Premier Clinician Performance Registry QCDR (Custom) Measure Specifications for MIPS 2020 Performance Year

2020 QCDR Measure ID	NQF Number	Measure Title	NQS Domain	Meaningful Measure Area	Measure Description	Denominator	Numerator	Denominator Exclusions	Denominator Exceptions	Numerator Exclusions	Risk-adjusted Measure	High Priority Measure	High Priority Type	Measure Type	Inverse Measure	Measure Reporting Indicator	Number of Required Performance Rates	MIPS Performance Rate (Used for Quality Category Score)
AQI18	N/A	Coronary Artery Bypass Graft (CABG): Prolonged Intubation – Inverse Measure	Effective Clinical Care	Preventable Healthcare Harm	Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require postoperative intubation > 24 hours	All patients, aged 18 years and older, undergoing isolated CABG surgery Definition: Isolated CABG refers to CABG using arterial and/or venous grafts only.	Patients who require intubation > 24 hours following exit from the operating room	Organ donors as designated by ASA Physical Status 6	None	None	No	Yes	Outcome	Outcome	Yes	Traditional (Proportion)	1	N/A
AQI48	N/A	Patient-Reported Experience with Anesthesia	Person and Caregiver Centered Experience and Outcomes	Patient's Experience of Care	Percentage of patients, aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care and who reported a positive experience. This measure will consist of two performance rates: AQI48a: Percentage of patients, aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care AQI48b: Percentage of patients, aged 18 and older, who completed a survey on their patient experience and satisfaction with anesthesia care who report a positive experience with anesthesia care NOTE: The measure requires that a valid survey, as defined in the numerator of AQI48a, be sent to patients between discharge from the facility and within 30 days of facility discharge. To report AQI48b, a minimum number of 20 surveys with the mandatory question completed must be reported. **In order to be scored on this measure, clinicians must report BOTH AQI48a AND AQI48b.	Patients, aged 18 and older, who undergo a procedure* under anesthesia (AQI48a) and who complete a survey on their patient experience and satisfaction with anesthesia care (AQI48b) Definition: *Any procedure including surgical, therapeutic or diagnostic Denominator Note: In order to report AQI48b, the denominator must include a minimum of 20 returned surveys.	Numerator AQI48a: Patients who received a survey within 30 days of the procedure to assess their experience and satisfaction with anesthesia. Numerator Note: The survey should be administered to the patient shortly following discharge from the facility. Definition: Practices and eligible clinicians may customize their patient experience and satisfaction with anesthesia surveys to meet local needs but, at a minimum, a valid survey must include a core set of questions that address three of the four following criteria related to patient experience and satisfaction and one mandatory question described below. 1. Pre-operative Education and Preparation 2. Patient and/or Family Communication 3. Care Team Response to Comfort and Well-Being 4. Post-operative pain control and/or management Mandatory question that must be included in each valid survey (practices must also include an option for patient to indicate "Not Applicable"): an option for patient to indicate "Not Applicable"): 1. On a scale of 1 to 5, where 1 indicates the worst anesthesia experience and where 5 indicates the best anesthesia experience, how would you rate your anesthesia experience? Numerator AQI48b: Patients who reported a positive experience with anesthesia care. Definition: A positive experience is defined as a response of 4 or 5 on the following mandatory patient experience and satisfaction survey question: On a scale of 1 to 5, where 1 indicates the worst anesthesia experience and where 5 indicates the best anesthesia experience, how would you rate your overall anesthesia experience? (Practices must include an option for patient to indicate "Not Applicable")	· AQI48a: Organ Donors as designated by ASA Physical Status 6 · AQI48a: Patient died within 30 days of the procedure · AQI48b: Patient did not complete the mandatory anesthesia satisfaction question	AQI48a: Documentation of patient reason(s), process reason(s)or medical reason(s) for not receiving survey (i.e. patients who are non-verbal, who are unable to be surveyed due to a medical or psychiatric reason, who are unable to be surveyed due to a language barrier, have not provided contact information, who are discharged to assisted living, skilled nursing facility or other similar location where direct access to the patient is not available, or who decline to be surveyed)	None	No	Yes	Outcome	Patient Reported Outcome (PRO)	No	Traditional (Proportion)	2	AQI48b
