QM 2018 is in Preview Mode Only. Save is NOT enabled. Contact your ACO Administrator.

Quality Measures 2018 Questionnaire

Please answer the following questionnaire accordingly.

Date of Entry:	02/15/2018
Patient Name:	JOHN SMITH
HICN:	111111111D
Patient DOB:	09/05/1944
Gender:	M
CCM:	enrolled
Primary Practice:	Non-assigned practice
MRN:	
Patient Medical Record Status?	(•) Medical Record Found ( ) Medical Record Not Found ( ) Not Qualified for Sample
Scoring:	Quality Score: 0.00% / Sum of points: 0 / Max Points: 0

ACO 12 **Care-1** **Care Coordination/Patient Safety**

Medication Reconciliation

( ) **N/A (Patient not discharged from inpatient facility during the measurement period)**

Patients aged 18 and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen in the office within 30 days following discharge by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care. If multiple discharges, each discharge needs to be addressed in the medical record and medication(s) reconciled.

For Discharge Date ______ and Office Visit Date ______ answer the following...

( ) Medication reconciliation completed during office visit within 30 days of discharge from an inpatient facility and documented in the outpatient medical record

( ) Medication reconciliation **NOT** completed due to no office visit within 30 days

( ) Medication reconciliation **NOT** completed by eligible professional and **NOT** documented in the medical record

Comments:

ACO 13 **Care-2** **Care Coordination/Patient Safety**

Falls: Screening for Future Fall Risk

( ) **N/A (Patient is assessed to be non-ambulatory at the most recent encounter during the measurement year.)**

Screening for Future Fall Risk: Assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure, however potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test.

Fall: A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epilectic seizure, or overwhelming external force.

Did the patient receive a Falls Screening during the measurement period with documentation in the medical record?

Cancel

- ◯ Falls Screening completed and documented in chart between January 1, 2018 to December 31, 2018
- ◯ Falls Screening **NOT** documented in medical record, no medical or other reason

Service Date:

Comments:

History +

ACO 20 PREV-5 Preventative Health

Breast Cancer Screening

- ◯ **N/A (Patient is male.)**
- ◯ **N/A (Patient greater than or equal 65 years of age and enrolled in institutional special needs plan or residing in a long term care facility.)**
- ◯ **N/A (Mammogram not performed due to medical reason (e.g. bilateral mastectomy))**

Mammography Screening for breast cancer of women ages 50 through 74 years during the measurement period or the 15 months prior.

Documentation in the medical record **must include** both of the following:

A note indicating the date the breast cancer screening was performed AND the result of the findings.

Denominator Note: The intent of the measure is that starting at age 50 women should have one or more mammograms every 24 months with a 3 month grace period.

Did the patient have a mammography screening performed during the measurement period or the 15 months prior to the measurement period?

- ◯ Mammogram performed during the measurement period or the 15 months prior to the measurement period
- ◯ Mammogram **NOT** performed during the measurement period or the 15 months prior to the measurement period, no medical reason documented

Service Date:

Comments:

History +

ACO 19 PREV-6 Preventative Health

Colorectal Cancer Screening

- ◯ **N/A (Patient not screened due to medical reason(s) (e.g. total colectomy))**
- ◯ **N/A (Patient greater than or equal 65 years of age and enrolled in institutional special needs plan or residing in a long term care facility.)**

Colorectal Cancer Screening of all patients age 50 - 75 years.

Cancel

Documentation in the medical record must include the date the colorectal cancer screening was performed and the result or findings.

Did the patient receive colorectal cancer screening? Please check most recent appropriate screening with documentation in medical record.

- Fecal immunochemical DNA test (FIT-DNA) during the reporting period or the two years prior
- Fecal occult blood test (FOBT) during the reporting period
- Flexible sigmoidoscopy or computed tomography (CT) colonography during the reporting period or the four years prior
- Colonoscopy during the reporting period or the nine years prior
- Patient **NOT** screened and no medical reason documented

Service Date:

Comments:

History +

ACO 14 **PREV-7** **Preventative Health**

Influenza Immunization

Patients age 6 months and older who received an Influenza Immunization between October 1, 2017 and March 31, 2018 OR who reported previous receipt (since August 1st, 2017) of an influenza immunization. Documentation of reason patient NOT vaccinated should be in medical record.

Previous Receipt – receipt of current season's influenza immunization from another provider OR from save provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st.

Did the patient receive an influenza immunization during the current flu season or from previous receipt?

