OMB Number: 0915-0387
Expiration date: 00/XX/XXXX

Federal Office of Rural Health Policy: Rural Health

Community-Based Programs

Performance Improvement and Measurement Systems (PIMS) Database

Small Health Care Provider Quality Improvement Grant Program

SECTION 1: ACCESS TO CARE *(applicable to all Quality grantees)*

Table Instructions: This table collects information about an aggregate count of the number of people served through the program and the types of services that were provided during this budget period. Please report responses using a numeric figure. If the total number is zero (0), please put zero in the appropriate section. Do ***not*** leave any sections blank. There should ***not*** be an N/A (not applicable) response since all measures are applicable to all grantees.

- **Note:** For the numbers reported as part of this table, numbers should be consistent with figures indicated in your project's grant application. For any numbers reported that are ***not*** consistent with the figures indicated in your project's grant application, please provide a justification describing why the numbers are not consistent with the figures indicated in your project's grant application in the form comment box. Please also include verification stating whether any noted changes have been communicated to your project's assigned HRSA Project Officer.
- **Note*:*** For organizations participating as part of an integrated health system, network and/or consortium for implementation their grant-funded project completing this section, please complete responses to questions provided in table **1a**, as applicable. If appropriate, please also utilize the form comment box for provision of any additional necessary information needed for interpreting values reported in this section.

Please refer to these detailed definitions and guidelines in providing your answers to the following measures:

Definitions - Section 1: Access to Care

Direct Services: A documented interaction between a patient/client and a clinical or non-clinical health professional that has been funded with FORHP grant dollars. Examples of direct services include (but are not limited to) patient visits, counseling and education. This includes both face-to-face in-person encounters as well as non face-to-face encounters.

Intervention Patient Population: Patient population targeted for the implementation of the FORHP grant funded quality improvement project intervention.

Quality Improvement Intervention Patient Population

1	Numerator		Denominator		Percent of Targeted Patients Served
	Number of unique individuals from your project's intervention patient population who received direct services during this budget period. Please report the number of unique (i.e. unduplicated count) patients/clients from your project's intervention patient population that received *direct services* from your organization.	**Number**	**Total number of unique individuals from your project's intervention patient population targeted to receive direct services during this budget period.** Please include the total planned number of unique (i.e. unduplicated count) patients/clients from your project's intervention patient population your project targeted to receive *direct services* from your organization for this budget period.	**Number**	**Percent**

1a	**Direct Service Encounters Across Partner Organizations** *(for projects participating as part of a Network and/or Consortium **only**).* Please provide information to the following based off the available data for project's partner organizations.	
	Are all Project Partner Sites Contributing to Direct Service Encounter Data? *If no, please indicate the contributing partner sites in the section below.* Please indicate whether all grant funded project partner sites are contributing to the direct service encounter values included for the purposes of this reporting.	**Yes/No or N/A**
	Number of Project Partner Sites Contributing Direct Service Encounter Data Please provide the total number of grant funded project partner sites contributing to the direct service encounter values included for the purposes of this reporting.	**Number or N/A**

2	**Type of direct service encounters** Please specify the type of services received by you project's intervention patients as part of your project's quality improvement intervention by selecting from the list below.	**Please Select All That Apply**
	Disease Management Education	
	Medication Management Education	
	Nutrition Education and/or Counseling	
	Physical Fitness/Exercise Education and/or Counseling	
	Mental/Behavioral Health Social Services and/or Counseling	
	Other (*Please specify)*	

SECTION 2: POPULATION DEMOGRAPHICS *(applicable to all Quality grantees)*

Table Instructions: This table collects information about an aggregate count of the people served by race, ethnicity and age. The total for *each* of the following questions should equal the total number of unique individuals from your project's intervention patient population who received direct services during this budget period *(same as the number reported for measure 1 reported in the previous section).* Please do ***not*** leave any sections blank. There should not be a N/A (not applicable) response since the measures are applicable to all grantees. If the number for a particular category is zero (0), please put zero in the appropriate section (e.g., if the total number that is Hispanic or Latino is zero (0), enter zero in that section).

Hispanic or Latino Ethnicity

- Column A (Hispanic/Latino): Report the number of persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, broken down by their racial identification and including those Hispanics/Latinos born in the United States. Do not count persons from Portugal, Brazil, or Haiti whose ethnicity is not tied to the Spanish language.

- Column B (Non-Hispanic/Latino): Report the number of all other people except those for whom there are neither racial nor Hispanic/Latino ethnicity data. If a person has chosen a race (described below) but has not made a selection for the Hispanic /non-Hispanic question, *the patient is presumed to be non-Hispanic/Latino.*

- Column C (Unreported/Refused to Report): Only one cell is available in this column. Report on Line 7, Column C only those patients who left the entire race and Hispanic/Latino ethnicity part of the intake form blank.

People who self-report as Hispanic/Latino but do not separately select a race must be reported on Line 7, Column A as Hispanic/Latino whose race is unreported or refused to report. Health centers may not default these people to "White," "Native American," "more than one race," or any other category.