AQI49	N/A	Adherence to Blood Conservation Guidelines for Cardiac Operations using Cardiopulmonary Bypass (CPB) – Composite	Effective Clinical Care	Preventable Healthcare Harm	Percentage of patients, aged 18 years and older, who undergo a cardiac operation using cardiopulmonary bypass for whom selected blood conservation strategies were used.	Patients, aged 18 years and older, who undergo a cardiac operation using cardiopulmonary bypass Denominator Note: Patients undergoing a re-operation are included in the denominator to the measure	Patients for whom selected blood conservation strategies were used. Numerator Scoring: Each blood conservation strategy of this measure accounts for 25% of the total composite score. Each of the four blood conservation strategies must be reported to be included in the performance measurement. The total composite score will be calculated by the data source and not the individual practitioner. 1. Use of Lysine analogues · Numerator Note: As indicated by Intraoperative Antifibrinolytic med: Aminocaproic Acid or Tranexamic Acid. 2. Use of mini-circuits or Retrograde Autologous Priming (RAP) or Ultrafiltration (Minimize hemodilution caused by cardiopulmonary bypass pump priming solution) · Numerator Note: Record the usage of retrograde autologous priming or a miniaturized circuit volume by the cardiopulmonary perfusion team prior to the onset of cardiopulmonary bypass. · Numerator Note: Capture the total volume of ultra filtrate removed by the cardiopulmonary perfusion team during cardiopulmonary bypass and during modified ultra-hemofiltration post-CPB. Record the data in milliliters. 3. Use of red cell salvage using centrifugation · Numerator Note: Capture the volume of cell saver collected and given. Do not include autologous, allogeneic, pump-residual, or chest-tube recirculated blood. 4. Use of transfusion algorithm supplemented with point-of-care testing · Numerator Note: Transfusion algorithm includes SCA/STS guideline recommendations or an evidence-based algorithm formulated at the local level.	· Emergent cases	None	None	No	No	N/A	Process	No		1	N/A
AQI55	N/A	Team-Based Implementation of a Care-and-Communication Bundle for ICU Patients	Communication and Care Coordination	Care is Personalized and Aligned with Patient's Goals	Percentage of patients, regardless of age, who are admitted to an intensive care unit (ICU) for ≥48 hours and who received critical care services who have documentation by managing physician of 1) attempted or actual identification of a surrogate decision maker, 2) an advance directive, and 3) the patient's preference for cardiopulmonary resuscitation, within 48 hours of ICU admission	All patients, regardless of age, who are admitted to an intensive care unit for ≥48 hours and who received critical care services	Patients who have documentation by managing physician of 1) attempted or actual identification of a surrogate decision maker, 2) an advance directive, and 3) the patient's preference for cardiopulmonary resuscitation, within the first 48 hours of ICU admission Numerator Note: To meet this measure, the managing physician must either document the required information or confirm that they have reviewed existing documentation of the information.	None	Documentation of patient reason(s) for not documenting all three required numerator elements within the first 48 hours of ICU admission (e.g., patient declines, patient unable to participate in discussion, other patient reason(s))	None	No	Yes	Care Coordination	Process	No	Traditional (Proportion)	1	N/A

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AQI56	N/A	Use of Neuraxial Techniques and/or Peripheral Nerve Blocks for Total Knee Arthroplasty (TKA)	Effective Clinical Care	Appropriate use of Healthcare	Percentage of patients, regardless of age, that undergo primary total knee arthroplasty for whom neuraxial anesthesia and/or a peripheral nerve block is performed	All patients, regardless of age, who undergo primary total knee arthroplasty	Patients for whom neuraxial anesthesia and/or a peripheral nerve block is performed. Numerator Note: For the purposes of this measure, a peripheral nerve block performed either as primary procedural anesthesia or performed for postoperative analgesia would meet the numerator.	Revision of Total Knee Arthroplasty Prosthesis Removal	Documentation of patient reason(s) for not using either neuraxial anesthesia or a peripheral nerve block (e.g., patient refusal)	None	No	No	N/A	Process	No	Traditional (Proportion)	1	N/A