- Patient received influenza immunization during the current flu season
- Patient/Parent reasons for declining immunization
- Patient not vaccinated due to medical reason, documentation in record (e.g. allergy)
- Patient not vaccinated due to system reasons
- Vaccination **NOT** received (no medical or other reason)

Service Date:

Comments:

History +

ACO 15 **PREV-8** **Preventative Health**

Pneumococcal Vaccination

Patients age 65 and older who have ever received a Pneumococcal Vaccine.

Cancel

Did the patient, age 65 and older, ever receive a Pneumococcal Vaccine?

- Patient received the pneumococcal vaccine
- Patient declined vaccine (not acceptable per CMS guidelines)
- Vaccination **NOT** received

Service Date:

Comments:

History +

ACO 16 **PREV-9** **Preventative Health**

Body Mass Index (BMI) Screening and Follow-up

- **N/A (Excluded from measure due to medical reasons (e.g. pregnancy, palliative care))**
- **N/A (Excluded from the measure due to documented patient refusal of height and/or weight measurement or refusal of follow-up)**

Patients aged 18 years and older with a BMI documented during the current encounter or during the previous 12 months and with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter.

Calculated BMI is done in the eligible clinician's office/facility (eligible clinician or their staff) or may be obtained by the eligible clinician from outside medical records within the the last 12 months.

Follow-up Plan may include but is not limited to: documentation of a future appointment, education, or referral.

Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m2

Did the patient have a calculated BMI at the most recent visit or within the previous 12 months? Did the patient require a follow-up plan for being outside normal parameters?

- Patient BMI within normal parameters in the past 12 months
- Patient BMI outside normal parameters and follow-up plan documented in medical record
- Patient BMI outside normal parameters and **NO** follow-up plan documented
- Patient did **NOT** have a BMI measurement performed, no reason documented
- Patient BMI outside normal parameters and NO follow-up plan documented due to medical reason documented (urgent or emergent medical situation or elderly patient (65 or older) for whom weight reduction/gain would complicate other underlying health conditions)

Service Date:

Comments:

History +

ACO 17 **PREV-10** **Preventative Health**

Cancel

Tobacco Use: Screening and Cessation Intervention

Patients age 18 and older who were screened for Tobacco Use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. This includes any type of tobacco: cigarettes, cigars, chew.

This measure does NOT, however, currently capture e-cigarette usage as either tobacco use or a cessation aid.

Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

Note: If tobacco use status of a patient is "unknown" then the patient cannot be counted in the numerator and should be considered a measure failure. If the patient has an allowable medical exception, then remove from denominator and report as a valid exception.

Was patient screened for tobacco use in last 24 months AND received cessation counseling/treatment if identified as a tobacco user?

- ○ Patient screened for tobacco use at least once within 24 months AND identified as a tobacco non-user
- ○ Patient identified as a tobacco user AND received counseling and/or treatment from eligible clinician
- ○ Patient not screened due to medical reasons (e.g. terminal illness)
- ○ Patient identified as a tobacco user and **NO** counseling and/or treatment plan provided by eligible clinician or not documented in medical record
- ○ Patient **NOT** screened or listed as "unknown" with no medical exceptions documented (not acceptable per CMS guidelines)
- ○ Patient is a tobacco user but was not provided cessation counseling because of medical reason (e.g. terminal illness, other medical reason).

Service Date:

Comments:

History +

ACO 18 **PREV-12** **Preventative Health**

Screening for Depression and Follow-up Plan

- ○ **N/A (Patient excluded from measure due to an active diagnosis of bipolar disorder or depression)**

All patients 12 years and older screened for depression on the date of an encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Follow up plan must include one of the following: additional evaluation for depression, suicide risk assessment, referral to a qualified practitioner, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression.

Age appropriate tools:

Adolescent Screening Tools: age 12 to <18 (Not limited to)
Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire, CES-D, and PRIME MD-PHQ 2.

Adult Screening Tools: 18 years and older (Not limited to)
Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), etc.

Did the patient receive the depression screening on the date of an encounter AND if positive, was a follow-up plan documented on the date of the positive screen?

NOTE: Use most recent screening for depression.