Race
All people must be classified in one of the racial categories (including a category for persons who are "Unreported/Refused to Report"). This includes individuals who also consider themselves to be Hispanic or Latino. People who self-report race, but do not separately indicate if they are Hispanic or Latino, are presumed to be non-Hispanic/Latino and are to be reported on the appropriate race line in Column B. People sometimes categorized as "Asian/Other Pacific Islander" in other systems are divided into three separate categories:

- Line 1, Asian: Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, or Vietnam
- Line 2a, Native Hawaiian: Persons having origins in any of the original peoples of Hawaii
- Line 2b, Other Pacific Islander: Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Truk, Yap, Saipan, Kosrae, Ebeye, Pohnpei or other Pacific Islands in Micronesia, Melanesia, or Polynesia
- Line 2, Total Native Hawaiian/Other Pacific Islander: Must equal lines 2a+2b

American Indian/Alaska Native (Line 4): Persons who trace their origins to any of the original peoples of North and South America (including Central America) and who maintain Tribal affiliation or community attachment.

More than one race (Line 6): "More than one race" should not appear as a selection option on your intake form. Use this line only if your system captures multiple races (but not a race and an ethnicity) and the person has chosen two or more races. This is usually done with an intake form that lists the races and tells the person to "check one or more" or "check all that apply." "More than one race" must not be used as a default for Hispanics/Latinos who do not check a separate race. They are to be reported on Line 7 (Unreported/Refused to Report), as noted above.

3	**Number of people served by race and ethnicity**					
	Line	Number of People Served By Race	Hispanic/Latino (a)	Non-Hispanic/ Latino (b)	Unreported/ Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
	1	Asian				
	2a.	Native Hawaiian				
	2b.	Other Pacific Islander				
	2.	Total Native Hawaiian/Other Pacific Islander (Sum lines				
	3.	Black/African American				

	4.	American Indian/ Alaska Native				
	5.	White				
	6.	More than one race				
	7.	Unreported/ Refused to report race				
	8.	Total of individuals served (Sum Line 1+2+3 to 7)				Equal to the total number of unique individuals who receive direct services

4	**Number of people served by age group**	**Number *(End of Budget Period)***
	Children (0-12)	
	Adolescents (13-17)	
	Adults (18-64)	
	Elderly (65 and over)	
	Unknown	
		Total (automatically calculated). Equal to the total of the number of unique individuals who received direct services

Insurance Status/Coverage

Table Instructions: Please respond to the following questions based on these guidelines

- Each patient for this section should be counted only ***once***.
- The total for this table should equal the total number of unique individuals from your project's intervention patient population who received direct services during this budget period *(same as the number reported for measure 1 reported in the previous section).*
- Please include Medicare Advantage coverage under "private insurance" as a private plan purchased through Medicare for the purposes of this reporting
- **Note:** For organizations participating as part of an integrated health system, network and/or consortium for implementation their grant-funded project completing this section, please complete responses, as data/information is available to do so. If data/information is not available, please utilize the form comment box for provision of any additional necessary information needed for interpreting values reported in this section. Responses reported in this table are still expected to equal the total number of unique individuals from your project's intervention

patient population who received direct services during this budget period *(same as the number reported for measure 1 reported in the previous section).*

Definitions Section 2: Population Demographics Insurance Status/Coverage

Private Insurance: Health insurance provided by commercial and not for profit companies. Individuals may obtain insurance through employers or on their own.

Uninsured: Those without health insurance.

Medicare: Federal insurance for the aged, blind, and disabled (Title XVIII of the Social Security Act). For the purposes of this reporting, coverage reported under Medicare, should also be inclusive of all Medicare coverage (other than dual eligible), including Medicare Advantage as well as beneficiaries with supplemental coverage such as Medigap, employer sponsored or Veteran's Administration (VA) coverage.

Medicaid: is defined as State-run programs operating under the guidelines of Titles XIX (and XXI as appropriate) of the Social Security Act. For the purposes of this reporting, insurance coverage under Children's Health Insurance Program (CHIP) should be included within the reporting for this category.

Dual Eligible: Covered by both Medicaid and Medicare

Children's Health Insurance Program (CHIP): Jointly funded state and federal government program which provides health coverage to eligible children, through both Medicaid and separate CHIP programs administered by states, in accordance to federal requirements. For the purposes of this reporting, please report Medicaid (not including CHIP) separately from those including CHIP under Medicaid.

Other Third Party: Includes coverage through state and/or local government programs such as state-sponsored or public assistance programs only.

5	**Number of people by health insurance status**	**Number *(End of Budget Period)***
	Private Insurance	
	None/Uninsured	
	Dual Eligible	
	Medicaid *(only)*	
	Medicare *(only)*	
	Other third party *(only)*	
	Unknown	
		Total (automatically calculated). Equal to the total of the number of unique individuals who received direct services

SECTION 3: SUSTAINABILITY *(applicable to all Quality grantees)*

Table Instructions: This table collects information/data about the grant's programmatic sustainability. Please select the type(s) of sources of funding for sustainability and include the dollar amount obtained by each source, if known. For the purposes of this report, sustainability efforts will be reported on at the end of each budget period (once per year).

