OMB Number: 0906-0024
Expiration Date: XX/XX/202X

Public Burden Statement: The purpose of this collection is to collect data from grantees that have been awarded funds for the Rural Health Care Coordination program through the Health Resources and Services Administration. The following measures will ask information about ongoing program activities on an annual basis. Information collected will be utilized by the Federal Office of Rural Health Policy to monitor and assess the impact of this program. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0906-0024 and it is valid until XX/XX/202X. This information collection is required to obtain or retain a benefit (Government Performance and Results Act of 1993, P.L 113-62, Section 1116). Data will be private to the extent permitted by the law. Public reporting burden for this collection of information is estimated to average 48.67 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Information Collection Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857 or paperwork@hrsa.gov. Please see https://www.hrsa.gov/about/508-resources for the HRSA digital accessibility statement.

Federal Office of Rural Health Policy
Community-Based Division
Rural Health Care Coordination Program
Performance Improvement and Measurement Systems (PIMS) Database

Measures Overview

This section provides an overview of all performance measures.

SECTION 1: ACCESS TO CARE (Applicable to all grantees)

1. Number of counties served during budget period
2. Identify counties served during budget period
3. Number of unique individuals served during this budget period
4. Total number of unique individuals in your target population during this budget period
5. Type of direct service encounters provided

SECTION 2: POPULATION DEMOGRAPHICS **AND SOCIAL DETERMINANTS OF HEALTH** (Applicable to all grantees)

6. Number of individuals served by RACE and/or ETHNICITY
7. Number of individuals served, by AGE GROUP
8. Number of individuals by INSURANCE STATUS
9. Ability to access healthy foods
10. Housing Conditions
11. Ability to pay bills and utilities
12. Transportation

SECTION 3: CARE COORDINATION AND NETWORK INFRASTRUCTURE (Applicable to all grantees)

13. Participant Follow-Up Rate (%)
14. Number of participants screened and referred to social determinants of health-related services and/or support
15. Number of people receiving services from a care coordinator
16. Number of participants enrolled in a case management program
17. Number of case-managed participants who received a primary care visit during budget period
18. Number of participants who have a self-management plan
19. Participant No-Show Rate (%)
20. Case management/care coordination contacts: referrals to non- medical
21. Network Infrastructure
22. Network Strength: Sustainability Indicators

SECTION 4: SUSTAINABILITY (Applicable to all grantees)

23. Revenue and Resources
24. Type of Financing Mechanism Utilized
25. Year 4 Sustainability Measures

SECTION 5: LEADERSHIP AND WORKFORCE (Applicable to all grantees)

26. Number of positions funded by grant dollars during this budget period
27. Did you provide health professional education/training to staff funded by this program?
28. Staffing/Workforce Composition

SECTION 6: ELECTRONIC HEALTH RECORD (Optional)

29. Does your consortium have an EHR installed and in use? (Please select one answer)
30. Summary of Care Record

SECTION 7: TELEHEALTH (Applicable to all grantees)

31. Did your organization use telehealth to provide remote clinical/non-clinical care services?
32. Number of unique participant care sessions by telehealth.

SECTION 8: UTILIZATION (Applicable to all grantees)

33. NQF3575: Total per Capita Cost
34. Emergency department (ED) utilization rate
35. NQF1789: 30-Day Hospital Readmission
36. Revenue per encounter or visit
37. Total Revenue (budget period)

SECTION 9: CLINICAL MEASURES/IMPROVED OUTCOMES (Complete Measures 2-10 as Applicable)

38. Measure 1: Care Coordination (Required)
39. Measure 2: Cardiovascular Disease

40. Measure 3: Body Mass Index (Screening and Follow-Up)
41. Measure 4: Blood Pressure
42. Measure 5: Tobacco Use
43. Measure 6: Cancer
44. Measure 7: Alcohol and Other Drug Dependence
45. Measure 8: Chronic lower respiratory disease
46. Measure 9: Timely Follow-Up After Acute Exacerbations of Chronic Conditions
47. Measure 10: Pregnancy Continuum of Care

SECTION 1: Access to Care (Applicable to all award recipients)

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 in this section are applicable to all awardees.

Definitions:

- **First Year – Fourth Year:** Data that is collected after the end of the respective budget period.
- **Direct Services:** A documented interaction between a patient/participant/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) counseling and education.
- **Indirect Services:** For the purposes of this data collection activity, indirect services will be limited to billboards, flyers, health fairs, mailings/newsletters, and other mass media (radio, television, newspaper, and social media). For radio, television and newspaper please report estimated total circulation. For social media, please report the reach (number of followers).
- **Unique individuals:** Unduplicated count of patients/participants served.

Access to Care	**Year 1**	**Year 2**	**Year 3**	**Year 4**
1. **Number of counties served during budget period** Note: This should be consistent with the figures reported in your grant application and should reflect your project's service area.				
2. **Identify counties served during budget period** Please list the names of the counties served through grant funded services and/or activities completed during the reporting period				
3. **Number of unique individuals served during this budget period** Please report the number of unique (i.e., unduplicated count) individuals served for all grant funded activities, including direct and indirect services/activities, during the reporting period.				
4. **Total number of unique individuals in your target population during this budget period.** Note: this is the unduplicated count of participants/clients from your target population				
5. **Type of direct service encounters provided (Select all that apply)**				
Cardiovascular disease prevention Cardiovascular disease treatment and management Cancer screening and prevention				

