, because cohorts for the readmission measures are determined independently of each other, a readmission in one measure (e.g. DSRIP # 1 AMI) may qualify as an index admission in another readmission measure (e.g. DSRIP # 2 COPD).

If a patient is readmitted to the same hospital on the same day of discharge for the same principal diagnosis as the index admission, the measure *combines* both stays to account for the index admission.

If a patient is readmitted to the same hospital on the same day as the index admission with a *different principal diagnosis* from the index admission, this is considered as a readmission.

Readmissions for transferred patients are attributed to the hospital that ultimately discharges the patient to a non-acute care setting (e.g., to home or a skilled nursing facility). If a patient is admitted to Hospital A, transferred to Hospital B, and ultimately discharged from Hospital B to a non-acute care setting, a readmission within 30 days of discharge to any acute care hospital is attributed to Hospital B.

If a patient has more than one unplanned admission within 30 days of discharge from the index admission, only the first one is counted as a readmission.

If the first readmission after discharge is planned, then no readmission is considered in the outcome, regardless of whether a subsequent unplanned readmission takes place because it would be unfair to attribute the unplanned readmission back to the care received during the index admission.

Result:
The result is expressed as a percentage.

Improvement Direction
Lower

Measure Qualifications:
Please note: The measure steward age stratification is based on Medicare age groupings. This has been adjusted to follow the Medicaid Adult Code age categories. The unplanned input files used were obtained from the Yale Group's SAS program package (2013 SAS pack) made available to the public.

The following link(s) may be used to obtain additional information regarding the original measure specification and risk standardization methodology. This is provided without assurances:

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

https://qualitynet.org/dcs/ContentServer?cid=1228773353043&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

Continuous Eligibility –
The patient is to be continuously enrolled for the 365 days prior to the Index discharge date through 30 days with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 45	Payment Method: UPP Substitution

Measure: **DSRIP #: 3**

30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization

Measure Description:
The percentage of 30-day all cause readmissions following heart failure (HF) hospitalization.

Data Source:	NQF #:
MMIS	**Based on 0330**
Measure Steward:	Measure Steward Version:
CMS	**March 2013, Version 6.0**

Measure Calculation Description

Numerator:
The number of unplanned 30-day all-cause readmissions from the date of discharge having a principle diagnosis of heart failure (HF) admission (Appendix A-344).

The measure assesses *unplanned readmissions* within a 30-day period from the date of discharge of an index admission. This standard time period is necessary so that the outcome for each patient is measured uniformly. The 30-day time frame is a clinically meaningful period for hospitals to collaborate with their communities in an effort to reduce readmissions.

Readmission Exclusions:

Admissions not counted as readmissions:
As published in the measure steward specifications, CMS follows a Planned Readmission Algorithm based on three principles (Appendix B-350):

1. A few specific, limited types of care are always considered planned (obstetric delivery, transplant surgery, maintenance chemotherapy/ radiotherapy/ immunotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The algorithm identifies admissions that are typically planned (Appendix B-350) and may occur within 30 days of discharge from the hospital. The details of the *index* admission (diagnosis or procedures) are not considered when determining whether a readmission is planned.

Denominator:
Of the hospital's attributed New Jersey Low Income population, the total number of hospital discharges with an acute admission having a principal diagnosis of heart failure (HF) (Appendix A-344).

Index admission – is the hospitalization considered for the readmission outcome.

Patients with an index hospitalization within an acute care hospital are included if they have been a New Jersey Low Income population member for the 365 days prior to the Index Discharge date through 30 days following the index discharge date to ensure a full year of administrative data for risk adjustment.

Index Admission Exclusion(s):

1. Patients with an in-hospital death: Admissions for patients with an in-hospital death are excluded because they are not eligible for readmission.

2. Less Than 30 Days Post-discharge Information: Admissions for patients without at least 30 days post-discharge as a member of the New Jersey Low Income population are excluded because the 30-day readmission outcome cannot be assessed for this group.

3. Transfers: Admissions for patients having a principal diagnosis of HF during the index hospitalization and subsequently transferred to another acute care facility are excluded because this measure applies to discharges to non-acute care settings.
    a. Admissions to another hospital within one day of discharge are considered transfers, regardless of the disposition of the previous admission.

4. Discharges Against Medical Advice (AMA): Patients who were discharged against medical advice (AMA).

5. Admissions within 30 days of discharge from an index admission will not be considered index admissions. No hospitalization will be counted as both a readmission and an index admission within the same measure. However, because cohorts for the readmission measures are determined independently of each other, a readmission in one measure (e.g. DSRIP # 1 AMI) may qualify as an index admission in another readmission measure (e.g. DSRIP # 2 COPD).

If a patient is readmitted to the same hospital on the same day of discharge for the same principal diagnosis as the index admission, the measure *combines* both stays to account for the index admission.

If a patient is readmitted to the same hospital on the same day as the index admission with a *different principal diagnosis* from the index admission, this is considered as a readmission.

Readmissions for transferred patients are attributed to the hospital that ultimately discharges the patient to a non-acute care setting (e.g., to home or a skilled nursing facility). If a patient is admitted to Hospital A, transferred to Hospital B, and ultimately discharged from Hospital B to a non-acute care setting, a readmission within 30 days of discharge to any acute care hospital is attributed to Hospital B.

If a patient has more than one unplanned admission within 30 days of discharge from the index admission, only the first one is counted as a readmission.

If the first readmission after discharge is planned, then no readmission is considered in the outcome, regardless of whether a subsequent unplanned readmission takes place because it would be unfair to attribute the unplanned readmission back to the care received during the index admission.

Result:
The result is expressed as a rate.

Improvement Direction
Lower

Measure Qualifications:

Please note: The measure steward age stratification is based on Medicare age groupings. This has been adjusted to follow the Medicaid Adult Code age categories. The unplanned input files used were obtained from the Yale's Group SAS program package (2013 SAS pack) made available to the public.

The following link(s) may be used to obtain additional information regarding the original measure specification and risk standardization methodology. This is provided without assurances:

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

Continuous Eligibility –
The patient is to be continuously enrolled for the 365 days prior to the Index discharge date through 30 days with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 6 - Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	Project Code: 6.6	Payment Method: P4P
Project Title: Project 7 - Extensive Patient CHF-Focused Multi-Therapeutic Model	Project Code: 7.7	Payment Method: P4P
Project Title: Project 8 - The Congestive Heart Failure Program (CHF-TP)	Project Code: 8.7	Payment Method: P4P
Universal Measure: Yes	Universal Code: 42	Payment Method: UPP Substitution

Measure: **DSRIP #: 4**

30-Day All-Cause Readmission Following Pneumonia Hospitalization

Measure Description:
The percentage of 30-day all cause readmissions following pneumonia (PN) hospitalization.

Data Source:	NQF #:
MMIS	**Based on 0506**
Measure Steward:	Measure Steward Version:
CMS	**March 2013, Version 6.0**

Measure Calculation Description

Numerator:
The number of 30-day all-cause unplanned readmission from the date of discharge of the index pneumonia (PN) (Appendix A-345).

Readmission Exclusions:

Admissions not counted as readmissions:
As published in the measure steward specifications, CMS follows a Planned Readmission Algorithm based on three principles (Appendix B-350):

1. A few specific, limited types of care are always considered planned (obstetric delivery, transplant surgery, maintenance chemotherapy/ radiotherapy/ immunotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The algorithm identifies admissions that are typically planned (Appendix B-350) and may occur within 30 days of discharge from the hospital. The details of the *index* admission (diagnosis or procedures) are not considered when determining whether a readmission is planned.

Denominator:
Of the hospital's attributed New Jersey Low Income population aged 18 years and older, the total number of patients with a principal diagnosis of pneumonia (PN) (Appendix A-345).

Index admission – is the hospitalization considered for the readmission outcome.

Patients with an index hospitalization within an acute care hospital are included if they have been a New Jersey Low Income population member for the 365 days prior to the Index Discharge date through 30 days following the index discharge date to ensure a full year of administrative data for risk adjustment.

Index Admission Exclusion(s):

1. Patients with an in-hospital death: Admissions for patients with an in-hospital death are excluded because they are not eligible for readmission.

2. Less Than 30 Days Post-discharge Information: Admissions for patients without at least 30 days post-discharge as a member of the New Jersey Low Income population are excluded because the 30-day readmission outcome cannot be assessed for this group.

3. Transfers: Admissions for patients having a principal diagnosis of PN during the index hospitalization and subsequently transferred to another acute care facility are excluded because this measure applies to discharges to non-acute care settings.
    a. Admissions to another hospital within one day of discharge are considered transfers, regardless of the disposition of the previous admission.

4. Discharges Against Medical Advice (AMA): Patients who were discharged against medical advice (AMA).

5. Admissions within 30 days of discharge from an index admission will not be considered index admissions. No hospitalization will be counted as both a readmission and an index admission within the same measure. However, because cohorts for the readmission measures are determined independently of each other, a readmission in one measure (e.g. DSRIP # 1 AMI) may qualify as an index admission in another readmission measure (e.g. DSRIP # 2 COPD).

If a patient is readmitted to the same hospital on the same day of discharge for the same principal diagnosis as the index admission, the measure *combines* both stays to account for the index admission.

If a patient is readmitted to the same hospital on the same day as the index admission with a *different principal diagnosis* from the index admission, this is considered as a readmission.

Readmissions for transferred patients are attributed to the hospital that ultimately discharges the patient to a non-acute care setting (e.g., to home or a skilled nursing facility). If a patient is admitted to Hospital A, transferred to Hospital B, and ultimately discharged from Hospital B to a non-acute care setting, a readmission within 30 days of discharge to any acute care hospital is attributed to Hospital B.

If a patient has more than one unplanned admission within 30 days of discharge from the index admission, only the first one is counted as a readmission.

If the first readmission after discharge is planned, then no readmission is considered in the outcome, regardless of whether a subsequent unplanned readmission takes place because it would be unfair to attribute the unplanned readmission back to the care received during the index admission.

Result:
The result is expressed as a rate.

Measure Qualifications:
Please note: The measure steward age stratification is based on Medicare age groupings. This has been adjusted to follow the Medicaid Adult Code age categories. The unplanned input files used were obtained from the Yale Group's SAS program package (2013 SAS pack) made available to the public.

The following link(s) may be used to obtain additional information regarding the original measure specification and risk standardization methodology. This is provided without assurances.:

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Improvement Target Goal (ITG): **TBD**		Absolute ITG Value: **TBD**	
Attribution Date: **Last day of measurement period**		Anchor Date: **Index discharge**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

Continuous Eligibility –
The patient is to be continuously enrolled for the 365 days prior to the Index discharge date through 30 days with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 17 – Patients Receive Recommended Care for Community-Acquired Pneumonia	Project Code: 17.6	Payment Method: P4P
Universal Measure: Yes	Universal Code: 44	Payment Method: UPP Substitution

Measure: **DSRIP #: 97**

Adherence to Chronic Medications for People with Diabetes Mellitus: Hypoglycemic Agents

Measure Description:
The percentage of eligible patients who had at least two prescriptions for insulin or an oral diabetic medication or at least two prescriptions for multiple agents within an anti-diabetic class and that have a Proportion of Days Covered (PDC) of at least 0.8 for at least 1 anti-diabetic class during the measurement year.

Data Source:	NQF #:
MMIS	**2468**
Measure Steward:	Measure Steward Version:
CMS	**2013, v 4.0**

Measure Calculation Description

Numerator:
Patients with at least two prescriptions for an oral diabetic medication (Appendix A-240), in any anti-diabetic class, with a Proportion of Days Covered (PDC) of at least 0.8 for at least one anti-diabetic class.

Proportion of Days Covered (PDC) - The PDC is the sum of the days covered by the days' supply of all drug claims in each respective drug class. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period.