- **Note:** For organizations participating as part of an integrated health system, network and/or consortium for implementation their grant-funded project completing this section, please complete responses, as data/information is available to do so. If data/information is not available, please utilize the form comment box for provision of any additional necessary information needed for interpreting values reported in this section.
- For the "Sources of Sustainability" question selections, if the dollar amount is unable to be determined for source of project sustainability, please utilize the selection box option and select "d/k" under the respective dollar amount options. Leave the selection box empty and select "n/a" for dollar funding amounts for the sources of sustainability listed not used for project sustainability.

In Year 3 of grant funding, grantees are required to report on these additional measures:

- Question #7 - The ratio impact for Economic Impact vs. HRSA Program Funding using HRSA's Economic Impact Analysis Tool (http://www.raconline.org/econtool/)
- Question #8 - If any of the activities will sustain after the grant project period is over

Definitions Section 3: Sustainability

Annual Program Revenue: Payments received for the services provided by the program that the grant supports. These services should be the same services outlined in your grant application work plan. Please do not include donations. If the total amount of annual revenue made is zero (0), please put zero in the appropriate section.

Additional Funding: Funding already secured to assist in sustaining the project. Donations should be included in this section.

In-Kind Contributions: Donations of anything other than money, including goods or services/time.

Accountable Care Organization (ACO): A group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to Medicare patients.

Chronic Care Management: Chronic care management is care coordination services done outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Annual Wellness Visit: Annual Wellness Visit (AWV) is a Medicare covered yearly appointment to discuss plan of preventive care in the coming year.

Initial Preventive Physical Examination (IPPE): The Initial Preventive Physical Examination (IPPE) is also known as the "Welcome to Medicare Preventive Visit." The goals of the IPPE are health promotion, disease prevention, and detection.

Advanced Care Planning: Advanced Care Planning, covered under Medicare Part B as part of the yearly wellness visit, is planning for care when patients become ill and unable to speak for themselves through an advance directive, a written document stating how a patient would like medical decisions to be made if ability to make them decisions for themselves is lost. This pay also include a living will and a durable power of attorney for health care.

Transitional Care Management: Transitional Care Management, under Medicare Part B, refers to coordination and management services for a patient's care the first 30 days following an inpatient stay.

Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs: The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs will provide incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology. These incentive programs are designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care.

Medication Therapy Management Program: Under Medicare Part D, Medication Therapy Management Program (MTMP) provides medical care provided by pharmacists whose aim is to optimize drug therapy and improve therapeutic outcomes for patients.

Medicare Diabetes Prevention Program (MDPP): Under Medicare Part B, the Medicare Diabetes Prevention Program Expanded Model initially announced in 2016 and, expanded model scheduled for starting 2018, is a structured intervention with the goal of preventing progression to type 2 diabetes in individuals with an indication of pre-diabetes. Based on results from National Institutes of Health-funded research, the clinical intervention for the program is includes completion of Centers for Disease Control and Prevention (CDC) approved curriculum furnished over six months in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control.

Diabetes Self-Management Training (DSMT): Under Medicare Part B, Diabetes Self-Management Training is available for patients at risk for complications from diabetes and focused on educating patients on diabetes management and risk reduction strategies for self-management such as nutrition, physical activity, blood sugar monitoring and medication management.

6	**Source of Sustainability**	**Annual Program Revenue** (Dollar Amount)	**Additional Funding** (Dollar Amount)	**Selection List** *(only if dollar amount is unable to be determined)*
	In-kind Contributions			
	Membership Fees/Dues			
	Fundraising/ Monetary Donations			
	Contractual Services			
	Other Grants			
	Fees Charged to Individuals for Services			
	Product sales			
	Government (non-grant)			
	Other – specify type			
	Incentive Payments/ Reimbursement from Third-Party Payers			
	Accountable Care Organization (ACO) Participation			
	Centers for Medicare and Medicaid (CMS) Medicare Preventive Services			

	Provision & Billing Participation			
	Chronic Care Management (CCM)			
	Annual Wellness Visits (AWV) *(also includes Initial Preventive Physical Examination)*			
	Advanced Care Planning (ACP)			
	Transitional Care Management (TCM)			
	Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs			
	Medication Therapy Management Program (MTMP) Participation			
	Medicare Diabetes Prevention Program (MDPP)			
	Diabetes Self-Management Training (DSMT)			

Measures 7 & 8: ***Year 3 Reporting Only***

7	**What is your ratio for Economic Impact vs. HRSA Program Funding?** Use the HRSA's Economic Impact Analysis Tool (http://www.raconline.org/econtool/) to identify your ratio.	**Ratio**
8	**Will any of the program's activities be sustained after the project period?**	**(Some/None/All)**

SECTION 4: CONSORTIUM/NETWORK *(optional)*

Table Instructions:

For organizations participating as part of an integrated health system, network and/or consortium for implementation their grant-funded project, please complete this section and provide information about the consortium or network members involved as part of the implementation of this grant project, if applicable.

Definitions Section 4: Consortium/Network

Consortium/Network: A consortium or network is defined as collaboration between two or more separately owned organizations. For the purposes of this reporting, this may include accountable care organizations (ACO) and other integrated health system structures and/or partnerships.