	Cancer treatment and management					
	Chronic Lower Respiratory Disease screening and prevention					
	Chronic Lower Respiratory Disease treatment and management					
	Emergency medical services					
	OB/GYN services					
	Prenatal Services					
	Postpartum services					
	All other Pregnancy Continuum of Care Services					
	Health education					
	STI/HIV screening and prevention					
	STI/HIV treatment and management					
	Mental/behavioral health treatment and/or education					
	Nutrition					
	Obesity prevention					
	Obesity treatment and management					
	All other chronic disease prevention					
	All other chronic disease treatment and management					
	All other health promotion/disease prevention					
	Primary care					
	Substance abuse treatment and/or education					
	Telehealth/telemedicine					
	Social Determinant of Health Screening *and* Referral					
	Workforce recruitment and/or retention					
	Health literacy education and/or services					
	All other services – *please specify in form comment box*					

SECTION 2: Population Demographics and Social Determinants of Health ***(Applicable to all award recipients)***

Table Instructions: This table collects information about an aggregate count of the people served by race, ethnicity, age, and insurance status. The total for *each* of the following questions **should equal the total of the number of unique individuals served** reported in the previous section. This number represents the total number of people served by all the activities outlined in your work plan and includes all direct clinical (if applicable) and non-clinical people served by the program. Please do ***not*** leave any sections blank. There should not be a N/A (not applicable) response since the measures are applicable to all awardees. 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).

		Year 1	Year 2	Year 3	Year 4
6. Number of individuals served by RACE and /or ETHNICITY:					
	American Indian or Alaska Native				
	Asian				
	Black or African American				
	Hispanic or Latino				
	Middle Eastern or North African				
	Native Hawaiian or Pacific Islander				
	White				
Total (equal to the total of the number of unique individuals served)		*(Automatically calculated by system)*	*(Automatically calculated by system)*	*(Automatically calculated by system)*	*(Automatically calculated by system)*
7. Number of individuals served, by AGE GROUP:					
	Children (0-12)				
	Adolescents (13-17)				
	Adults (18-64)				
	Elderly (65 and over)				
	Unknown				
	Total (equal to the total of the number of unique individuals served)	*(Automatically calculated by system)*	*(Automatically calculated by system)*	*(Automatically calculated by system)*	*(Automatically calculated by system)*

	Year 1- Year 4			
8. Number of individuals by INSURANCE STATUS:	Count	Payer Mix (*See Appendix A for definition)*		
		Numerator (Count)	Denominator (Total insured and uninsured)	Percent *(Automatically calculated by system*
Uninsured/Self- Pay				
Total Uninsured				
Number enrolled during the budget period *(From total uninsured participants)*				
Private Health Plans				
CMS Marketplace				
Dual Eligible (covered by both Medicaid and Medicare)				
Medicaid/CHIP only				
Medicare only				
Medicare plus supplemental				
Other third party				
Total insured	*(Automatically calculated by system)*			
Unknown				
Table Total *(equal to the total of the number of unique individuals served)*	*(Automatically calculated by system)*			

Table: Social Determinants of Health
Table Instructions: This table collects information about an aggregate count of the people served by four categories of social determinants of health. The total number of participants in this section should equal the total number of participants screened and referred to social determinant of health support (see Section 3). Please do ***not*** leave any sections blank. There should not be a N/A (not applicable) response since the measures are applicable to all awardees. If the number for a particular category is zero (0), please put zero in the appropriate section (e.g., if the total number of participants receiving food assistance is zero (0), enter zero in that section).

	Year 1	Year 2	Year 3	Year 4

9. Ability to access healthy food								
Number of participants receiving food assistance (i.e., SNAP/Food Stamps/WIC, etc.)								
Number of participants served residing in food deserts								
10. Housing conditions – safe & free of environmental hazards								
Number of participants served by housing stability (See Appendix A for definitions)	Homeless		Homeless		Homeless		Homeless	
	Housing Unstable		Housing Unstable		Housing Unstable		Housing Unstable	
	Unknown		Unknown		Unknown		Unknown	
11. Ability to pay for utilities and basic bills								
Number of participants receiving governmental assistance with utility (including internet, and mobile phones) bills								
12. Transportation								
Number of participants provided with transportation by type (e.g., car, bus tickets, rideshare, taxi, etc.)								

SECTION 3: Care Coordination and Network Infrastructure ***(Applicable to all award recipients)***

Table: Care Coordination

Table Instructions: Please select the care coordination activities realized by network/consortium members because of being in the network/consortium.

Measure	**Year 1- Year 4**		
	Numerator	Denominator	Percent *(Automatically*

	(Number)	(Number)	*calculated by system)*	
13. **Participant Follow-Up Rate (%)** = (Number of Follow-Ups / Total Participants) *100				
14. **Participant No-Show Rate (%)** = (Number of no-shows per facility/total patients/participants x 100				
Measure	**Year 1**	**Year 2**	**Year 3**	**Year 4**
15. **Number of participants screened *and* referred to social determinants of health-related services and/or support**				
16. **Number of participants receiving services from a care coordinator**				
17. **Number of participants enrolled in a case management program**				
18. **Number of case-managed participants who received a primary care visit during budget period**				
19. **Number of participants who have a self-management plan**				
20. **Case**	Yes/No	Yes/No	Yes/No	Yes/No

	management/care coordination contacts: referrals to non- medical *(Please Specify)*				

21. Table: Network Infrastructure

Table Instructions: Please provide information about the network/consortium members and operations. Network members are defined as members who have signed a Memorandum of Understanding or Memorandum of Agreement or have a letter of commitment to participate in the network. Network members do not include other partner organizations who are playing a role in the grant but who are not member. If the organization type is not applicable, please insert 0. DO NOT leave any space blank under the current budget year for your grant.

