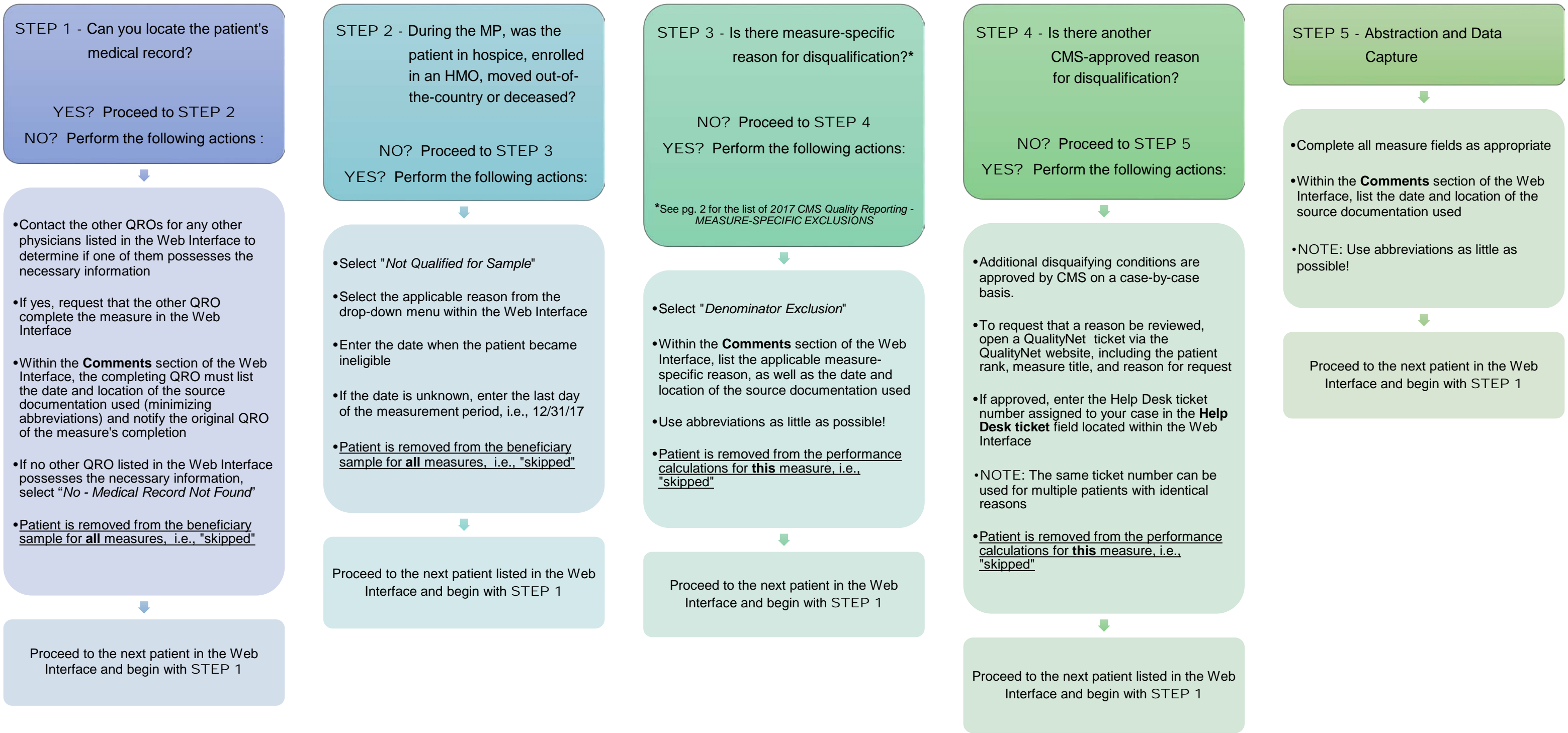


2017 CMS Quality Reporting - ABSTRACTION PROCESS OVERVIEW



2017 CMS Quality Reporting - MEASURE-SPECIFIC EXCLUSIONS

Measure Title	Measure-Specific Exclusions
CARE-1 <i>Medication Reconciliation Post-Discharge</i>	No current medications listed No discharge medications listed No follow-up visit in chart Follow-up > 32 days (30 days, +/- 2 days from prefilled discharge date) Author is not a prescribing practitioner, RN, or clinical pharmacist
CARE-2 <i>Screening for Future Falls</i>	Patient non-ambulatory at most recent encounter on 9/1/17
DM-2 <i>Diabetes - Hemoglobin A1c (HbA1c) Poor Control (>9%)</i>	Patient has no diagnosis of Type 1 or 2 diabetes on chart Patient has no <i>active</i> diagnosis of Type 1 or 2 diabetes on chart Elevated blood sugar is due to another medical condition, e.g., steroids for asthma Hemoglobin A1c (HbA1c) is ≤ 9% No Hemoglobin A1c (HbA1c) on chart
DM-7 <i>Diabetes - Eye Exam</i>	Patient has no diagnosis of Type 1 or 2 diabetes on chart Patient has no <i>active</i> diagnosis of Type 1 or 2 diabetes on chart during MP Elevated blood sugar is due to another medical condition, e.g., steroids for asthma Retinal or dilated eye exam was not performed as part of exam No eye exam on chart Exam performed outside of measure-specified time period, i.e., 1/1/2016 - 12/31/2017
HTN-2 <i>Controlling High Blood Pressure</i>	No active diagnosis of essential hypertension between 01/01 and 06/30/2017 Systolic blood pressure > 140 Diastolic blood pressure > 90
IVD-2 <i>Ischemic Vascular Disease (IVD) - Use of Aspirin or Another Antiplatelet</i>	No acute myocardial infarction between 01/01 - 12/31/2016 No coronary artery bypass graft between 01/01 - 12/31/2016 No percutaneous coronary intervention between 01/01 - 12/31/2016 No active diagnosis of ischemic vascular disease during the measurement period No documented use of aspirin or other antiplatelet medication during the measurement period Patient is taking one of the Denominator Exclusion Anticoagulant Medications
MH-1 <i>Depression Remission at Twelve Months</i>	Patient has an active diagnosis of bipolar disorder Patient has an active diagnosis of personality disorder No <u>index</u> PHQ-9 on chart between 12/01/2015 - 11/30/2016 Index PHQ-9 score is ≤ 9 No <u>repeat</u> PHQ-9 on chart at 12 months after the <u>index</u> PHQ-9 (+/- 30 days) Repeat PHQ-9 score ≥ 5
PREV-5 <i>Breast Cancer Screening</i>	Patient had a bilateral mastectomy Patient had two (2) unilateral mastectomies No mammogram on chart between 10/01/2015 - 12/31/2017 Most recent mammogram was before 10/01/2015 Patient received an MRI or Ultrasound instead of a mammogram Patient-reported results are listed by the provider, however either the test type, date, or result is missng
PREV-6 <i>Colorectal Cancer Screening</i>	Patient has a history of colorectal cancer Patient has a history of total colectomy Patient received only digital rectal exam Patient-reported results are listed by the provider, however either the test type, date, or result is missng

Measure Title	Measure-Specific Exclusions
PREV-7 <i>Influenza Immunization</i>	No chart documentation reflecting that the patient received an influenza immunization during a clinic visit between 10/01/2016 - 03/31/2017 No chart documentation reflecting that the patient reported having previously received an influenza immunization between 08/01/2016 - 03/31/2017
PREV-8 <i>Pneumococcal Vaccination Status for Older Adults</i>	No chart documentation that the patient ever received either the PCV13 or PPSV23 pneumonia vaccination, either alone or in combination Patient-reported results are listed by the provider, however either the test type, date, or result is missing