AQI57	N/A	Safe Opioid Prescribing Practices	Effective Clinical Care	Prevention and Treatment of Opioid and Substance Use Disorders	Percentage of patients, aged 18 years and older, prescribed opioid medications for longer than six weeks' duration for whom ALL of the following opioid prescribing best practices are followed: 1. Chemical dependency screening (includes laboratory testing and/or questionnaire) within the immediate 6 months prior to the encounter 2. Co-prescription of naloxone or documented discussion regarding offer of Naloxone co-prescription, if prescription is ≥50 MME/day 3. Non co-prescription of benzodiazepine medications by prescribing pain physician and documentation of a discussion with patient regarding risks of concomitant use of benzodiazepine and opioid medications.	All patients aged 18 years and older prescribed opioid medications for longer than six weeks' duration	Patients for whom ALL of the following opioid prescribing best practices are followed: 1. Chemical dependency screening (includes laboratory testing and/or questionnaire) within the immediate 6 months prior to the encounter 2. Co-prescription of Naloxone, or documented discussion regarding offer of Naloxone co-prescription, if opioid prescription is ≥50 MME/day 3. Non co-prescription of benzodiazepine medications by prescribing pain physician and documentation of a discussion with patient regarding risks of concomitant use of benzodiazepine and opioid medications. Numerator Note: Chemical Dependency Screening: Questionnaires for chemical dependency screening can include the Opioid Risk Tool (ORT), Screener and Opioid Assessment for Patients with Pain (SOAPP), Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R), or the Diagnosis, Intractability, Risk, Efficacy (DIRE) tool.	None	None	None	No	Yes	Opioid-related Measure	Process	No	Traditional (Proportion)	1	N/A
AQI58	N/A	Infection Control Practices for Open Interventional Pain Procedures	Patient Safety	Healthcare-associated Infections	Percentage of patients, regardless of age, that undergo an open interventional pain procedure for whom ALL of the following infection control best practices are followed by anesthesiologist(s) and scrub technologist(s), in addition to standard sterile technique: 1. Double gloving (two pairs of sterile gloves are worn) 2. Chlorhexidine with alcohol used for surgical site preparation 3. Weight-based preoperative antibiotic dosing and, if indicated by procedure duration, weight-based re-dosing 4. Administration of pre-operative antibiotics within 1 hour, or 2 hours for vancomycin, prior to surgical incision	All patients, regardless of age, who undergo an open interventional pain procedure	Patients for whom ALL of the following infection control best practices are followed in addition to standard sterile technique: 1. Double gloving (two pairs of sterile gloves are worn) 2. Chlorhexidine with alcohol used for surgical site preparation 3. Weight-based preoperative antibiotic dosing and, if indicated by procedure duration, weight-based re-dosing 4. Administration of pre-operative antibiotics within 1 hour, or 2 hours for vancomycin, prior to surgical incision (or start of procedure if no incision is required	None	None	None	No	Yes	Patient Safety	Process	No	Traditional (Proportion)	1	N/A
AQI61	N/A	Ambulatory Post-Discharge Patient Follow-Up	Person and Caregiver Centered Experience and Outcomes	Patient's Experience of Care	Percentage of patients, regardless of age, who received anesthesia services in an ambulatory setting whose post-discharge status was assessed within 72 hours of discharge	Patients, regardless of age, who received anesthesia services in an ambulatory setting	Patients whose post-discharge status was assessed within 72 hours of discharge. The post-discharge status assessment must address at least four of the following domains: • Pain Management; including an assessment of patient satisfaction with pain control • Nausea/Vomiting; including an assessment of severity. • Activities of Daily Living; including an assessment of the patient's ability to return to baseline ADLs • Satisfaction with Care; including an assessment of the patient's overall satisfaction with their anesthetic care • Questions or Concerns Regarding Discharge Instructions; including an assessment of compliance with anesthetic discharge instructions. • Questions assessing complications related to anesthetic care (e.g. possible nerve catheter infections, etc) Numerator Note: A post-discharge assessment can be conducted by any member of the care team via a range of communication modalities, including phone call, email, patient portal interaction, patient survey, or other means of communicating with the patient. Documentation of the assessment should include any instructions or recommendations that are given to address problems or complications that are identified. If applicable, it is appropriate for a caregiver or legal proxy to complete the assessment on the patient's behalf.	Patients who were transferred to higher level of care Patients who were unable to be contacted or did not complete assessment after at least 2 contact attempts	None	None	No	Yes	Patient Experience	Process	No	Traditional (Proportion)	1	N/A