For prescriptions with a days' supply that extends beyond the measurement period, only the days for which the drug was available to the individual will be counted during the measurement period.

If there are prescriptions for the same drug (generic name) on the same date of service, the prescription with the largest days' supply will be retained.

If prescriptions for the same drug (generic name) overlap, then the prescription start date will be adjusted to be the day after the previous fill has ended.

Denominator:
Of the hospital's attributable New Jersey Low Income population, those patients 18 years or older with diabetes mellitus (Appendix A-235) and at least two prescriptions for an oral diabetic medication (Appendix A-240) or at least two prescriptions for multiple agents within an anti-diabetic class (Appendix A-241).

Patients with diabetes mellitus are identified using diagnosis codes and/or pharmacy data within the inpatient or outpatient claims data. Only one method to identify patients is needed to be included in the denominator.

Claims data.

a. Patients with at least two encounters with a principal or secondary diagnosis of diabetes Appendix A-235) with different dates of service in an outpatient setting or non-acute inpatient (Appendix A-236) setting during the measurement year .
b. Patients with at least one encounter with a principal or secondary diagnosis of diabetes Appendix A-235) in an acute inpatient or emergency department (Appendix A-237) setting during the measurement year.

Pharmacy data.

a. Patients with at least one ambulatory prescription claim for insulin or other anti-diabetic medication dispensed during the measurement period . (Refer to Appendix A-241 for a list of NDC codes.

Exclusion(s):

1. Diagnosis active gestational diabetes (Appendix A-239).
2. Diagnosis active steroid induced diabetes (Appendix A-239).
3. Diagnosis active polycystic ovaries (Appendix A-239).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher.

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html?redirect=/QUALITYMEASURES/

http://www.qualityforum.org/QPS/2468

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 12, 14, 15, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 11 – Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: Substitution measure	Payment Method: P4P
Project Title: Project 12 – Diabetes Group Visits for Patients and Community Education	Project Code: Substitution measure	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 96**

Adherence to Chronic Medications for People with Diabetes Mellitus: Statins

Measure Description:
The percentage of eligible patients who had at least two prescriptions for statins and who had a Proportion of Days Covered (PDC) of at least 0.8 during the measurement year (12 months).

Data Source:	NQF #:
MMIS	**0545**
Measure Steward:	Measure Steward Version:
CMS	**2013, v 4.0**

Measure Calculation Description

Numerator:
Patients with at least two prescriptions for statins with a Proportion of Days Covered (PDC) of at least 0.8 for statins (Appendix A-117).

PDC Calculation:
PDC Numerator
The PDC is the sum of the days covered by the days' supply of all drug claims in each respective prescription drug class. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period.

For prescriptions with a days' supply that extends beyond the measurement period, only the days for which the drug was available to the individual will be counted during the measurement period.

If there are prescriptions for the same drug (generic name) on the same date of service, the prescription with the largest days' supply will be retained.

If prescriptions for the same drug (generic name) overlap, then the prescription start date will be adjusted to be the day after the previous fill has ended.

PDC Denominator
The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients 18 years and older (at the beginning of the measurement period) with diabetes mellitus and at least two prescriptions for statins during the measurement year (Appendix A-117).

Patients with diabetes mellitus (Appendix A-235) are identified using diagnosis codes and/or pharmacy data within the inpatient or outpatient claims data. Only one method to identify patients is needed to be included in the denominator.
Claims data.

a. Patients with at least two encounters with a principal or secondary diagnosis of diabetes (Appendix A-235) with different dates of service in an outpatient setting or non-acute inpatient (Appendix A-236) setting during the measurement year.
b. Patients with at least one encounter with a principal or secondary diagnosis of diabetes (Appendix A-235) in an acute inpatient or emergency department (Appendix A-237) setting during the measurement year.

Pharmacy data.

b. Patients with at least one ambulatory prescription claim for insulin or other anti-diabetic medication dispensed during the measurement period. (Refer to Appendix A-238 for a list of NDC codes.

1. Exclusion(s):Individuals with a diagnosis of polycystic ovaries who do not have a visit with a diagnosis of diabetes in any setting during the measurement period. (Appendix A-239).

2. Individuals with a diagnosis of gestational diabetes or steroid-induced diabetes who do not have a visit with a diagnosis of diabetes mellitus in any setting during the measurement period. (Appendix A-239).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html?redirect=/QUALITYMEASURES/

http://www.qualityforum.org/QPS/0545

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		**Baseline Period: CY 2013**	
Claim Type(s): **01, 03, 04, 12, 14, 15, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 11 – Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: Substitution measure	Payment Method: P4P
Project Title: Project 12 – Diabetes Group Visits for Patients and Community Education	Project Code: Substitution measure	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 5**

Adolescent Well-Care Visit

Measure Description:
The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Data Source:	NQF #:
MMIS	**NA**
Measure Steward:	Measure Steward Version:
NCQA	**2016**

Measure Calculation Description

Numerator:
At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. [**Well-Care Visit** –Appendix A-145]

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition will not count toward the measure.

Denominator:

Of the hospital's attributable New Jersey Low Income population, those age 12-21 years as of December 31 of the measurement year.

Exclusions:

1. Do not include services rendered during an inpatient or ED visit.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Multiple visits per unique patient will not be counted.

Please note:
The following New Jersey provider specialties will be included as a PCP:

1. 80 – Family Practice
2. 82 – NP Family
3. 110 – Internal Medicine
4. 370 – Pediatrics
5. 372 – NP Pediatric
6. 450 - NP Community Health
7. 470 – NP Adult Health

Measure Collection Description			
Setting of Care: **Outpatient**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **03, 04, 13, 14, 15, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 5 - Electronic Self-Assessment Decision Support Tool	Project Code: 5.7	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 6**

Adult Asthma Admission Rate

Measure Description:
This measure is used to assess the number of admissions for asthma in adults per 1,000, ages 18 and older

Data Source:
MMIS

NQF #:
Based on 0283

Measure Steward:
AHRQ

Measure Steward Version:
September 2010, Version 4.2

Measure Calculation Description

Numerator:
All discharges for patients ages 18 years and older with a principal ICD-9-CM or ICD-10-CM diagnosis of asthma. [Appendix A-146]

Exclusion(s):

1. Any-listed ICD-9-CM or ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system. (Appendix A-147)
2. Transfer from a hospital (different facility). ((Appendix A- 119)
3. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). ((Appendix 119)
4. Transfer from another health care facility. (Appendix A-119)
5. Obstetrical cases of pregnancy, childbirth and puerperium as identified through MDC 14. (Appendix A- 92)

Denominator:
Of the hospital's attributable New Jersey Low Income population, those patients who are 18 years and older.

Result:
The result is expressed as a rate.

The rate will be expressed as the number of admits per 1,000 in each attributable population per hospital.

Improvement Direction:
Lower

Measure Qualifications:

Please note: This measure has been modified to remove consideration of the metropolitan or county area and instead will monitor the attributed DSRIP population.

This measure is based on a version of Prevention Quality Indicate # 15 which is included in the Medicaid Adult Core measure set.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf

http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V42/TechSpecs/PQI%2015%20Adult%20Asthma%20Admission%20Rate.pdf

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**	
Experience Period: **6 month period**		Baseline Period: **SA July – December 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: Project 1 - Hospital-Based Educators Teach Optimal Asthma Care	Project Code: 1.6	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 7**

Adult Body Mass Index (BMI) assessment

Measure Description:
The percentage of patients 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Data Source:	NQF #:
MMIS	**Not Found**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:
Patients who had a documented body mass index (BMI) assessment. (Appendix A-150)

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients that are 18 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year and who had an outpatient visit (Appendix A-151) during the measurement year or the year prior to the measurement year.

Exclusion(s):

1. Patients with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year. (Appendix A-50)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 14, 15, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year and the year prior to the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 5 - Electronic Self-Assessment Decision Support Tool	Project Code: 5.6	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 8**

Ambulatory Care – Emergency Department Visits

Measure Description:
The rate of emergency department visits per attributable patient during the measurement year.

Data Source: **MMIS**

NQF #: **Not Found**

Measure Steward: **NCQA**

Measure Steward Version: **2013**

Measure Calculation Description

Numerator:
Emergency department (ED) visits that do not result in an inpatient stay. Each visit will be counted once, regardless of the intensity or duration of the visit.

Multiple ED visits on the same date of service will be counted as one visit.

CPT.UB rEVENUE
(Appendix A-155)

OR

CPT		POS
(APPENDIX A-156)	AND	(APPENDIX A-157)

Exclusion(s):
- The measure does not include mental health or chemical dependency services.

CPT/ Principal ICD-9-CM Diagnosis/ ICD-9-CM Procedure		
(APPENDIX A-158)		
Principal ICD-9-CM Diagnosis	AND	**Secondary ICD-9-CM Diagnosis**
(APPENDIX A-159)		(APPENDIX A-160)

Denominator:
Of the hospital's attributable New Jersey Low Income population, all patients as categorized in the following age stratifications:
1. Patients under age 65
2. Patients 65 and older
3. Total Patients

Result:
The result is expressed as a rate.
The result is expressed as a rate per 1,000 member months for the measurement period.

Improvement Direction:
Lower

Measure Qualifications:

Please note: The measure steward stratifies age ranges in ten age groups. This stratification has been modified to follow the general Medicaid Adult Core measure set.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **03, 04, 14, 15**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 33	Payment Method: UPP

Measure: **DSRIP #: 11**

Antidepressant Medication Management – Effective Acute Phase Treatment

Measure Description:
The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 84 days (12 weeks).

Data Source:	NQF #:
MMIS	**0105**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:
Patients from the denominator who have at least 84 days (12 weeks) of continuous treatment with an antidepressant medication during the 114-day period following the Index Prescription Start Date (IPSD). (Refer to Appendix A-3 for the NDC list.)

Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period.

Denominator:

Of the hospital's attributable New Jersey Low Income population, those that are 18 years and older as of April 30 of the measurement year, with continuous enrollment of 90 days (3 months) prior to the Index Episode Start Date (IESD) through 245 days after the IESD with a diagnosis of depression and were newly treated with an antidepressant medication (Refer to Appendix A-3 for the NDC list.).

Identify all patients who met at least one of the following criteria during the in-take period:

1. At least one principal diagnosis of major depression (Appendix A_161) in an outpatient, ED, (Appendix A-155) intensive outpatient or partial hospitalization setting (Appendix A-162) or (Appendix A-163 and Appendix A-164).
2. At least two visits in an outpatient, ED (Appendix A-155), intensive outpatient or partial hospitalization setting (Appendix A-162, 163,164) on different dates of service with any diagnosis of major depression (Appendix A-161)
3. At least one inpatient (acute or nonacute) (Appendix A-165) claim with any diagnosis or major depression (Appendix A-161).

For each patient that meets one of the three above criteria, the Index Episode Start Date (IESD) will be determined. The date of the *earliest* encounter during the Intake Period with any diagnosis of major depression will be identified. If the patient had more than one encounter during the Intake Period, only the first encounter will be included.

Intake period - The intake period is the 12 month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.

Index Episode Start Date – The earliest encounter during the Intake Period with any diagnosis of major depression and a 90-day Negative Medication History.

For an *inpatient* (acute or nonacute) claim, the IESD is the date of discharge.

For a *direct transfer*, the IESD is the discharge date from the facility to which the patient was transferred.

Then, the Index Prescription Start Date (IPSD) will be identified. The IPSD is the date of the earliest dispensing event for an antidepressant medication (Appendix A-3) during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive). Patients who did not fill a prescription for an antidepressant medication during the period will be excluded.

Index Prescription Start Date – The earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).

Then, the Negative Medication History will be tested. Patients who filled a prescription for an antidepressant medication 90 days (3 months) prior to the IPSD will be excluded.

Negative Medication History – A period of 90 days (3 months) prior to the IPSD when the patient had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.

