

COLORADO STATE INNOVATION MODEL

Clinical Quality Measure

Specifications Guidebook

TABLE OF CONTENTS

TABLE OF CONTENTS	2
Introduction.....	5
Acknowledgements	6
Authors.....	6
Correspondence.....	6
Asthma.....	7
Reporting Requirements.....	7
Measure Specifications.....	7
Measure Flowchart: Establishing a Numerator and Denominator.....	10
Resources.....	10
Depression	10
Reporting Requirements.....	10
Measure Specifications.....	10
Measure Flowchart: Establishing a Numerator and Denominator*.....	14
Resources.....	16
Developmental Screening.....	16
Reporting Requirements.....	16
Measure Specifications.....	16
Measure Flowcharts: Establishing a Numerator and Denominator	21
Diabetes: Hemoglobin A1c.....	25
Reporting Requirements.....	25
Measure Specifications.....	25
Measure Flowchart: Establishing a Numerator and Denominator.....	27

Resources	27
Fall Safety	27
Reporting Requirements	27
Measure Specifications	28
Measure Flowchart: Establishing a Numerator and Denominator	30
Resources	30
Hypertension	31
Reporting Requirements	31
Measure Specifications	31
Measure Flowchart: Establishing a Numerator and Denominator	34
Resources	35
Maternal Depression	35
Reporting Requirements	35
Measure Specifications	35
Measure Flowchart: Establishing a Numerator and Denominator	37
Resources	37
Obesity: Pediatric	38
Reporting Requirements	38
Measure Specifications	38
Measure Flowchart: Establishing a Numerator and Denominator	40
Resources	40
Obesity: Adult	41
Reporting Requirements	41
Measure Specifications	41
Measure Flowchart: Establishing a Numerator and Denominator	45
Resources	45

Substance Use Disorder: Alcohol	46
Reporting Requirements.....	46
Measure Specifications.....	46
Measure Flowchart: Establishing a Numerator and Denominator.....	47
Resources.....	47
Substance Use Disorder: Alcohol and Other Drug Dependence	48
Reporting Requirements.....	48
Measure Specifications.....	48
Measure Flowchart: Establishing a Numerator and Denominator.....	50
Substance Use Disorder: Tobacco	50
Reporting Requirements.....	50
Measure Specifications.....	50
Measure Flowchart: Establishing a Numerator and Denominator.....	53
Additional SIM CQM documents:	54
SIM Clinical Quality Measures List.....	54
Colorado SIM CQM Reporting Schedule	54
SIM, TCPI, CPC+, QPP crosswalk of measures.....	54
Implementing Measures into SIM Practice Workflows	54
Asthma - Medication Management for People with Asthma.....	54
Depression - Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan	54
Diabetes – Hemoglobin A1c Poor Control	54
Fall Safety - Falls Screening for Future Fall Risk.....	55
Hypertension - Controlling High Blood Pressure	55
Maternal Depression – Maternal depression Screening	55
Obesity: Adult	55
Substance Use Disorder: Tobacco.....	55

Introduction

The Colorado State Innovation Model (SIM) Clinical Quality Measures Guidebook offers SIM participants the information needed for taking the first steps toward integrative healthcare and practice transformation. To be successful in understanding and implementing the Colorado SIM measures, this guidebook offers the measure specifications approved for Colorado SIM practice sites, flowcharts establishing each measure's numerator and denominator, as well as additional clinical resourcing and supplemental information for embedding new measures into a practice workflow.

We encourage use of this document by both SIM practices and Practice Transformation Organizations (PTOs). The intent is to use the information available to plan accordingly for each practice's data quality needs, as identified in their Data Quality Assessment and Practice Improvement Plans. The Clinical Health Information Technology Advisors (CHITAs) and Practice Facilitators can each benefit from the information provided, in order to support practices to meet their defined SIM SMART goals. CHITAs will likely use the specification and flowcharts to support new measure build or existing measure optimization, in order to generate accurate reports per SIM data submission requirements. Practice Facilitators can make use of additional resourcing to assist practices and care teams in realizing new measures within their practice workflow. Through this tandem approach, the SIM CQM Guidebook is of use across PTOs to support SIM practices with successful implementation.

SIM practices and/or PTOs can submit their Clinical Quality Measures as either provider-level or practice-level data in the form of numerators and denominators within SPLIT. [The Colorado SIM CQM Reporting Schedule](#) provides the list of core SIM measures by population reporting (Adult or Pediatric), as well as the measurement periods and reporting timeframes and deadlines. For additional SIM documents, please reference the [Addendum](#).

Acknowledgements

Authors

Andrew Bienstock, MHA

Clinical Health Information Technology Advisor
Department of Family Medicine
University of Colorado School of Medicine
Aurora, CO

Ellen Kaufmann, MA

Evaluation Specialist
Colorado Department of Healthcare Policy and Financing
Denver, CO

Kyle Knierim, MD

Assistant Director of Practice Transformation
Department of Family Medicine
University of Colorado School of Medicine
Aurora, CO

Leilani Russell, MPH

Data Coordinator
Colorado State Innovation Model Office
Denver, CO

Correspondence

Please direct comments and feedback to:
PracticeTransformation@ucdenver.edu

Asthma

Reporting Requirements

Data Source: Registry

Who Reports: All Practices

Schedule: Secondary Measure

Measure Specifications

Measure Title: Medication Management for People with Asthma

CMS e-Measure Identifier: n/a

NQF Number: 1799

NQF Domain: Efficiency and Cost Reduction

PQRS Number: 444

Description: Percentage of patients 5-64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.

Denominator: Patients 5-64 years of age with persistent asthma and a visit during the measurement period.

Denominator Exclusions: Patients with emphysema, COPD, chronic bronchitis, cystic fibrosis or acute respiratory failure during or prior to the measurement period. Exclude any patients who have no asthma controller medications dispensed during the measurement period or who use hospice services any time during the measurement period.

Numerator: The number of patients who achieved a proportion of days (PDC) of at least 75% for their asthma controller medications during the measurement year.

Numerator Exclusions: Not Applicable

Measure Steward: National Committee for Quality Assurance

Measure Developer: National Committee for Quality Assurance

Endorsed by: National Quality Forum

Definitions:

PDC:

The proportion of days covered by at least one asthma controller medication prescription, divided by the number of days in the treatment period. The treatment period is the period of time beginning on the earliest prescription dispensing date for any asthma controller medication during the measurement year through the last day of the measurement year.

Treatment Period:

The period of time beginning on the IPSD through the last day of the measurement year.

IPSD:

The earliest prescription dispensing date for any asthma controller medication during the measurement year.

Oral Medication Dispensing Event:

- One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the day's supply by 30 and round down to convert. Allocate the dispensing events to the appropriate year based on the date when the prescription is filled.
- Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the day's supply and divide by 30.

Inhaler Dispensing Event:

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Injection Dispensing Event:

Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Guidance:

Rationale:

This measure assesses adherence to long-term asthma controller medications in patients with persistent asthma. The improvement in quality envisioned by the use of this measure is increasing adherence to long-term asthma controller medications in patients with persistent asthma. Increasing adherence to asthma controller medications can prevent and control asthma symptoms, improve quality of life,

reduce the frequency and severity of asthma exacerbations, and potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits and missed work and school days)

Data Criteria (QDM Data Elements)

- "Diagnosis, Active: Acute Respiratory Failure" using "Acute Respiratory Failure Grouping Value Set (2.16.840.1.113883.3.464.1003.102.12.1018)"
- "Diagnosis, Active: Chronic Obstructive Pulmonary Disease" using "Chronic Obstructive Pulmonary Disease Grouping Value Set (2.16.840.1.113883.3.464.1003.102.12.1007)"
- "Diagnosis, Active: Cystic Fibrosis" using "Cystic Fibrosis Grouping Value Set (2.16.840.1.113883.3.464.1003.102.12.1002)"
- "Diagnosis, Active: Emphysema" using "Emphysema Grouping Value Set (2.16.840.1.113883.3.464.1003.102.12.1004)"
- "Diagnosis, Active: Obstructive Chronic Bronchitis" using "Obstructive Chronic Bronchitis Grouping Value Set (2.16.840.1.113883.3.464.1003.102.11.1024)"
- "Diagnosis, Active: Persistent Asthma" using "Persistent Asthma Grouping Value Set (2.16.840.1.113883.3.464.1003.102.12.1023)"
- "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: Home Healthcare Services" using "Home Healthcare Services Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "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)"
- "Medication, Dispensed: Preferred Asthma Therapy" using "Preferred Asthma Therapy Grouping Value Set (2.16.840.1.113883.3.464.1003.196.12.1212)"
- "Patient Characteristic Birthdate: birth date" using "birth date LOINC Value Set (2.16.840.1.113883.3.560.100.4)"

Measure Flowchart: Establishing a Numerator and Denominator

Coming soon

Resources

Agency for Healthcare Research and Quality

- National Quality Measures Clearinghouse
<https://qualitymeasures.ahrq.gov/summaries/summary/49707/medication-management-for-people-with-asthma-percentage-of-members-5-to-85-years-of-age-during-the-measurement-year-who-were-identified-as-having-persistent-asthma-and-who-were-dispensed-an-asthma-controller-medication-that-they-remained-on-for-at-least-75-of-?q=medication+management>

MDInteractive

2017 MIPS Quality Measures

https://mdinteractive.com/files/uploaded/file/CMS2017/2017_Measure_444_Registry.pdf

National Heart, Lung, and Blood Institute

- 2012 Asthma Care Quick Reference <http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/quick-reference-html>

National Committee for Quality Assurance

- [Medication Management for People with Asthma](#)

Depression

Reporting Requirements

Data Source: EHR / 2014 or 2015 Ed. CEHRT

Who Reports: All practices

Schedule: Primary Measure

Measure Specifications

Measure Title: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

CMS e-Measure Identifier: CMS 2v6

NQF Number: 0418

NQF Domain: Community/Population Health
PQRS Number: 134

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

Denominator: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

Denominator Exclusions: Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder.

Denominator Exceptions:

Patient Reason(s)

Patient refuses to participate

OR

Medical Reason(s)

Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

OR

Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

Numerator: Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen

Numerator Exclusions: Not Applicable

Measure Steward: Centers for Medicare & Medicaid Services

Measure Developer: Quality Insights of Pennsylvania

Endorsed by: National Quality Forum

Definitions

Screening:

Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool - A normalized and validated depression screening tool developed for the patient population in which it is being utilized

Examples of depression screening tools include but are not limited to:

- * Adolescent Screening Tools (12-17 years)
 - Patient Health Questionnaire for Adolescents (PHQ-A)
 - Beck Depression Inventory-Primary Care Version (BDI-PC)
 - Mood Feeling Questionnaire(MFQ)
 - Center for Epidemiologic Studies Depression Scale (CES-D)
 - Patient Health Questionnaire (PHQ-9)
 - Pediatric Symptom Checklist (PSC-17)
 - PRIME MD-PHQ2
- * Adult Screening Tools (18 years and older)
 - Patient Health Questionnaire (PHQ9)
 - Beck Depression Inventory (BDI or BDI-II)
 - Center for Epidemiologic Studies Depression Scale (CES-D)
 - Depression Scale (DEPS)
 - Duke Anxiety-Depression Scale (DADS)
 - Geriatric Depression Scale (SDS)
 - Cornell Scale Screening
 - PRIME MD-PHQ2

Follow-Up Plan:

Documented follow-up for a positive depression screening must include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Guidance

A depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Screening Tools:

- The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record
- The depression screening must be reviewed and addressed in the office of the provider, filing the code, on the date of the encounter
- The screening and encounter must occur on the same date
- Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record

Follow-Up Plan:

- The follow-up plan must be related to a positive depression screening, example: “Patient referred for psychiatric evaluation due to positive depression screening.”