Identify the types and number of organizations in the consortium/network for your project:

Type of Member Organizations in the Consortium/Network	**Year 1**		**Year 2**		**Year 3**		**Year 4**	
	(Number)	**Check all that apply**	**(Number)**	**Check all that apply**	**(Number)**	**Check all that apply**	**(Number)**	**Check all that apply**
Health Education								
Behavioral/Mental Health Organization								
Community Health Center								
Critical Access Hospital								
Faith-based organization								
Foundation/ Philanthropy								
Free Clinic								
Health Department								
Home Health Agency								
Hospice								
Hospital								
Migrant Health Center								
Non-profit								
For-profit								
Private Practice Primary Care								
Private Practice Specialty Care								

Rural Emergency Hospital								
CMS- Certified Rural Health Clinic								
School District								
Social Services Organization								
University/College								
Other – (Please Specify):								
Total	*(Automatically calculated by system)*		*(Automatically calculated by system)*		*(Automatically calculated by system)*		*(Automatically calculated by system)*	
Are all consortium/network partners contributing to direct service encounter data? *If no, please indicate the contributing partner sites in the question below.* Please indicate whether all funded partner sites are contributing to the direct service encounter values included for the purposes of this reporting. (Yes/No)								
Number of consortium/network partners contributing direct service encounter data. Please provide the total number of funded network partner sites contributing to the direct service encounter values included for the purposes of this reporting.								

(Number/NA)				

22. Table: Network Strength

Table Instructions: Assess network's strength across 7 out of 8 characteristics of a sustained network (See RHI's Aim for Sustainability Portal or PIMS Guide for specific indicator definitions); Please select the following indicators of network strength experienced by the network/consortium as a result of this funding.

Sustainability Indicator (Complete if Applicable)				
	Year 1 (Yes/No/Unsure)	**Year 2** (Yes/No/Unsure)	**Year 3** (Yes/No/Unsure)	**Year 4** (Yes/No/Unsure)
Collaborative Leadership				
Member-Driven Decisions				
Effective Communication				
Change-Ready and Adaptable Workforce				
Continuous Improvement				
On-Going Evaluation and Measurement				
Sound Financial Infrastructure				

SECTION 4: Sustainability ***(Applicable to all award recipients)***

Table Instructions: Please fill out the following tables for project years 1-4. No baseline data needed. If applicable and data is available, include information pertaining to funding stream sources contributing to your organization's project, accrued during the budget period.

23. Revenue and Resources *(Yes/No/Unsure)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Membership due with a formal structure				
Service Reimbursement				
Resource sharing (Shared space, staff, etc.)				
Negotiating agreements with payers				

24. Type of Financing Mechanism Utilized (*Yes/No/Unsure)*	Year 1	Year 2	Year 3	Year 4
Per Member per Month (PMPM) fee structure				
Multi-Payer Payment for Shared Capacity				
Population-Based Payments				
Grant Funding				
Medicare Care Coordination Current Procedural Terminology (CPT) Codes				
Other *(Please specify)*				

25. Year 4 Sustainability Measures – To be collected during Year 4 reporting period only		
	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**
	Will the network/consortium sustain after this federal funding period? • Yes, the network and/or activities of the network are expected to operate after the period of performance. • No, the network is not expected to continue after the period of performance.	(Y/N)

***SECTION 5: Leadership and Workforce Composition* (Applicable to all award recipients)**

Table Instructions: The following tables collect information about an aggregate number of clinical and non- clinical positions funded by this award during this budget period. If you are not sure who is funded by this award, please refer to the staffing plan and budget narrative that was submitted with your grant application. Please report a numeric figure. **There should not be a N/A (not applicable) response since all measures are applicable to all awardees.**

	Year 1	Year 2	Year 3	Year 4
26. Number of positions funded by grant dollars during this budget period				
Total number of care coordination staff				
Total number FTE amount of all staff paid via grant (0.0 Format)				

	Year 1	Year 2	Year 3	Year 4
27. Did you provide health professional				

education/training to staff funded by this program? (Yes/No) Health professional education/training does not include continuing education units. If your response is "yes" for this measure, please complete the following measures, as applicable.				
28a. Please indicate the total number of unique (non-duplicated) care coordinators (clinical or non-clinical) trained				
28b. Please indicate the total number of health professional education/trainings provided during the reporting period.				

28. Staffing/Workforce Composition		**Year 1**	**Year 2**	**Year 3**	**Year 4**
29a.	Types and number of personnel providing care coordination (i.e., Community Health Workers (CHWs), Care Coordinators, Nurses, Physician Assistants (PA), Primary Care Physicians)				
29b.	Clinicians: participant panel size				
29c.	Support staff: c.1: number of participants assigned; c.2: total number served per year c.3.Number of care coordinators/community health workers/participant navigators trained to serve participants using evidence-based curricula				

SECTION 6: Electronic Health Record (Optional to grantees)

Table Instructions: *Electronic Health Record (EHR):* This table collects information about coordinating care across consortium partners may often involve navigating multiple Electronic Health Records (EHR) systems.

29. Does your consortium have an EHR installed and in use? (Please select one answer)	**Year 1**	**Year 2**	**Year 3**	**Year 4**
If yes, a. Yes, installed at all consortium members' sites and used by all providers b. Yes, but only installed at some members' sites and used by some providers If no, a. No, members will install the EHR system in 3 months b. No, members will install the EHR system in 6 months c. No, members will install the EHR system in 1 year or more d. No, members have not planned on installing the EHR system				
30. Summary of Care Record: Use of certified EHR technology (CEHRT) to create a summary of care record and electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals. (Yes/No/Not Sure)				

SECTION 7: Telehealth (Applicable to all award recipients)

Table Instructions: *Telehealth:* This table collects information about telehealth activities as part of the Care Coordination Program. This table is applicable to all grantees.