AQI62	N/A	Obstructive Sleep Apnea: Patient Education	Effective Clinical Care	Management of Chronic Conditions	Percentage of patients aged 18 years or older, who undergo an elective procedure requiring anesthesia services who are screened for obstructive sleep apnea (OSA) AND, if positive, have documentation that they received education regarding their risk for OSA prior to PACU discharge	All patients aged 18 years or older, who undergo an elective procedure requiring anesthesia services Denominator Note: For the purposes of this measure, anesthesia services only include cases using general anesthesia, neuraxial anesthesia and monitored anesthesia care (MAC)	Patients who are screened for obstructive sleep apnea (OSA) AND, if positive, have documented education regarding their risk for obstructive sleep apnea prior to PACU discharge Numerator Definition: Patient education regarding OSA must include documentation that a conversation addressing potential implications of OSA on the patient's perioperative course and any applicable recommendations for follow-up care and disease management occurred. Self-help materials (e.g., brochures, audio/video materials, pamphlets) alone are not sufficient to meet the numerator.	Patient has an existing diagnosis of OSA Documentation of patient reason for not providing education regarding risk for OSA (e.g., severe dementia, patient is intubated, patient is not alert or responsive enough to participate in education, other patient reason(s)	None	None	No	No	N/A	Process	No	Traditional (Proportion)	1	N/A
AQI65	N/A	Avoidance of Cerebral Hyperthermia for Procedures Involving Cardiopulmonary Bypass	Patient Safety	Preventable Healthcare Harm	Percentage of patients, aged 18 years and older, undergoing a procedure using cardiopulmonary bypass who did not have a documented intraoperative pulmonary artery, oropharyngeal, or nasopharyngeal temperature ≥37.0 degrees Celsius during the period of cardiopulmonary bypass	All patients aged 18 years or older, who undergo a procedure using cardiopulmonary bypass	Patients who did not have an intraoperative pulmonary artery, oropharyngeal, or nasopharyngeal temperature ≥37.0 degrees Celsius during cardiopulmonary bypass	None	None	None	No	Yes	Outcome	Outcome	No	Traditional (Proportion)	1	N/A

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AQI67	N/A	Consultation for Frail Patients	Communication and Care Coordination	Management of Chronic Conditions	Percentage of patients aged 70 years or older, who undergo an inpatient procedure requiring anesthesia services and have a positive frailty screening result who receive a multidisciplinary consult or care during the hospital encounter	All patients aged 70 years or older, who undergo an inpatient procedure requiring anesthesia services and have a positive frailty screening result Denominator Definition: Frailty can be screened using an established tool including but not limited to following tools: •Fried Frailty Phenotype Criteria •Modified Frailty Index •The Vulnerable Elders Survey •Initial Clinical Impression ("First Minute Impression")	Patients who receive a multidisciplinary consult and/or multidisciplinary care during the hospital encounter Numerator Definition: A multidisciplinary consult should include documentation of a discussion of the frailty screening result and can include consultation initiated by the anesthesiologist or other qualified anesthesia provider with surgery, geriatrics, hospital medicine, palliative care, or other appropriate specialty to help manage the perioperative care of a frail patient.	Emergent Cases	None	None	No	Yes	Care Coordination	Process	No	Traditional (Proportion)	1	N/A