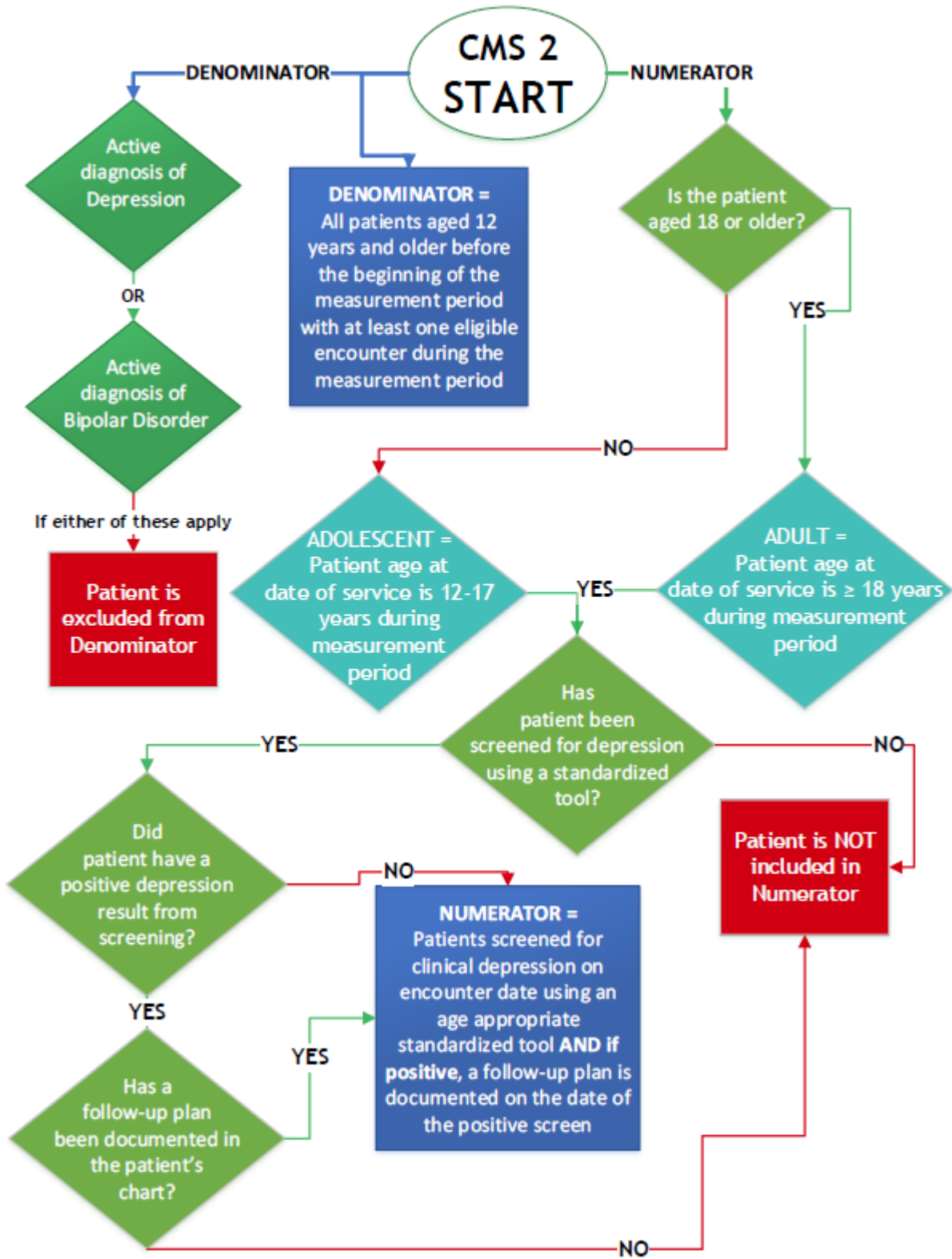
Data Criteria (QDM Data Elements)

- "Diagnosis, Active: Bipolar Diagnosis" using "Bipolar Diagnosis Grouping Value Set (2.16.840.1.113883.3.600.450)"
- "Diagnosis, Active: Depression diagnosis" using "Depression diagnosis Grouping Value Set (2.16.840.1.113883.3.600.145)"
- "Encounter, Performed: Depression Screening Encounter Codes" using "Depression Screening Encounter Codes Grouping Value Set (2.16.840.1.113883.3.600.1916)"
- "Intervention, Order: Referral for Depression Pediatric" using "Referral for Depression Pediatric SNOMEDCT Value Set (2.16.840.1.113883.3.600.537)"
- "Intervention, Order: Referral for Depression Adult" using "Referral for Depression Adult SNOMEDCT Value Set (2.16.840.1.113883.3.600.538)"
- "Intervention, Performed: Additional evaluation for depression Pediatric" using "Additional evaluation for depression Pediatric SNOMEDCT Value Set (2.16.840.1.113883.3.600.1542)"
- "Intervention, Performed: Additional evaluation for depression adult" using "Additional evaluation for depression adult SNOMEDCT Value Set (2.16.840.1.113883.3.600.1545)"
- "Intervention, Performed: Follow-up for depression Pediatric" using "Follow-up for depression Pediatric SNOMEDCT Value Set (2.16.840.1.113883.3.600.467)"
- "Intervention, Performed: Follow-up for depression adult" using "Follow-up for depression adult SNOMEDCT Value Set (2.16.840.1.113883.3.600.468)"
- "Medication, Order: Depression medications Pediatric" using "Depression medications Pediatric RXNORM Value Set (2.16.840.1.113883.3.600.469)"
- "Medication, Order: Depression medications adult" using "Depression medications adult RXNORM Value Set (2.16.840.1.113883.3.600.470)"
- "Procedure, Performed: Suicide Risk Assessment" using "Suicide Risk Assessment SNOMEDCT Value Set (2.16.840.1.113883.3.600.559)"

- "Risk Category Assessment: Pediatric Depression Screening" using "Pediatric Depression Screening LOINC Value Set (2.16.840.1.113883.3.600.2452)"
- "Risk Category Assessment: Adult Depression Screening" using "Adult Depression Screening LOINC Value Set (2.16.840.1.113883.3.600.2449)"
- "Risk Category Assessment not done: Medical or Other reason not done" using "Medical or Other reason not done SNOMEDCT Value Set (2.16.840.1.113883.3.600.1.1502)"
- "Risk Category Assessment not done: Patient Reason refused" using "Patient Reason refused SNOMEDCT Value Set (2.16.840.1.113883.3.600.791)"
- Attribute: "Result: Negative Depression Screening" using "Negative Depression Screening SNOMEDCT Value Set (2.16.840.1.113883.3.600.2451)"
- Attribute: "Result: Positive Depression Screening" using "Positive Depression Screening SNOMEDCT Value Set (2.16.840.1.113883.3.600.2450)"

Measure Flowchart: Establishing a Numerator and Denominator*

*Flow chart does not include denominator exceptions. Please refer to the [measure specifications](#) above for additional details.



Resources

US Preventive Services Taskforce (USPSTF):

- 2016 American College of Physicians (ACP) Annals of Internal Medicine
<http://www.medscape.org/viewarticle/851593>
- 2009 archived/historical recommendations
<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening>

Oregon Health Authority

- 2014 Depression Screening and Follow-up Guidance Document
[https://www.oregon.gov/oha/analytics/CCOData/Depression%20Screening%20Guidance%20Document%20\(revised%20Dec%202014\).pdf](https://www.oregon.gov/oha/analytics/CCOData/Depression%20Screening%20Guidance%20Document%20(revised%20Dec%202014).pdf)

Developmental Screening

Reporting Requirements

Data Source: Practice-self report

Who Reports: Pediatric practices (Other practices may report as an optional measure)

Schedule: Primary Measure

Measure Specifications

Measure Title: Developmental Screening in the First Three Years of Life

CMS e-Measure Identifier: 664

NQF Number: NQF 1448

NQF Domain: N/A

PQRS Number: PQRS N/A

Description: This measure assesses the proportion of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.

Denominator:

- Denominator 1: All patients who turn one-year-old during the measurement period with at least one eligible outpatient encounter during the measurement period.
- Denominator 2: All patients who turn two years old during the measurement period with at least one eligible outpatient encounter during the measurement period.
- Denominator 3: All patients who turn three years old during the measurement period with at least one eligible outpatient encounter during the measurement period.
- Denominator 4: All patients who turn one, two, or three years old during the measurement period with at least one eligible outpatient encounter during the measurement period.

Denominator Exclusions: None

Denominator Exceptions: None

Numerator:

- Numerator 1: Children in Denominator 1 who had screening for risk of developmental, behavioral, and social delays using an age appropriate standardized screening tool that was documented before or on their first birthday. Applicable tools include the ASQ, BINS, Brigance Screens II, Infant Development Inventory, PEDS, and PEDS-DM.
- Numerator 2: Children in Denominator 2 who had a screening for risk of developmental, behavioral, and social delays using an age appropriate standardized screening tool that was documented after their first and before or on their second birthday. Applicable tools include the ASQ, BINS, Brigance Screens II, CDI, Infant Development Inventory, PEDS, and PEDS-DM.
- Numerator 3: Children in Denominator 3 who had a screening for risk of developmental, behavioral, and social delays using an age appropriate standardized screening tool that was documented after their second and before or on their third birthday. Applicable tools include the ASQ, Brigance Screens II, CDI, PEDS, and PEDS-DM.

Numerator 4: Children in Denominator 4 who had a screening for risk of developmental, behavioral, and social delays using an age appropriate

standardized screening tool that was documented in the 12 months preceding their first, second, or third birthday.

Measure Steward: OHSU

Measure Developer: Mathematica Policy Research

Endorsed by: None

Definitions:

The measure logic uses days instead of months to calculate the measure with accurate and precise information. Information on the month to day equivalence is provided below.

60 days = 2 months

90 days = 3 months

365 days = 12 months

547 days = 18 months

730 days = 24 months

1095 days = 36 months

In the measure's specifications there are three different types of timing statements, each with a specific goal. These statement types and associated goals include:

- 1) For logical statements where the population is not restricted by age ranges appropriate for the tool, the logical statements capture screenings completed the day after the lower bound birthday to those completed on the upper bound birthday.
- 2) For logical statements where the population is restricted by a lower bound age range appropriate for the tool, the logical statements capture screenings completed on the day the child becomes the lower bound age range (e.g. 18 months) to those completed on the upper bound birthday.
- 3) For logical statements where the population is restricted by an upper bound age range appropriate for the tool, the logical statements capture screening completed the day after the lower bound birthday to those completed on the day before the child turns the upper bound age limit (e.g. 18 months).