The term "telehealth" includes "telemedicine" services but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

31. Did your organization use	**Year 1**	**Year 2**	**Year 3**	**Year 4**

telehealth to provide remote clinical/non-clinical care services? (Yes/No)				
If yes, then answer the following:				
32. Number of unique participant care sessions by telehealth. Note: this is a unique count of participants that receive a telehealth consult facilitated by the organization and/or network/consortium during the budget period.				
If no, then answer the following question:				
If you did not have telehealth services, please comment why (select all that apply) a. Have not considered/unfamiliar with telehealth service options b. Policy barriers (Select all that apply) 1) Lack of or limited reimbursement Credentialing, licensing, or privileging 2) Privacy and security 3) Other (specify): c. Inadequate broadband/ telecommunication service (Select all that apply) 1) Cost of service 2) Lack of infrastructure 3) Other (specify): d. Lack of funding for telehealth equipment e. Lack of training for telehealth services f. Not needed g. Other - specify:				

SECTION 8: Utilization ***(Applicable to all award recipients)***

Table Instructions: *Utilization:* This table collects information about how healthcare services were accessed by participants across consortium partners and community resources.

Utilization is defined as the quantification or description of the use of services by persons for the purpose of preventing and curing health problems, promoting maintenance of health and well-being, or obtaining information about one's health status and prognosis.

	Year 1-Year 4		
Measure	Numerator (Number)	Denominator (Number)	Percent *(Automatically*

					calculated by system)
33. NQF3575: Total per Capita Cost					
34. Emergency department (ED) utilization rate					
35. NQF1789: 30-Day Hospital Readmission					
36. Revenue per encounter or visit					
Measure	**Y1**	**Y2**	**Y3**	**Y4**	**Total *(Automatically calculated by system)***
37. Total Revenue (budget period)					

SECTION 9: CLINICAL MEASURES/IMPROVED OUTCOMES

Table Instructions:
Please use your electronic participant registry and/or electronic health records system to extract the clinical data requested for participants through the program.

- Please refer to the specific definitions for each field below and consult each measure's weblink provided for additional measure guidance and instructions. See definitions in Appendix A.
- 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 participant population values only. **The denominator should equal the total of the number of unique individuals served in section one: access to care.**

Note: 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. Submit clinical measures for Years 1-4 of the project period.

Clinical Measures: *#39-48*	
	Year 1- Year 4

Measure Number	Clinical Measure	Numerator (Number)	Denominator (Number)	Percent *(Automatically calculated by system)*
Measure 1: Care Coordination (Required)	CMS50v10: Closing the referral loop: receipt of specialist report NQF 0419 (CMS68v9) : Documentation of Current Medications in the Medical Record Percentage of visits for participants 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. NQF 0097: Medication Reconciliation Post-Discharge: Percentage of participants 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			
Measure 2: Cardiovascular Disease	CMS347v6: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease: Percentage of the following participants - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period.			
Measure 3: Body Mass Index	NQF 0421 (CMS69v11): Body Mass Index (BMI) Screening and			

(Screening and Follow-Up)	Follow-Up: Percentage of participants 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(CMS165v11): Controlling High Blood Pressure: Percentage of participants 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.			
Measure 5: Tobacco Use	NQF 0028 (CMS138v11) Tobacco Use: Screening & Cessation Intervention: Percentage of participants aged 18 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user. Three rates are reported: a. Percentage of participants aged 18 years and older who were screened for tobacco use one or more times during the measurement period.			

	b. Percentage of participants aged 18 years and older who were identified as a tobacco user during the measurement period who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period. c. Percentage of participants aged 18 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user			

Measure 6: Cancer	NQF 0032 (CMS124v11): Cervical Cancer Screening NQF 0034: (CMS130v11) Colorectal Cancer Screening NQF 2372 (CMS125v11): Breast Cancer Screening NQF: 3510 Screening/Surveillance Colonoscopy			
Measure 7: Alcohol and Other Drug Dependence	CMS137v11: Percentage of participants 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 participants who initiated treatment within 14 days of the diagnosis. 2) Percentage of participants who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.			
Measure 8: Chronic lower respiratory disease	NQF0102:Chronic Obstructive Pulmonary Disease (COPD) NQF1800: Asthma Medication Ratio NQF3668: Follow-up After Emergency Department Visits for Asthma Total number of participants with one or more classifications of CLRD during the reporting			

Measure 9: Timely Follow-Up After Acute Exacerbations of Chronic Conditions	NQF3455: Timely Follow-Up After Acute Exacerbations of Chronic Conditions: The percentage of issuer-product-level acute events requiring either an emergency department (ED) visit or hospitalization for one of the following 6 chronic conditions: hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes mellitus (Type I or Type II), where follow-up was received within the timeframe recommended by clinical practice guidelines in a non-emergency outpatient setting.			
Measure 10: Pregnancy Continuum of Care	(NQF1517) Prenatal and Postpartum Care- Timeliness of Prenatal Care (PPC-CH): The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. ii. Percent of pregnant participants who receive case management contact in budget period. (CMS2v12):Preventive Care and Screening- Screening for Clinical Depression and Follow-Up Plan: Percentage of participants aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow up plan documented.			
Upload an attachment of at least 3 Project-Specific Measures	*[Awardees can provide project-specific measures, including:* • *Description of numerator* • *Description of denominator* • *Data Sources and Collection*			

Appendix A: Definitions

The following questions related to the Rural Health Care Coordination Program PIMS measures for 4 reporting years:

Sept 1, 2023-Aug 31, 2024 = **Year 1** PIMS Reporting Period: Sept 1-30, 2024
Sept 1, 2024-Aug 31, 2025 = **Year 2** PIMS Reporting Period: Sept 1-30, 2025
Sept 1, 2025-Aug 31, 2026 = **Year 3** PIMS Reporting Period: Sept 1-30, 2026
Sept 1, 2026- Aug 31, 2027= **Year 4** PIMS Reporting Period: Sept 1-30, 2027

Definitions: Section 2: POPULATION DEMOGRAPHICS AND SOCIAL DETERMINANTS OF HEALTH

Race and/or Ethnicity:

American Indian or Alaska Native:
Individuals with origins in any of the original peoples of North, Central, and South America, including, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, and Maya.

