Telehealth

Measures At A Glance

Disclaimer: URAC reserves the right to update its measures and measure sets to maintain measure relevancy and to remedy any unintended consequences that may arise during implementation. Further, URAC may add and/or align its measures with regulatory requirements of federal, state, and local governments.

Mandatory Measures (7)

Note: Mandatory measures are those measures that are a requirement of accreditation and must be reported to URAC on an annual basis.

Measure #	Measure Name	Measure Steward	URAC Domain	Measure Description	Numerator	Denominator	Data Source
ACO2014-02	Reconciled Medication List Received by Discharged Patients	AMA-PCPI	Communication & Care Coordination	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories.	Patients or their caregiver(s) who received a reconciled medication list at the time of discharge.	All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.	Administrative Claims; Electronic Clinical Data: Electronic Health Record, Paper Medical Records
ACO2014-03	Transition Record with Specified Elements Received by Discharged Patients	AMA-PCPI	Communication & Care Coordination	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation 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 including, at a minimum, all of the specified elements.	Patients 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.	All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.	Administrative Claims; Electronic Clinical Data: Electronic Health Record, Paper Medical Records)

Measure #	Measure Name	Measure Steward	URAC Domain	Measure Description	Numerator	Denominator	Data Source
ACO2014-07	Optimal Diabetes care	MN Community Measurement	Prevention & Treatment	The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes and whose diabetes was optimally managed during the measurement period as defined by achieving ALL of the following: • HbA1c less than 8.0 mg/dL • Blood Pressure less than 140/90 mmHg • On a statin medication, unless allowed contraindications or exceptions are present • Non-tobacco user • Patient with ischemic vascular disease is on daily aspirin or antiplatelets, unless allowed contraindications or exceptions are present.	Patients ages 18 or older at the start of the measurement period AND less than 76 years at the end of the measurement period with diabetes who meet all of the following targets from the most recent visit during the measurement year: The most recent HbA1c in the measurement period has a value less than 8.0 mg/dL • The most recent Blood Pressure in the measurement period has a systolic value of less than 140 mmHg AND a diastolic value of less than 90 mmHg • On a statin medication, unless allowed contraindications or exceptions are present • Patient is not a tobacco user • Patient with ischemic vascular disease (Ischemic Vascular Disease Value Set) is on daily aspirin or anti-platelets, unless allowed contraindications or exceptions are present.	Patients ages 18 or older at the start of the measurement period AND less than 76 years at the end of the measurement period with a diagnosis of diabetes with any contact during the current or prior measurement period OR had diabetes present on an active problem list at any time during the measurement period AND have at least one patient office visit performed or supervised by an eligible provider in an eligible specialty for any reason during the measurement period.	Administrative Claims; Electronic Clinical Data: Electronic Health Record, Paper Medical Records

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DM2012-13	Drug-Drug Interactions	Pharmacy Quality Alliance (PQA)	Safe Care	This measure assesses the percentage of patients who received a prescription for a target medication during the measurement period and who were dispensed a concurrent prescription for a precipitant medication. Stratify by Commercial, Medicaid, and Medicare (i.e., report each product line separately).	The number of patients in the denominator who were dispensed a concurrent precipitant medication during the measurement period.	Patients who received a target medication.	Pharmacy Claims; Enrollment Data
PH2015-01	Primary Medication Non-Adherence (PMN)	Pharmacy Quality Alliance (PQA)	Engagement & Experience of Care	The percentage of prescriptions for chronic medications e-prescribed by a prescriber and not obtained by the patient in the following 30 days. This rate measures the level of primary medication non-adherence across a population of patients.	The number of e-prescribing transactions in the denominator where there was no pharmacy dispensing event that matched the patient and the prescribed drug or appropriate alternative drug within 30 days following the e-prescribing event.	The number of e-prescriptions for newly initiated drug therapy for chronic medications for PMN during the measurement period and for the eligible population.	Prescription Claims
ACO2014-19	Heart Failure: Beta-blocker therapy for Left Ventricular Systolic Dysfunction	AMA-PCPI	Effective Clinical Care *	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	Patients who were prescribed beta-blocker therapy within a 12 month period when seen in the outpatient setting.	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%.	Administrative Claims; Electronic Clinical Data: Electronic Health Record, Paper Medical Records

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DTM2010-04	Call Center Performance	URAC	Health Care Mgmt	This measure has two parts: *Part A* evaluates the percentage of calls during normal business hours to the organization's call service center(s) during the measurement period that were answered by a live voice within 30 seconds; *Part B* evaluates the percentage of calls made during normal business hours to the organization's call service center(s) during the reporting year that were abandoned by callers before being answered by a live customer service representative.	*Part A*: The number of calls answered by a live customer service representative within 30 seconds of being placed in the organization's ACD call queue. *Part B*: The number of calls abandoned by callers after being placed in the ACD call queue and before being answered by a live customer service representative.	Total number of calls received by the organization's call service center during normal business hours during the measurement period.	Automatic Call Distribution (ACD) Data

Exploratory Measures (5)

Note: Exploratory measures are measures "on the cutting edge", meaning that either the industry has not come to consensus on how to measure a particular concept or the measure is experimental or in development. In the case of exploratory measure, the organization has the option to report.

Measure #	Measure Name	Measure Steward	URAC Domain	Measure Description	Numerator	Denominator	Data Source
ACO2014-04	Hospital-Wide All-Cause Unplanned Readmission Measure	CMS	Patient Safety	This measure estimates a hospital-level risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge. 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, each of which will be described in greater detail below. The measure also indicates the hospital-level standardized risk 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 for the index admission (the admission included in the measure cohort). A specified set of planned readmissions do not count in the readmission outcome. CMS annually reports the measure for patients who are 65 years or older, are enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals.	The outcome for the HWR measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of 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.	The measure at the hospital level includes admissions for Medicare beneficiaries who are 65 years and older and are discharged from all nonfederal, acute care inpatient US hospitals (including territories) with a complete claims history for the 12 months prior to admission.	Administrative Claims

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CM2013-06	3-Item Care Transition Measure	University of Colorado Health Sciences Center	Communication & Care Coordination	The 3-Item Care Transition Measure* (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. This measures the satisfaction rate across CMT-3 survey respondents.	The hospital level sum of CTM-3 scores for all eligible sampled patients.	The number of eligible sampled adult patients discharged from a general acute care hospital during the measurement period.	Survey Data
ACO2014-20	Chronic Stable Coronary Artery Disease: Lipid Control	AMA-PCPI	Communication & Care Coordination	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who have a LDL-C result <100 mg/dL OR patients who have a LDL-C result >=100 mg/dL and have a documented plan of care to achieve LDL-C <100mg/dL, including at a minimum the prescription of a statin.	Patients who have a LDL-C result <100 mg/dL OR Patients who have a LDL-C result >=100 mg/dL and have a documented plan of care1 to achieve LDL-C <100 mg/dL, including at a minimum the prescription of a statin within a 12 month period.	All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period.	Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record; Registry data
ACO2019-05	CG CAHPS (Getting Timely Appointments, Care, and Information; How Well Providers (or Doctors) Communicate with Patients; and Access to Specialists)	AHRQ	Patient Engagement/ Experience	The Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months. The survey includes standardized questionnaires for adults and children.	N/A	N/A	Patient Reported; Survey

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TH2015-01	Clinicians/Groups' Health Literacy Supplemental Items	AHRQ	Patient Engagement/ Experience	These measures are based on CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician & Group Survey. The item set includes the following domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms.	N/A	N/A	Patient Reported; Survey