PREV-9 <i>Body Mass Index (BMI) Screening and Follow-Up Plan</i>	Patient is pregnant Patient refused height and/or weight measurement Patient refused follow-up Patient is ≥ 65 years and weight loss or gain would complicate other health conditions, such as: illness or physical disability; mental illness, dementia, confusion; or vitamin/mineral deficiency Patient is emergent or urgent and a treatment delay would jeopardize patient health No BMI charted during current encounter or during the six (6) months prior to current encounter Patient's Body Mass Index is on the patient chart and is within normal range Patient's Body Mass Index is on the chart and abnormal but there is no follow-up plan
PREV-10 <i>Tobacco Use - Screening and Cessation Intervention</i>	Patient was not screened between 01/01/2016 and 12/31/2017 Patient is a non-smoker Patient had a positive screen however cessation counseling was not provided to the patient
PREV-12 <i>Screening for Depression and Follow-Up Plan</i>	Patient has an active diagnosis of bipolar disorder Patient has an active diagnosis of personality disorder No depression screen on chart Patient refuses assessment Patient is emergent or urgent and a treatment delay would jeopardize patient health Patient's functional capacity or motivation to improve may impact the accuracy of results Patient was not screened with a standardized tool Patient has positive screen but no follow-up plan is documented Follow-up plan is present but missing the minimum requirement Follow-up plan does not refer to the positive screen
PREV-13 <i>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</i>	Patient not "high-risk" i.e., patient does not meet at least one (1) of the three (3) reporting criteria for this measure Patient pregnant or breastfeeding or diagnosed with rhabdomyolysis Patient is allergic or intolerant of statin medication Patient has active liver/hepatic disease or insufficiency Patient has end-stage renal disease (ESRD) Patient is diabetic with most recent fasting or direct LDL-C < 70 mg/dl and is not taking a statin

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Measure	Description	Exclusions	Definitions	Data Guidance	
CARE-1 Medication Reconciliation Post-Discharge	<p>Patients ≥ 18 yrs who were:</p> <ul style="list-style-type: none"> -- discharged from any inpatient facility <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> -- seen within 30 days post-discharge (+ or - 2 days either before or after the pre-filled discharge date) by professional providing ongoing care <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> -- discharge medication list was reconciled with the current medication list in the MR. 	<ul style="list-style-type: none"> • Deceased during CY 2017 • In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 • Moved out of country at anytime during CY 2017 • Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> • CY = Calendar Year • <i>Inpatient facility</i> = acute care hospital, inpatient psychiatric facility, skilled nursing or inpatient rehabilitation • HMO = Health Maintenance Organization • MP = Measurement Period = 01/01/2017 - 12/31/2017 • MR = Medical Record • OV = Office visit • <i>Professional providing ongoing care</i> = physician, prescribing practitioner, registered nurse, or clinical pharmacist • WI = Web Interface 	<ol style="list-style-type: none"> (1) Inpatient discharges are pre-populated by CMS using claims data (2) Denominator is based on individual discharges followed by an OV, not individual patients. As a result, there may be multiple charge dates for the same patient (3) Documentation of the current medications with a notation that references the discharge medications, such as: <ul style="list-style-type: none"> -- <i>no changes in meds since discharge</i> -- <i>same meds at discharge</i> -- <i>discontinue all discharge meds</i> (4) Documentation of the patient's current medications with a notation that the discharge medications were reviewed. (5) Documentation that the provider "reconciled the current and discharge meds." (6) Documentation of a current medication list, a discharge medication list <u>and</u> notation that the appropriate practitioner type reviewed both lists on the same date of service (7) Notation that no medications were prescribed or ordered upon discharge. (8) Medication reconciliation post-discharge <u>can</u> be performed during telehealth encounter 	