You will notice that some timing statements in the logic appear to be off by one day, for example ≥ 59 days representing two months instead of ≥ 60 days. This is due to the way the Quality Data Model (QDM) calculates time durations and is meant for

consumption by a computer programmed with QDM logic. These off-by-one numbers should be understood to represent the number of days/months specified above in the equivalence table rather than actually representing a one-day difference.

Guidance

To identify the completion of a standardized screening tool during the 12 months preceding the patient's birthday, information on the completion of the tool may need to be extracted from the patient's record during the time period prior to the measurement period's timeframe. For example, if the measurement period is January 1, 2014 to December 31, 2014 and a patient turns 1 on July 1, 2014 the patient will be included in denominator 1. To assess if the patient qualifies for numerator 1, the calculation requires information from July 1, 2013 through July 1, 2014 to assess if an appropriate screening was completed during that timeframe.

The tools used in the electronic specifications each evaluate four developmental domains including, motor, language, cognitive, and social-emotional development. Each screening tool has reliability, validity, and sensitivity and specificity scores above 0.70.

The tools included in this measure are those that are both listed in the American Academy of Pediatrics' Bright Future guidelines and also have associated codes available for inclusion in a value set. As the guidelines are updated and new codes are created for the screening tools, the measure's e-specifications should be updated to align with these changes.

The tools included in the electronic specifications are appropriate for children within certain age limits. The age guidelines for each of the tools are indicated below.

Ages and Stages Questionnaire (ASQ): 2 months to 5 years

Bayley Infant Neuro-developmental Screen (BINS): 3 months to 2 years

Brigance Screens II: Birth to 90 months

Child Development Inventory (CDI): 18 months to 6 years

Infant Development Inventory: Birth to 18 months

Parents' Evaluation of Developmental Status (PEDS): Birth to 8 years

Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM):
Birth to 11 years

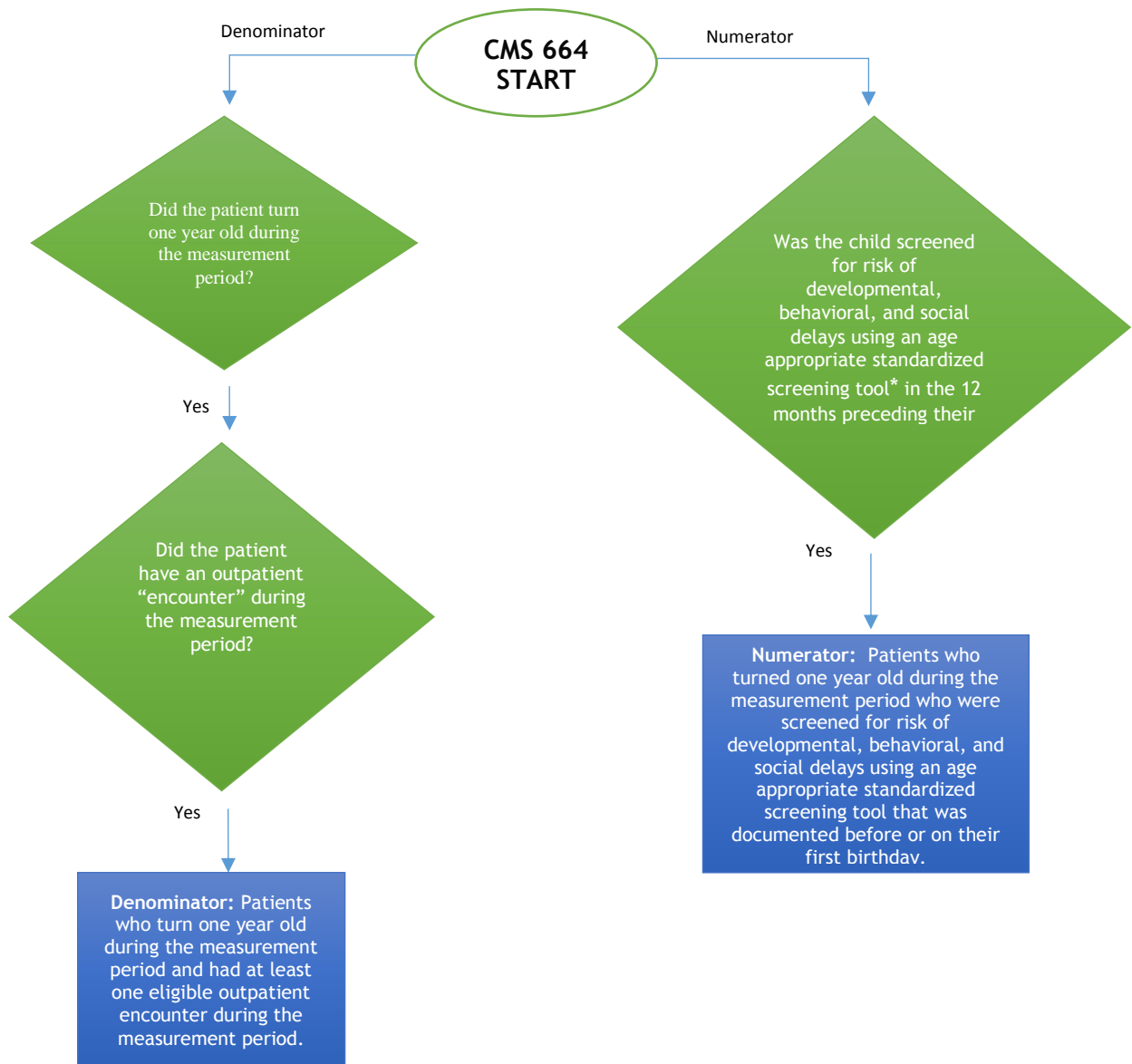
Data Criteria (QDM Data Elements)

- "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: Home Healthcare Services" using "Home Healthcare Services Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"

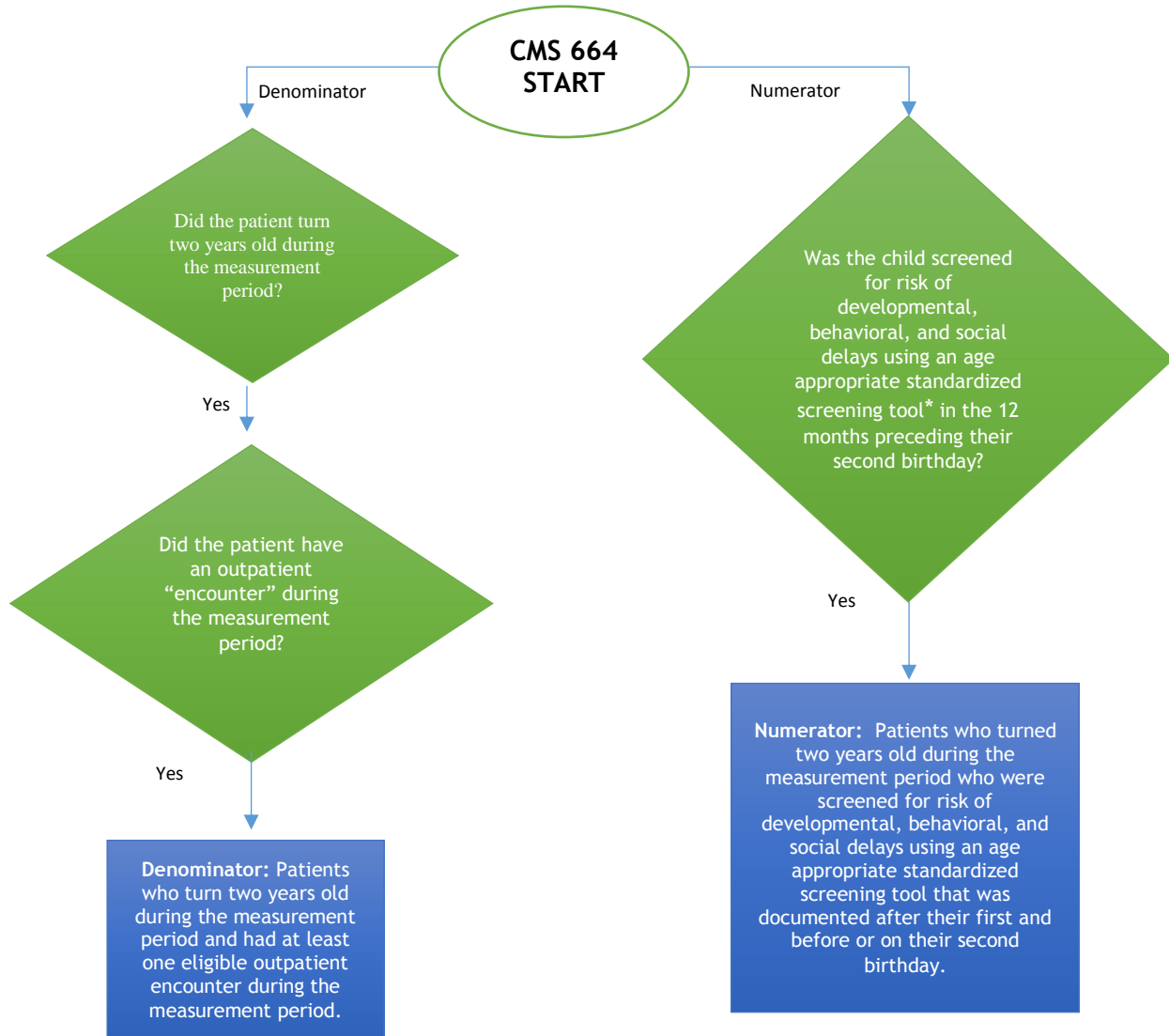
- "Encounter, Performed: Preventive Care - Established Office Visit, 0 to 17" using "Preventive Care - Established Office Visit, 0 to 17 Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1024)"
- "Encounter, Performed: Preventive Care- Initial Office Visit, 0 to 17" using "Preventive Care- Initial Office Visit, 0 to 17 Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1022)"
- "Risk Category Assessment: Ages and Stages Questionnaire" using "Ages and Stages Questionnaire LOINC Value Set (2.16.840.1.113762.1.4.1145.17)"
- "Risk Category Assessment: Bayley Infant Neurodevelopmental Screen (BINS)" using "Bayley Infant Neurodevelopmental Screen (BINS) LOINC Value Set (2.16.840.1.113762.1.4.1145.18)"
- "Risk Category Assessment: Brigance Screens II" using "Brigance Screens II LOINC Value Set (2.16.840.1.113762.1.4.1145.19)"
- "Risk Category Assessment: Child Development Inventory" using "Child Development Inventory LOINC Value Set (2.16.840.1.113762.1.4.1145.23)"
- "Risk Category Assessment: Infant Development Inventory" using "Infant Development Inventory LOINC Value Set (2.16.840.1.113762.1.4.1145.20)"
- "Risk Category Assessment: Parents' Evaluation of Development Status (PEDS)" using "Parents' Evaluation of Development Status (PEDS) LOINC Value Set (2.16.840.1.113762.1.4.1145.21)"
- "Risk Category Assessment: Parents' Evaluation of Development Status Developmental Milestones (PEDS DM)" using "Parents' Evaluation of Development Status Developmental Milestones (PEDS DM) LOINC Value Set (2.16.840.1.113762.1.4.1145.22)"