Then, continuous enrollment will be tested.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0105

Measure Collection Description			
Setting of Care: **Multi-Setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 12, 14, 15, 18, 19**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for 90 days (3 months) prior to the Index Episode Start Date (IESD) through 245 days after the IESD with no more than 45 days in coverage.

DSRIP Incentive Impact		
Project Title: Project 3 - Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: 3.7	Payment Method: P4P
Project Title: Project 5 - Electronic Self-Assessment Decision Support Tool	Project Code: 5.11	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 12**

Antidepressant Medication Management – Effective Continuation Phase Treatment

Measure Description:
The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 180 days (6 months).

Data Source:	NQF #:
MMIS	**0105**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:
Patients from the denominator who have at least 180 days (6 months) of continuous treatment with an antidepressant medication during the 231-day period following the Index Prescription Start Date (inclusive). (Refer to Appendix A-3 for the NDC list.)

Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period.

Denominator:

Of the hospital's attributable New Jersey Low Income population, those that are 18 years and older as of April 30 of the measurement year, with continuous enrollment of 90 days (3 months) prior to the Index Episode Start Date (IESD) through 245 days after the IESD with a diagnosis of depression and were newly treated with an antidepressant medication.

Identify all patients who met at least one of the following criteria during the in-take period:

1. At least one principal diagnosis of major depression (Appendix A–161) in an outpatient, ED (Appendix A-155), intensive outpatient or partial hospitalization setting (Appendix A-162-164).
2. At least two visits in an outpatient, ED (Appendix A-155), intensive outpatient or partial hospitalization setting (Appendix A-162-164) on different dates of service with any diagnosis of major depression (Appendix A-161)
3. At least one inpatient (acute or nonacute) claim with any diagnosis or major depression (Appendix A-161)

For each patient that meets one of the three above criteria, the Index Episode Start Date (IESD) will be determined. The date of the *earliest* encounter during the Intake Period with any diagnosis of major depression will be identified. If the patient had more than one encounter during the Intake Period, only the first encounter will be included.

Intake period - The intake period is the 12 month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.

Index Episode Start Date – The earliest encounter during the Intake Period with any diagnosis of major depression and a 90-day Negative Medication History.

For an *inpatient* (acute or nonacute) claim, the IESD is the date of discharge.

For a *direct transfer*, the IESD is the discharge date from the facility to which the patient was transferred.

Then, the Index Prescription Start Date (IPSD) will be identified. The IPSD is the date of the earliest dispensing event for an antidepressant medication (Appendix A-3)during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive). Patients who did not fill a prescription for an antidepressant medication during the period will be excluded.

Index Prescription Start Date – The earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).

Then, the Negative Medication History will be tested. Patients who filled a prescription for an antidepressant medication 90 days (3 months) prior to the IPSD will be excluded.

Negative Medication History – A period of 90 days (3 months) prior to the IPSD when the patient had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.

Then, continuous enrollment will be tested.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0105

Measure Collection Description			
Setting of Care: **Multi-Setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 12, 14, 15, 18, 19**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for 90 days (3 months) prior to the Index Episode Start Date (IESD) with no more than 45 days in coverage.

DSRIP Incentive Impact		
Project Title: Project 3 - Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: 3.2	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 13**

Asthma admission rate

Measure Description:
Admissions with a principal diagnosis of asthma per 1,000, ages 2 – 17. Excludes cases with a diagnosis code for cystic fibrosis and anomalies of the respiratory system, obstetric admissions and transfers from other institutions (PDI 14).

Data Source:	NQF #:
MMIS	**0728**
Measure Steward:	Measure Steward Version:
AHRQ	**October 2015, v5.0**

Measure Calculation Description

Numerator:
All discharges for patients ages 2 through 17 years with a principal diagnosis code of asthma (Appendix A-146).
Exclusion(s):

1. Patients with any listed ICD-9-CM or ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system. (Appendix A-147)
2. Transfer from a hospital (different facility). (Appendix A-119)
3. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). (Appendix A-119)
4. Transfer from another health care facility. (Appendix A-119)
5. Obstetrical cases of pregnancy, childbirth and puerperium as identified through MDC 14 (Appendix A-92).

Denominator:
Of the hospital's attributable New Jersey Low Income population, those patients age 2 through 17.

Result:
The result is expressed as a rate.

The rate will be expressed as number of admits per 1,000 in each attributable population per hospital.

Improvement Direction:
Lower

Measure Qualifications:

Please note: This measure has been modified to remove consideration of the metropolitan or county area and instead will monitor the DSRIP population.

This measure is based on the Pediatric Quality Indicator measure #14.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://qualityindicators.ahrq.gov/Downloads/Modules/PDI/V50-ICD10/TechSpecs/PDI%2014%20Asthma%20Admission%20Rate.pdf

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **1st Semi- Annual Report = April** **2nd Semi-Annual Report = October**	
Experience Period: **6 month calendar period**		Baseline Period: **SA July – December 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: Project 1 - Hospital-Based Educators Teach Optimal Asthma Care	Project Code: 1.7	Payment Method: P4P
Project Title: Project 2 - Pediatric Asthma Case Management and Home Evaluations	Project Code: 2.7	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 14**

Asthma in Younger Adults Admission

Measure Description:
Admissions for a principal diagnosis of asthma per 1,000, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetrical admissions and transfers from other institutions. (PQI 15)

Data Source:	NQF #:
MMIS	**Based on 0283**
Measure Steward:	Measure Steward Version:
AHRQ	**October 2015, v5.0**

Measure Calculation Description

Numerator:
All discharges for patients age 18 through 39 years with a principal ICD-9-CM or ICD-10-CM diagnosis of asthma. (Appendix A-146)

Exclusion(s):
1. Any diagnosis code of cystic fibrosis and anomalies of the respiratory system (Appendix A-147).
2. Transfer from a hospital (different facility) (Appendix A-119).
3. Transfer from a skilled nursing facility (SNF) or intermediate care facility (ICF) (Appendix A-119)..
4. Transfer from another health care facility (Appendix A-119).
5. Obstetrical cases of pregnancy, childbirth and puerperium as identified through MDC 14 (Appendix A-92).

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients aged 18 through 39 years.

Result:
The result is expressed as a rate.

The rate will be expressed as number of admits per 1,000 in each attributable population per hospital.

Improvement Direction:
Lower

Measure Qualifications

Please note: This measure has been modified to remove consideration of the metropolitan or county area and instead will monitor the DSRIP population.

This measure is based on Prevention Quality Indicator # 15 which is included in the 2016 Medicaid Adult Core measure set.

MDC 14 was added as an exclusion for DSRIP. Per AHRQ, discharges with a principal diagnosis of COPD are precluded from an assignment of MDC 14 by the grouper software that is used. However, as there are variations between the groupers, to ensure that obstetrical discharges are removed, exclusion #5 was added.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://qualityindicators.ahrq.gov/Downloads/Modules/PQI/V50-ICD10/TechSpecs/PQI%2015%20Asthma%20in%20Younger%20Adults%20Admission%20Rate.pdf

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 31	Payment Method: UPP

Measure: Asthma Medication Ratio

DSRIP #: 90

Measure Description:
The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Data Source:	NQF #:
MMIS	**1800**
Measure Steward:	Measure Steward Version:
NCQA	**2013, 2016**

Measure Calculation Description

Numerator:
The number of patients who have a medication ratio of controlled medications to total asthma medications of 0.50 or greater during the measurement year.

The numerator will be stratified in the following ranges:

1. 5 through 17 years of age
2. 18 through 64 years of age
3. Total (sum of the age stratifications)

Asthma medication ratio - will be calculated by completing the following steps:

1. For each patient, the units of controller medications dispensed during the measurement year will be counted. Each dispensing event is one unit (Refer to Appendix A-325 for the NDC list).
2. For each patient, the units of reliever medications dispensed during the measurement year will be counted. Each dispensing event is one unit. (Refer to Appendix A-338 for the NDC list).
3. For each patient, the units will be summed to determine the units of total asthma medications.
4. For each patient, the ratio of controller medications to total asthma medications will be calculated using the following formula:

$$\frac{\text{Units of Controller Medications}}{\text{Units of Total Asthma Medications}}$$

Oral Medication Dispensing Event - One prescription for an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, the days supply will be divided by 30 and rounded down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). The dispensing events will be allocated to the appropriate year based on the date on which the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day are assessed separately. If multiple prescriptions for the same medication are dispensed on the same day, the days supply will be summed and divided by 30. The Drug ID will be used to determine if the prescriptions are the same or different.

Inhaler Dispensing Event - Each inhaler (i.e., canister) counts as one dispensing event. Multiple dispensing events of the same or different medication are assessed separately (even if medications

were filled on the same date of service). The dispensing events will be allocated to the appropriate year based on the date when the prescription was filled

Injection Dispensing Event - Injections count as one dispensing event. Multiple dispensing events of the same or different medication are assessed separately. The dispensing events will be allocated to the appropriate year based on the date when the prescription was filled.

Denominator:
Of the hospital's attributable New Jersey Low Income population, those patients 5-64 years of age as of December 31 of the measurement year with persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year.
The criteria does not have to be the same across both years.

1. Patients with at least one ED visit (Appendix A-155), with asthma as the principal diagnosis (Appendix A-146).

2. At least one acute inpatient claim (Appendix A-172), with asthma as the principal diagnosis (Appendix A-146).

3. At least four outpatient asthma visits (Appendix A-324) on different dates of service, with asthma as one of the listed diagnoses (Appendix A-146) and at least two asthma medication dispensing events. (Refer to Appendix A-170 for the NDC list)

4. At least four asthma medication dispensing events. (Refer to Appendix A-326 for a list of NDC codes.)
    a. If leukotriene modifiers were the sole asthma medication dispensed in the year (Refer to Appendix A-171 for a list of NDC codes) the patient must also have at least one diagnosis of asthma (Appendix A-146), in any setting, in the same year as the leukotriene modifier (i.e. the measurement year, or the year prior to the measurement year).

Exclusion(s):
1. Patients who had at least one encounter in any setting, with any code to identify a diagnosis of emphysema, COPD, cystic fibrosis or acute respiratory failure (Appendix A-174) . Look as far back as possible in the patient's history through December 31 of the measurement year.

2. Patients who have no asthma controller or reliever medications dispensed during the measurement year. (Refer to Appendix A-325 or Appendix A- 338 for NDC codes.)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/1800

Measure Collection Description			
Setting of Care: **Multi-Setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 12, 13, 14, 15, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 1 - Hospital-Based Educators Teach Optimal Asthma Care	Project Code: Substitution measure	Payment Method: P4P
Project Title: Project 2 - Pediatric Asthma Case Management and Home Evaluations	Project Code: Substitution measure	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: Breast Cancer Screening

DSRIP #: 16

Measure Description:

The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.

Data Source:	NQF #:
MMIS	**0031, No longer endorsed**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:
Patients who have received one or more mammograms during the measurement year or the year prior to the measurement year.

A woman had a mammogram if a submitted claim contains any code.
(Appendix A-120)

Denominator:
Of the hospital's attributable New Jersey Low Income population, those patients age 40-69 as of December 31 of the measurement year.

Exclusion(s): Women who had a bilateral mastectomy. Look for evidence of a bilateral mastectomy as far back as possible in the patient's history through December 31 of the measurement year. (Appendix A-126)(Table 16.2)

1. Any of the following meet criteria for bilateral mastectomy:
   a. A bilateral mastectomy code. (Appendix A-121)
   b. A unilateral mastectomy code with a bilateral modifier. (Appendix A-122)
   c. Two unilateral mastectomy codes on different dates of service. (Appendix A-122)
   d. A unilateral mastectomy code with a right side modifier and a unilateral mastectomy code with a left side modifier (may be on the same date of service). (Appendix A-122 and Appendix A-123) or (Appendix A-122 and Appendix A-124), or (Appendix A-124) or (Appendix A-122 and Appendix A-125)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0031

Measure Collection Description			
Setting of Care: **Multi-Setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 14, 15, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient must be continuously eligible for the measurement year and the year prior to the measurement year with no more than a 45 day gap during each year of continuous enrollment.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 16	Payment Method: Pay for Reporting

Measure:

CD4 T-Cell Count

DSRIP #: 20

Measure Description:

The percentage of patients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year.