- ○ Negative clinical depression screening, follow-up plan not required

Cancel

- Positive clinical depression screening and follow-up plan documented in medical record
- Patient/Parent refused to participate and reason(s) documented in medical record
- Medical reason screening not completed (e.g. emergent situation, delirium)
- Positive clinical depression screening but **NO** follow-up plan documented
- Patient **NOT** screened, no medical/patient reason documented in record

Service Date:

Comments:

History +

ACO 42 PREV-13 Preventative Health

Statin Therapy

- **N/A (Patient is in no risk category or in Risk Category 3 without an LDL-C of 70 – 189 mg/dL during the measurement year or two years prior.**
- **N/A (Medical Reason (pregnancy, breastfeeding, diagnosis of rhabdomyolysis)**

Clinical Atherosclerotic Cardiovascular Disease (ASCVD) is defined as: Acute Coronary Syndromes, History of Myocardial Infarction, Stable or Unstable Angina, Coronary or other Arterial Revascularization, Stroke or Trans Ischemic Attack (TIA), Peripheral Artery Disease (PAD) of atherosclerotic origin

Medical Exclusions: Patients who are pregnant, are breastfeeding, or who are diagnosed with rhabdomyolysis.

Medical Exceptions: Patients with documented adverse effect, allergy or intolerance, active liver or hepatic disease or insufficiency, end stage renal disease (ESRD), or most recent fasting or direct LDL-C lab test <70 mg/dL for diabetes diagnosis

Does the patient belong to a specified Risk Category and have they received a prescription for statin during the measurement period?

- [ ] **Patient is in Risk Category 1** – Patient aged 21 years and older with a diagnosis of ASCVD (active or history of) at any time up through the last day of the measurement period
- [ ] **Patient is in Risk Category 2** – Patient aged 21 years and older that has ever had a fasting or direct LDL-C >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia.
- [ ] **Patient is in Risk Category 3** - Patient aged 40-75 years with a diagnosis of Type 1 or Type 2 diabetes **AND** has had a fasting or direct LDL-C level of 70-189 mg/dL in the measurement period or two years prior the beginning of the measurement period
- [ ] **Patient is in Risk Category 3** - Patient aged 40-75 years with a diagnosis of Type 1 or Type 2 diabetes and has **NOT** had a fasting or direct LDL-C level of 70-189 mg/dl in the measurement period or two years prior to the beginning of the measurement period. *Patient is excluded from the measure if this is the only Risk Category selected.*

- Patient is taking Statin or was prescribed Statin
- Patient is **NOT** taking Statin and was **NOT** prescribed Statin for medical reasons (adverse effect, allergy, or intolerance to Statin medication, active liver disease or hepatic disease or insufficiency, end stage renal disease (ESRD) or patient with diabetes who has the most recent or fasting LDL-C result < 70 mg/dL)
- Patient is **NOT** taking Statin and was **NOT** prescribed Statin - **NO REASON**

Service Date:

Comments:

Cancel

History +

ACO 27 DM-2 At Risk Population

☐ N/A (Patient does not have a diagnosis of Diabetes Mellitus.)

Composite/DM with HbA1c > 9 percent (poor control)

Patients ages 18 -75 with a diagnosis of Diabetes Mellitus (DM) who had a Hemoglobin A1c (HbA1c) > 9.0 percent in the measurement period.

Guidance: at a minimum the medical record must include a note indicating the date on which the HbA1c test was performed and the result documented. Use the following priority ranking:

1. Lab report draw date
2. Lab report date
3. Flow sheet documentation
4. Practitioner notes
5. Other documentation.

If test was performed but result not documented, record 0 (zero).

NOTE: Patient is numerator compliant if most recent HbA1c level is > 9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.

This measure is scored inversely, because a normal HbA1c value is considered a non-performance answer. The goal of this measure is to have the lowest score possible as opposed to the other measures where performance is measured by higher scores.

On the display, the non-performance answer (Most recent HbA1c less than or equal to 9.0 percent) is shown as a performance response to indicate that it is best to have as many patients screened with an HbA1c in range (9.0% or lower).

Did the patient have a diagnosis of DM and the most recent HbA1c > 9 percent (poor control)?

○ Most recent HbA1c less than or equal to 9.0 percent

○ Most recent HbA1c >9 percent (poor control)

○ HbA1c NOT done during measurement year, no medical reason documented

Date Performed (2018):

Most recent HbA1c value: (0-25%):

Comments:

History +

ACO 41 DM-7 At Risk Population

Composite/DM and Eye Exam

Patients 18 -75 years of age with diabetes (Type 1 OR Type 2) who had an eye screening for diabetic retinal disease.

Numerator Statement: Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period.

Denominator Statement: Patients 18 – 75 years of age with diabetes with a visit during the measurement period.

Did the patient have a diagnosis of diabetes (type 1 OR type 2) and had an eye exam (retinal) performed?