Measure Flowcharts: Establishing a Numerator and Denominator

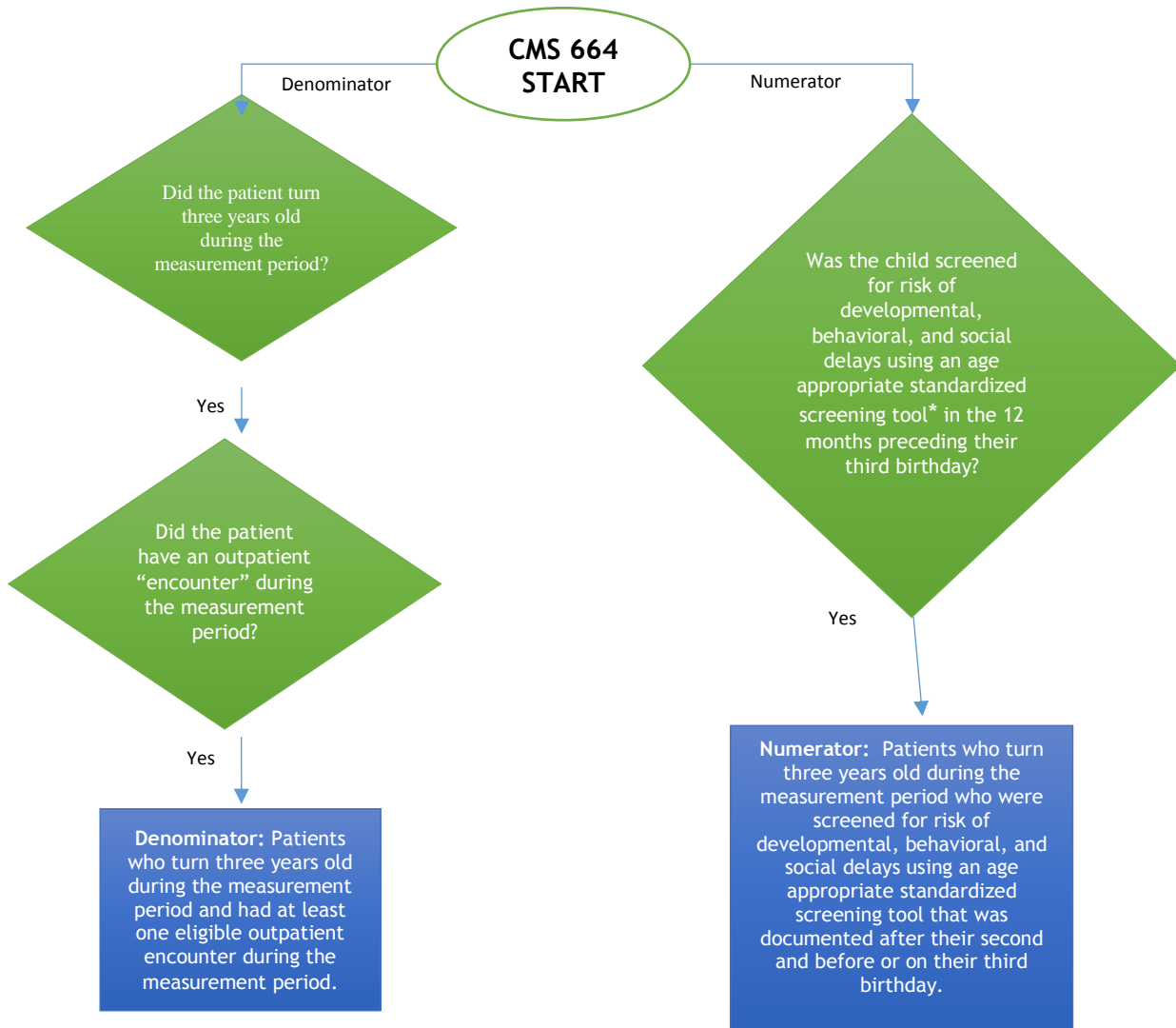
Measure Flowchart: Establishing a Numerator and Denominator Developmental Screening in the First Three Years of Life (First Year)



Measure Flowchart: Establishing a Numerator and Denominator Developmental Screening in the First Three Years of Life (Second Year)



Measure Flowchart: Establishing a Numerator and Denominator Developmental Screening in the First Three Years of Life (Third Year)



Measure Flowchart: Establishing a Numerator and Denominator Developmental Screening in the First Three Years of Life (All)



Diabetes: Hemoglobin A1c

Reporting Requirements

Data Source: EHR / 2014 or 2015 Ed. CEHRT

Who Reports: Adult practices (Other practices may report as an optional measure)

Schedule: Primary measure

Measure Specifications

Measure Title: Hemoglobin A1c Poor Control

CMS e-Measure Identifier: CMS 122v5

NQF Number: NQF 0059

NQF Domain: Effective Clinical Care

PQRS Number: PQRS 001

Description: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c>9.0% during the measurement period

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

Denominator Exclusions: None

Denominator Exceptions: None

Numerator: Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%.

Numerator Exclusions: Not Applicable

Measure Steward: National Committee for Quality Assurance

Measure Developer: National Committee for Quality Assurance

Endorsed by: National Quality Forum

Definitions: None

Guidance

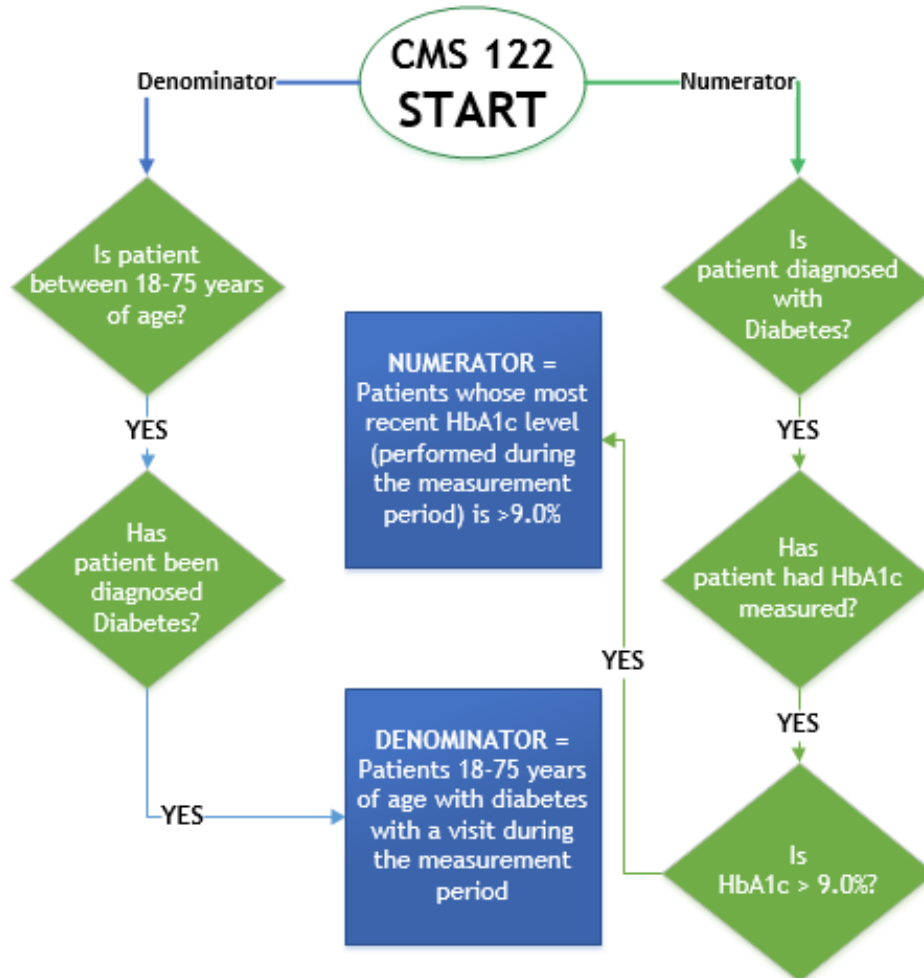
Patient is numerator compliant if most recent HbA1c level >9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.

Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.

Data Criteria (QDM Data Elements)

- "Diagnosis: Diabetes" using "Diabetes Grouping Value Set (2.16.840.1.113883.3.464.1003.103.12.1001)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit Grouping Value Set (2.16.840.1.113883.3.526.3.1240)"
- "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: Home Healthcare Services" using "Home Healthcare Services Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "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)"
- "Laboratory Test, Performed: HbA1c Laboratory Test" using "HbA1c Laboratory Test Grouping Value Set (2.16.840.1.113883.3.464.1003.198.12.1013)"

Measure Flowchart: Establishing a Numerator and Denominator



Resources

American Diabetes Association

- National Diabetes Education Initiative diabetes management guidelines
<http://www.ndei.org/ADA-diabetes-management-guidelines-diagnosis-A1C-testing.aspx>

Fall Safety

Reporting Requirements

Data Source: EHR / 2014 or 2015 Ed. CEHRT

Who Reports: Adult practices

Schedule: Secondary measure

Measure Specifications

Measure Title: Falls: Screening for Future Fall Risk

CMS e-Measure Identifier: CMS 139v5

NQF Number: NQF 0101

NQF Domain: Patient Safety

PQRS Number: PQRS 318

Description: Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

Denominator: Patients aged 65 years and older with a visit during the measurement period.

Denominator Exclusions: None

Denominator Exceptions: Documentation of medical reason(s) for not screening for fall risk (eg, patient is not ambulatory)

Numerator: Patients who were screened for future fall risk at least once within the measurement period

Numerator Exclusions: Not Applicable

Measure Steward: National Committee for Quality Assurance

Measure Developer: American Medical Association (AMA), National Committee for Quality Assurance, and PCPI(R) Foundation (PCPI[R])

Endorsed by: National Quality Forum

Definitions

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, epileptic seizure, or overwhelming external force.