Data Source:	NQF #:
MMIS	**Not Found**
Measure Steward:	Measure Steward Version:
HRSA	**July 2008**

Measure Calculation Description

Numerator:
The number of HIV-infected patients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year. (Appendix A-153)

Denominator:
Of the hospital's attributable New Jersey Low Income population, those HIV-infected patients (Appendix A-154) who had a medical visit with a provider with prescribing privileges, (i.e. MD, NP) at least once during the measurement year.

Exclusion(s):

1. Patients newly enrolled in care during the last six months of the year.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://hab.hrsa.gov/deliverhivaidscare/files/habgrp1pms08.pdf

Measure Collection Description			
Setting of Care: **Multi-Setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 13, 14, 15, 16, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 21	Payment Method: Pay for Reporting

Measure: Cervical Cancer Screening

DSRIP #: 22

Measure Description:

The percentage of women 24-64 years of age who received one or more PAP tests to screen for cervical cancer.

Data Source:	NQF #:
MMIS	**0032**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:
Patients who have received one or more Pap tests during the measurement year or the two years prior to the measurement year.

A patient had a Pap test if a submitted claim contains any code (Appendix A-166).

Denominator:

Of the hospital's attributable New Jersey Low Income population, those women aged 24-64 years as of December 31 of the measurement year.

Exclusion(s):

1. Women who had a hysterectomy with no residual cervix (Appendix A-167). Look as far back as possible in the patient's history for evidence of a hysterectomy through December 31 of the measurement year.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0032

Measure Collection Description			
Setting of Care: **Multi-Setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 14, 15, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 24	Payment Method: Pay for Reporting

Measure: Child Immunization Status

DSRIP #: 25

Measure Description:
The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (Dtap); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitus B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitus A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

The measure calculates a rate for each vaccine and nine separate combination rates.

Data Source: **MMIS**

NQF #: **Based on 0038**

Measure Steward: **NCQA**

Measure Steward Version: **2013**

Measure Calculation Description

Numerator:

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 2	✓	✓	✓	✓	✓	✓				
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 4	✓	✓	✓	✓	✓	✓	✓	✓		
Combination 5	✓	✓	✓	✓	✓	✓	✓		✓	
Combination 6	✓	✓	✓	✓	✓	✓	✓			✓
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 8	✓	✓	✓	✓	✓	✓	✓	✓		✓
Combination 9	✓	✓	✓	✓	✓	✓	✓		✓	✓
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

For MMR, hepatitis B, VZV and hepatitis A, count any of the following:
Evidence of the antigen or combination vaccine, ***or***

For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count *only* evidence of the antigen or combination vaccine.

For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), evidence of all the antigens.

1. ***DTaP -*** At least four DTaP vaccinations, with different dates of service on or before the child's second birthday. A vaccination administered prior to 42 days after birth will not be counted. (.(Appendix A-168)

2. ***IPV -*** At least three IPV vaccinations, with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth will not be counted. (Appendix A-169)

3. ***MMR -*** At least one MMR vaccination, with a date of service falling on or before the child's second birthday. (Appendix A-328)

4. ***HiB -*** At least three HiB vaccinations, with different dates of service on or before the child's second birthday. HiB administered prior to 42 days after birth will not be counted. (Appendix A-327)

5. ***Hepatitis B -*** At least three hepatitis B vaccinations, with different dates of service on or before the child's second birthday. (Appendix A-181)

5. ***VZV -*** At least one VZV vaccination, with a date of service falling on or before the child's second birthday. (Appendix A-183)

6. ***Pneumococcal conjugate -*** At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday. A vaccination administered prior to 42 days after birth will not be counted. (Appendix A-184)

7. ***Hepatitis A -*** At least one hepatitis A vaccination, with a date of service falling on or before the child's second birthday. (Appendix A-175)

8. ***Rotavirus -*** The child must receive the required number of rotavirus vaccinations on different dates of service on or before the second birthday. A vaccination administered prior to 42 days after birth will not be counted. The following vaccine combinations are compliant:
    a. Two doses of the two-dose vaccine,
    b. One dose of the two-dose vaccine and two doses of the three-dose vaccine, or
    c. Three doses of the three-dose vaccine.
    d. The vaccines are identified by different CPT codes (Appendix A- 176)

9. ***Influenza -*** At least two influenza vaccinations, with different dates of service on or before the child's second birthday. A vaccination administered prior to six months (180 days) after birth will not be counted. (Appendix A-177)

Denominator:

Of the hospital's New Jersey Low Income population, those patients who turn 2 years of age during the measurement year.

Exclusion(s):

1. Children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. Exclude contraindicated children only if the administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

   The exclusion must have occurred by the second birthday. Look for exclusions as far back as possible in the member's history and use the codes in (Appendix A-178) or (Appendix A-179 and Appendix A-180) to identify allowable exclusions.

Result:
The result is expressed as a rate.

Combination 1 calcuates a rate for each vaccine.

Combination 2-9 calculates a separate rate for patiens who received a combination vaccine.

Improvement Direction:
Higher

Measure Qualifications:

Combination 1 calculates a rate for each vaccine.

Combination 2 – 9 calculates a separate rate for patients who have received a combination of vaccines.

Please note: The measure specification was adjusted to remove the criteria that allows for documented history of an illness or a seropositive test result to be counted for MMR, hepatitis B, VZV and hepatitis A. This adjustment allows the remaining data to be collected through administrative claims data.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0038

Measure Collection Description			
Setting of Care: **Multi-Setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **1, 3, 4, 6, 12, 13, 14, 15, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

A patient must be continuously enrolled for the twelve months prior to the child's second birthday with no more than a 45 day gap during the measurement period.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 26	Payment Method: Pay for Reporting

Measure: **DSRIP #: 27**

Children and Adolescents' Access to Primary Care Practitioners

Measure Description:

The percentage of members 12 months–19 years of age who had a visit with a primary care physician (PCP).

Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.

Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Data Source:	NQF #:
MMIS	**Not Found**
Measure Steward:	Measure Steward Version:
NCQA	**2016**

Measure Calculation Description

Numerator:

For 12–24 months, 25 months–6 years: One or more visits with a PCP during the measurement year. (Appendix A-214)

For 7–11 years, 12–19 years: One or more visits with a PCP during the measurement year or the year prior to the measurement year. (Appendix A-214)

Primary Care Physician (PCP) - A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs. (Appendix A-215)

Exclusion(s):

1. Exclude specialty visits

Denominator:
Of the attributable New Jersey Low Income population, the eligible patients ages 12 months-19 years as of December 31 of the measurement year.

12–24 months as of December 31 of the measurement year. All children who are at least 12 months old but younger than 25 months old during the measurement year will be included.

25 months–6 years as of December 31 of the measurement year. All children who are at least 2 years and 31 days old but not older than 6 years during the measurement year will be included.

7-11 years as of December 31 of the measurement year.

12-19 years as of December 31 of the measurement year.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following New Jersey provider specialties will be included as a PCP:

1. 80 – Family Practice
2. 82 – NP Family
3. 110 – Internal Medicine
4. 370 – Pediatrics
5. 372 – NP Pediatric
6. 450 - NP Community Health
7. 470 – NP Adult Health

Measure Collection Description			
Setting of Care: **Outpatient**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **04, 13, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

For those 12-24 months, 25 months-6 years the patients must be continuously eligible for the measurement year with no more than a 45 day gap during the year.

For those 7-11 years, 12-19 years the patients must be continuously eligible for the measurement year and the year prior to the measurement year with no more than a 45 day gap during each year of continuous enrollment.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

DSRIP Incentive Impact		
Project Title: Project 15 - After-School Obesity Program	Project Code: 15.2	Payment Method: Pay for Reporting
Universal Measure: Yes	Universal Code: 28	Payment Method: Pay for Reporting

Measure: Chlamydia Screening in Women

DSRIP #: 28

Measure Description:

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

Data Source:	NQF #:
MMIS	**0033**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:
Patients who received at least one chlamydia test during the measurement year. A woman is counted as having had a test if she had a claim with a service date during the measurement year (Appendix A-208)

Denominator:

Of the hospital's New Jersey Low Income population, those women 16-24 who were identified as sexually active.

Sexually active - Two methods are used to identify sexually active women: pharmacy data and claims data. A patient will only be identified in one method to be eligible for the measure.

a. Pharmacy data - Patients who were dispensed prescription contraceptives during the measurement year. (Refer to Appendix A-209 for a list of NDC codes.)

b. Claims data - Patients who had at least one claim during the measurement year.(Appendix A-210)

Exclusion(s):

1. Patients who had a pregnancy test during the measurement year, followed within seven days (inclusive) by ***either*** a prescription for isotretinoin (Accutane) ***or*** an x-ray. (Appendix A-211 and Appendix A-213) or (Appendix A-211 and Refer to Appendix A-212 for a list NDC codes.)

   This exclusion does not apply to patients who qualify for the denominator based on services other than the pregnancy test alone. (Appendix A-211)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0033

Measure Collection Description			
Setting of Care: **Multi-Setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 12, 13, 14, 15, 16, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**	Risk Adjustment: **No**		Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient must be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 25	Payment Method: Pay for Reporting

Measure: **DSRIP #: 29**

Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) testing

Measure Description:
The percentage of patients 18-75 years of age with diabetes (Type 1 and Type 2) who had: Hemoglobin A1c (HbA1c) testing

Data Source:	NQF #:
MMIS	**0057**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:
An HbA1c test performed during the measurement year. (Appendix A-187)

Denominator:

Of the hospital's New Jersey Low Income population, those patients aged 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).(Appendix A-28)

Two methods are provided to identify patients with diabetes during the measurement year, or the year prior to the measurement year.

1. Pharmacy data – Patients who were dispensed insulin or oral hypoglycemic/ antihyperglycemics during the measurement year or the year prior to the measurement year. (Refer to Appendix A-205 for NDC codes)

2. Claims data –
    a. Patients who had two encounters, in an outpatient setting or nonacute inpatient setting (Appendix A-206), on different dates of service, with a diagnosis of diabetes. (Appendix A-28)

    b. Patients who had one encounter in an acute inpatient or ED setting (Appendix A-207), with a diagnosis of diabetes (Appendix A-28), during the measurement year or the year prior to the measurement year. Services may be counted over both years.

Exclusion(s):
1. Diagnosis of active polycystic ovaries. (Appendix A-91)
2. Diagnosis of active gestational diabetes. (Appendix A-91)
3. Diagnosis of active steroid induced diabetes. (Appendix A-91)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0057

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 12, 13, 14, 15, 16, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 11 – Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: 11.4	Payment Method: Pay for Reporting
Project Title: Project 12 – Diabetes Group Visits for Patients and Community Education	Project Code: 12.4	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 32**

COPD Admission Rate

Measure Description:
This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) patient's age 18 years and older per 1,000 of the attributable population. Excludes obstetric admissions and transfers from other institutions (PQI 5).

Data Source:	NQF #:
MMIS	**Based on 0275**
Measure Steward:	Measure Steward Version:
AHRQ	**– 2009 v 4.1**

Measure Calculation Description

Numerator:
All non-maternal discharges for patients age 18 years and older with ICD-9-CM principal diagnosis code for COPD (Appendix A-118) or (Appendix A-185 and Appendix A-118)

Exclusion(s):
1. Transfer from a hospital (different facility). (Appendix A-119)
2. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). (Appendix A-119)
3. Transfer from another health care facility. (Appendix A-119)
4. Obstetrical cases of pregnancy, childbirth and puerperium as identified through MDC 14. (Appendix A-92)

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients age 18 years and older.