9	**Number of member organizations in the Consortium/Network**	**Number**
	Area Agency on Aging	

	Area Health Education Center (AHEC)	
	Business	
	Community Health Center/ Federally Qualified Health Center (FQHC)	
	Critical Access Hospital	
	Emergency Medical Service	
	Faith-Based Organization	
	Health Department	
	HIT Regional Extension Center	
	Hospice	
	Hospital, not Critical Access	
	Long Term Care Facility	
	Mental Health Center	
	Migrant Health Center	
	Pharmacy	
	Private Practice (Medical and/or Dental)	
	Professional Association	
	Public Health Department	
	Rural Health Clinic	
	School District	
	Social Services Organization	
	Tribal Entity	
	University/College/Community College/Technical College	
	Other – Specify Type:	

SECTION 5: QUALITY IMPROVEMENT IMPLEMENTATION STRATEGIES

(applicable to all Quality grantees)

Table Instructions:

Please report, using the selection list, all types of intervention approaches to quality improvement utilized for implementation of your organization's FORHP grant-funded quality improvement project.

Note: For organizations participating as part of an integrated health system, network and/or consortium for implementation their grant-funded project completing this section:

- Please complete responses, as data/information is available to do so.
- If data/information is not available, please utilize the form comment box for provision of any additional necessary information needed for interpreting values reported in this section.

- For reporting responses related to the Medical Home question under the "organizational positioning" portion of the table, please indicate "not applicable" or "N/A" and provide additional information pertaining to project partner site medical home model participation and accreditation separately outside of the table as part of this form comment box.

Definitions Section 5: Quality Improvement Implementation Strategies

Computerized Provider Order Entry (CPOE): CPOE is the process of a medical professional entering orders for medications, diagnostic studies, imaging studies, therapeutic services, nutrition and food services, nursing services, and other orderables to be supplied into an computer system application. For the purposes of this reporting, CPOE systems instituted as either a module or component of an integrated information system or electronic health record (EHR), or as a standalone system that is interfaced or integrated through a clinical data repository in addition to physician offices or clinic are included. Modules may also not necessarily be called CPOE by name, but have a similar functionality embedded in their EHR.

Electronic Entry of Prescriptions/E-Prescribing: Electronic entry of prescriptions, or e-prescribing**,** is a technology framework that allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacies electronically instead of using handwritten, faxed notes or calling in prescriptions. For the purposes of this reporting, this measure includes both standalone e-prescribing systems as well as e-prescribing systems that are part of an EHR system.

Electronic Medical Records (EMR): An electronic medical record is a digital version of a paper chart that contains all the standard medical and clinical data gathered in one provider's office.

Health Information Exchange (HIE): Electronic health information exchange allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care. Definition is inclusive of all three current key forms of HIE including:

- ***Directed Exchange*:** ability to send and receive secure information electronically between care providers to support coordinated care
- ***Query-Based Exchange:*** ability for providers to find and/or request information on a patient from other providers, often used for unplanned care
- ***Consumer Mediated Exchange:*** ability for patients to aggregate and control the use of their health information among providers

Population Health Management Tools: Population health management tools help providers aggregate and analyze data to create a comprehensive, actionable clinical picture of each patient. Using the information generated by these tools, providers can track and improve clinical outcomes — and lower health care costs.

Patient/Disease Registry: defines a disease/immunization registry as "a tool for tracking the clinical care and outcomes of a defined patient population" as defined by The Agency for Healthcare Research and Quality (AHRQ). Disease/immunization registries are often used to support patients with chronic diseases, such as diabetes, coronary artery disease, or asthma.

Patient Portal: A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view health information.

Telehealth / Telemedicine: Telehealth / telemedicine is the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related

education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Mobile Technology (mHealth): mHealth (mobile health) is a general term for the use of mobile phones and other wireless technology in medical care. The most common application of mHealth is the use of mobile phones and communication devices to educate consumers about preventive health care services.

Remote Patient Monitoring (RPM): Remote patient monitoring uses digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

Certified Electronic Health Record System (CEHR): Certification of health IT assures purchasers and other users that an electronic health record system, or other relevant technology, offers the technological capability, functionality, and security to help them meet the meaningful use criteria established for a given phase.

Electronic Clinical Quality Measures (eCQM): eCQMs use data from electronic health records and/or health information technology systems to measure health care quality. The Centers for Medicare & Medicaid use eCQMs in a variety of quality reporting and incentive programs.

Referral Management / Tracking System Strategies: A comprehensive institutional framework, agreements, system, processes and/or strategies that connects various health care facilities and professionals with well-defined processes for effective coordination follow-up and of patient care health care service delivery.

Health Literacy / Cultural Competency: Health Literacy refers to the degree of which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions. Cultural Competency refers to the provision of culturally and linguistically appropriate services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients. For the purposes of this reporting, cultural competency and health literacy have been combined with the intention to that health literacy/cultural competency refers to practices that address cross-cultural communications skills, delivery of culturally and linguistically appropriate healthcare services to diverse populations, and/or development programs and policies to improve health outcomes and reduce health disparities.

Integrated Care Delivery System: For the purposes of this reporting, integrated care delivery systems refers to agreements with specialists, hospitals, community organizations, etc. to coordinate care of patients. This definition is inclusive of integration across different levels of service, multiple care sites and/or across policy-making and management that bring together decisions about different parts of the health services, at different levels.