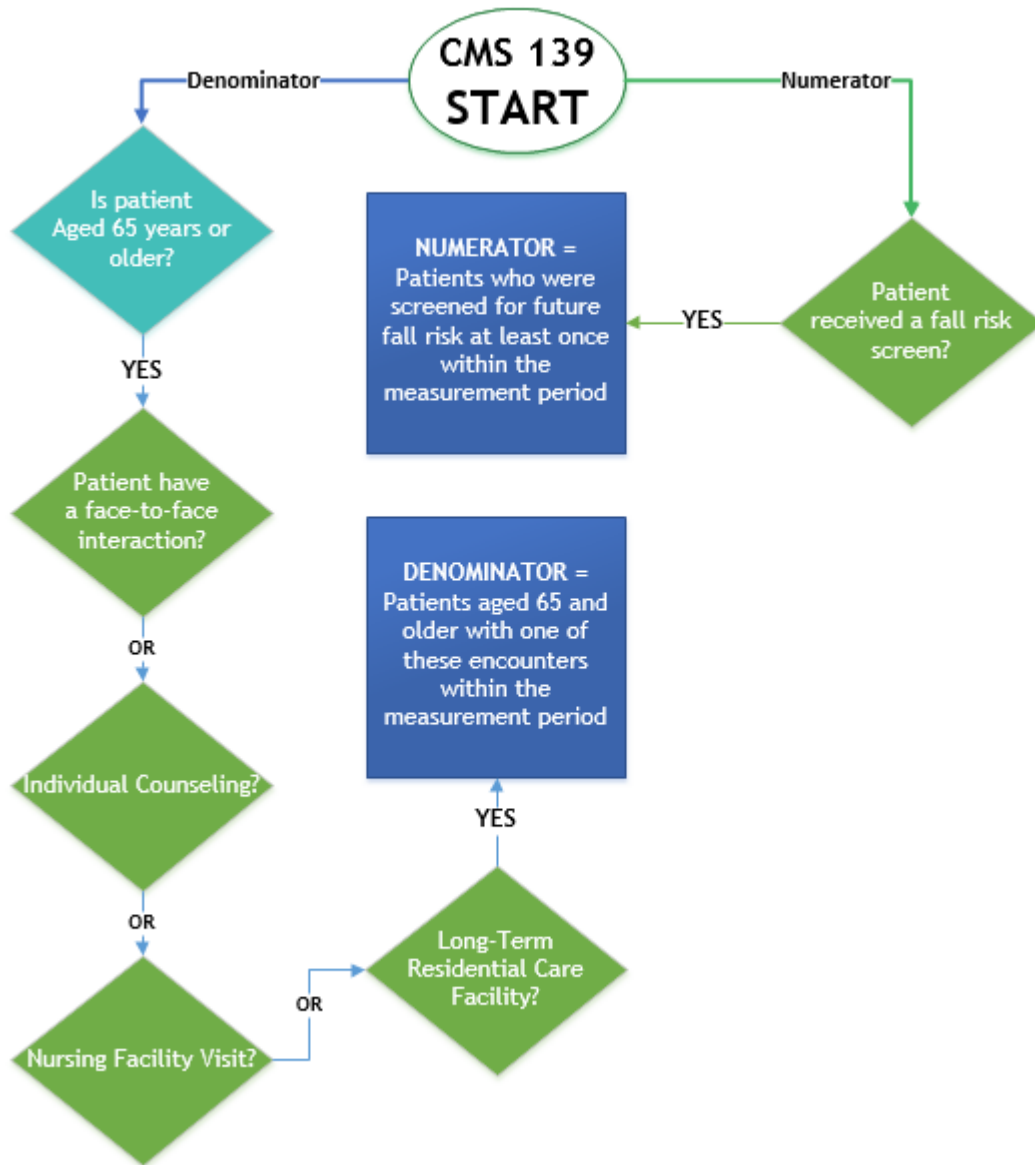
Guidance: None

Data Criteria (QDM Data Elements)

- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit Grouping Value Set (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Audiology Visit" using "Audiology Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1066)"
- "Encounter, Performed: Care Services in Long-Term Residential Facility" using "Care Services in Long-Term Residential Facility Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1014)"
- "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: Home Healthcare Services" using "Home Healthcare Services Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Nursing Facility Visit" using "Nursing Facility Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1012)"
- "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 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-Individual Counseling" using "Preventive Care Services-Individual Counseling Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1026)"
- "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)"
- "Risk Category Assessment: Falls Screening" using "Falls Screening Grouping Value Set (2.16.840.1.113883.3.464.1003.118.12.1028)"
- "Risk Category Assessment: Patient not ambulatory" using "Patient not ambulatory Grouping Value Set (2.16.840.1.113883.3.464.1003.118.12.1009)"
- "Risk Category Assessment not done: Medical Reason" using "Medical Reason Grouping Value Set (2.16.840.1.113883.3.526.3.1007)"

Measure Flowchart: Establishing a Numerator and Denominator

*Flow chart does not include denominator exceptions. Please refer to the [measure specifications](#) above for additional details.



Resources

The American Geriatrics Society (AGS):

- Clinical Practice Guidelines
http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/prevention_of_falls_summary_of_recommendations

GroupHealth

- 2013 Fall Prevention Guide
<https://www1.ghc.org/static/pdf/public/guidelines/falls.pdf>

Hypertension

Reporting Requirements

Data Source: EHR / 2014 or 2015 Ed. CEHRT

Who Reports: Adult practices (Other practices may report as an optional measure)

Schedule: Secondary measure

Measure Specifications

Measure Title: Controlling High Blood Pressure

CMS e-Measure Identifier: CMS 165v5

NQF Number: NQF 0018

NQF Domain: Effective Clinical Care

PQRS Number: PQRS 236

Description: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

Denominator: Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period

Denominator Exclusions: Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.

Denominator Exceptions: None

Numerator: Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

Numerator Exclusions: Not Applicable

Measure Steward: National Committee for Quality Assurance

Measure Developer: National Committee for Quality Assurance

Endorsed by: National Quality Forum

Definitions: None

Guidance

In reference to the numerator element, only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient's home (including readings directly from monitoring devices) are not acceptable.

If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."

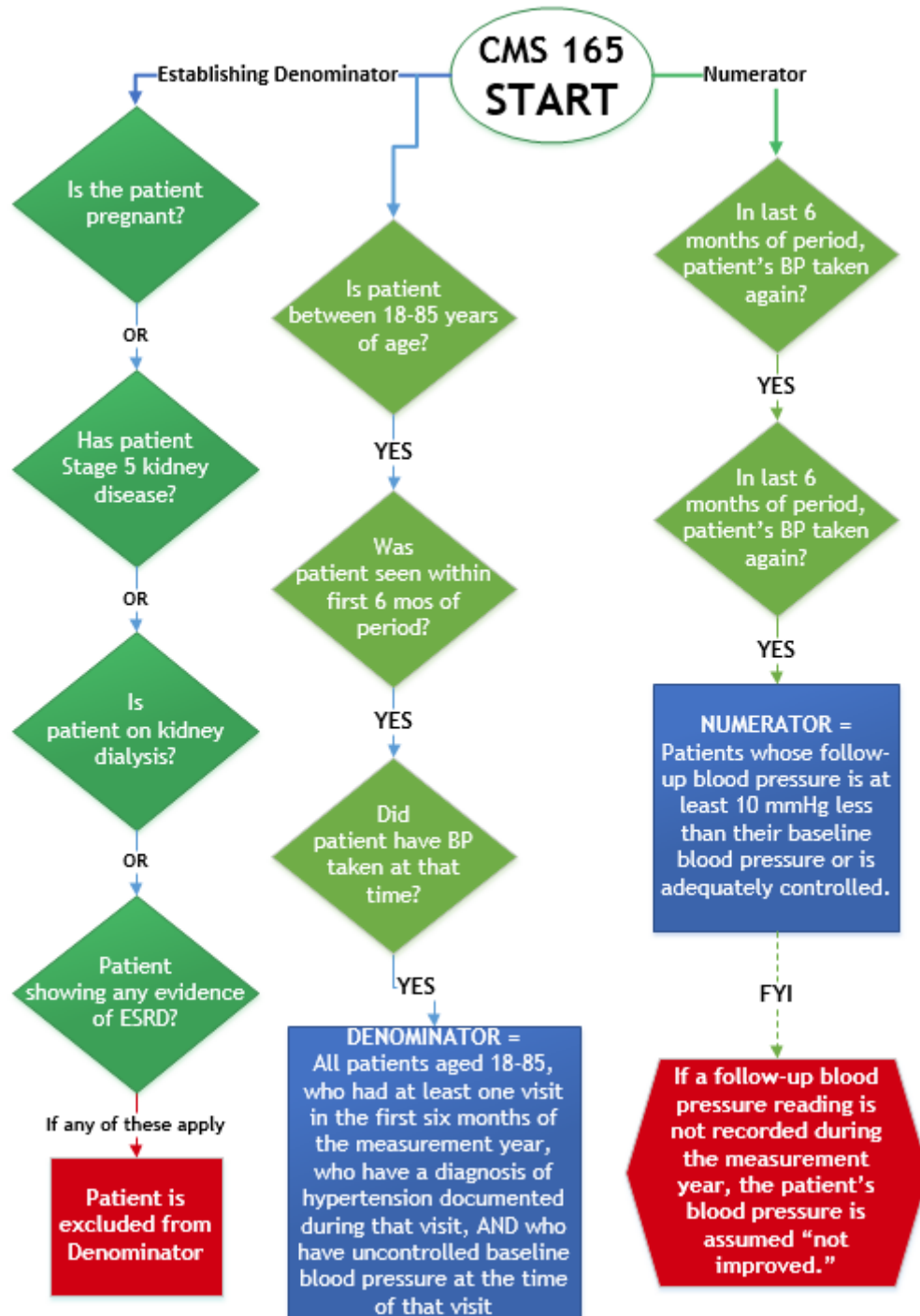
If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

Data Criteria (QDM Data Elements)

- "Diagnosis: Chronic Kidney Disease, Stage 5" using "Chronic Kidney Disease, Stage 5 Grouping Value Set (2.16.840.1.113883.3.526.3.1002)"
- "Diagnosis: End Stage Renal Disease" using "End Stage Renal Disease Grouping Value Set (2.16.840.1.113883.3.526.3.353)"
- "Diagnosis: Essential Hypertension" using "Essential Hypertension Grouping Value Set (2.16.840.1.113883.3.464.1003.104.12.1011)"
- "Diagnosis: Pregnancy" using "Pregnancy Grouping Value Set (2.16.840.1.113883.3.526.3.378)"
- "Encounter, Performed: Adult Outpatient Visit" using "Adult Outpatient Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1065)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit Grouping Value Set (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: ESRD Monthly Outpatient Services" using "ESRD Monthly Outpatient Services Grouping Value Set (2.16.840.1.113883.3.464.1003.109.12.1014)"

- "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: Home Healthcare Services" using "Home Healthcare Services Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "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)"
- "Intervention, Performed: Dialysis Education" using "Dialysis Education Grouping Value Set (2.16.840.1.113883.3.464.1003.109.12.1016)"
- "Intervention, Performed: Other Services Related to Dialysis" using "Other Services Related to Dialysis Grouping Value Set (2.16.840.1.113883.3.464.1003.109.12.1015)"
- "Physical Exam, Performed: Diastolic Blood Pressure" using "Diastolic Blood Pressure Grouping Value Set (2.16.840.1.113883.3.526.3.1033)"
- "Physical Exam, Performed: Systolic Blood Pressure" using "Systolic Blood Pressure Grouping Value Set (2.16.840.1.113883.3.526.3.1032)"
- "Procedure, Performed: Dialysis Services" using "Dialysis Services Grouping Value Set (2.16.840.1.113883.3.464.1003.109.12.1013)"
- "Procedure, Performed: Kidney Transplant" using "Kidney Transplant Grouping Value Set (2.16.840.1.113883.3.464.1003.109.12.1012)"
- "Procedure, Performed: Vascular Access for Dialysis" using "Vascular Access for Dialysis Grouping Value Set (2.16.840.1.113883.3.464.1003.109.12.1011)"

Measure Flowchart: Establishing a Numerator and Denominator



Resources

American Heart Association:

- 2013 Recommendations
http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/PreventionTreatmentofHighBloodPressure/American-Heart-Association-backs-current-BP-treatments_UCM_459129_Article.jsp#.Vw7ZxtQrK00

The Journal of the American Medical Association (JAMA):

- 2014 Evidence-Based Guideline
<http://jama.jamanetwork.com/article.aspx?articleid=1791497>

Harvard Medical School:

- 2013 Guidelines <http://www.health.harvard.edu/blog/new-guidelines-published-for-managing-high-blood-pressure-201312186953>

Maternal Depression

Reporting Requirements

Data Source: EHR / 2014 or 2015 Ed. CEHRT

Who Reports: Pediatric practices; Secondary measure for adult practices

Schedule: Primary pediatric measure; Secondary adult measure

Measure Specifications

Measure Title: Maternal Depression Screening

CMS e-Measure Identifier: CMS 82v4

NQF Number: NQF 1401

NQF Domain: Community/Population Health

PQRS Number: PQRS 372

Description: The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.

