RI Care Transformation Collaborative (CTC)
Adult Clinical Quality Measures (CQM) Strategy Checklist (v8.16)
(Based on CTC document: "May 2016 CTC/OHIC Measure Specifications")

Rhode Island Quality Institute has developed this checklist to assist practices in achievement of clinical quality measure (CQM) reporting for CTC. This is not an exhaustive plan, but rather a guide to help navigate the requirements. Use this checklist as supplement to: "May 2016 CTC/OHIC Measure Specifications". To learn more about Rhode Island Quality Institute, call(888) 858-4815, e-mail RIREC@riqi.org or go: http://transformyourpracticeri.org/Services

Practice Name:

Reviewed Check list with name/s): **Date(s) Reviewed:**

RI REC Relationship Manager: Sue Dettling (sdettling@riqi.org) OR Ashley Fishback (afishback@riqi.org)

Current NCQA Level / Expiration: **EHR Vendor/ Version:**

	Important Steps	Notes/ Planning / Timeline
☐	**Define roles, responsibilities and processes for**: ☐ Attend Practice Reporting Workgroup meetings: ________________ ☐ Develop and generate EHR reports: __________________________ ☐ Report to RIQI/CTC: _______________________________________ ☐ Disseminate results within practice: __________________________ ☐ Use results to drive quality improvement activities within practice	
☐	**Understand measure definitions:** ☐ Review Measures ☐ Examine EHR reporting capabilities/ or pursue external vendor ☐ Identify and address any problems with EHR reporting capabilities ☐ Develop reports – run test reports and examine for accuracy	Any questions about quality measure specifications, please contact your Relationship Manager: Sue Dettling – email: sdettling@riqi.org Ashley Fishback – email: afishback@riqi.org

☐	**Create Milestone Plan for CTC quality measure submission:** ☐ Date Initial Review Completed: ______________________________ ☐ Gather all measures to be reported, including NCM and IBH, if applicable ☐ As submission time approaches, you will receive an email from RIQI with a direct link to your data collection form. Use this link to submit results ☐ Results are due by 15th of month following quarter end)	Any questions about CTC reporting portal, contact Marie Sarrasin - email: msarrasin@riqi.org The portal form assumes all measures are submitted at the same time so it's best to have all results ready at time of submission. If this is not possible, you may submit data on more than one occasion. Be sure to follow instructions on the form about submitting with missing data. -If you do not receive an email about a week before submission deadline, go to https://www.ctc-ri.org, locate your practice site and submit your quality data.
☐	**Timeline for required Quarterly Submission of quality measures:** *(use rolling quarters)* Due 7/15/2016; Q2 2016 (data from 7/1/15 ending 6/30/16) – *completed* Due 10/15/2016; Q3 2016 (data from 10/1/15 ending 9/30/16) Due 1/15/2017; Q4 2016 (data from 1/1/15 ending 12/31/16) Due 4/15/2017; Q1 2017 (data from 4/1/16 ending 3/31/17) Due 7/15/2017; Q2 2017 (data from 7/1/16 ending 6/30/17) Due 10/15/2017; Q3 2017 (data from 10/1/16 ending 9/30/17)	Practices that are running the report the first time need to plan to run data one month before due date and meet with Relationship Manager to discuss data and how report was generated. *Practices need to formally ask for an extension if not able to report data; such an extension MUST be APPROVED by CTC. In order to be considered for an exclusion, please send an email to each of these CTC reporting contacts: Andrea Galgay: agalgay@ripcpc.com Patty Kelly-Flis: pkelly-flis@welloneri.org Susanne Campbell: Susanne.Campbell@umassmed.edu Marie Sarrasin: msarrasin@riqi.org

CTC Clinical Quality Measures (CQMs)

Note: These measure definitions are based on the NQF and/or HEDIS measure definitions but are not exactly the same as the quality measures required for Meaningful Use. EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the EHR report may result in duplication of patients.