Individualized Patient Care Plans: A document developed with a purpose to maximize improvement of individual patient health outcomes following an initial patient assessment which identifies patient-specific care goals and objectives relative to the individual patient's specific diagnoses, intervention, medication, referral and care needs. The plan typically also includes an operative timeframe for accomplishment and evaluation and formulated with input from the patient and the patient's family.

Patient Self-Management Support: Self-management support is particularly important for patients dealing with chronic disease and those with emerging modifiable risks, Understanding an individual's readiness to change, or his or her activation level, can help care managers employ motivational interviewing to set goals, track progress toward these goals, and foster individual's self-management for their medical conditions.

Multidisciplinary Care Management Team(s): For the purposes of this reporting, a multidisciplinary care team is defined as a partnership among health care professionals of different disciplines, which can be inclusive of those inside as well as outside of the health sector and community, with the goal of providing quality continuous, comprehensive and efficient health care services.

Merit-based Incentive Payment System (MIPS): The Merit-based Incentive Payment System a Centers for Medicare and Medicaid (CMS) quality reporting program that is one of two tracks under the Quality Payment Program, which moves Medicare Part B providers to a performance-based payment system. MIPS streamlines three historical Medicare programs — the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM) Program and the Medicare Electronic Health Record (EHR) Incentive Program (Meaningful Use) — into a single payment program.

Alternative Payment Model (APM): An alternative payment model is a payment approach that rewards providers for delivering high-quality and cost-efficient care. Advanced APMs are a subset of APMs that let practices earn more rewards in exchange for taking on risk related to patient outcomes.

Lean Model: This model defines value by what a customer (i.e., patient) wants. It maps how the value flows to the customer (i.e., patient), and ensures the competency of the process by making it cost effective and time efficient.

Six Sigma: Six Sigma is a measurement-based strategy for process improvement and problem reduction. It is completed through the application of the QI project and accomplished with the use of two Six Sigma models: 1) DMAIC (define, measure, analyze, improve, control), which is designed to examine existing processes, and 2) DMADV (define, measure, analyze, design, verify) which is used to develop new processes.

Lean Six Sigma: Combined practice of Six Sigma and Lean models

Plan Do Study Act (PDSA): The Plan-Do-Study-Act cycle is a methodology utilized for testing a change as part of the Institute for Healthcare Improvement Model for Improvement. The cycle involves assessment of change specifically through the scientific method, used for action-oriented learning by planning, implementing, observing results, and acting on what is learned.

Model for Improvement: This model focuses on three questions to set the aim or organizational goal, establish measures, and select changes. It incorporates Plan-Do-Study-Act (PDSA) cycles to test changes on a small scale.

Chronic Care Model: There are six fundamental aspects of care identified in the Care Model, which creates a system that promotes high-quality disease and prevention management. It does this by supporting productive interactions between patients, who take an active part in their care, and providers, who have the necessary resources and expertise.

FADE Model: There are four broad steps to the FADE QI model which include 1. ***Focus*** define process to be improved; 2.***Analyze*** collect and analyze data; 3. ***Develop*** develop action plans for improvement and; 4. ***Execute & Evaluate*** implement the action plans and evaluate measure and monitor the system to ensure success.

Accountable Care Organization (ACO): A group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to Medicare patients.

Advanced Payment ACO Model: The Advance Payment Model was designed for physician-based and rural providers who have come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Through the Advance Payment ACO Model, selected participants received upfront and monthly payments, which they could use to make important investments in their care coordination infrastructure.

***Pioneer ACO Model*:** The Pioneer ACO Model was designed for health care organizations and providers that were already experienced in coordinating care for patients across care settings. It allowed these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program. And it was designed to work in coordination with private payers by aligning provider incentives, which improved quality and health outcomes for patients across the ACO, and achieved cost savings for Medicare, employers and patients.

***Next Generation ACO Model*:** The Next Generation ACO Model offers a new opportunity in accountable care—one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.

Medicare Shared Savings Program: According to the Centers for Medicare & Medicaid Services (CMS), the Medicare Shared Savings Program (MSSP) aims to encourage coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.

ACO Investment Model: The ACO Investment Model is an initiative designed for organizations participating as accountable care organizations (ACOs) in the Medicare Shared Savings Program (Shared Savings Program). The ACO Investment Model is a model of pre-paid shared savings that builds on the experience with the Advance Payment Model. This model will test the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk.

Medical Home: Comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes. To become a medical home an organization generally gains a level of certification from an accrediting body.

National Committee for Quality Assurance (NCQA): The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

Accreditation Association for Ambulatory Health Care (AAAHC): The Accreditation Association for Ambulatory Health Care (AAAHC) is a private, non-profit organization formed in 1979 and serves as a leader in developing standards to advance and promote patient safety, quality care, and value for ambulatory health care through peer-based accreditation processes, education, and research. A certificate of accreditation is awarded to organizations that are found to be in compliance with AAAHC Standards.