Result:
The result is expressed as a rate.

The rate will be expressed as number of admits per 1,000 in each attributable population per hospital.

Improvement Direction:
Lower

Measure Qualifications:
Please note: This measure has been modified to remove consideration of the metropolitan or county area and instead will monitor the attributed DSRIP population.

This measure was based on Prevention Quality Indicator #5.

MDC 14 was added as an exclusion for DSRIP. Per AHRQ, discharges with a principal diagnosis of COPD are precluded from an assignment of MDC 14 by the grouper software that is used. However, as there are variations between the groupers, to ensure that obstetrical discharges are removed, exclusion #4 was added.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V50-ICD10/TechSpecs/PQI%2005%20Chronic%20Obstructive%20Pulmonary%20Disease%20(COPD)%20or%20Asthma%20in%20Older%20Adults%20Admission%20Rate.pdf

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Risk Adjustment: **No**		Sampling: **No**	

Sampling or Risk Adjustment Methodology

NA

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 34	Payment Method: UPP

Measure: **DSRIP #: 34**

Diabetes Long-Term Complications Admission Rate

Measure Description:
Admissions with a principal diagnosis code of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) per 1,000, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions. (PQI 3)

Data Source:	NQF #:
MMIS	**Based on 0274**
Measure Steward:	Measure Steward Version:
AHRQ	**October 2015, v5.0**

Measure Calculation Description

Numerator:
All discharges for patients age 18 years and older with a principal ICD-9-CM or ICD-10-CM diagnosis code for diabetes long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified). (Appendix A-182)

Exclusion(s):
1. Transfer from a hospital (different facility). (Appendix A-119)
2. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). (Appendix A-119)
3. Transfer from another health care facility. (Appendix A-119)
4. Obstetrical cases of pregnancy, childbirth and puerperium as identified through MDC 14. (Appendix A-92)

Denominator:
Of the hospital's attributable New Jersey Low Income population, those patients who are 18 years and older.

Result:
The result is expressed as a rate.

The rate will be expressed as the number of admits per 1,000 in each attributable population per hospital.

Improvement Direction:
Lower

Measure Qualifications:
Please note: This measure has been modified from the steward specification to only collect information regarding the attributed DSRIP population.

This measure was based on Prevention Quality Indicator #3.

MDC 14 was added as an exclusion for DSRIP. Per ARHQ, discharges with a principal diagnosis of diabetes with long-term complications are precluded from an assignment of MDC 14 by the grouper software that is used. However, as there are variations between groupers, to ensure that obstetrical discharges are removed, exclusion #4 was added.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://qualityindicators.ahrq.gov/Downloads/Modules/PQI/V50-ICD10/TechSpecs/PQI%2003%20Diabetes%20Long-term%20Complications%20Admission%20Rate.pdf

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: Project 11- Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: 11.9	Payment Method: P4P
Project Title: Project 12 – Diabetes Group Visits for Patients and Community Education	Project Code: 12.9	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 92**

Diabetes Monitoring for People with Diabetes and Schizophrenia

Measure Description:
The percentage of patients 18-64 with schizophrenia and diabetes who had both an LDL-C test and an Hb1A1c test during the measurement year.

Data Source:	NQF #:
MMIS	**1934**
Measure Steward:	Measure Steward Version:
NCQA	**2016**

Measure Calculation Description

Numerator:
Patients who had an LDL-C test and an HbA1c test performed during the measurement year. The patient must have had both tests to be included in the numerator. (Appendix A-330 and Appendix A-312)

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients aged 18-64 as of December 31 of the measurement year diagnosed with schizophrenia and diabetes.

Patients with schizophrenia will be identified as those who meet the following criteria:

1. Patients who have had at least one acute inpatient claim Appendix A-331) with any diagnosis of schizophrenia (Appendix A-332).

2. Patients who have had at least two outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting (Appendix A-333) OR (Appendix A-334) OR (Appendix A-335) on different dates of service, with any diagnosis of schizophrenia Appendix A-332).

Of those patients diagnosed with schizophrenia, those who also have diabetes will be identified as those who meet the following criteria:

1. Pharmacy data - Patients who were dispensed insulin or oral hypoglycemic/ antihyperglycemics during the measurement year or year prior to the measurement year. (Appendix A-336)

2. Claim data -
    a. Patients who had two face-to-face encounters in an outpatient setting or nonacute inpatient setting ((Appendix A-173) OR (Appendix A-313), on different dates of service, with a diagnosis of diabetes Appendix A-28) during the measurement year or the year prior to the measurement year. Services that occurred over both years will be counted.

    b. Patients who had one face-to-face encounter in an acute inpatient setting or ED setting (Appendix A-172) OR (Appendix A-155), with a diagnosis of diabetes Appendix A-28) during the measurement year or the year prior to the measurement year.

Exclusion(s):

1. Patients with gestational diabetes. (Appendix A-314)
2. Patients with steroid-induced diabetes. (Appendix A-314)
3. Patients with a diagnosis of polycystic ovaries. (Appendix A-314)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/1934

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 12, 13, 14, 15, 18, 19**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 3 – Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: Substitution measure	Payment Method: P4P
Project Title: Project 5 – Electronic Self-Assessment Decision Support Tool	Project Code: Substitution measure	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 35**

Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)

Measure Description:

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

Data Source:	NQF #:
MMIS	**1932**
Measure Steward:	Measure Steward Version:
NCQA	**2016**

Measure Calculation Description

Numerator:
Patients from the denominator who have received a glucose test Appendix A-186) or an HbA1c test Appendix A-187) performed during the measurement year.

Denominator:

Step 1: Of the hospital's New Jersey Low Income population, those patients age 18-64 years with schizophrenia or bipolar disorder who meet at least one of the following criteria:

1. Patients who have had at least one acute inpatient claim (Appendix A-190) or (Appendix A-191 and Appendix A-192) with any diagnosis of schizophrenia Appendix A-188) or bipolar disorder Appendix A-189).
2. Patients who have had at least two visits in an outpatient, intensive outpatient, partial hospitalization(Appendix A-193) or (Appendix A-194 and Appendix A-195), ED (Appendix A-196) or (Appendix A-197 and Appendix A-157)or nonacute inpatient setting Appendix A-198) or (Appendix A-199 and Appendix A-200), on different dates of service, with any diagnosis of schizophrenia Appendix A-188).
3. Patients who have had at least two visits in an outpatient, intensive outpatient, partial hospitalization (Appendix A-193) or (Appendix A-194 and Appendix A-195), ED (Appendix A-196) or (Appendix A-197 and Appendix A-157) or nonacute inpatient setting (Appendix A-198) or (Appendix A-199 and Appendix A-200), on different dates of service, with any diagnosis of bipolar disorder (Appendix A-189)

Exclusion(s):

Step 2: Identify patients from Step 1 who also have diabetes.

Patients with diabetes. There are two ways to identify patients with diabetes: by pharmacy data and by claim data. Both methods are used to identify patients with diabetes, but a patient need only to be identified by one method to be excluded from the measure. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year.

a. Pharmacy data - Patients who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. (Refer to Appendix A-43 for NDC codes.)

b. Claim data -

i. Patients who had two face-to-face encounters in an outpatient setting (Appendix A-201 or nonacute inpatient setting Appendix A-202), on different dates of service, with a diagnosis of diabetes. (Appendix A-28)

ii. Patients with one face-to-face encounter in an acute inpatient (Appendix A-172) or ED (Appendix A-196) setting, during the measurement year, or the year prior to the measurement year. Services that occur over both years will be counted.

iii. Patients who had no antipsychotic medications (Table 35.9) dispensed during the measurement year.(Appendix A-203) or (Refer to Appendix A-204 for NDC codes.)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/1932

Measure Collection Description			
Setting of Care: **Multi-Setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 02, 03, 04, 12, 14, 15, 16, 18, 19**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 3: Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: 3.3	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure:

DSRIP #: 36

Diabetes Short-Term Complications Admission Rate

Measure Description:
Admissions for a principal diagnosis code of diabetes short-term complications (ketoacidosis, hyperosmolarity, coma) per 1,000, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions. (PQI 1)

Data Source:	NQF #:
MMIS	**Based on 0272**
Measure Steward:	Measure Steward Version:
AHRQ	**October 2015, v5.0**

Measure Calculation Description

Numerator:

All discharges for patients age 18 years and older with a principal ICD-9-CM or ICD-10-CM diagnosis code for diabetes short-term complications (ketoacidosis, hyperosmolarity, coma). (Appendix A-337)

Exclusion(s):
1. Transfer from a hospital (different facility). (Appendix A-119)
2. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). (Appendix A-119)
3. Transfer from another health care facility. (Appendix A-119)
4. Obstetrical cases of pregnancy, childbirth and puerperium as identified through MDC 14. (Appendix A-92)

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients who are 18 years and older.

Result:
The result is expressed as a rate.

The rate will be expressed as number of admits per 1,000 in each attributable population per hospital.

Improvement Direction:
Lower

Measure Qualifications:

Please note: This measure has been modified to remove consideration of the metropolitan or county and instead will monitor the attributed DSRIP population.

This measure is based on the Prevention Quality Indicator #1.

MDC 14 was added as an exclusion for DSRIP. Per ARHQ, discharges with a principal diagnosis of diabetes with long-term complications are precluded from an assignment of MDC 14 by the grouper software that is used. However, as there are variations between groupers, to ensure that obstetrical discharges are removed, exclusion #4 was added.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://qualityindicators.ahrq.gov/Downloads/Modules/PQI/V50-ICD10/TechSpecs/PQI%2001%20Diabetes%20Short-term%20Complications%20Admission%20Rate.pdf

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: Project 11 - Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: 11.6	Payment Method: P4P
Project 12 - Diabetes Group Visits for Patients and Community Education	12.7	P4P
Universal Measure: Yes	Universal Code: 32	Payment Method: UPP

Measure: Engagement of alcohol and other drug treatment

DSRIP #: 38

The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or additional services with a diagnosis of AOD within 30 days of the initiation visit.

Data Source:	NQF #:
MMIS	**0004**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:

All patients who initiated alcohol or other drug (AOD) treatment and who had *two or more* inpatient admissions, (Appendix A-226) or outpatient visits, intensive outpatient encounters,(Appendix A-227) or (Appendix A-228 and Appendix A-229)_or partial hospitalizations (Appendix A-230 and Appendix A-231) with any AOD diagnosis (Appendix A- 225) *within 30 days* after the date of the Initiation encounter (inclusive).

Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

1. *For patients who initiated treatment via an inpatient stay,* the discharge date will be used as the start of the 30-day engagement period.
2. *If the engagement encounter is an inpatient admission,* the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive).
3. Engagement encounters that include detoxification codes (including inpatient detoxification) will not be counted (Appendix A-232).

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients age 13 years and older as of December 31 of the measurement year who had a *new* episode of AOD during the Intake Period.

Intake Period: January 1–November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.

Index Episode: The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD.

Step 1: The following identify the Index Episode:

1. An outpatient visit, intensive outpatient encounter (Appendix A-227) or (Appendix A-228 and Appendix A-229) or partial hospitalization Appendix A-230 and Appendix A-231) with a diagnosis of AOD (Appendix A -225).
2. A detoxification visit (Appendix A-232).
3. An ED visit (Appendix A-233) with a diagnosis of AOD (Appendix A-225).
4. An inpatient discharge with a diagnosis of AOD as identified by either of the following:
    a. An inpatient facility code (Appendix A-226) in conjunction with a diagnosis of AOD (Appendix A-225 .
    b. An inpatient facility code (Appendix A-226) in conjunction with an AOD procedure code Appendix A-234).