Asian:
Individuals with origins in any of the original peoples of Central or East Asia, Southeast Asia, or South Asia, including, for example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, and Japanese.

Black or African American:
Individuals with origins in any of the Black racial groups of Africa, including, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali.

Hispanic or Latino:
Includes individuals of Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, and other Central or South American or Spanish culture or origin.

Middle Eastern or North African:
Individuals with origins in any of the original peoples of the Middle East or North Africa, including, for example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, and Israeli.

Native Hawaiian or Pacific Islander:
Individuals with origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands,

including, for example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese.

White:
Individuals with origins in any of the original peoples of Europe, including, for example, English, German, Irish, Italian, Polish, and Scottish.

Social Determinants of Health[1]: the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH include:

- Safe and affordable housing
- Access to transportation
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Food Desert[2]: Low-income census tracts with a substantial number or share of residents with low levels of access to retail outlets selling healthy and affordable foods are defined as food deserts. A census tract is a small, relatively permanent subdivision of a county that usually contains between 1,000 and 8,000 people but generally averages around 4,000 people.

- ***Census tracts qualify as food deserts if they meet low-income and low-access thresholds:***
    - **Low-income:** a poverty rate of 20 percent or greater, or a median family income at or below 80 percent of the statewide or metropolitan area median family income;
    - **Low access:** at least 500 persons and/or at least 33 percent of the population lives more than 1 mile from a supermarket or large grocery store (10 miles, in the case of rural census tracts).

Homeless[3]: An individual is classified as experiencing homelessness if they meet the definitions below:

(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

[1] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

[2] Michele Ver Ploeg, David Nulph, and Ryan Williams. " U.S. Department of Agriculture, Economic Research Service (ERS). USDA ERS - Data Feature: Mapping Food Deserts in the U.S.

[3] Criteria for defining homeless - Hud Exchange. (n.d.) https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

(2) **Homeless under other Federal statutes[4]:** Unaccompanied youth under 25 years of age, or families with Category 3 children and youth, who do not otherwise qualify as homeless under this definition, but who: (i) Are defined as homeless under the other listed federal statutes; (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application; (iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and (iv) Can be expected to continue in such status for an extended period of time due to special needs or barriers.

(3) **Fleeing/ Attempting to Flee Domestic Violence (DV)[5]:** Any individual or family who: (i) Is fleeing or is attempting to flee dv; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing.

Housing Unstable: An individual is classified as housing unstable is they meet the definition below:

(1) Imminent Risk of Homelessness[6]: Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

(2) An individual having trouble paying rent, living in overcrowded housing, moving frequently, or spending the bulk of household income on housing.[7,8]

Unknown: Report on only individuals who did not provide information regarding their housing status.

Definitions Section 3: CARE COORDINATION

Care Coordination: The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as the deliberate organization of care activities between two or more participants (including the patient/participant) involved in the facilitation of appropriate delivery of health care services.[9] Care coordination connects primary care physicians, specialists, hospitals, behavioral health providers, other health care organizations, and non-health social service organizations, including schools, housing agencies, correctional facilities, and transportation organizations. All these entities work together to communicate information and organize a patient or participant's care to make it safer, more appropriate, and more effective.[10] Care coordination creates smooth transitions as a patient/participant interacts with

[4] Criteria for defining homeless - Hud Exchange. (n.d.)
https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

[5] Criteria for defining homeless - Hud Exchange. (n.d.)
https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

[6] Criteria for defining homeless - Hud Exchange. (n.d.)
https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

[7] Kushel, M. B., Gupta, R., Gee, L., & Haas, J. S. (2006). Housing instability and food insecurity as barriers to health care among low-income Americans. *Journal of General Internal Medicine, 21*(1), 71–77. doi: 10.1111/j.1525-1497.2005.00278.x

[8] Kushel, M. B., Gupta, R., Gee, L., & Haas, J. S. (2006). Housing instability and food insecurity as barriers to health care among low-income Americans. *Journal of General Internal Medicine, 21*(1), 71–77. doi: 10.1111/j.1525-1497.2005.00278.x

[9] Agency for Healthcare Research and Quality. (2014). Chapter 2. What is Care Coordination? Available at: https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html.

