	Measure Name	NQF Number	Steward	CMS Number	Description	Condition	Measure Type	Populations	Data Source
1	**READM-30-AMI: Heart Attack Readmit**	**0505**	Centers for Medicare & Medicaid Services		The measure estimates a hospital-level 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of acute myocardial infarction (AMI). The outcome is defined as readmission for any cause within 30 days of the discharge date for the index admission, excluding a specified set of planned readmissions. The target population is patients aged 18 years and older. CMS annually reports the measure for individuals who are 65 years and older and are either Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal hospitals or patients hospitalized in Department of Veterans Affairs (VA) facilities.	Cardiovascular	Outcome	Adult	Claims
2	**READM-30-PN: Pneumonia Readmit**	**0506**	Centers for Medicare & Medicaid Services		The measure estimates a hospital-level risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of pneumonia. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. A specified set of planned readmissions do not count as readmissions. The target population is patients 18 and over. CMS annually reports the measure for patients who are 65 years or older and are either enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are hospitalized in Veterans Health Administration (VA) facilities.	Respiratory	Outcome	Adult	Claims
3	**Medication Reconciliation Post-Discharge**	**0554**	National Committee for Quality Assurance		Percentage of discharges during the first 11 months of the measurement year (e.g., January 1–December 1) for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Patient Safety	Process	Older Adult	Claims or Clinical Data
4	**Post-Discharge Continuing Care Plan Created (HBIPS-6)**	**0557**	The Joint Commission		Patients discharged from a hospital-based IP psychiatric setting with a continuing care plan created overall and stratified by age groups	Mental Health	Process	All Ages	Clinical Data
5	**HBIPS-7a: Post Discharge Continuing Care Plan Transmitted – Overall Rate**	**0558**	The Joint Commission		The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post discharge continuing care plan, all the components of which are transmitted to the next level of care provider upon discharge This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-6 (Post Discharge Continuing Care Plan Created).	Mental Health	Process	All Ages	Clinical Data
6	**Transition Record with Specified Elements Received by Discharged Patients**	**0647**	AMA-PCPI (American Medical Association-convened		Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge	NA	Process	All Ages	Clinical Data

Measure Name	NQF Number	Steward	CMS Number	Description	Condition	Measure Type	Populations	Data Source
7 **Care Transition Record Transmitted to Health Care Professional**	**0648**	AMA-PCPI (American Medical Association-convened		Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the designated health care provider for follow-up care within 24 hours	NA	Process	All Ages	Clinical Data
8 **Plan All-Cause Readmission**	**1768**	National Committee for Quality Assurance		For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays* (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission	Patient Safety	Outcome	Adult	Claims
9 **READM-30-HOSP-WIDE: Hospital-wide Readmit**	**1789**	Centers for Medicare & Medicaid Services		This measure estimates the 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. 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 (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.	Patient Safety	Outcome	Adult	Claims
10 **30-day Psychiatric Inpatient Readmission**	**NA**	Washington DSHS (homegrown)		For members 18 years of age and older, the number of acute inpatient psychiatric stays during the measurement year that were followed by an acute readmission for a psychiatric diagnosis within 30 days	Patient Safety	Outcome	Adult	Claims

Measure Name	NQF Number	Steward	CMS Number	Description	Condition	Measure Type	Populations	Data Source
Transitions of Care ***(New Proposed HEDIS Measure)***	**NA**	National Committee for Quality Assurance		The percentage of discharges for members 18 years of age and older who had each of the following during the measurement year. Four rates are reported: □ Notification of Inpatient Admission. Documentation of primary care practitioner (PCP) notification of inpatient admission on the day of admission or the following day. □ Receipt of Discharge Information. Documentation of PCP receipt of discharge information on the day of discharge or the following day. □ Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided by the PCP within 30 days after discharge. □ Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 days, total).	Patient Safety	Outcome	Adult	Claims/Clinical Data

	Measure Name	NQF-Endorsed	Steward	Description	Condition	Measure Type	Population	Data Source
12	Advance Care Plan	326	NCQA	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	NA	Process	Older Adult	Clinical
13	Acute Care Hospitalization During the First 60 Days of Home Health	171	CMS	Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.	NA	Outcome	Older Adult	Claims
14	Emergency Department Use Without Hospitalization During the First 60 Days of Home Health	173	CMS	Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.	NA	Outcome	Older Adult	Claims
15	Proportion of Patients with a Chronic Condition that Have a Potentially Avoidable Complication During the Calendar Year	709	Altarum Institute	Percent of adult population aged 18+ years who were identified as having at least one of the following six chronic conditions: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Heart Failure (HF), Hypertension (HTN), or Diabetes Mellitus (DM), were followed for at least one-year, and had one or more potentially avoidable complications (PACs) during the most recent 12 months. PACs defined as one of two types.	Multiple	Outcome	Adults	Claims
16	Care Transition Measure (CTM-3)	228	University of Colorado Denver	The CTM-3 is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among adult patients discharged from general acute care hospitals within the past 30 days. (Patient-reported data via survey)	NA	Outcome	Adults	Patient Reported