CARE-2 Falls - Screening for Future Fall Risk	<p>Patients ≥ 65 yrs who were:</p> <ul style="list-style-type: none"> -- screened for future fall risk during CY 2017 	<ul style="list-style-type: none"> • Patient non-ambulatory at most recent encounter during CY 2017 • Deceased during CY 2017 • In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 • Moved out of country at anytime during CY 2017 • Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> • CY = Calendar Year • <i>Fall</i> = 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. • HMO = Health Maintenance Organization • MP = Measurement Period = 01/01/2017 - 12/31/2017 • MR = Medical Record • <i>Screening for Future Fall Risk</i> = assessment of whether an individual has experienced a fall or problems with gait or balance. While a specific screening tool is not required for this measure, potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test. • WI = Web Interface 	<ol style="list-style-type: none"> (1) A clinician with appropriate skills and experience may perform the screening (2) <i>Documentation of no falls is sufficient</i> (3) MR must include documentation of screening performed (4) Any history of falls screening during CY 2017 is acceptable (5) A gait or balance assessment is acceptable (6) A specific screening tool is not required (7) Fall risk screening is embedded within the Medicare Annual Wellness Visit documentaion (8) Fall risk screening <u>can</u> be performed during telehealth encounter 	
DM Composite - All or Nothing	DM-2 Diabetes - Hemoglobin A1c (HbA1c) Poor Control (>9%)	<p>Patients 18 - 75 yrs during CY 2017 with:</p> <ul style="list-style-type: none"> -- active diagnosis or documented history of Type 1 or Type 2 DM during CY 2016 or CY 2017 <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> -- most recent HbA1c > 9% during CY 2017 	<ul style="list-style-type: none"> • Diagnosis of secondary DM due to other condition • Deceased during CY 2017 • In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 • Moved out of country at anytime during CY 2017 • Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> • <i>Active Diagnosis</i> = a diagnosis that is: <ul style="list-style-type: none"> -- on the patient's problem list -- a diagnosis code on the encounter, or -- documented in a progress note indicating that the patient is being treated or managed for the disease or condition during the CY 2017 • CY = Calendar Year • DM = Diabetes Mellitus • HMO = Health Maintenance Organization • MP = Measurement Period = 01/01/2017 - 12/31/2017 • MR = Medical Record • WI = Web Interface 	<ol style="list-style-type: none"> (1) Synonyms for HbA1c testing may include Glycohemoglobin A1c, HbA1c, Hemoglobin A1c, HgbA1c, A1c (2) Data source priority ranking: <ul style="list-style-type: none"> -- Lab report draw date (also known as collection date) -- Lab report date -- Flow sheet documentation -- Practitioner notes -- Other documentation -- Patient reported result (source of last resort) (3) Both patient reported and chart listed results must include date of test and numeric result (range unacceptable) (4) Documentation of most recent HbA1c result <u>can</u> be completed during a telehealth encounter
	DM-7 Diabetes - Eye Exam	<p>Patients 18 - 75 yrs with:</p> <ul style="list-style-type: none"> -- active diagnosis or documented history of Type 1 or Type 2 DM during CY 2016 or CY 2017 <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> -- a retinal or dilated eye exam performed or read by an ophthalmologist or optometrist during CY 2017 or -- a <u>negative</u> retinal or dilated eye exam (e.g. no evidence of retinopathy) during CY 2016 	<ul style="list-style-type: none"> • Diagnosis of secondary DM due to other condition • Deceased during CY 2017 • In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 • Moved out of country at anytime during CY 2017 • Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> • <i>Active Diagnosis</i> = a