For patients with more than one episode of AOD, the first episode will be used.

For patients whose first episode was an ED visit that resulted in an inpatient stay, the inpatient discharge will be used.

Then, the earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD (Appendix A-225) will be used as the Index Episode Start Date (IESD).

For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED (not resulting in an inpatient stay) claim, the IESD is the date of service.

For an inpatient (acute or nonacute) claim, the IESD is the date of discharge.

For an ED visit that results in an inpatient stay, the IESD is the date of the inpatient discharge.

For direct transfers, the IESD is the discharge date from the second admission.

Step 2: Then, the Negative Diagnosis History will be tested. Patients who had a claim with a diagnosis of AOD Appendix A-225) during the 60 days (2 months) before the IESD will be excluded.

For an inpatient IESD, the admission date will be used to determine the Negative Diagnosis History.

For an ED visit that results in an inpatient stay, the ED date of service will be used to determine the Negative Diagnosis History.

For direct transfers, the first admission will be used to determine the Negative Diagnosis History.

Step 3: Then, continuous enrollment will be calculated.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0004

Measure Collection Description			
Setting of Care: **Multi-Setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 14, 15, 18, 19**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

Patients must be continuously enrolled without any gaps 60 days (2 months) before the Index Episode Start Date (IESD) through 44 days after the IESD.

DSRIP Incentive Impact		
Project Title: Project 9 - Hospital-Wide Screening for Substance Use Disorder	Project Code: 9.4	Payment Method: P4P
Universal Measure: Yes	Universal Code: 12	Payment Method: Pay for Reporting

Measure: **DSRIP #: 40**

Follow-up After Hospitalization for Mental Illness – 30 days post discharge

Measure Description:
The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge.

Data Source:	NQF #:
MMIS	**0576**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:
Patients 6 years of age and older who received an outpatient visit, intensive outpatient encounter or partial hospitalization (Appendix A-131) OR (Appendix A-132 AND Appendix A-133) OR (Appendix A-134 AND Appendix A-135) OR (Appendix A-136) OR (Appendix A-137) with a mental health practitioner (Appendix A-138) within 30 days after discharge.

Outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge will be included.

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (Appendix A-139) on or between January 1 and December 1 of the measurement year with continuous enrollment through 30 days post discharge.

Only facility claims will be used to identify discharges with a principal mental health diagnosis. Diagnoses from professional claims to identify discharges will not be used.

The denominator for this measure is based on discharges, not patients. If patients have more than one discharge, all discharges on or between January 1 and December 1 of the measurement year will be included.

If the discharge is followed by a readmission or direct transfer to an *acute facility* for a mental health principal diagnosis (Appendix A-141) OR (Appendix A-142) within the 30-day follow-up period, only the readmission discharge or the discharge from the facility to which the patient was transferred will be counted. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Exclusion(s):

1. Discharges followed by readmission or direct transfer to a *nonacute facility* (Appendix A-144) for a mental health principal diagnosis (Appendix A-141) OR (Appendix A-142) within the 30-day follow-up period will be excluded. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.
2. Discharges followed by readmission or direct transfer to an *acute or nonacute* facility for a *non-mental health principal* diagnosis within the 30-day post discharge period will be excluded. This includes an ICD-9-CM and ICD-10-CM Diagnosis code or DRG code.. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.

Result:
The result is expressed as a percentage.

Improvement Direction
Higher

Measure Qualifications:

The age will be calculated based on the patient's age as of the date of discharge.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0576

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 02, 03, 04, 06, 14, 15, 18, 19**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible.

DSRIP Incentive Impact		
Project Title: Project 3 - Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: 3.1	Payment Method: Pay for Reporting
Project Title: Project 5 - Electronic Self-Assessment Decision Support Tool	Project Code: 5.1	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 41**

Follow-up After Hospitalization for Mental Illness – 7 days post discharge

Measure Description:
The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.

Data Source:	NQF #:
MMIS	**0576**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:
Patients 6 years of age and older who received an outpatient visit, intensive outpatient encounter or partial hospitalization (Appendix A-131) OR (Appendix A-132 AND Appendix A-133) OR (Appendix A-134 AND Appendix A-135) OR (Appendix A-136) OR (Appendix A-137) with a mental health practitioner (Appendix A-138) within 7 days after discharge.

Outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge will be included.

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (Appendix A-139) on or between January 1 and December 1 of the measurement year with continuous enrollment through 30 days post discharge.

Only facility claims will be used to identify discharges with a principal mental health diagnosis. Diagnoses from professional claims to identify discharges will not be used.

The denominator for this measure is based on discharges, not patients. If patients have more than one discharge, all discharges on or between January 1 and December 1 of the measurement year will be included.

If the discharge is followed by readmission or direct transfer to an *acute facility* for a mental health principal diagnosis (Appendix A-141) OR (Appendix A-142) within the 30-day follow-up period, only the readmission discharge or the discharge from the facility to which the member was transferred will be counted. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Exclusion(s):

1. Discharges followed by readmission or direct transfer to a *nonacute facility* (Appendix A-144) for a mental health principal diagnosis (Appendix A-141) OR (Appendix A-142) within the 30-day follow-up period will be excluded. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.

Discharges followed by readmission or direct transfer to an *acute or nonacute* facility for a *non-mental health principal* diagnosis within the 30-day post discharge period will be excluded. This includes an ICD-9-CM or ICD-10-CM Diagnosis code or DRG code. These discharges are excluded from the measure because readmission or

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Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications/ Definitions:

The age will be calculated based on the patient's age as of the date of discharge.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0576

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 02, 03, 04, 06, 14, 15, 18, 19**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible.

DSRIP Incentive Impact		
Project Title: Project 3 - Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: 3.6	Payment Method: P4P
Project Title: Project 5 - Electronic Self-Assessment Decision Support Tool	Project Code: 5.8	Payment Method: P4P
Universal Measure: Yes	Universal Code: 11	Payment Method: Pay for Reporting

Measure: **DSRIP #: 42**

Follow-up Care for Children Prescribed ADHD Medication

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

Initiation Phase. The percentage of patients 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase. The percentage of patients 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Data Source:	NQF #:
MMIS	**0108**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:

Initiation Phase –
Patients who have had one outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date (IPSD). (Appendix A-306) OR (Appendix A-307) AND (Appendix A-308) OR (Appendix A-134) AND (Appendix A-135).

Visits on the same day of the IPSD will not be counted.

Continuation and Management Phase –
Patients must be compliant with the Initiation Phase and have had at least two follow-up visits from 31-300 days (10 months) after the IPSD. (Appendix A-306) OR (Appendix A-307) AND (Appendix A-308) OR (Appendix A-134) AND (Appendix A-135) One of the two visits (during days 31-300) may be a telephone visit with a practitioner. (Appendix A-319)

> **Continuous medication treatment** - The number of medication treatment days during the 10-month follow-up period which must be ≥210 days (i.e. 300 treatment days – 90 gap days).

Treatment days - The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g. a prescription of a 90 days supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

Denominator:

Initiation Phase –

Of the hospital's attributable New Jersey Low Income patient population, those who were six years of age as of March 1 of the year prior to the measurement year to 12 years as of February 29 of the measurement year and who were newly dispensed an ADHD medication during the 12-month Intake Period. (Appendix A-306) OR (Appendix A-307) AND (Appendix A-308) OR (Appendix A-134) AND (Appendix A-135) (Refer to Appendix A-2 for a list of NDC codes.)

Only patients with a negative medication history will be included. The Index Prescription Start Date (IPSD) is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Intake Period – The 12-month window starting March 1 of the year prior to the measurement year and ending February 29 of the measurement year.

Index Prescription Start Date – The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.

Negative Medication History – A period of 120 days (4 months) prior to the IPSD when the patient had no ADHD medications dispensed for either new or refill prescriptions. (Refer to Appendix A2 for NDC codes)

Initiation Phase Exclusion(s):

1. Patients who had an acute inpatient claim with a principal diagnosis or DRG for mental health Appendix A-141) (Appendix A-321) or substance abuse (Appendix A-322,323) during the 300 days after the IPSD.

Continuation and Management Phase –

Patients who meet all of the initiation phase numerator and denominator criteria and who have remained patients with continuous medication treatment. A patient must have filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period. Continuous medication treatment allows for gaps in medication treatment up to a total of 90 days during the 300-day period. (This period spans the Initiation Phase [1 month] and the Continuation and Management Phase [9 months].)

Continuation and Management Phase Exclusion(s):

1. Patients diagnosed with narcolepsy at any point in their medical history. (Appendix A-320)
2. Patients who had an acute inpatient claim with a principal diagnosis or DRG for mental health (Appendix A-141) (Appendix A-321) or substance abuse Appendix A-322,323) during the 300 days (10 months) after the IPSD.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications/ Definitions:

This measure includes two rates. In order to monitor pay for performance, the Continuation and Management Phase rate will apply to the P4P incentive.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0108

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 12, 14, 15, 18, 19**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for 120 days (4 months) prior to the Index Prescription Start Date (IPSD) and 30 days after the IPSD for the Initiation Phase, and 300 days (10 months) after the IPSD with no more than a 45 day gap for the Continuation and Management Phase.

DSRIP Incentive Impact		
Project Title: Project 5 - Electronic Self-Assessment Decision Support Tool	Project Code: 5.10	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 45**

Heart Failure Admission Rate

Measure Description:
Admissions with a principal diagnosis of heart failure per 1,000, ages 18 years and older. Excludes cardiac procedure admissions, obstetric admissions, and transfers from other institutions. (PQI 8)

Data Source:	NQF #:
MMIS	**Based on 0277**
Measure Steward:	Measure Steward Version:
AHRQ	**March 2015 v 5.0**

Measure Calculation Description

Numerator:
All discharges for patients age 18 years and older with a principal ICD-9-CM or ICD-10-CM diagnosis code for heart failure. (Appendix A-309)
Exclusion(s):

1. Any-listed ICD-9-CM procedure codes for cardiac procedure. (Appendix A-310)
2. Transfer from a hospital (different facility). (Appendix A-119)
3. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). (Appendix A-119)
4. Transfer from another health care facility. (Appendix A-119)
5. Obstetrical cases of pregnancy, childbirth and puerperium as identified through MDC 14. (Appendix A-92)

Denominator:

Of the hospital's attributable New Jersey Low income population, those patients who are 18 years and older.

Result:
The result is expressed as a rate.

The rate will be expressed as number of admits per 1,000 in each attributable population per hospital.

Improvement Direction:
Lower

Measure Qualifications/ Definitions:

Please note: This measure has been modified to remove consideration of the metropolitan or county area and instead will monitor the attributed DSRIP population.

This measure is based on Prevention Quality Indicator #8.

MDC 14 was added as an exclusion for DSRIP. Per AHRQ, discharges with a principal diagnosis of heart failure are precluded from an assignment of MDC 14 by the grouper software that is used. However, as there are variations between groupers, to ensure that obstetrical discharges are removed, exclusion #5 was added.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V50/TechSpecs/PQI_08_Heart_Failure_Admission_Rate.pdf

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**	Risk Adjustment: **No**	Sampling: **No**	

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: Project 6 - Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	Project Code: 6.8	Payment Method: P4P
Project Title: Project 7 - Extensive Patient CHF-Focused Multi-Therapeutic Model	Project Code: 7.9	Payment Method: P4P
Project Title: Project 8 - The Congestive Heart Failure Program (CHF-TP)	Project Code: 8.9	Payment Method: P4P
Universal Measure: Yes	Universal Code: 35	Payment Method: UPP

Measure: **DSRIP #: 46**

Hemoglobin A1c (HbA1c) Testing for Pediatric Patients

Measure Description:
Percentage of pediatric patients 5-17 with diabetes who had a HbA1c test in a 12-month measurement period.