AQI68	N/A	Obstructive Sleep Apnea: Mitigation Strategies	Patient Safety	Preventable Healthcare Harm	Percentage of patients aged 18 years or older, who undergo an elective procedure requiring anesthesia services who are screened for obstructive sleep apnea (OSA) AND, if positive, for whom two or more selected mitigation strategies was used prior to PACU discharge	All patients aged 18 years or older, who undergo an elective procedure requiring anesthesia services Denominator Note: For the purposes of this measure, anesthesia services only include cases using general anesthesia, neuraxial anesthesia and monitored anesthesia care (MAC)	Patients who are screened for obstructive sleep apnea (OSA) AND, if positive, have documentation that two or more of the following mitigation strategies were used prior to PACU discharge: •Preoperative initiation of continuous positive airway pressure (CPAP) or non-invasive positive pressure ventilation (NIPPV) •Preoperative use of mandibular advancement devices or oral appliances •Intraoperative administration of CPAP, nasopharyngeal airway, or oral appliance during sedation •Use of major conduction anesthesia (spinal/epidural) or peripheral nerve block •Multimodal analgesia •Extubation while patient is awake •Verification of full reversal of neuromuscular block •Extubation and recovery carried out in lateral, semiupright, or other nonsupine position •Postoperative administration of CPAP, nasopharyngeal airway, or oral appliance in the post anesthesia care unit (PACU)	None	Documentation of medical reason(s) for not screening for obstructive sleep apnea and/or documenting the use of two or more mitigation strategies (i.e. patient remains intubated postoperatively, listed mitigation strategies contraindicated, other medical reason(s))	None	No	Yes	Patient Safety	Process	No	Traditional (Proportion)	1	N/A
ONSQIR21	N/A	Patient Reported Health-Related Quality of Life (HRQoL) during Treatment for Advanced Cancer	Person and Caregiver Centered Experience and Outcomes	Functional Outcomes	Percentage of patients aged 18 and older with an active diagnosis of advanced cancer (Stage III or Stage IV) receiving chemotherapy and/or immunotherapy for treatment of cancer, who have HRQoL assessed on the FACT-G (Version 4) or PROMIS Global Health short form (Version 1.2) at least twice during the measurement period at least 90 days apart, where the most recent total score indicates the same or better quality of life. Two rates are reported: 1. Percentage of patients aged 18 and older with an active diagnosis of advanced cancer (Stage III or Stage IV) receiving chemotherapy and/or immunotherapy for treatment of cancer, who have HRQoL assessed on the FACT-G (Version 4) or PROMIS Global Health short form (Version 1.2) at least twice during the measurement period at least 90 days apart. 2. Percentage of patients aged 18 and older with an active diagnosis of advanced cancer (Stage III or Stage IV) receiving chemotherapy and/or immunotherapy for treatment of cancer, who have HRQoL assessed on the FACT-G (Version 4) or PROMIS Global Health short form (Version 1.2) at least twice during the measurement period at least 90 days apart, where the most recent total score indicates the same or better quality of life.	All patients aged 18 and older with an active diagnosis of advanced cancer (Stage III or Stage IV) receiving a chemotherapy and/or immunotherapy for treatment of cancer during the measurement period. Population 1: Equals Initial Population. Population. 2: Equals Initial Population who were assessed on the FACT-G (Version 4) or PROMIS Global Health short form (Version 1.2) at least twice during the measurement period at least 90 days apart, where the same tool was used for both assessments.	Population 1: Patients who were assessed for health-related quality of life (HRQOL) using FACT-G (Version 4) or PROMIS Global Health short form (Version 1.2) assessment tool at least twice during the measurement period at least 90 days apart, where the same tool was used for both assessments. Population 2: Patients whose most recent assessment total score during the measurement period is equal to or greater than any earlier assessment total score during the measurement period that is at least 90 days prior to the most recent assessment, where the same tool was used for both assessments.	Hospice care at any time during the measurement period. Patient expired during the measurement period.	None	None	No	Yes	Outcome	Patient Reported Outcome (PRO)	No	Traditional (Proportion)	2	Percentage of patients aged 18 and older with an active diagnosis of advanced cancer (Stage III or Stage IV) receiving chemotherapy and/or immunotherapy for treatment of cancer, who have HRQoL assessed on the FACT-G (Version 4) or PROMIS Global Health short form (Version 1.2) at least twice during the measurement period at least 90 days apart, where the most recent total score indicates the same or better quality of life.