Denominator: Children with a visit who turned 6 months of age in the measurement period.

Denominator Exclusions: None

Denominator Exceptions: None

Numerator: Children with documentation of maternal screening or treatment for postpartum depression for the mother.

Numerator Exclusions: Not Applicable

Measure Steward: National Committee for Quality Assurance

Measure Developer: National Committee for Quality Assurance

Endorsed by: None

Definitions: None

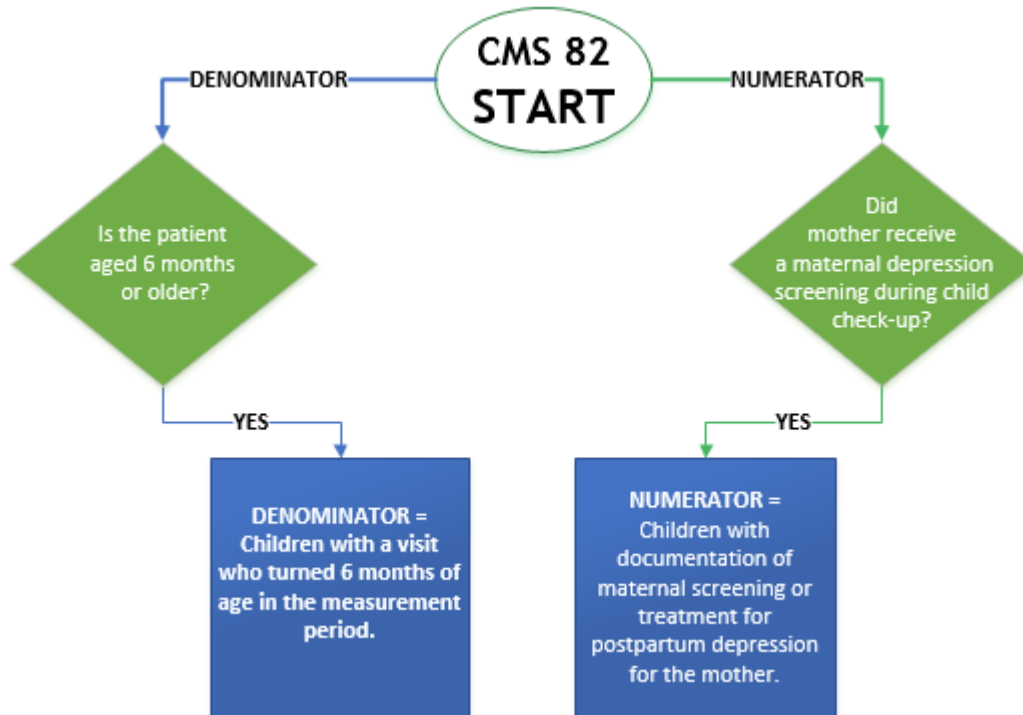
Guidance

The eMeasure specifies only patient's (baby) chart, looking for the newly allocated SNOMED codes that allow providers to record the screening and treatment of the mother, but the endorsed measure relies on notes from the patient's and mother's charts.

Data Criteria (QDM Data Elements)

- "Encounter, Performed: BH Medical or psychiatric consultation" using "BH Medical or psychiatric consultation Grouping Value Set (2.16.840.1.113883.3.1257.1.1652)"
- "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)"
- "Intervention, Performed: Maternal Post-Partum Depression Care" using "Maternal Post-Partum Depression Care Grouping Value Set (2.16.840.1.113883.3.464.1003.111.12.1013)"
- "Intervention, Performed: Maternal Post-Partum Depression Screening" using "Maternal Post-Partum Depression Screening Grouping Value Set (2.16.840.1.113883.3.464.1003.111.12.1014)"

Measure Flowchart: Establishing a Numerator and Denominator



Resources

American Academy of Pediatrics (AAP):

- 2016 Recognition and Management in Pediatric Practice <http://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf>

Colorado Children's Healthcare Access Program (CCHAP):

- Pregnancy Related Depression Screening Guidance <http://cchap.org/our-services/behavioral-health/pregnancy-related-depression/>

American Academy of Family Physicians (AAFP):

- Postpartum Depression Toolkit <http://www.aafp.org/patient-care/nrn/studies/all/trippd/ppd-toolkit.html>

Obesity: Pediatric

Reporting Requirements

Data Source: EHR / 2014 or 2015 Ed. CEHRT

Who Reports: Pediatric practices (Other practices may report as an optional measure)

Schedule: Primary Measure

Measure Specifications

Measure Title: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

CMS e-Measure Identifier: CMS 155v5

NQF Number: NQF 0024

NQF Domain: Community/Population Health

PQRS Number: PQRS 239

Description: Percentage of patients 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement period. Three rates are reported:

- Percentage of patients with height, weight, and BMI percentile documentation
- Percentage of patients with counseling for nutrition
- Percentage of patients with counseling for physical activity

Denominator: Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN during the measurement year.

Denominator Exclusions: Patients who have a diagnosis of pregnancy during the measurement period.

Denominator Exceptions: None

Numerator

- Numerator 1: Patients who had a height, weight and BMI percentile recorded during the measurement period
- Numerator 2: Patients who had counseling for nutrition during a visit that occurs during the measurement period
- Numerator 3: Patients who had counseling for physical activity during a visit that occurs during the measurement period

Numerator Exclusions: Not Applicable

Measure Steward: National Committee for Quality Assurance

Measure Developer: National Committee for Quality Assurance

Endorsed by: National Quality Forum

Definitions: None

Guidance

The visit must be performed by a PCP or OB/GYN.

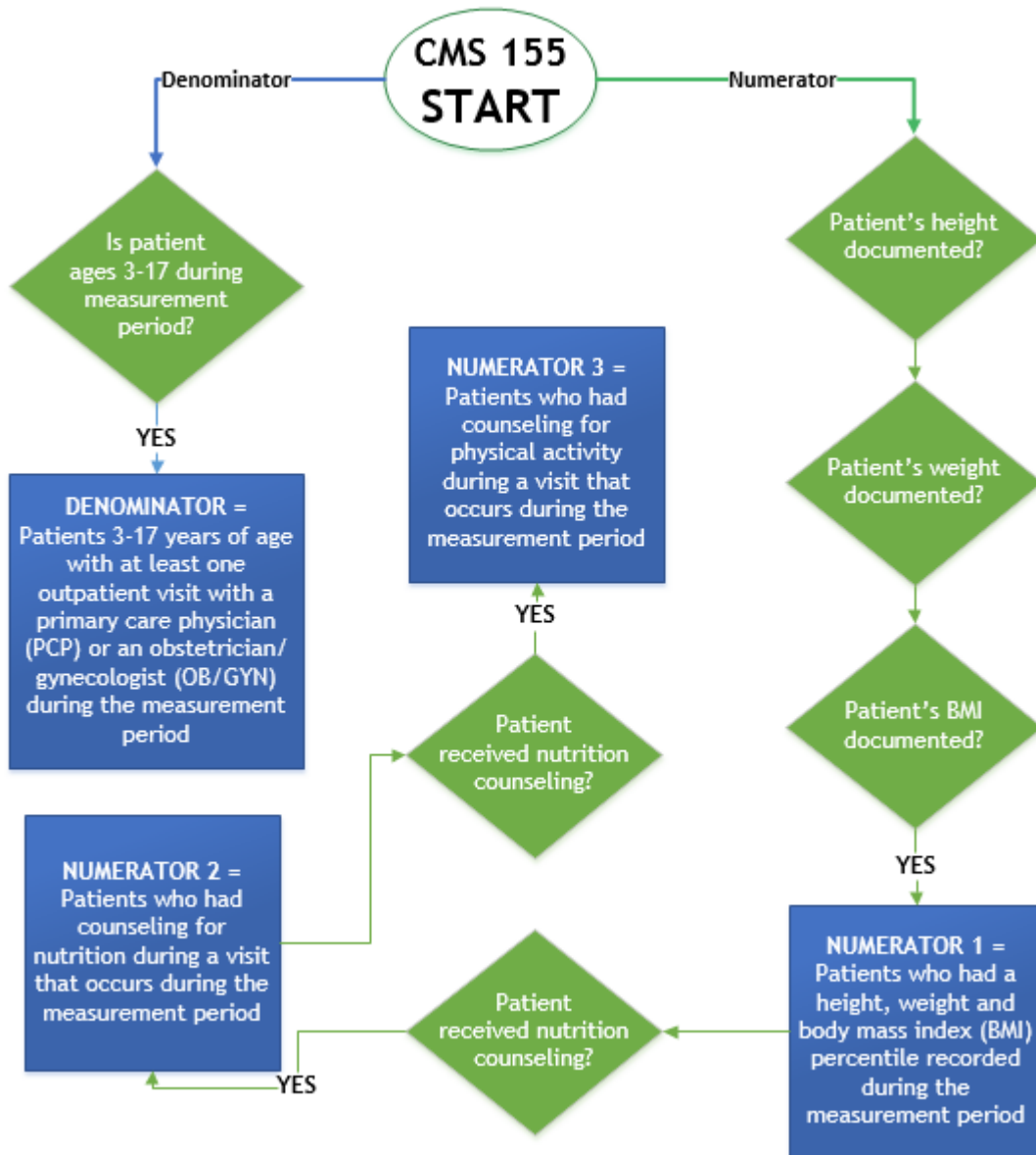
Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Data Criteria (QDM Data Elements)

- "Diagnosis, Active: Pregnancy" using "Pregnancy Grouping Value Set (2.16.840.1.113883.3.526.3.378)"
- "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: Home Healthcare Services" using "Home Healthcare Services Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "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 Group Counseling" using "Preventive Care Services Group Counseling Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1027)"
- "Encounter, Performed: Preventive Care Services-Individual Counseling" using "Preventive Care Services-Individual Counseling Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1026)"
- "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: Counseling for Nutrition" using "Counseling for Nutrition Grouping Value Set (2.16.840.1.113883.3.464.1003.195.12.1003)"
- "Intervention, Performed: Counseling for Physical Activity" using "Counseling for Physical Activity Grouping Value Set (2.16.840.1.113883.3.464.1003.118.12.1035)"
- "Physical Exam, Performed: BMI percentile" using "BMI percentile Grouping Value Set (2.16.840.1.113883.3.464.1003.121.12.1012)"

- "Physical Exam, Performed: Height" using "Height Grouping Value Set (2.16.840.1.113883.3.464.1003.121.12.1014)"
- "Physical Exam, Performed: Weight" using "Weight Grouping Value Set (2.16.840.1.113883.3.464.1003.121.12.1015)"

Measure Flowchart: Establishing a Numerator and Denominator



Resources

Centers for Disease Control and Prevention (CDC):

2015 Child & Teen BMI Guidance

http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

American College of Preventive Medicine (ACPM):
Primary Care Recommendations

http://www.acpm.org/?page=adobesity_clinref#8.%20PRIMARY%20CARE%20RECOMMENDATIONS