[10] Rural Health Information Hub. (2018). Defining Care Coordination. Rural Care Coordination Toolkit. Available at: https://www.ruralhealthinfo.org/toolkits/care-coordination.

various providers and services and allows for holistic care and engagement in care management.[11]

Care coordination, or care management, encompasses a cultural shift from a focus on periodic, acute care visits to a more comprehensive view of managing care for those with chronic disease and complex conditions. Care coordination often includes use of staff as care coordinators to specifically work with and support individuals.[12]

Care **Coordination**	Care **Coordinator**
A function	A person
Based on a population and their needs	Individualized action and support for a patient/participant
A deliberate, systematic organization of patient/participant care	Could involve case management, coaching, advocacy
Infrastructure, policies, communication, and resources	May be clinical or non-clinical
A function that helps ensure that the participant's needs and preferences for health services and information sharing across people, functions, and sites that are met over time	A person in charge of coordinating client care in a clinical or health care setting, typically responsible for developing care plans, arranging, and tracking appointments, educating patients/clients/participants, and coordinating other aspects of clients' well-being

Source: Rural Policy Research Institute (RUPRI) and Stratis Health, 2014

Definitions Section 4: SUSTAINABILITY

Payer Mix for participant population = percentage of participants insured by insurance type (private health plans, CMS Marketplace, Medicare, Medicaid, uninsured).

Numerator: Number of payments for each payer segment
Denominator: Number of payments for all payer segments

Definitions Section 5: LEADERSHIP AND WORKFORCE COMPOSITION

Participant/Patient Panel Size: *Use sections 1 and 2 of the worksheet below to calculate the actual patient panel size for each clinician.*

	PATIENT PANEL SIZE WORKSHEET[13]		
1	**CURRENT PANEL**	**Example**	**Your practice**

[11] Stanek M, Hanlon C, Shiras T. (2014). Realizing Rural Care Coordination: Considerations and Action Steps for State Policy-Makers. Robert Wood Johnson Foundation. Available at: https://www.shvs.org/wp-content/uploads/2014/04/RWJF_SHVS_Realizing-Rural-Care-Coordination.pdf.

[12] Rural Policy Research Institute and Stratis Health. (2014). Care Coordination: A Self-Assessment for Rural Health Providers and Organizations. Available at: https://ruralhealthvalue.public-health.uiowa.edu/files/RHV%20Care%20Coordination%20Assessment.pdf.

[13] American Academy of Family Physicians. Murray M, Davies M, Boushon B. Panel size: how many participants can one doctor manage? *Fam Pract Manag.* April 2007:44–51. Available at: https://www.aafp.org/fpm/20070400/44pane.html.

A	The practice panel: The number of unique patients who have seen any provider (MD, NP, or PA) in the practice in the last 12 or 18 months	6000	
B	Full-time-equivalent (FTE) providers	4.00	
C	FTE providers devoted to non-visit work	1.00	
D	FTE clinical providers (B - C)	3.00	(B - C)
E	The "target" panel for each FTE clinical provider (A ÷ D)	2000	(A ÷ D)
2	**For Clinicians**		
F	Clinical FTE of the individual provider being analyzed	0.80	
G	Actual panel for the individual provider (This can be determined using the "four-cut" method described above and, in the article, linked below.)	2000	
H	Difference between actual and target panel for the individual provider (G - (E x F))	400	(G - (E x F))
	Optional		
3	**IDEAL PANEL**	**Example**	**Your practice**
I	Visits per patient per year (The average is 3.19, but your number may vary and can be adjusted based on patient acuity, as described in the article.)	3.19	
J	Provider visits per day	24.0	
K	Provider days per year	240.0	
L	Ideal panel size ((J x K) ÷ I)	1806	((J x K) ÷ I)
M	Difference between actual and ideal panel for the individual provider (G - L)	194	(G - L)
	Note: Strategies for reconciling the actual and ideal panels are provided in the article.		

Definitions Section 8: UTILIZATION

NQF3575: Total per Capita Cost:
The TPCC measures the overall cost of care delivered to a patient with a focus on the primary care they receive from their provider(s). The measure is a payment-standardized, risk-adjusted, and specialty-adjusted measure. The measure is attributed to clinicians, who are identified by their unique Taxpayer Identification Number and National Provider Identifier pair (TIN-NPI) and clinician groups, identified by their TIN number. The TPCC measure can be attributed at the TIN or TIN-NPI level. In all supplemental documentation, the term “cost” generally means the standardized1 Medicare allowed amount.2

Numerator: The numerator for the measure is the sum of the risk-adjusted, payment-standardized, and specialty-adjusted Medicare Parts A and B costs across all beneficiary months attributed to a TIN or TIN-NPI during the performance period.

Denominator: The denominator for the measure is the number of beneficiary months attributed to a TIN or TIN-NPI during the performance period.

Exclusion Criteria:

- They were not enrolled in both Medicare Part A and Part B for every month during the

performance period unless part year enrollment was the result of new enrollment or death.
- They were enrolled in a private Medicare health plan (e.g., a Medicare Advantage or a Medicare private FFS plan) for any month during the performance period.
- They resided outside the United States or its territories during any month of the performance period.
- They are covered by the Railroad Retirement Board.

NQF1789: Hospital-Wide All-cause Unplanned Readmission Measure
This measure estimates a hospital-level, risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission within 30 days of discharge from an index admission with an eligible condition or procedure. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology. The measure also indicates the hospital-level standardized readmission ratios (SRR) for each of these five specialty cohorts. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date from the index admission (the admission included in the measure cohort). A specified set of readmissions are planned and do not count in the readmission outcome. CMS annually reports the measure for Medicare fee-for-service (FFS) patients who are 65 years or older and are hospitalized in non-federal short-term acute care hospitals.
For the All-Cause Readmission (ACR) measure version used in the Shared Savings Program (SSP) beginning in 2017, the measure estimates an Accountable Care Organization (ACO) facility-level RSRR of unplanned, all-cause readmission after admission for any eligible condition or procedure within 30 days of hospital discharge. The ACR measure is calculated using the same five specialty cohorts and estimates an ACO-level standardized risk ratio for each. CMS annually reports the measure for patients who are 65 years or older, are enrolled in Medicare FFS, and are ACO assigned beneficiaries.
The updates in this form reflect changes both to the original HWR measure and the ACS measure version. For instances where the two versions differ, we provide additional clarifications below the original description.