Data Source:	NQF #:
MMIS	**0060**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:
Patients from the denominator who had an HbA1c test performed during the measurement year. (Appendix A-312)

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients 5-17 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

Two methods are used to identify patients with diabetes during the measurement year, or the year prior to the measurement year: pharmacy and claim data. Both methods will be used, but a patient only needs to meet one method in order to be eligible in the denominator.

1. Pharmacy – Patients who were dispensed insulin or oral hypoglycemic/ antihyperglycemics during the measurement year or the year prior to the measurement year**.** (Appendix A-311)

2. Claims –
   a. Patients who had two encounters in an outpatient setting or nonacute inpatient setting (Appendix A-173) (Appendix A-313) (Appendix A-172), on different dates of service, with a diagnosis of diabetes (Appendix A-28) during the measurement year or the year prior to the measurement year.

   b. Patients with one encounter in an acute inpatient or ED setting (Appendix A-155), with a diagnosis of diabetes (Appendix A-28), during the measurement year or the year prior to the measurement year.

Exclusion(s):
1. Diagnosis of active polycystic ovaries. (Appendix A-314)
2. Diagnosis of active gestational diabetes. (Appendix A-314)
3. Diagnosis of active steroid induced diabetes. (Appendix A-314)

Result:
The result is expressed as a percentage.

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Improvement Target Goal: **NA**		Absolute ITG Value: **NA**	
Attribution Date: **Last day of measurement period**		Anchor Date: **Last day of measurement period**	
Claim Type(s): **01, 03, 04, 12, 13, 14, 15, 16, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**	Risk Adjustment: **No**		Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 12 - Diabetes Group Visits for Patients and Community Education	Project Code: 12.5	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 48**

Hypertension Admission Rate

Measure Description:
All discharges of patients age 18 years and older with ICD-9-CM or ICD-10-CM principal diagnosis code for hypertension.

Data Source:	NQF #:
MMIS	**0276, No longer endorsed**
Measure Steward:	Measure Steward Version:
AHRQ	**March 2012, V4.4**

Measure Calculation Description

Numerator:
All discharges for patients age 18 years and older with a principal diagnosis code for hypertension. (Appendix A-315)

Exclusion(s):
1. Cases with any diagnosis of Stage I-IV kidney disease Appendix A-316), only if accompanied by procedure code for preparation for hemodialysis (dialysis access procedures). (Appendix A-317)
2. Cases with a cardiac procedure code.(Appendix A-318)
3. Transfer from a hospital (different facility). (Appendix A-119)
4. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). (Appendix A-119)
5. Transfer from another health care facility. (Appendix A-119)
6. Obstetrical cases of pregnancy, childbirth and puerperium through MDC 14. (Appendix A-92)

Denominator:
Of the hospital's attributable New Jersey Low Income population, those patients who are 18 years and older.

Result:
The result is expressed as a rate.

The rate will be expressed as number of admits per 1,000 in each attributable population per hospital.

Improvement Direction:
Lower

Measure Qualifications:

Please note: This measure has been modified to remove consideration of the metropolitan or county area and instead will monitor the attributable DSRIP population.

This measure is based on Prevention Quality Indicator #7.

MDC 14 was added as an exclusion for DSRIP. Per AHRQ, discharges with a principal diagnosis of COPD are precluded from an assignment of MDC 14 by the grouper software that is used. However, as there are variations between the groupers, to ensure that obstetrical discharges are removed, exclusion #4 was added.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://qualityindicators.ahrq.gov/Downloads/Modules/PQI/V50-ICD10/TechSpecs/PQI%2007%20Hypertension%20Admission%20Rate.pdf

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: Project 11 - Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: 11.7	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: Initiation of alcohol and other drug treatment

DSRIP #: 52

Measure Description:
The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.

Data Source:	NQF #:
MMIS	**0004**
Measure Steward:	Measure Steward Version:
NCQA	**2013**

Measure Calculation Description

Numerator:

All patients who initiated alcohol or other drug (AOD) treatment through an inpatient admission (Appendix A-226), outpatient visit, intensive outpatient encounters (Appendix A-227) or (Appendix A-228 and Appendix A-229) or partial hospitalization (Appendix A-230 and Appendix A-231) within 14 days of diagnosis. (Appendix A-225)

1. *If the Index Episode was an inpatient discharge,* the inpatient stay is considered initiation of treatment and the patient is compliant.
2. *If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit,* the patient must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization with an AOD diagnosis within 14 days of the Index Episode Start Date (IESD) (inclusive).
3. *If the initiation encounter is an inpatient admission,* the admission date (not the discharge date) must be within 14 days of the IESD (inclusive).
4. Index Episodes that include detoxification codes (including inpatient detoxification) (Appendix A-232) will not be counted as being initiation of treatment.

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients age 13 years and older as of December 31 of the measurement year who had a *new* episode of AOD during the Intake Period.

Intake Period - January 1–November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.

Index Episode - The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD.

For ED visits that result in an inpatient stay, the inpatient stay is the Index Episode.

Step 1: The following identify the Index Episode

1. An outpatient visit, intensive outpatient encounter (Appendix A-227) or (Appendix A-228 and Appendix A-229) or partial hospitalization (Appendix A-230 and Appendix A-231) with a diagnosis of AOD (Appendix A-225).
2. A detoxification visit (Appendix A-232).
3. An ED visit (Appendix A-233) with a diagnosis of AOD (Appendix A-225).
4. An inpatient discharge with a diagnosis of AOD as identified by either of the following:
   a. An inpatient facility code (Appendix A-226) in conjunction with a diagnosis of AOD (Appendix A-225).
   b. An inpatient facility code (Appendix A-226) in conjunction with an AOD procedure code (Appendix A-234).

For patients with more than one episode of AOD, the first episode will be used.

For patients whose first episode was an ED visit that resulted in an inpatient stay, the inpatient discharge will be used.

Then, the earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD (Appendix A-225) will be used as the Index Episode Start Date (IESD).

For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED (not resulting in an inpatient stay) claim, the IESD is the date of service.

For an inpatient (acute or nonacute) claim, the IESD is the date of discharge.

For an ED visit that results in an inpatient stay, the IESD is the date of the inpatient discharge.

For direct transfers, the IESD is the discharge date from the second admission.

Step 2: Then, the Negative Diagnosis History will be tested. Patients who had a claim with a diagnosis of AOD (Appendix A-225) during the 60 days (2 months) before the IESD will be excluded.

For an inpatient IESD, the admission date will be used to determine the Negative Diagnosis History.

For an ED visit that results in an inpatient stay, the ED date of service will be used to determine the Negative Diagnosis History.

For direct transfers, the first admission will be used to determine the Negative Diagnosis History.

Step 3: Then, continuous enrollment will be calculated.

Exclusion(s):

1. Patients from the denominator whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year will be excluded.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The measure steward age stratifies the results by 13-17, 18+ and a Total. In order to monitor P4P, only the age stratification that includes all ages (Total) will be used for DSRIP.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0004

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 14, 15, 18, 19**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**	Risk Adjustment: **No**		Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

Patients must be continuously enrolled without any gaps 60 days (2 months) before the Index Episode Start Date (IESD) through 44 days after the IESD.

DSRIP Incentive Impact		
Project Title: Project 9 - Hospital-Wide Screening for Substance Use Disorder	Project Code: 9.3	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 60**

Medication Management for People with Asthma – 75%

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

Data Source:	NQF #:
MMIS	**Based on 1799**
Measure Steward:	Measure Steward Version:
NCQA	**2016**

Measure Calculation Description

Numerator:

The number of patients who achieved a proportion of days covered (PDC) of at least 75% for their asthma controller medications during the measurement year. (Refer to Appendix A-219 for a list of NDC codes.)

Index prescription start date (IPSD) - The earliest prescription dispensing date for any asthma controller medication during the measurement year.

Treatment period - The period of time beginning on the IPSD through the last day of the measurement year

Proportion of days covered (PDC) - The number of days that a member is covered by at least one asthma controller medication prescription, divided by the number of days in the treatment period.

Calculating number of days covered for multiple prescriptions:

If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a controller medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a controller medication (for the numerator). For example, three controller prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a controller.

Use the drug ID provided by the NDC to determine if the prescriptions are the same or different.

Follow the steps below to identify numerator compliance.

STEP 1

Identify the IPSD. The IPSD is the earliest dispensing event for any asthma controller medication (Refer to Appendix A-219 for a list of NDC codes) during the measurement year.

STEP 2
To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year.

STEP 3
Count the days covered by at least one prescription for an asthma controller medication (Refer to Appendix A-219 for a list of NDC codes) during the treatment period. To ensure that the days supply does not exceed the treatment period, subtract any days supply that extends beyond December 31 of the measurement year.

STEP 4
Calculate the patient's PDC using the following equation.

$$\frac{\text{Total Days Covered by a Controller Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications.

Patients will be stratified in the following ranges:
1. Under 18 years of age
2. 18 years through 64

Step 1: Identify patients as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years:
1. At least one ED visit (Appendix A-155), with asthma as the principal diagnosis. (Appendix A-216)
2. At least one acute inpatient claim (Appendix A-172), with asthma as the principal diagnosis. (Appendix A-216)
3. At least four outpatient asthma visits or observation visits (Appendix A-201) on different dates of service, with asthma as one of the listed diagnoses Appendix A-216) and at least two asthma medication dispensing events. (Appendix A-218)
4. At least four asthma medication dispensing events. (Appendix A-218)

Step 2: A patient identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers (Refer to Appendix A-217 for NDC codes) were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Appendix A-216), in any setting, in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).

Oral medication dispensing event -

One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). The dispensing events will be allocated to the appropriate year based on the date on which the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.

a. *Two prescriptions* for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each).
b. *Two prescriptions* for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each).
c. *Two prescriptions* for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days).
d. *Two prescriptions* for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).

Inhaler dispensing event - Each inhaler (i.e., canister) counts as one dispensing event. Multiple dispensing events of the same or different medication are counted as separate dispensing events (even if medications were filled on the same date of service). The dispensing events will be allocated to the appropriate year based on the date when the prescription was filled.

Injection dispensing event - Injections count as one dispensing event. Multiple dispensing events of the same or different medication are counted as separate dispensing events. The dispensing events will be allocated to the appropriate year based on the date when the prescription was filled.

Exclusion(s):

1. Patients with one encounter, in any setting, with any code to identify a diagnosis of emphysema, COPD, cystic fibrosis or acute respiratory failure. (Appendix A-174)
2. Patients who have no asthma controller medications dispensed during the measurement year. (Refer to Appendix A-219 for a list of NDC codes)

Result:
The result is expressed as a percentage.

Improvement Direction
Higher

Measure Qualifications:

Please note: The measure steward stratifies this measure into five categories. This has been adjusted to two age categories to correspond to the Medicaid Adult Core measure set.

Incentive payment for the projects will be based on the following age ranges:
1. Project 1 – Results for those patients 18 years through 64
2. Project 2 – Results for those patients under 18 years of age

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/1799

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 12, 13, 14, 15, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year and the year prior to the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 1 - Hospital-Based Educators Teach Optimal Asthma Care	Project Code: 1.4	Payment Method: P4P
Project Title: Project 2 - Pediatric Asthma Case Management and Home Evaluations	Project Code: 2.4	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 62**

Mental Health Utilization

Measure Description:
The percentage and number of of patients who utilized mental health services categorized by discharges, emergency department/ outpatient services and stratified by age.

Data Source:	NQF #:
MMIS	**Not Found**
Measure Steward:	Measure Steward Version:
NCQA	**2016**

Measure Calculation Description

Numerator:
The percentage and count of unique patients who received the following services with any mental health benefit, regardless of the number of visits during the measurement period.