Obesity: Adult

Reporting Requirements

Data Source: EHR / 2014 or 2015 Ed. CEHRT

Who Reports: Adult practices (Other practices may report as an optional measure)

Schedule: Primary Measure

Measure Specifications

Measure Title: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

CMS e-Measure Identifier: CMS 69v5

NQF Number: NQF 0421

NQF Domain: Community/Population Health

PQRS Number: PQRS 128

Description: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter

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

Denominator: All patients 18 and older on the date of the encounter with at least one eligible encounter during the measurement period

Denominator Exclusions:

- Patients who are pregnant

- Patients receiving palliative care
- Patients who refuse measurement of height and/or weight or refuse follow-up

Denominator Exceptions: Patients with a documented Medical Reason:

- Elderly Patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:
- Illness or physical disability
- Mental illness, dementia, confusion
- Nutritional deficiency, such as Vitamin/mineral deficiency
- Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Numerator: Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter

Numerator Exclusions: Not Applicable

Measure Steward: Centers for Medicare & Medicaid Services

Measure Developer: Quality Insights of Pennsylvania

Endorsed by: National Quality Forum

Definitions

BMI- Body mass index (BMI) is a number calculated using the Quetelet index: weight divided by height squared (W/H^2) and is commonly used to classify weight categories. BMI can be calculated using:

Metric Units: $BMI = \text{Weight (kg)} / (\text{Height (m)} \times \text{Height (m)})$

OR

English Units: $BMI = \text{Weight (lbs.)} / (\text{Height (in)} \times \text{Height (in)}) \times 703$

Follow-Up Plan - Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include, but is not limited to: documentation of education, referral (for example a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling or nutrition counseling.

Guidance

- There is no diagnosis associated with this measure.

- This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period.
- This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding.

BMI Measurement Guidance:

- Height and Weight - An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within six months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.
- The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider.
- If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous six months of the current encounter.
- If more than one BMI is reported during the measurement period, the most recent BMI will be used to determine if the performance has been met.
- Review the exclusions criteria to determine those patients that BMI measurement may not be appropriate or necessary.

Follow-Up Plan Guidance:

- The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above or below normal parameters."

(See Definitions for examples of follow-up plan treatments).

Variation has been noted in studies exploring optimal BMI ranges for the elderly (see Donini et al., (2012); Holme and Tonstad (2015); and Diehr et al. (2008). Notably however, all these studies have arrived at ranges that differ from the standard range for ages 18 and older, which is ≥ 18.5 and < 25 kg/m². For instance, both Donini et al. (2012) and Holme and Tonstad (2015) reported findings that suggest that higher BMI (higher than the upper end of 25kg/m²) in the elderly may be beneficial. Similarly, worse outcomes have been associated with being underweight (at a threshold higher than 18.5 kg/m²) at age 65 (Diehr et al. 2008). Because of optimal BMI range variation recommendations from these studies, no specific optimal BMI range for the elderly is used. However, It may be appropriate to exempt certain patients from a follow-up plan by applying the exception criteria. Review the following to apply the Medical Reason exception criteria:

The Medical Reason exception

could include, but is not limited to, the following patients as deemed appropriate by the health care provider:

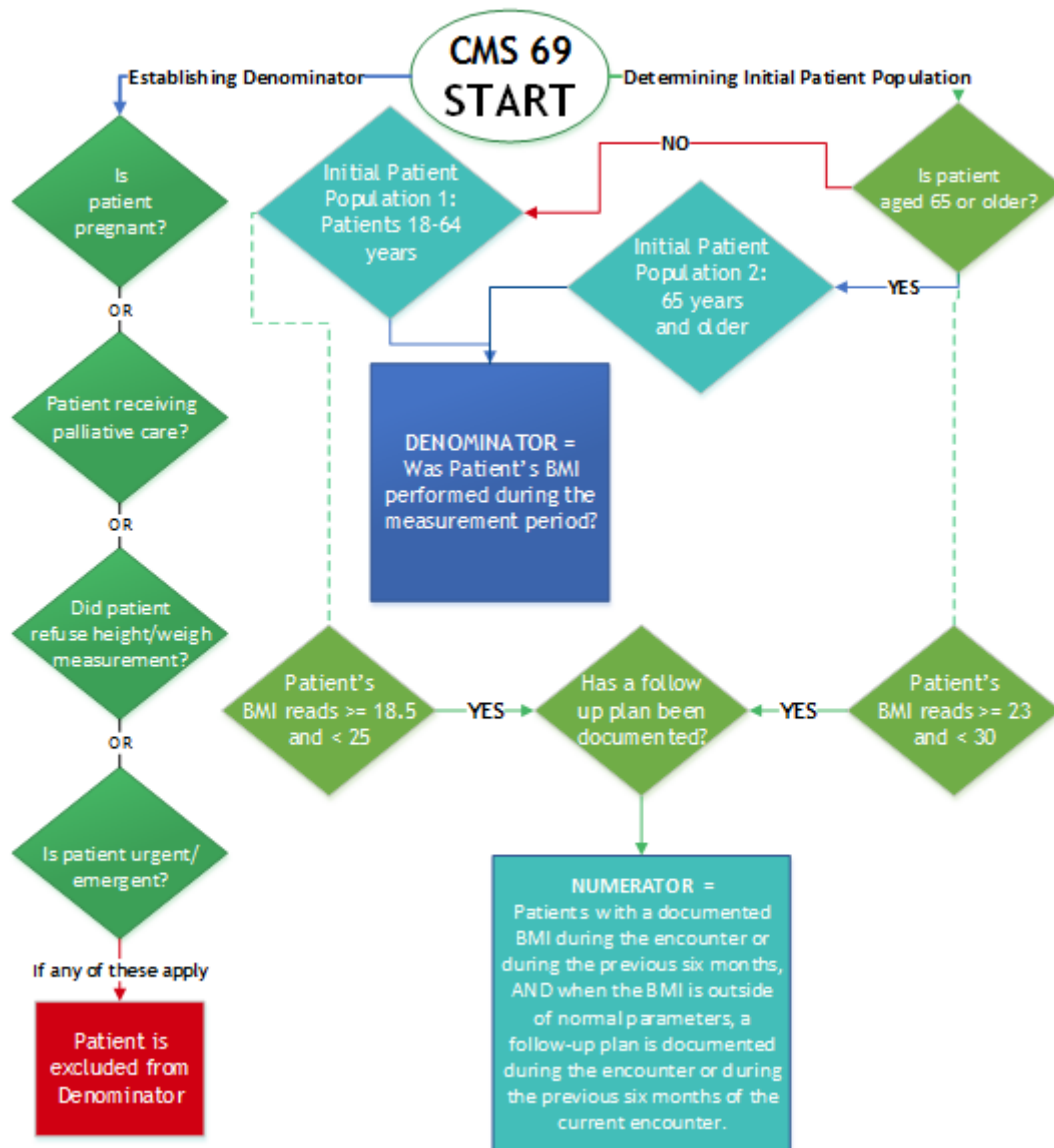
- Elderly Patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:
- Illness or physical disability
- Mental illness, dementia, confusion
- Nutritional deficiency such as Vitamin/mineral deficiency*
- Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Data Criteria (QDM Data Elements)

- "Diagnosis, Active: Pregnancy Dx" using "Pregnancy Dx Grouping Value Set (2.16.840.1.113883.3.600.1.1623)"
- "Encounter, Performed: BMI Encounter Code Set" using "BMI Encounter Code Set Grouping Value Set (2.16.840.1.113883.3.600.1.1751)"
- "Intervention, Order: Above Normal Follow-up" using "Above Normal Follow-up Grouping Value Set (2.16.840.1.113883.3.600.1.1525)"
- "Intervention, Order: Below Normal Follow up" using "Below Normal Follow up Grouping Value Set (2.16.840.1.113883.3.600.1.1528)"
- "Intervention, Order: Referrals where weight assessment may occur" using "Referrals where weight assessment may occur Grouping Value Set (2.16.840.1.113883.3.600.1.1527)"
- "Medication, Order: Above Normal Medications" using "Above Normal Medications RXNORM Value Set (2.16.840.1.113883.3.600.1.1498)"
- "Medication, Order: Below Normal Medications" using "Below Normal Medications RXNORM Value Set (2.16.840.1.113883.3.600.1.1499)"
- "Physical Exam, Performed: BMI LOINC Value" using "BMI LOINC Value LOINC Value Set (2.16.840.1.113883.3.600.1.681)"
- "Physical Exam, Performed not done: Medical or Other reason not done" using "Medical or Other reason not done SNOMEDCT Value Set (2.16.840.1.113883.3.600.1.1502)"
- "Physical Exam, Performed not done: Patient Reason refused" using "Patient Reason refused SNOMEDCT Value Set (2.16.840.1.113883.3.600.791)"
- "Procedure, Order: Palliative Care" using "Palliative Care Grouping Value Set (2.16.840.1.113883.3.600.1.1579)"
- Attribute: "Reason: Underweight" using "Underweight SNOMEDCT Value Set (2.16.840.1.113883.3.600.2388)"
- Attribute: "Reason: Overweight" using "Overweight SNOMEDCT Value Set (2.16.840.1.113883.3.600.2387)"

Measure Flowchart: Establishing a Numerator and Denominator

*Flow chart does not include denominator exceptions. Please refer to the [measure specifications](#) above for additional details.



Resources

U.S. Preventive Service Task Force (USPSTF):

- 2012 Recommendation Statement
<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-management>

Substance Use Disorder: Alcohol

Reporting Requirements

Data Source: Registry

Who Reports: Adult practices (Other practices may report as an optional measure)

Schedule: Secondary Measure

Measure Specifications

Measure Title: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

CMS e-Measure Identifier: n/a

NQF Number: NQF 2152

NQF Domain: Community/Population Health

PQRS Number: 431

Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user

Denominator: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Denominator Exclusions: None

Denominator Exceptions: Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

Numerator: Patients who were screened for unhealthy alcohol use using a systematic screening method* at least once within the last 24 months AND who received brief counseling** if identified as an unhealthy alcohol user

Numerator Exclusions: Not Applicable

Measure Steward: Physician Consortium for Performance Improvement

Measure Developer: Physician Consortium for Performance Improvement

Endorsed by: National Quality Forum

Definitions:

*Systematic screening method - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:

- AUDIT Screening Instrument (score ≥ 8)
- AUDIT-C Screening Instrument (score ≥ 4 for men; score ≥ 3 for women)

Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥ 2)

**Brief counseling - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

Screening Tools associated with this Measure

- Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument
- AUDIT-C Screening Instrument

Guidance:

The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. (Grade B recommendation) (USPSTF, 2014)

Data Criteria (QDM Data Elements):

- For measure reporting via registry CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. Refer to

[Measure Flowchart: Establishing a Numerator and Denominator](#)

Coming soon

[Resources](#)

American Medical Association:

- 2016 PQRS Specification for registry only
https://www.auanet.org/common/pdf/practices-resources/quality/pqrs-toolkit/2016/Measured-Specs/measure_431.pdf

Agency for Healthcare Research and Quality

- National Quality Measures Clearinghouse
<https://qualitymeasures.ahrq.gov/summaries/summary/50213/preventive-care-and-screening-percentage-of-patients-aged-18-years-and-older-who-were-screened-for-unhealthy-alcohol-use-using-a-systematic-screening-method-at-least-once-within-the-last-24-months-and-who-received-brief-counseling-if-identified-as-an-unhealthy/add#>

Substance Use Disorder: Alcohol and Other Drug Dependence

Reporting Requirements

Data Source: EHR / 2014 or 2015 Ed. CEHRT

Who Reports: Adult practices (Other practices may report as an optional measure)

Schedule: Primary Measure

Measure Specifications

Measure Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

CMS e-Measure Identifier: CMS 137v5

NQF Number: NQF 0004

NQF Domain: Effective Clinical Care

PQRS Number: 305

Description: Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported.