Numerator: The outcome for both the original HWR and ACR measures is 30-day readmission. We define readmission as an inpatient admission for any cause, except for certain planned readmissions, within 30 days from the date of discharge from an eligible index admission. If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission.

Denominator: The measure includes admissions for Medicare beneficiaries who are 65 years and older and are discharged from all non-federal, acute care inpatient US hospitals (including territories) with a complete claims history for the 12 months prior to admission.
ACR-Specific: The measure at the ACO level includes all relevant admissions for ACO assigned beneficiaries who are 65 and older, and are discharged from all non-Federal short-stay acute care hospitals, including critical access hospitals.

Exclusions:
Both the original HWR and ACR versions of the measure exclude index admissions for patients:
1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals;

2. Without at least 30 days post-discharge enrollment in Medicare FFS;
3. Discharged against medical advice;
4. Admitted for primary psychiatric diagnoses;
5. Admitted for rehabilitation; or
6. Admitted for medical treatment of cancer.

Definitions Section 9: CLINICAL MEASURES

Measure 1: Care Coordination (required)

CMS50v10: Closing the referral loop: receipt of specialist report
Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.
Numerator: Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred
Denominator: Number of patients, regardless of age, who had a visit during the measurement period and were referred by one provider to another provider

NQF 0419 (CMS68v9) : 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.

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.

Measure 2: Cardiovascular Disease

(CMS347v3) 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:
*All patients with an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or ever had an ASCVD procedure; OR
*Patients aged >= 20 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR
*Patients aged 40-75 years with a diagnosis of diabetes

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):
Population 1:
All patients who have an active diagnosis of clinical ASCVD or ever had an ASCVD procedure.
Population 2:
Patients aged >= 20 years at the beginning of the measurement period who have ever had a laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia.
Population 3:
Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes.

- Denominator Exclusions:
  - Patients who are breastfeeding at any time during the measurement period.
  - Patients who have a diagnosis of rhabdomyolysis at any time during the measurement period.

- Denominator Exceptions
  - Patients with statin-associated muscle symptoms or an allergy to statin medication.
  - Patients who are receiving palliative or hospice care.
  - Patients with active liver disease or hepatic disease or insufficiency.
  - Patients with end-stage renal disease (ESRD).
  - Patients with documentation of a medical reason for not being prescribed statin therapy.

Measure 3: Body Mass Index (BMI) Screening and Follow-Up
NQF 0421 (CMS069v11): Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the measurement period AND who had a follow-up plan documented if BMI was outside of normal parameters (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 measurement period, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the measurement period

Denominator: All patients aged 18 and older on the date of the encounter with at least one eligible encounter during the measurement period.

Measure 4: Blood Pressure
NQF 0018 (CMS165v11): Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.
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 (CMS138v11): 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
Three rates are reported:
a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period.
b. Percentage of patients aged 18 years and older who were identified as a tobacco user during the measurement period who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period.
c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user.

Numerator: Population 1:
Patients who were screened for tobacco use at least once during the measurement period.
Population 2:
Patients who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period
Population 3:
Patients who were screened for tobacco use at least once during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user.

Denominator:
Population 1:
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.
Population 2:
All patients aged 18 years and older who were screened for tobacco use during the measurement period and identified as a tobacco user.
Population 3:
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: Cancer
NQF 0032 (CMS124v11): Cervical Cancer Screening
Percentage of women and other participants assigned female at birth 21-64 years of age who were screened for cervical cancer using either of the following criteria:

* Women and other participants assigned female at birth aged 21-64 who had cervical cytology performed within the last 3 years
* Women and other participants assigned female at birth aged 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years

Numerator: Women and other participants assigned female at birth with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:
* Cervical cytology performed during the measurement period or the two years prior to the measurement period for women and other participants assigned female at birth who are at least 21 years old at the time of the test
* Cervical human papillomavirus (HPV) testing performed during the measurement period or the four years prior to the measurement period for women and or participants assigned female at birth who are 30 years or older at the time of the test

Denominator: Women and other participants assigned female at birth 24-64 years of age by the end of the measurement period with a visit during the measurement period

Denominator Exclusions:
Women and other participants assigned female at birth who had a hysterectomy with no residual cervix or a congenital absence of cervix.
Exclude patients who are in hospice care for any part of the measurement period.
Exclude patients receiving palliative care for any part of the measurement period.

NQF 0034: (cms130v11) Colorectal Cancer Screening
Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer.
Numerator: Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:
- Fecal occult blood test (FOBT) during the measurement period
- FIT-DNA during the measurement period or the two years prior to the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- CT Colonography during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period

Denominator: Patients 46-75 years of age by the end of the measurement period with a visit during the measurement period

Denominator Exclusions:
Exclude patients who are in hospice care for any part of the measurement period.
Exclude patients with a diagnosis or past history of total colectomy or colorectal cancer.
Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period.
Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
- Advanced illness with two outpatient encounters during the measurement period or the year prior
- OR advanced illness with one inpatient encounter during the measurement period or the year prior
- OR taking dementia medications during the measurement period or the year prior
Exclude patients receiving palliative care for any part of the measurement period.