ONSQIR22	N/A	PCR Test with MR2 or greater result (BCR-ABL1 transcript level <= 1% [IS]) for patients receiving TKI for at least 6 months for Chronic Myelogenous Leukemia	Effective Clinical Care	Medication Management	Percentage of patients aged 18 and older with chronic myelogenous leukemia who are receiving TKI therapy for at least 6 months, who have at least 1 PCR test performed with the most recent result equal to or greater than MR2 (BCR-ABL1 transcript level <= 1% [IS]) during the measurement period.	Percentage of patients aged 18 and older with chronic myelogenous leukemia who have been receiving TKI therapy for at least 6 months at any time during the measurement period.	Percentage of patients that have at least 1 PCR test performed with the most recent result equal to or greater than MR2 (BCR-ABL1 transcript level <= 1% [IS]) during the measurement period.	Hospice care at any time during the measurement period. Patient expired during the measurement period	None	None	No	Yes	Outcome	Intermediate Outcome	No	Traditional (Proportion)	1	N/A
ONSQIR23	N/A	Assessment for and management of immune-related adverse events during cancer treatment with checkpoint inhibitors (ICPi)	Effective Clinical Care	Medication Management	Percentage of patients aged 18 and older receiving a checkpoint inhibitor (ICPi) for cancer experiencing immune-related adverse events of documented grade 3+ diarrhea OR documented grade 3+ hypothyroidism OR documented grade 3+ dermatitis OR documented grade 3+ pneumonitis AND for each adverse event, there is guideline concordant intervention (per ASCO/NCCN guideline) during the measurement period.	Percentage of patients aged 18 and older receiving an immune checkpoint inhibitor (ICPi) for cancer experiencing immune-related adverse events of documented grade 3+ diarrhea OR documented grade 3+ hypothyroidism OR documented grade 3+ dermatitis OR documented grade 3+ pneumonitis during the measurement period.	Patients who have, for each immune-related adverse event, guideline concordant intervention during the measurement period to include the following interventions for these Checkpoint Inhibitor (ICPi) Medications – Atezolizumab – Avelumab – Durvalumab – Ipilimumab – Nivolumab – Pembrolizumab: Grade 3+ Diarrhea in the presence of ICPi: - 7+ stools/day over baseline - Requiring hospitalization for diarrhea - Limited ability to perform self-care - IV fluids required >24 hours - Enterocolitis diagnosis; Best-available intervention for Diarrhea: - Antidiarrheals (loperamide, atropine/diphenoxylate) - Corticosteroids (prednisone, prednisolone, methylprednisolone) - ICPi discontinuation or hold; Grade 3+ Hypothyroidism in the presence of ICPi: - TSH >10mIU/L - Bradycardia - Hypothermia - Limited ability to perform self-care - Hospitalization indicated; Best available intervention for Hypothyroidism: - Corticosteroids (prednisone, prednisolone, methylprednisolone) - ICPi discontinuation or hold - Endocrine consultation - Thyroid supplementation (levothyroxine sodium); Grade 3+ Dermatitis in the presence of ICPi: - Intense, widespread pruritis - Rash, pustules >30% of body - Limited ability to perform self-care - Sleep interruption due to pruritis; Best-available intervention for Dermatitis: - Corticosteroids (prednisone, prednisolone, methylprednisolone) - ICPi discontinuation or hold;	None	None	None	No	Yes	Outcome	Intermediate Outcome	No	Traditional (Proportion)	1	N/A

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							Grade 3+ Pneumonitis in the presence of ICPI: - Diffuse lung parenchyma inflammation, >50%+ of lung parenchyma - Limited ability to perform self-care - Requiring hospitalization; Best available intervention for Pneumonitis: - ICPi discontinuation - Corticosteroids (prednisone, prednisolone, methylprednisolone) - Bronchoscopy with BAL - Infliximab, IVIG, mycophenolate, or mofetil - Pulmonary and/or infectious disease consultation.											