The Joint Commission: An independent, not-for-profit organization, The Joint Commission accredits and certifies nearly 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

10 Approaches to Quality Improvement

Please select from the lists below all responses which best reflect the quality improvement approaches utilized as part of your grant funded quality improvement project implementation.

Health Technology *(Please check all that apply)*	**Selection list**
Computerized Provider Order Entry (CPOE)	
Electronic Entry of Prescriptions/E-Prescribing	
Electronic Medical Records/Electronic Health Records	
Health Information Exchange (HIE)	
Population Health Management Tools	
Patient/Disease Registry	

Patient Portal	
Telehealth/Telemedicine	
Mobile Technology (mHealth)	
Remote Patient Monitoring	
Certified Electronic Health Record System (CEHR)	
Electronic Clinical Quality Measures (eCQM)	
Patient Care / Service Delivery *(Please check all that apply)*	**Selection list**
Referral Management / Tracking System Strategies	
Health Literacy / Cultural Competency	
Individualized Patient Care Plans	
Integrated Care Delivery System (agreements with specialists, hospitals, community organizations, etc. to coordinate care)	
Patient Self-Management Support	
Multidisciplinary Care Management Team(s)	
Provider Performance *(Please check all that apply)*	**Selection list**
Merit-based Incentive Payment System (MIPS) Participation	
Alternative Payment Model (APM) Participation	
Provision of Targeted Quality Improvement Training / Education *(includes training for providers and mid-level practitioners)*	
Quality Improvement Methodology *(Please check all that apply)*	**Selection list**
Lean Model	
Six Sigma	
Lean Six Sigma	
Model for Improvement *(with PDSA)*	
Chronic Care Model	
FADE Model	
Other – please specify	
Organizational Positioning *(Please check all that apply)*	**Selection list**
Advanced Payment ACO Model	
Pioneer ACO Model	
Next Generation ACO Model	
Medicare Shared Savings Program *(includes ACO Investment Model)*	
Other – please specify	

Participation in a Medical Home or Patient Centered Medical Home (PCMH) initiative? *(if yes, form will require completion of item 12a)*	**Yes/No or N/A (Selection List)**

10a	If applicable, please indicate the selection below which best represents your organization's current medical home certification and highest level of medical home accreditation achieved, as appropriate. *(For organizations participating in a Medical Home, or Patient Centered Medical Home (PCMH) initiative, **only.**)*	
	National Committee for Quality Assurance (NCQA) *If applicable, please indicate the selection below which best represents your organization's current highest level of accreditation achieved.*	**Yes/No or N/A (Selection List)**
	Level 1	
	Level 2	
	Level 3	
	Accreditation Association for Ambulatory Health Care (AAAHC)	**Yes/No or N/A (Selection List)**
	The Joint Commission	**Yes/No or N/A (Selection List)**
	State/Medicaid Program	**Yes/No or N/A (Selection List)**
	Other – specify	**Yes/No or N/A (Selection List)**

10b	**Agency for Healthcare Research and Quality (AHRQ)**	
	Please select, from the list below, all responses which best reflect the utilization of any AHRQ resources, tools, guidelines, measures, etc. as part of your grant funded quality improvement project implementation, as applicable.	**Yes/No or N/A (Selection List)**
	Agency for Healthcare Research and Quality (AHRQ) Clinical Guideline(s) and/or Recommendation(s)	
	Agency for Healthcare Research and Quality (AHRQ) Toolkit(s)	
	Agency for Healthcare Research and Quality (AHRQ) Evidence-Based Model(s)	
	Agency for Healthcare Research and Quality (AHRQ) Measure(s)/Indicator(s)	
	Agency for Healthcare Research and Quality (AHRQ) Other Resource(s)	

SECTION 6: UTILIZATION *(optional)*

Table Instructions: Please complete the following table based on your project's hospital utilization tracking for your grant funded quality improvement project's specified intervention population, if applicable.

Definitions Section 6: Utilization

Emergency Department Utilization (ED) Calculation

Numerator / Denominator = Emergency Department Utilization (ED)

Numerator **=** Total number of patient ED admissions
Numerator Inclusion Criteria

- Patients are counted as patients within your *grant project's specified intervention patient population* ***only***.
- ED admissions are to be counted with respect to your *grant project's specified intervention focus* ***only*** (this is not intended to be all-cause admissions).
- ED admission are counted as ED admissions that occurred within the current grant budget reporting period timespan
- Multiple ED admissions for the same patient *is* included in this value. Ex. Ms. Doe was admitted to the ED and then re-admitted two months later, both within the budget period timeframe. Ms. Doe's admissions would be counted as a total of two (2) for this numerator.

Denominator **=** Total number of unique individuals from your project's intervention patient population who received direct services during this budget period.
Denominator Inclusion Criteria

- Value reported should be consistent with the same numerical value reported for the numerator reported for measure 1.
- The total number reported includes the total number of unique individual patients only. No patient should be counted more than once.
- Patients are counted as patients within your grant project's specified intervention patient population

30-Day Hospital Re-Admission Calculation

Numerator / Denominator = 30-Day Hospital Re-Admission

Numerator **=** Total number of patient 30-Day ED re-admissions
Numerator Inclusion Criteria

- 30-day re-admission of patients include patients within your *grant project's specified intervention patient population* ***only***.
- 30-day ED admissions are to be counted with respect to your *grant project's specified intervention focus* ***only*** (this is not intended to be all-cause re-admissions).
- 30-day re-admissions that occurred within the current grant budget reporting period timespan.
- Duplicate 30-day re-admission for the same patient *is* included in this value. Ex. Ms. Doe was admitted to the ED within 30 days on two different accounts within the budget period timeframe. Ms. Doe's 30-day re-admissions would be counted as a total of two (2) for this numerator.