NQF 2372 (CMS125v11): Breast Cancer Screening
Percentage of women and other participants assigned female at birth 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the Measurement Period

Numerator: Women and other participants assigned female at birth with one or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period

Denominator: Women and other participants assigned female at birth 52-74 years of age by the end of the measurement period with a visit during the measurement period

Denominator Exclusions:
Women and other participants assigned female at birth who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy.
Exclude patients who are in hospice care for any part of the measurement period.
Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period.
Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
- Advanced illness with two outpatient encounters during the measurement period or the year prior
- OR advanced illness with one inpatient encounter during the measurement period or the year prior
- OR taking dementia medications during the measurement period or the year prior
Exclude patients receiving palliative care for any part of the measurement period.

Measure 7: Alcohol and Drug Dependence Treatment
NQF 0004 (CMS137v11): Percentage of patients 13 years of age and older with a new substance use disorder (SUD) episode who received the following (Two rates are reported):
a. Percentage of patients who initiated treatment, including either an intervention or medication for the treatment of SUD, within 14 days of the new SUD episode.
b. Percentage of patients who engaged in ongoing treatment, including two additional interventions or short-term medications, or one long-term medication for the treatment of SUD, within 34 days of the initiation.
Numerator 1: Initiation of treatment includes either an intervention or medication for the treatment of SUD within 14 days of the new SUD episode.
Numerator 2: Engagement in ongoing SUD treatment within 34 days of initiation includes:
1. A long-acting SUD medication on the day after the initiation through 34 days after the initiation of treatment
2. One of the following options on the day after the initiation of treatment through 34 days after the initiation of treatment: a) two engagement visits, b) two engagement medication treatment events, c) one engagement visit and one engagement medication treatment event
Denominator: Patients aged 13 years of age and older as of the start of the measurement period who were diagnosed with a new SUD episode during a visit between January 1 and November 14 of the measurement period

Denominator Exclusions: Exclude patients who are in hospice care for any part of the measurement period.

Measure 8: Chronic lower respiratory disease
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)

NQF1800: Asthma Medication Ratio
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.

Numerator: The number of patients with persistent asthma who have a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Denominator: All patients 5–64 years of age as of December 31 of the measurement year who have persistent asthma by meeting at least one of the following criteria during both the measurement year and the year prior to the measurement year:
• At least one emergency department visit with asthma as the principal diagnosis
• At least one acute inpatient encounter or discharge with asthma as the principal diagnosis
• At least four outpatient visits, observation visits, telephone visits, or online assessments on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits.
• At least four asthma medication dispensing events for any controller medication or reliever medication

NQF3668: Follow-up After Emergency Department Visits for Asthma
This process measure seeks to capture follow up after asthma-related emergency department (ED) visits for children with asthma after discharge from the ED, as recommended by the NHLBI 2007 guidelines. This measure assesses the percentage of asthma-related ED visits for children ages 3-21 with a follow-up visit with a primary care clinician or an asthma subspecialist within 14 days of discharge from the ED, within the reporting year, for patients who are enrolled in the health plan for two consecutive months following the ED visit.

Numerator: The numerator assesses whether there was a follow-up visit within 14 days to a primary care or asthma-specific subspecialty provider.

Denominator: Children 3-21 years of age with an asthma-related ED visit (primary or second diagnosis (in the second diagnostic spot) of asthma) during the measurement year, with at least 2 months of insurance enrollment after the ED visit.

Measure 9: Timely Follow-Up After Acute Exacerbations of Chronic Conditions
NQF3455: Timely Follow-Up After Acute Exacerbations of Chronic Conditions: The percentage of issuer-product-level acute events requiring either an emergency department (ED) visit or hospitalization for one of the following 6 chronic conditions: hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes mellitus (Type I or Type II),

where follow-up was received within the timeframe recommended by clinical practice guidelines in a non-emergency outpatient setting.

Numerator: The numerator is the sum of the issuer-product-level denominator events (Emergency Room [ED], observation hospital stay or inpatient hospital stay) for acute exacerbation of hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes where follow-up was received within the timeframe recommended by clinical practice guidelines, as detailed below:

• Hypertension: Within 7 days of the date of discharge
• Asthma: hanged Within 14 days of the date of discharge
• HF: Within 14 days of the date of discharge
• CAD: Within 14 days of the date of discharge
• COPD: Within 30 days of the date of discharge
• Diabetes: Within 30 days of the date of discharge

Denominator: The denominator is the sum of the plan-product-level acute exacerbations that require either an ED visit, observation stay, or inpatient stay (i.e., acute events) for any of the six conditions listed above (hypertension, asthma, HF, CAD, COPD, or diabetes).

Denominator Exclusions:

The measure excludes events with:

1. Subsequent acute events that occur two days after the prior discharge, but still during the follow-up interval of the prior event for the same reason. To prevent double counting, only the first acute event will be included in the denominator.
2. Acute events after which the patient does not have continuous enrollment for 30 days in the same product.
3. Acute events where the discharge status of the last claim is not “to community” (“Left against medical advice” is not a discharge to community.)
4. Acute events for which the calendar year ends before the follow-up window ends (e.g., acute asthma events ending fewer than 14 days before December 31)
5. Acute events where the patient enters a skilled nursing facility (SNF), non-acute care, or hospice care within the follow-up interval.

Measure 10: Pregnancy Continuum of Care

NQF1517) Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH): The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Numerator (Prenatal Care): The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization.

Denominator: The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.

Exclusions: Non-live births

Percent of pregnant participants who receive case management contact in the budget period.
Case Management Contact is defined as verbal or written communication (i.e., phone call, home visit, video conference, email/text exchange, etc.) to participant by their designated case worker.

Numerator: Number of pregnant participants who received case management contact in budget period
Denominator: Number of total pregnant participants served in budget period

NQF 0418 (CMS2v12): Percentage of participants aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Numerator: Participants screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Denominator: All participants aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period.