eMeasure Title	**Closing the Referral Loop: Receipt of Specialist Report**		
eMeasure Identifier (Measure Authoring Tool)	50	**eMeasure Version number**	5.0.000
NQF Number	Not Applicable	**GUID**	f58fc0d6-edf5-416a-8d29-79afbfd24dea
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	Centers for Medicare & Medicaid Services (CMS)		
Measure Developer	National Committee for Quality Assurance		
Endorsed By	None		
Description	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		
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Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Problems in the outpatient referral and consultation process have been documented, including lack of timeliness of information and inadequate provision of information between the specialist and the requesting physician (Gandhi, 2000; Forrest, 2000; Stille, 2005). In a study of physician satisfaction with the outpatient referral process, Gandhi et al. (2000) found that 68% of specialists reported receiving no information from the primary care provider prior to referral visits, and 25% of primary care providers had still not received any information from specialists 4 weeks after referral visits. In another study of 963 referrals (Forrest, 2000), pediatricians scheduled appointments with specialists for only 39% and sent patient information to the specialists in only 51% of the time. In a 2006 report to Congress, MedPAC found that care coordination programs improved quality of care for patients, reduced hospitalizations, and improved adherence to evidence-based care guidelines, especially among patients with diabetes and CHD. Associations with cost-savings were less clear; this was attributed to how well the intervention group was chosen and defined, as well as the intervention put in place. Additionally, cost-savings were usually calculated in the short-term, while some argue that the greatest cost-savings accrue over time (MedPAC, 2006). Improved mechanisms for information exchange could facilitate communication between providers, whether for time-limited referrals or consultations, on-going co-management, or during care transitions. For example, a study by Branger et al. (1999) found that an electronic communication network that linked the computer-based patient records of physicians who had shared care of patients with diabetes significantly increased frequency of communications between physicians and availability of important clinical data. There was a 3-fold increase in the likelihood that the specialist provided written communication of results if the primary care physician scheduled appointments and sent patient information to the specialist (Forrest, 2000). Care coordination is a focal point in the current health care reform and our nation's ambulatory health information technology (HIT) framework. The National Priorities Partnership recently highlighted care coordination as one of the most critical areas for development of quality measurement and improvement (NPP, 2008).		
Clinical Recommendation Statement	None		
Improvement Notation	A higher score indicates better quality		

Reference	Branger, P. J., Van't Hooft, A., Van Der Wouden, J. C., Moorman, P. W., and Van Bemmel, J. H. (1999). Shared care for diabetes: supporting communication between primary and secondary care. International Journal of Medical Informatics 53(2-3), 133-142.
Reference	Forrest, C. B., Glade, G. B., Baker, A. E., Bocian, A., Von Schrader, S., and Starfield, B. (2000). Coordination of specialty referrals and physician satisfaction with referral care. Archives of Pediatrics and Adolescent Medicine 154(5), 499-506.
Reference	Gandhi, T. K., Sittig, D. F., Franklin, M., Sussman, A. J., Fairchild, D. G., and Bates, D. W. (2000). Communication breakdown in the outpatient referral process. Journal of General Internal Medicine 15(9), 626-631.
Reference	Medicare Payment Advisory Commission (MedPAC) Report to the Congress: Medicare Payment Policy.March, 2006. Retrieved January 21, 2016, from http://www.medpac.gov/documents/reports/Mar06_EntireReport.pdf?sfvrsn=0
Reference	National Priorities Partnership. National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare. Washington, DC: National Quality Forum; 2008.
Reference	Stille, C. J., Jerant, A., Bell, D., Meltzer, D., and Elmore, J. G. (2005). Coordinating care across diseases, settings, and clinicians: a key role for the generalist in practice. Annals of Internal Medicine 142(8), 700-708.
Definition	Referral: A request from one physician or other eligible provider to another practitioner for evaluation, treatment, or co-management of a patient's condition. This term encompasses referral and consultation as defined by Centers for Medicare and Medicaid Services.
Guidance	The provider to whom the patient was referred should be the same provider that sends the report. If there are multiple referrals for a patient during the measurement period, use the first referral. The consultant report that will fulfill the referral should be completed after the referral. Eligible professionals reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, eligible professionals who see patients towards the end of the reporting period (ie, December in particular), should communicate the consultant report as soon as possible in order for those patients to be counted in the measure numerator. Communicating the report as soon as possible will ensure the data is included in the submission to CMS.
Transmission Format	TBD
Initial Population	Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred
Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

- Population Criteria
- Data Criteria (QDM Variables)
- Data Criteria (QDM Data Elements)
- Supplemental Data Elements
- Risk Adjustment Variables

Population Criteria

- **Initial Population =**
  - AND: First: "Occurrence A of Intervention, Performed: Referral" during "Measurement Period"
  - AND: Union of:
    - "Encounter, Performed: Preventive Care- Initial Office Visit, 0 to 17"
    - "Encounter, Performed: Preventive Care - Established Office Visit, 0 to 17"
    - "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up"
    - "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up"
    - "Encounter, Performed: Office Visit"
    - "Encounter, Performed: Face-to-Face Interaction"
    - "Encounter, Performed: Ophthalmological Services"
    - during "Measurement Period"
- **Denominator =**

  - AND: Initial Population
- **Denominator Exclusions =**
  - None
- **Numerator =**
  - AND: "Communication: From Provider to Provider: Consultant Report" satisfies all:
    - fulfills "Occurrence A of Intervention, Performed: Referral"
    - starts after start of "Occurrence A of Intervention, Performed: Referral"
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - None
- **Stratification =**
  - None

Data Criteria (QDM Variables)

- None

Data Criteria (QDM Data Elements)

- "Communication: From Provider to Provider: Consultant Report" using "Consultant Report Grouping Value Set (2.16.840.1.113883.3.464.1003.121.12.1006)"
- "Encounter, Performed: Face-to-Face Interaction" using "Face-to-Face Interaction Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1048)"
- "Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services Grouping Value Set (2.16.840.1.113883.3.526.3.1285)"
- "Encounter, Performed: Preventive Care - Established Office Visit, 0 to 17" using "Preventive Care - Established Office Visit, 0 to 17 Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1024)"
- "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up" using "Preventive Care Services - Established Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1025)"
- "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up" using "Preventive Care Services-Initial Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Encounter, Performed: Preventive Care- Initial Office Visit, 0 to 17" using "Preventive Care- Initial Office Visit, 0 to 17 Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1022)"
- "Intervention, Performed: Referral" using "Referral Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1046)"

Supplemental Data Elements

- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity CDCREC Value Set (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer SOP Value Set (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race CDCREC Value Set (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex AdministrativeGender Value Set (2.16.840.1.113762.1.4.1)"

Risk Adjustment Variables

- None

Measure Set	Not Applicable