The results will be stratified by these services:

1. Inpatient mental health services. Include inpatient care at either a hospitalor treatment facility (Appendix A-221and Appendix A-220) with mental health as the principal diagnosis. Exclude discharges with principle diagnosis of behavioral health (Appendix A-221 and A-222).
2. Emergency Department services and Outpatient services Appendix A-223) with a principal mental health diagnosis Appendix A-220).

For patients who had more than one visit, only the first visit will be counted in the measurement period and reported by the respective age category.

Denominator:
Of the hospital's attributable New Jersey Low Income population, the total patients with any mental health benefit during the measurement period stratified into the following age categories:

Stratified by the following age groups:
1. Below 18 years of age
2. 18 years of age through 64
3. 65 years of age and above
4. Total

Result:
The result is expressed as a percentage.

Measure Qualifications:

Please note: The measure steward indicates that the measure is to report information about intensive outpatient and partial hospitalization services. This will not be reported separately for DSRIP.

Only total counts will be reported as adjusted for age to align with the MedicaidAdult Core measure set.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 14, 15, 18, 19, 22**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: Project 3 – Integrated Health Home for the Seriously Mentally Ill (SMI)	Project Code: 3.5	Payment Method: Pay for Reporting
Project Title: Project 5 – Electronic Self-Assessment Decision Support Tool	Project Code: 5.4	Payment Method: Pay for Reporting
Universal Measure: Yes	Universal Code: 2	Payment Method: Pay for Reporting

Measure:

DSRIP #: 66

Percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months

Measure Description:
This measure is used to assess the percent of patients aged 5–18 or 5-64 who have had a visit to an Emergency Department (ED) for asthma in the past six months.

Data Source:	NQF #:
MMIS	**Not Found**
Measure Steward:	Measure Steward Version:
HRSA	**Not Found**

Measure Calculation Description

Numerator:
The number of patients from the denominator who had a visit to an Emergency Department (ED) for a principal diagnosis of asthma during the six month measurement period. (Appendix A-155)

The numerator will be stratified in the following ranges:
1. 5 through 18 years of age (Project 2, P4P)
2. 5 through 64 years of age, Total (Project 1, P4P)

Denominator:
Of the hospital's attributable New Jersey Low Income population, those patients aged 5-18 or 5-64 with an asthma diagnosis during the twelve months prior to the six-month measurement period. (Appendix A-300)

Exclusion(s):
1. Patients with one encounter, in any setting, with any code to identify a diagnosis of emphysema, COPD, cystic fibrosis or acute respiratory failure Appendix A-301) .

Result:
The result is expressed as a percentage.

Improvement Direction:
Lower

Measure Qualifications:

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.qualitymeasures.ahrq.gov/content.aspx?id=27599

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **1st Semi-Annual = April** **2nd Semi-Annual = October**	
Experience Period: **6 month period**		Baseline Period: **SA July - December 2013**	
Claim Type(s): **01, 02, 03, 04, 05, 06, 09, 13, 14, 15, 16, 18, 19**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the six-month measurement period with no more than a 22 day gap during the six-month measurement period and the year prior to the measurement period with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: Project 1 - Hospital-Based Educators Teach Optimal Asthma Care	Project Code: 1.5	Payment Method: P4P
Project Title: Project 2 - Pediatric Asthma Case Management and Home Evaluations	Project Code: 2.5	Payment Method: P4P
Universal Measure: Yes	Universal Code: 13	Payment Method: Pay for Reporting

Measure: **DSRIP #: 67**

Percentage of Live Births Weighing Less than 2,500 grams

Measure Description:
Low birth weight (<2,500 grams) infants per 1,000 newborns. Excludes transfers from other institutions. (PQI 9)

Data Source:	NQF #:
MMIS	**Based on 0278**
Measure Steward:	Measure Steward Version:
CDC	**2013**

Measure Calculation Description

Numerator:
Number of newborns with any-listed ICD-9-CM or ICD-10-CM diagnosis codes for birth weight less than 2,500 grams. (Appendix A-302)

Denominator:
Of the hospital's attributable New Jersey Low Income population, those patients who are newborns.

A newborn is defined as any discharge meeting the definition of:

1. Any-listed ICD-9-CM or ICD-10-CM code for in-hospital live birth (Appendix A-303) and age in days equal to zero or missing; **or**

2. An admission type of newborn (Admission Type = 4) and age in days equal to zero without any-listed ICD-9-CM or ICD-10-CM diagnosis codes for out-of-hospital live birth Appendix A-304) ; **or**

3. An admission type of newborn (Admission Type = 4) with point of origin for born inside this hospital (Admission Source =5).

Exclusion(s):
1. Transfer from another institution

Result:
The result is expressed as a percentage.

Improvement Direction:
Lower

Measure Qualifications:

This measure is based on Prevention Quality Indicator #9.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://qualityindicators.ahrq.gov/Downloads/Modules/PQI/V50-ICD10/TechSpecs/PQI%2009%20Low%20Birth%20Weight%20Rate.pdf

http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%20Appendices.pdf

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 39	Payment Method: UPP

DSRIP #:
81

Measure:

Uncontrolled Diabetes Admission Rate

Measure Description:
Admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 1,000, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions. (PQI 14)

Data Source:	NQF #:
MMIS	**Based on 0638**
Measure Steward:	Measure Steward Version:
AHRQ	**October 2015 v 5.0**

Measure Calculation Description

Numerator:
All discharges for patients age 18 years and older, with a principal diagnosis code for uncontrolled diabetes without mention of short-term or long-term complication. (Appendix A-305)
Exclusion(s):

1. Transfer from a hospital (different facility). (Appendix A- 119)
2. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). (Appendix A- 119)
3. Transfer from another health care facility. (Appendix A- 119)
4. Obstetrical cases of pregnancy, childbirth and puerperium as identified through MDC 14. (Appendix A- 92)

Denominator:
Of the hospital's attributable New Jersey Low Income population, those patients who are 18 years and older.

Result:
The result is expressed as a rate.

The rate will be expressed as number of admits per 1,000 in each attributable population per hospital.

Improvement Direction:
Lower

Measure Qualifications:

Please note: This measure has been modified to remove consideration of the metropolitan or county area and instead will monitor the attributed DSRIP population.

This measure is based on Prevention Quality Indicator #14.

MDC 14 was added as an exclusion for DSRIP. Per AHRQ, discharges with a principal diagnosis of COPD are precluded from an assignment of MDC 14 by the grouper software that is used. However, as there are variations between the groupers, to ensure that obstetrical discharges are removed, exclusion #4 was added.

The following link(s) may be used to obtain additional information regarding the original measure specifications. This is provided without assurances:

http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V50-ICD10/TechSpecs/PQI%2014%20Uncontrolled%20Diabetes%20Admission%20Rate.pdf

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

NA

DSRIP Incentive Impact		
Project Title: Project 11 – Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	Project Code: 11.5	Payment Method: P4P
Project Title: Project 12 – Diabetes Group Visits for Patients and Community Education	Project Code: 12.8	Payment Method: P4P
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 83**

Use of Appropriate Medications for People with Asthma

Measure Description:
The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Data Source:	NQF #:
MMIS	**0036, No longer endorsed**
Measure Steward:	Measure Steward Version:
NCQA	**2016**

Measure Calculation Description

Numerator:
Patients who were dispensed at least one prescription for an asthma controller medication during the measurement year. (Refer to Appendix A-219 for a list of NDC codes.)

Denominator:

Of the hospital's attributable New Jersey Low Income population, those patients 5–64 years of age by December 31 of the measurement year who were identified as having persistent asthma. Patients will be stratified in the following ranges:

1. Under 18 years of age
2. 18 years through 64

Identify patients as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

1. At least one ED visit (Appendix A-155), with asthma as the principal diagnosis (Appendix A-216).
2. At least one acute inpatient claim (Appendix A-172), with asthma as the principal diagnosis (Appendix A-216).
3. At least four outpatient asthma visits (Appendix A-201) on different dates of service, with asthma as one of the listed diagnoses (Appendix A-216) and at least two asthma medication dispensing events (Refer to A-224 for NDC codes).
4. At least four asthma medication dispensing events (Refer to A-224 for NDC codes).
    a. A patient identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers (Appendix A-339) were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma Appendix A-216), in any setting, in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).

Oral medication dispensing event -

One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day

prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). The dispensing events will be allocated to the appropriate year based on the date on which the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.

a. *Two prescriptions* for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each).
b. *Two prescriptions* for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each).
c. *Two prescriptions* for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days).
d. *Two prescriptions* for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).

Inhaher Dispensing Event - Each inhaler (i.e., canister) counts as one dispensing event. Multiple dispensing events of the same or different medication are counted as separate dispensing events (even if medications were filled on the same date of service). The dispensing events will be allocated to the appropriate year based on the date when the prescription was filled.

Injection Dispensing Event - Injections count as one dispensing event. Multiple dispensing events of the same or different medication are counted as separate dispensing events. The dispensing events will be allocated to the appropriate year based on the date when the prescription was filled.

Exclusion(s):

1. Patients who had at least one encounter, in any setting, with any code to identify a diagnosis of emphysema, COPD, cystic fibrosis or acute respiratory failure Appendix A-174).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

Please note: The measure steward stratifies this measure into five categories. This has been adjusted to two age categories that correspond to the Medicaid Adult Core measure set.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/0036

Measure Collection Description			
Setting of Care: **Multi-setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **01, 03, 04, 12, 13, 14, 15, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year and the year prior to the measurement year with no more than a 45 day gap during each year.

DSRIP Incentive Impact		
Project Title: Project 1 – Hospital-Based Educators Teach Optimal Asthma Care	Project Code: 1.3	Payment Method: Pay for Reporting
Project Title: Project 2 – Pediatric Asthma Case Management and Home Evaluations	Project Code: 2.3	Payment Method: Pay for Reporting
Universal Measure: No	Universal Code: NA	Payment Method: NA

Measure: **DSRIP #: 88**

Well-Child Visits in First 15 Months of Life

Measure Description:
The percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care physician (PCP) during their first 15 months of life:

- No well-child visits
- 1-3 well-child visits
- 4 or more well-child visits

Data Source:	NQF #:
MMIS	**Based on 1392**
Measure Steward:	Measure Steward Version:
NCQA	**2016**

Measure Calculation Description

Numerator:

Three separate numerators are calculated, corresponding to the number of members who had 0, 1-3, 4 or more well-child visits with a PCP during their first 15 months of life. The well-child visit must occur with a PCP. (Appendix A-145)

Primary care practitioner (PCP) - A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.

Denominator:
Of the hospital's New Jersey Low Income population, those patients 15 months during the measurement year.

The 15-month birthday will be calculated as the child's first birthday plus 90 days. For example, a child born on January 9, 2011, and included in the rate of "four or more well-child visits" must have had four or more well-child visits by April 8, 2012.

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Qualifications:

The following New Jersey provider specialties will be included as a PCP:

1. 80 – Family Practice
2. 82 – NP Family
3. 110 – Internal Medicine
4. 370 – Pediatrics
5. 372 – NP Pediatric
6. 450 - NP Community Health
7. 470 – NP Adult Health

Please note: This measure has been adjusted from the measure steward from seven separate rates to three.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

http://www.qualityforum.org/QPS/1392

Measure Collection Description			
Setting of Care: **Outpatient setting**		Reporting Period: **Annual; April**	
Experience Period: **Calendar Year**		Baseline Period: **CY 2013**	
Claim Type(s): **04, 13, 18**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**		Risk Adjustment: **No**	Sampling: **No**

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology

The patient is to be continuously enrolled for the measurement year with no more than a 45 day gap during the year.

DSRIP Incentive Impact		
Project Title: NA	Project Code: NA	Payment Method: NA
Universal Measure: Yes	Universal Code: 27	Payment Method: Pay for Reporting