Cancel

- Patient diagnosed with diabetes and an eye screening for diabetic retinal disease was performed.
- Patient diagnosed with diabetes and **NO** eye screening for diabetic retinal disease was performed.

Eye Exam Date (2018 or 2017 if negative) - optional:

Comments:

History +

ACO 28 HTN-2 At Risk Population

Controlling High BP

- **N/A (Patient does not have a diagnosis of Hypertension.)**
- **N/A (HTN diagnosis but excluded due to medical reasons (ESRD, dialysis, renal transplant or pregnancy))**
- **N/A (Patient greater than or equal 65 years of age and enrolled in institutional special needs plan or residing in a long term care facility.)**

Patients ages 18 -85 with a diagnosis of Hypertension (HTN) within the first six months of the measurement period or any time prior to the measurement period who had adequate control of BP (<140/90 mmHG) during the measurement year.

Did the patient have a diagnosis of hypertension and have a controlled blood pressure during the measurement year?

- Most recent BP controlled (< 140/90mmHg)
- Most recent BP NOT controlled (≥140mmHg systolic and/or ≥90mmHg diastolic)
- Patient did NOT have BP measurement performed, no medical reason given

Date Performed (2018):
Systolic Value: (0-350mmHg):
Diastolic Value: (0-200mmHg):

Comments:

History +

ACO 30 IVD-2 At Risk Population

IVD and Use of Aspirin or another Antiplatelet

- **N/A (Patient does not have a diagnosis of AMI, CABG, PCI or active diagnosis of IVD)**
- **N/A (Patient prescribed Anticoagulant medication documented in medical record overlapping the measurement year)**

Patients 18 years and older diagnosed with AMI, CABG, or PCI in the 12 months prior to the measurement period or who had an active diagnosis of IVD during the measurement period and have documented use of aspirin or another antiplatelet medication (see drug codes provided by CMS for complete list) during the measurement period.

Cancel

Was the patient diagnosed with AMI, CABG, or PCI in the 12 months prior to the measurement period or did the patient have an active diagnosis of IVD during the measurement period and have documentation of use of aspirin or another antiplatelet during the measurement period?

- ○ Patient prescribed Aspirin or Antiplatelet medication and documented in record.
- ○ No prescription for Aspirin or Antiplatelet medication documented in record.

Service Date:

Comments:

History +

ACO 40 MH-1 At Risk Population

Depression Remission

- ○ **N/A (Patient has NO diagnosis of major depression or dysthymia.)**
- ○ **N/A (Medical Reason (patient is permanent resident of a nursing home or has diagnosis of bipolar or personality disorder))**
- ○ **N/A (Patient did not receive initial screening)**

Patients age 18 years and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

Twelve months is defined as the point in time from the date in the measurement period that a patient meets the inclusion criteria (diagnosis and PHQ-9 > 9) extending out 12 months and then allowing a grace period of thirty days prior to and thirty days after this date. The most recent PHQ-9 score less than 5 obtained during this two month grace period is deemed as remission at twelve months, values obtained prior to and after this period are not counted as numerator compliant (remission).

Numerator Statement: Patients who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days grace period) PHQ-9 score less than 5.

Denominator Statement: Patients age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during the index visit.

Exclusions: Patients who die, are receiving hospice or palliative care services, are permanent nursing home residents, have a diagnosis of bipolar disorder or personality disorder are excluded.

Does patient have a diagnosis of major depression or dysthymia determined by an initial PHQ-9 score >9 and demonstrate remission at 12 months determined by a PHQ-9 score < 5?

- ○ N/A (Patient's initial screening result was less than or equal to 9)
- ○ Patient diagnosed with depression and at 12 months of diagnosis in remission with a PHQ-9 score of < 5
- ○ Patient did receive initial screening but no follow-up test was done
- ○ Patient diagnosed with depression and at 12 months of diagnosis NOT in remission with a PHQ-9 score of equal to or > 5

Initial Screening/Index Date (12/1/2016 - 11/30/2017):

Initial PHQ-9 Result:

Remission Screening Date (Index Date + 11-13 Months):

Remission Result:

Comments:

Cancel

History

Hospital Demo Account (AXXXX)

The latest claims import process for CCLF completed on 12/16/2018 for data through 11/30/2018

The latest claims import process for BCBS completed on 10/26/2018 for data through 07/31/2018

The latest claims import process for Medicare Advantage completed on 10/26/2018 for data through 08/31/2018

Attributed Population as of: 2017 Q4

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Cancel