- a. Percentage of patients who initiated treatment within 14 days of the diagnosis.

b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Denominator: Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period

Denominator Exclusions: Patients with a previous active diagnosis of alcohol or drug dependence in the 60 days prior to the first episode of alcohol or drug dependence

Denominator Exceptions: None

Numerator:

Numerator 1: Patients who initiated treatment within 14 days of the diagnosis

Numerator 2: Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit

Numerator Exclusions: Not Applicable

Measure Steward: National Committee for Quality Assurance

Measure Developer: National Committee for Quality Assurance

Endorsed by: National Quality Forum

Definitions: The initiation visit is the first visit for alcohol or other drug dependence treatment within 14 days after a diagnosis of alcohol or other drug dependence.

Treatment includes inpatient AOD admissions, outpatient visits, intensive outpatient encounters or partial hospitalization.

Guidance: The new episode of alcohol and other drug dependence should be the first episode of the measurement period that is not preceded in the 60 days prior by another episode of alcohol or other drug dependence.

Data Criteria (QDM Data Elements)

- "Diagnosis: Alcohol and Drug Dependence" using "Alcohol and Drug Dependence Grouping Value Set (2.16.840.1.113883.3.464.1003.106.12.1001)"
- "Encounter, Performed: Alcohol and Drug Dependence Treatment" using "Alcohol and Drug Dependence Treatment Grouping Value Set (2.16.840.1.113883.3.464.1003.106.12.1005)"
- "Encounter, Performed: Detoxification Visit" using "Detoxification Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1059)"
- "Encounter, Performed: Discharge Services - Hospital Inpatient" using "Discharge Services - Hospital Inpatient Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1007)"

- "Encounter, Performed: Discharge Services - Hospital Inpatient Same Day Discharge" using "Discharge Services - Hospital Inpatient Same Day Discharge Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1006)"
- "Encounter, Performed: Emergency Department Visit" using "Emergency Department Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1010)"
- "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: Hospital Inpatient Visit - Initial" using "Hospital Inpatient Visit - Initial Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1004)"
- "Encounter, Performed: Hospital Observation Care - Initial" using "Hospital Observation Care - Initial Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1002)"
- "Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Psych Visit - Psychotherapy" using "Psych Visit - Psychotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1496)"

Measure Flowchart: Establishing a Numerator and Denominator

Coming soon

Substance Use Disorder: Tobacco

Reporting Requirements

Data Source: EHR / 2014 or 2015 Ed. CEHRT

Who Reports: Adult practices (Other practices may report as an optional measure)

Schedule: Primary Measure

Measure Specifications

Measure Title: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

CMS e-Measure Identifier: CMS 138v5

NQF Number: NQF 0028

NQF Domain: Community/Population Health

PQRS Number: 226

Description: Percentage of patients aged 18 years 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

Denominator: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Denominator Exclusions: None

Denominator Exceptions: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)

Numerator: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Numerator Exclusions: Not Applicable

Measure Steward: PCPI(R) Foundation (PCPI[R])

Measure Developer: American Medical Association (AMA) and PCPI(R) Foundation (PCPI[R])

Endorsed by: National Quality Forum

Definitions:

Tobacco Use - Includes any type of tobacco

Tobacco Cessation Intervention - Includes brief counseling (3 minutes or less), and/or pharmacotherapy

Guidance: If a patient uses any type of tobacco (ie, smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.

If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and should be considered a measure failure. Instances where tobacco use status of "unknown" is recorded include: 1) the patient was not screened; or 2) the patient was screened and the patient (or caregiver) was unable to provide a definitive answer. If the patient does not meet the screening component of the numerator but has an allowable medical exception, then the patient should be removed from the denominator of the measure and reported as a valid exception.

The medical reason exception only applies to the screening data element of the measure; once a patient has been screened, there are no allowable medical reason exceptions for not providing the intervention.

If a patient has a diagnosis of limited life expectancy, that patient has a valid denominator exception for not being screened for tobacco use or for not receiving tobacco use cessation intervention (counseling and/or pharmacotherapy) if identified as a tobacco user.

As noted above in a recommendation statement from the USPSTF, the current evidence is insufficient to recommend electronic nicotine delivery systems (ENDS) including electronic cigarettes for tobacco cessation. Additionally, ENDS are not currently classified as tobacco in the recent evidence review to support the update of the USPSTF recommendation given that the devices do not burn or use tobacco leaves. In light of the current lack of evidence, the measure does not currently capture e-cigarette usage as either tobacco use or a cessation aid.

Data Criteria (QDM Data Elements)

- "Diagnosis: Limited Life Expectancy" using "Limited Life Expectancy Grouping Value Set (2.16.840.1.113883.3.526.3.1259)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit Grouping Value Set (2.16.840.1.113883.3.526.3.1240)"
- "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: Health & Behavioral Assessment - Individual" using "Health & Behavioral Assessment - Individual Grouping Value Set (2.16.840.1.113883.3.526.3.1020)"
- "Encounter, Performed: Health and Behavioral Assessment - Initial" using "Health and Behavioral Assessment - Initial Grouping Value Set (2.16.840.1.113883.3.526.3.1245)"
- "Encounter, Performed: Health and Behavioral Assessment, Reassessment" using "Health and Behavioral Assessment, Reassessment Grouping Value Set (2.16.840.1.113883.3.526.3.1529)"
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Occupational Therapy Evaluation" using "Occupational Therapy Evaluation Grouping Value Set (2.16.840.1.113883.3.526.3.1011)"
- "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 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 - Group Counseling" using "Preventive Care Services - Group Counseling Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1027)"
- "Encounter, Performed: Preventive Care Services - Other" using "Preventive Care Services - Other Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1030)"
- "Encounter, Performed: Preventive Care Services-Individual Counseling" using "Preventive Care Services-Individual Counseling Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1026)"
- "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: Psych Visit - Diagnostic Evaluation" using "Psych Visit - Diagnostic Evaluation Grouping Value Set (2.16.840.1.113883.3.526.3.1492)"
- "Encounter, Performed: Psych Visit - Psychotherapy" using "Psych Visit - Psychotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1496)"
- "Encounter, Performed: Psychoanalysis" using "Psychoanalysis Grouping Value Set (2.16.840.1.113883.3.526.3.1141)"
- "Encounter, Performed: Speech and Hearing Evaluation" using "Speech and Hearing Evaluation Grouping Value Set (2.16.840.1.113883.3.526.3.1530)"
- "Intervention, Performed: Tobacco Use Cessation Counseling" using "Tobacco Use Cessation Counseling Grouping Value Set (2.16.840.1.113883.3.526.3.509)"
- "Medication, Active: Tobacco Use Cessation Pharmacotherapy" using "Tobacco Use Cessation Pharmacotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1190)"
- "Medication, Order: Tobacco Use Cessation Pharmacotherapy" using "Tobacco Use Cessation Pharmacotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1190)"
- "Patient Characteristic: Tobacco Non-User" using "Tobacco Non-User Grouping Value Set (2.16.840.1.113883.3.526.3.1189)"
- "Patient Characteristic: Tobacco User" using "Tobacco User Grouping Value Set (2.16.840.1.113883.3.526.3.1170)"
- "Risk Category Assessment: Tobacco Use Screening" using "Tobacco Use Screening Grouping Value Set (2.16.840.1.113883.3.526.3.1278)"
- "Risk Category Assessment not done: Medical Reason" using "Medical Reason Grouping Value Set (2.16.840.1.113883.3.526.3.1007)"

Measure Flowchart: Establishing a Numerator and Denominator

Coming soon

Addendum

Additional SIM CQM documents:

[SIM Clinical Quality Measures List](#)

**Family practices choose to report on either adult or pediatric practice measure set*

Colorado SIM CQM Reporting Schedules

- [SIM Cohort 1](#)
- [SIM Cohort 2](#)

*Please work with your CHITA to determine the reporting schedule that best fits with your practice

SIM, TCPI, CPC+, QPP crosswalk of measures

Available on the Practice Innovation Colorado website here:

http://www.practiceinnovationco.org/wp-content/uploads/2017/02/Clinical-Quality-Measures-CQM-Crosswalk-of-Measures_SIM_TCPI_CPC_QPP.pdf

Implementing Measures into SIM Practice Workflows

Asthma - Medication Management for People with Asthma

Practice Fusion Suggested Workflow

<http://knowledgebase.practicefusion.com/knowledgebase/articles/485848-cqm-use-of-appropriate-medications-for-asthma-cm>

Depression - Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan

Practice Fusion Suggested workflow

<http://knowledgebase.practicefusion.com/knowledgebase/articles/485871-cqm-preventive-care-and-screening-screening-for>

SAMHSA-HRSA Center for Integrated Solutions

Understanding and Implementing UDS measures for Depression Screening, Documentation, and Practice http://www.integration.samhsa.gov/about-us/UDS_Depression_Screening_Final.pdf

Diabetes - Hemoglobin A1c Poor Control

Health Resources and Services Administration (HRSA) Critical Pathway for Diabetes HbA1c (Figure 3.1)

<http://www.hrsa.gov/quality/toolbox/measures/diabetes/part3.html>

Practice Fusion Suggested workflow

<http://knowledgebase.practicefusion.com/knowledgebase/articles/485705-cqm-diabetes-hemoglobin-a1c-poor-control-cms122>

Fall Safety - Falls Screening for Future Fall Risk

Practice Fusion Suggested workflow

<http://knowledgebase.practicefusion.com/knowledgebase/articles/485841-cqm-falls-screening-for-future-fall-risk-cms-13>

Hypertension - Controlling High Blood Pressure

Health Resources and Services Administration (HRSA): Critical Pathway for Hypertension Control (Figure 3.1)

<http://www.hrsa.gov/quality/toolbox/measures/hypertension/index.html>

Practice Fusion Suggested Workflow

<http://knowledgebase.practicefusion.com/knowledgebase/articles/485873-cqm-controlling-high-blood-pressure-cms165v3-n>

Maternal Depression - Maternal depression Screening

Practice Fusion Suggested Workflow

<http://knowledgebase.practicefusion.com/knowledgebase/articles/485871-cqm-preventive-care-and-screening-screening-for>

Obesity: Adult

Practice Fusion Suggested Workflow

<http://knowledgebase.practicefusion.com/knowledgebase/articles/485875-cqm-preventive-care-and-screening-body-mass-inde>

Substance Use Disorder: Tobacco

Practice Fusion Suggested Workflow

<http://knowledgebase.practicefusion.com/knowledgebase/articles/485865-cqm-preventive-care-and-screening-tobacco-use-s>