PINC55	N/A	Appropriate Documentation of a Malnutrition Diagnosis	Effective Clinical Care	Transfer of Health Information and Interoperability	Percentage of patients age 18 years and older who are found to be severely or moderately malnourished based on a nutrition assessment that have appropriate documentation in the medical record of a malnutrition diagnosis	All patients age 18 years and older on the date of the encounter with a completed nutrition assessment that resulted in findings of moderate or severe malnutrition. Included Populations: Patients age 18 years and older who have documented findings of severe or moderate malnutrition from a completed nutrition assessment as defined by value set OIDs: • Severe malnutrition: 2.16.840.1.113762.1.4.1095.43 • Moderate malnutrition: 2.16.840.1.113762.1.4.1095.47	Patients in the denominator with a documented diagnosis of malnutrition. Included Populations: Patients in the denominator with a documented diagnosis of malnutrition as defined by value set OID: 2.16.840.1.113762.1.4.1095.55	None	None	None	No	No	N/A	Process	No	Traditional (Proportion)	1	N/A
PINC56	N/A	Assessment of Nutritionally At-Risk Patients for Malnutrition and Development of Nutrition Recommendations/Interventions by a Registered Dietitian Nutritionist	Effective Clinical Care	Patient-Focused Episode of Care	Percentage of patients age 18 years and older who are nutritionally at-risk that have documented nutrition intervention recommendations by a registered dietitian nutritionist or clinical qualified nutrition professional if identified with moderate or severe malnutrition as part of a nutrition assessment	All patients age 18 years and older who were identified to be at-risk for malnutrition based on a malnutrition screening, OR that were referred to a registered dietitian nutritionist or clinically qualified nutrition professional. It is recommended that a malnutrition screening be performed using a validated screening tool, which may include but is not limited to, one of the following validated tools: • Malnutrition Screening Tool (MST) (Wu, 2012), • Nutrition Risk Classification (NRC) (Kovacevich, 1997), • Nutritional Risk Index (NRI) (Honda, 2016), • Nutritional Risk Screening 2002 (NRS-2002) (Bauer, 2005), • Short Nutrition Assessment Questionnaire (SNAQ) (Pilgrim, 2016). Bauer JM, Vogl T, Wicklein S, Trögner J, Mühlberg W, Sieber CC. Comparison of the Mini Nutritional Assessment, Subjective Global Assessment, and Nutritional Risk Screening (NRS 2002) for nutritional screening and assessment in geriatric hospital patients. Z Gerontol Geriatr. 2005;38(5):322-7. Kovacevich DS, Boney AR, Braunschweig CL, Perez A, Stevens M. Nutrition risk classification: a reproducible and valid tool for nurses. Nutr Clin Pract. 1997;12(1):20-5. Honda Y, Nagai T, Iwakami N, et al. Usefulness of Geriatric Nutritional Risk Index for Assessing Nutritional Status and Its Prognostic Impact in Patients Aged ≥65 Years With Acute Heart Failure. Am J Cardiol. 2016; Pilgrim AL, Baylis D, Jameson KA, et al. Measuring Appetite with the Simplified Nutritional Appetite Questionnaire Identifies Hospitalized Older People at Risk of Worse Health Outcomes. J Nutr Health Aging. 2016;20(1):3-7. Wu ML, Courtney MD, Shortridge-baggett LM, Finlayson K, Isenring EA. Validity of the malnutrition screening tool for older adults at high risk of hospital readmission. J Gerontol Nurs. 2012;38(6):38-45. Included Populations: Patients with a malnutrition screening result of "at risk" (as defined by value set OID: 2.16.840.1.113762.1.4.1095.38) OR who have a referral to a registered dietitian or clinically qualified nutrition professional.	Patients in the denominator with a completed nutrition assessment by registered dietitian nutritionist or clinically qualified nutrition professional who have findings of moderate or severe malnutrition AND recommendations for nutrition intervention(s) OR a nutrition care plan documented in the medical record. Nutrition interventions are categorized by those outlined by the Academy of Nutrition and Dietetics' nutrition intervention terminology: 1. Food and Nutrient Delivery 2. Nutrition Education 3. Nutrition Counseling 4. Coordination of Nutrition Care Recommended nutrition assessment tools include: • Nutrition-Focused Physical Exam (White, 2012) • Subjective Global Assessment (Detsky, 1987), • Patient Generated Subjective Global Assessment (Bauer, 2002) American Society for Parenteral and Enteral Nutrition and Academy of Nutrition and Dietetics: Revised 2014 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Nutrition Support, December 2014 Volume 114 Number 12. Detsky AS, Mclaughlin JR, Baker JP, et al. What is subjective global assessment of nutritional status? JPEN J Parenter Enteral Nutr. 1987;11(1):8-13. Bauer J, Capra S, Ferguson M. Use of the scored Patient-Generated Subjective Global Assessment (PG-SGA) as a nutrition assessment tool in patients with cancer. Eur J Clin Nutr. 2002;56(8):779-85. Included Populations: Patients with a completed nutrition assessment (as defined by value set OID: 2.16.840.1.113762.1.4.1095.29), who are identified with severe or moderate malnutrition and have a documented nutrition care plan or nutrition intervention recommendations.	None	Documented patient reason for not participating in nutrition assessment or with advanced care directives.	None	No	No	N/A	Process	No	Traditional (Proportion)	1	N/A