Denominator **=** Total number of patient ED admissions
Denominator Inclusion Criteria

- Patients are counted as patients within your grant project's *specified intervention patient population*
- ED admissions are to be counted with respect to your *grant project's specified intervention focus* ***only*** (this is not intended to be all-cause admissions).
- ED admission are counted as ED admissions that occurred within the current grant budget reporting period timespan.

- Multiple re-admissions for the same patient is included in this value. Ex. Ms. Doe was admitted to the ED and then re-admitted two months later, both within the budget period timeframe. Ms. Doe's admissions would be counted as a total of two (2).
- Value reported should be consistent with same value reported for the numerator used for the calculation of the Emergency Department Admission Rate.

11	**Hospital Utilization**	**Numerator**	**Denominator**	**Calculation (%)**
	Emergency department (ED) rate			
	30-day hospital readmission rate			

SECTION 7: TELEHEALTH *(applicable to grantees utilizing telehealth services)*

Table Instructions: Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. If your Quality grant program utilizes telehealth please fill out the following table.

In the table, enter the names of each consultant site (hub site) in column 1 and each originating site (patient data site) in column 2. For many programs, the telehealth provider site will be serving all your remote sites. We ask that you still list the telehealth provider (hub) site in column 1.

Estimate the distance between the two (in miles) and enter this number into column 3. This information can be obtained by using Google maps (https://www.google.com/maps) or other mapping resources.

Enter the number of patient care sessions between the two locations in column 5. For group sessions/clinics, each patient should be counted separately, as each would have had to travel for these sessions. For simplicity reasons (and to avoid collecting information from each patient) the distance a patient travels from their home to the remote site is intentionally omitted. Home patients should be excluded from this entire reporting sheet. Patients being stabilized prior to transport should be excluded as well, as their travel is not averted, only delayed.

Columns 4 and 6 will fill in automatically. You do not need to enter anything into these cells.

Definitions:
Consultant Site/Hub Site: Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

Originating Site/Patient Data Site: Site at which the patient is located or where patient data is collected at the time the service is provided via telecommunications system.

Patient-Care Sessions: Include therapy and counseling (including nutritional, group, etc.) but NOT didactic education, community meetings or administrative sessions.

Question 12					
1	2	3	4	5	6
Consultant Site	**Patient/Patient-data Site**	**Distance Between (miles)**	**Miles Roundtrip** ('column 3' X 2)	**# Patient Care Sessions**	**Miles Saved** ('column 4' X 'column 5')
			0		0
			0		0
			0		0
			0		0
			0		0
		Total:	0	0	0

SECTION 8: CLINICAL MEASURES *(applicable to all Quality grantees)*

Table Instructions:
Please use your electronic patient registry system to extract the clinical data requested for patients served through the grant program.

- Please refer to the specific definitions for each field below and consult each measure's weblink provided for additional measure guidance and instructions.
- Please indicate a numerical figure or N/A for not applicable for your specific grant activities.
- All responses reported should be reflective of grant project target intervention patient population values only.

Note: For organizations participating as part of an integrated health system, network and/or consortium for implementation their grant-funded project completing this section:

- Please complete responses, as data/information is available to do so.
- If data/information is not available, please utilize the form comment box for provision of any additional necessary information needed for interpreting values reported in this section.

Definitions Section 7: Clinical Measures

Measure 1: Cardiovascular Disease

(CMS347v1) Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period:

- Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR
- Adults aged >= 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR
- Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL

Numerator: Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period

Denominator: All patients who meet one or more of the following criteria (considered at high risk for cardiovascular events, under ACC/AHA guidelines):

1) Patients aged >= 21 years at the beginning of the measurement period with clinical ASCVD diagnosis

2) Patients aged >= 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia

3) Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period

Measure 2: Comprehensive Diabetes Care (HbA1C)

NQF 0059 (CMS122v5): Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

Numerator: Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%

Denominator: Patients 18-75 years of age with diabetes with a visit during the measurement period.

Measure 3: Body Mass Index (BMI) Screening and Follow-Up

NQF 0421 (CMS69v5): Percentage of patients aged 18 years and older with a documented 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. (Normal Parameters: Age 65 years and older BMI > or = 23 and < 30; Age 18 – 64 years BMI > or = 18.5 and < 25)

Numerator: Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters.

Denominator: All patients aged 18 years and older

Measure 4: Blood Pressure

NQF 0018 (CMS165v5): The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Numerator: Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

Denominator: Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period

Measure 5: Tobacco Use

NQF 0028 (CMS138v5): Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user

Numerator: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.
*Includes use of any type of tobacco
** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy

Denominator: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.

Measure 6: Depression
NQF 0418 (CMS2v6): Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

Numerator: Patients screened for 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.