	Measure	Helpful Tips	Notes/ Planning / Timeline Where Captured in EHR?
☐	**Active Patient criteria –** same definition for ALL measures – refer to *May 2016 CTC/OHIC Measure Specification* document (Spec Doc.) for additional details Patient seen by a primary care clinician of the PCMH anytime within the last 24 months. (outpatient visit)	**Helpful Tip:** Important to "clean" up your data and ensure that you are reporting on your active patients. Be sure to review your lists regularly with your providers (annotate properly who is deceased, or transferred out according to the active patient definition). This will yield more accurate results with your quality data. Have a procedure to make a patient inactive for reasons such as "moved, but did not transfer", "outreach to patient 3 or more times (using 2 or more outreach methods)"	Refer to pg. 1 of *May 2016 CTC/OHIC Measure Specification* document for: CPT office visit codes, acceptable exclusions, outpatient visit criteria and encounter types.
☐	**Adult BMI Assessment (ABA) – Age 18-74 (HEDIS)** **Contract Measure** • Look Back Period: 24 months • 2015- 2016 Threshold: N/A • 2015- 2017 Non-FQHC Threshold: 90% • 2015- 2017 FQHC Threshold: 90%	**Helpful Tips:** It is OPTIONAL to run report with exclusions or not; if exclusions are applied, data will yield more accurate results. Documentation must include BMI value/percentile, height and weight	
☐	**Screening for Clinical Depression and Follow Up Plan (PQRS)** **Contract Measure** • Look Back Period: 12 months • 2015- 2016 Threshold: N/A • 2015- 2017 Non-FQHC Threshold: 50% • 2015- 2017 FQHC Threshold: 50%	**Helpful Tips:** Acceptable tools include the Patient Health Questionnaire (PHQ-9), 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 (GDS), Cornell Scale Screening, and PRIME MD-PHQ2. The tool used must be documented in the record. Completion of PHQ-9 satisfies "follow-up" through means of a continued screening.	

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<table>
<tr><td colspan="4">Note: These measure definitions are based on the NQF and/or HEDIS measure definitions but are not exactly the same as the quality measures required for Meaningful Use. EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the EHR report may result in duplication of patients.</td></tr>
<tr><th colspan="2">Measure</th><th>Helpful Tips</th><th>Notes/ Planning / Timeline
Where Captured in EHR?</th></tr>
<tr><td>☐</td><td>Diabetes Mellitus – HbA1c Control (<8)
- Age 18-75
(HEDIS)
Contract Measure

• Look Back Period to identify diabetics: 24 months
• Look Back Period for A1C results: 12 months
• 2015- 2016 Threshold: 72%
• 2015- 2017 Non-FQHC Threshold: 72%
• 2015- 2017 FQHC Threshold: 67%</td><td>Helpful Tips: Denominator includes active patients with diagnosis of diabetes or listed as diabetic in “problem list”/ or “assessment”; need to be age 18 – 75 at the end of the reporting period with documentation of diabetes during the measurement year or year prior. Practices are required to report on most recent result (if 2 are normal and 3rd most recent is out of range, it still has to be counted; If patient does NOT have A1C recorded, this counts against you; Use CurrentCare Viewer to look up missing labs – will allow for more accurate reporting)

May use Active Patients who have been on practice panel for at least 6 mos. (see Exclusion on “Spec Doc.”)</td><td></td></tr>
<tr><td>☐</td><td>Controlling High Blood Pressure - Age 18-75
(HEDIS)
Contract Measure
• Patients age 18-59 w/ BP <140/90 mm Hg
• Patients age 60 – 85 w/ diagnosis diabetes w/ BP < 140/90
• Patients age 60 – 85 w/out diagnosis diabetes w/ BP < 150/90

• Look Back Period: 12 months
• 2015- 2016 Threshold: 80%
• 2015- 2017 Non-FQHC Threshold: 80%
• 2015- 2017 FQHC Threshold: 68%</td><td>Helpful Tips: BP is viewed as 2 separate values systolic and diastolic. If there are multiple readings for single date, the lowest of each may be used. Pay close attention to measure definition as it includes diabetics and non-diabetics by age and BP range; Report on ONE Numerator/Denominator by adding all together (age 18 – 85).
Practices may limit denominator to only include those patients with a diagnosis of hypertension in the first 6 months of the measurement year, however, most practices include any with an active problem list</td><td>Vitals</td></tr>
</table>

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Measure		**Helpful Tips**	**Notes/ Planning / Timeline Where Captured in EHR?**
		diagnosis of hypertension. The first six months rule applies more to health insurers being held accountable to the measure rather than practices, but to remain consistent with specifications, the exclusion was included for CTC. If able, do not include patients with new diagnosis of hypertension in most recent 6 months.	
☐	**Tobacco Cessation Intervention (NQF/PQRS)** **Contract Measure** • Look Back Period: *2 different look back periods; see specification document for details* • 2015- 2016 Threshold: 90% • 2015- 2017 Non-FQHC Threshold: 90% • 2015- 2017 FQHC Threshold: 98%	**Helpful Tips:** patients' use of e-cigarette doesn't constitute as tobacco cessation intervention unless noted by provider as "quit method"	
	Additional Notes:		