Denominator: All patients aged 12 years and older.

Clinical Measures				
Measure Number	**Clinical Measure**	**Numerator (Number)**	**Denominator (Number)**	**Percent** *(Automatically calculated by system)*
Measure 1: Cardiovascular Disease	(CMS347v1) *Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*: Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period.			
Measure 2: Diabetes (HbA1C)	NQF 0059 (CMS122v5): *Comprehensive Diabetes Care:* Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.			
Measure 3: Body Mass Index (Screening and Follow-Up)	NQF 0421 (CMS69v5): *Body Mass Index (BMI) Screening and Follow-Up*: Percentage of patients aged 18 years and older with a documented 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. (Normal Parameters: Age 65 years and older BMI > or = 23 and < 30; Age 18 – 64 years BMI > or = 18.5 and < 25).			
Measure 4: Blood Pressure	NQF 0018 (CMS165v5): *Controlling High Blood Pressure:* The number of patients 18 to 85 years of age who has a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year.			
Measure 5: Tobacco Use	NQF 0028 (CMS138v5): *Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention:* Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.			
Measure 6: Depression	NQF 0418 (CMS2v6): *Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan:* Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow up plan documented**.**			

SECTION 9: OPTIONAL CLINICAL MEASURES *(optional)*

Table Instructions:
Please use your electronic patient registry system to extract the clinical data requested for patients served through the grant program.

- Please refer to the specific definitions for each field below and consult each measure's weblink provided for additional measure guidance and instructions.
- Please indicate a numerical figure or N/A for not applicable for your specific grant activities.
- All responses reported should be reflective of grant project target intervention patient population values only.

Note: For organizations participating as part of an integrated health system, network and/or consortium for implementation their grant-funded project completing this section:

- Please complete responses, as data/information is available to do so.
- If data/information is not available, please utilize the form comment box for provision of any additional necessary information needed for interpreting values reported in this section.
- For reporting responses related to the Medical Home question under the "organizational positioning" portion of the table, please indicate "not applicable" or "N/A" and provide additional information pertaining to project partner site medical home model participation and accreditation separately outside of the table as part of this form comment box.

Definitions Section 8: Optional Clinical Measures

Optional Measure 1: Weight Assessment and Counseling for Children/Adolescents
NQF 0024 (CMS155v6): Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year:

- Body mass index (BMI) percentile documentation
- Counseling for nutrition
- Counseling for physical activity

Numerator: Body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Denominator: Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN.

Optional Measure 2: Alcohol and Drug Dependence Treatment
NQF 0004 (CMS137v6): Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported:
1) Percentage of patients who initiated treatment within 14 days of the diagnosis.

2) Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Numerator 1: Patients who initiated treatment within 14 days of the diagnosis

Numerator 2: Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit

Denominator: Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period

Optional Measure 3: 30-Day Hospital Readmission
NQF1789: Hospital-Wide All-Cause Unplanned Readmission Measure (HWR): Hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older.

Numerator: Unplanned all-cause 30-day readmission (readmission defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission). All readmissions are counted except those that are considered planned.

Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older.

Optional Measure 4: Medication Reconciliation
NQF 0097 Medication Reconciliation Post Discharge: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.

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

Denominator: All patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care.

Optional Measure 5: Chronic Obstructive Pulmonary Disease (COPD)
NQF 0102 Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy
Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC < 70% and have symptoms who were prescribed a long acting inhaled bronchodilator.

Numerator: Patients who were prescribed an inhaled bronchodilator

Denominator: All patients aged 18 years and older with a diagnosis of COPD, who have an FEV1/FVC <70% and have symptoms (e.g. dyspnea, cough/sputum, wheezing)

Optional Measure 6: Care Coordination (Medication Documentation)
NQF 0419 (CMS68v7): Documentation of Current Medications in the Medical Record Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

Numerator: Eligible professional attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration.

Denominator: All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period.

Optional Clinical Measures				
Measure Number	**Clinical Measures**	**Numerator (Number)**	**Denominator (Number)**	**Percent** *(Automatically calculated by system)*
Optional Measure 1: Weight Assessment & Counseling for Children/ Adolescents	NQF 0024 (CMS155v6): : *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:* Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: - Body mass index (BMI) percentile documentation - Counseling for nutrition - Counseling for physical activity			
Optional Measure 2: Alcohol & Drug Dependence Treatment	NQF0004 (CMS137v6): *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*: Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported: 1) Percentage of patients who initiated treatment within 14 days of the diagnosis. 2) Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.			
Optional Measure 3: 30-Day Hospital Readmission	NQF1789: *Hospital-Wide All-Cause Unplanned Readmission Measure (HWR):* Hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older.			
Optional Measure 4: Medication Reconciliation	NQF 0097 *Medication Reconciliation Post Discharge:* Percentage of patients aged 65 years and older discharged from			

(Post Discharge)	any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.			
Optional Measure 5: Chronic Obstructive Pulmonary Disorder (COPD)	NQF 0102 *Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy*: Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC < 70% and have symptoms who were prescribed a long acting inhaled bronchodilator.			
Measure 6: Care Coordination (Medication Documentation)	NQF 0419 (CMS68v7): Documentation of Current Medications in the Medical Record Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.			