diagnosis that is: <ul style="list-style-type: none"> -- on the patient's problem list -- a diagnosis code on the encounter, or -- documented in a progress note indicating that the patient is being treated or managed for the disease or condition during the MP • CY = Calendar Year • DM = Diabetes Mellitus • HMO = Health Maintenance Organization • MP = Measurement Period = 01/01/2017 - 12/31/2017 • MR = Medical Record • WI = Web Interface 	<ol style="list-style-type: none"> (1) Patient Reported Requirement: Date (year) and result/finding (2) If an endocrinologist or PCP performs the appropriate imaging in their office and the results are reviewed by an eye care professional (<i>optometrist or ophthalmologist</i>) during CY 2017 or CY 2016 (if negative for retinopathy) then it is eligible for use in reporting (3) If the eye exam is not performed or reviewed by an ophthalmologist or optometrist, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist (4) Documentation of diabetic retinal disease screening <u>can</u> be completed during a telehealth encounter

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Measure	Description	Exclusions	Definitions	Data Guidance
HTN-2 Controlling High Blood Pressure	Patients 18 - 85 yrs with: -- an active diagnosis of essential HTN between <u>01/01/2017</u> and <u>06/30/2017</u>	<ul style="list-style-type: none"> Active diagnosis through <i>start</i> of CY 2017: -- ESRD -- Pregnancy -- Stage 5 CKD Diagnosed <i>before or during</i> CY 2017: -- Dialysis -- History of renal transplant Patients ≥ 65 yrs in an Institutional SNP or residing in a long-term care facility with a POS code 32, 33, 34, 54, or 56 at anytime during CY 2017 Deceased during CY 2017 In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 Moved out of country at anytime during CY 2017 Enrolled in HMO at any time during CY 2017 Diagnosis of pregnancy during CY 2017 	<ul style="list-style-type: none"> CKD = Chronic Kidney Disease CY = Calendar Year ESRD = End-Stage Renal Disease HMO = Health Maintenance Organization MP = Measurement Period = 01/01/2017 - 12/31/2017 MR = Medical Record SNP = Special Needs Plan WI = Web Interface 	<ol style="list-style-type: none"> Only BP readings performed by a clinician in the provider office are acceptable If there are multiple BP readings on the same day, use the <i>lowest systolic</i> and <i>lowest diastolic</i> measurements (from different readings, if appropriate) as the most recent BP reading Patient-reported BP values are <i>not acceptable</i> If no BP is recorded during CY 2017, the patient's blood pressure is assumed "<i>not controlled</i>" BP screening <u>cannot</u> be completed during a telehealth encounter
IVD-2 Ischemic Vascular Disease (IVD) - Use of Aspirin or Another Antiplatelet	Patients ≥ 18 yrs who were: -- diagnosed with AMI, CABG, or PCI during CY 2016 OR -- active diagnosis of IVD <i>during</i> CY 2017 <i>and</i> -- had documentation of ASA or other antiplatelet use during CY 2017	<ul style="list-style-type: none"> Documentation of Denominator Exclusion Anticoagulant Medication use overlapping CY 2017 Diagnosis of PVD and/or PAD do not qualify as IVD Deceased during CY 2017 In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 Moved out of country at anytime during CY 2017 Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> <i>Active Diagnosis</i> = a diagnosis that is: -- on the patient's problem list -- a diagnosis code on the encounter, or -- documented in a progress note indicating that the patient is being treated or managed for the disease or condition during CY 2017 AMI = Acute Myocardial Infarction ASA = Aspirin CABG = Coronary Artery Bypass Graft CY = Calendar Year HMO = Health Maintenance Organization IVD = Ischemic Vascular Disease MP = Measurement Period = 01/01/2017 - 12/31/2017 MR = Medical Record PAD = Peripheral Arterial Disease PCI = Percutaneous Coronary Intervention PVD = Peripheral Vascular Disease WI = Web Interface 	<ol style="list-style-type: none"> Denominator Exclusion Anticoagulant Medications: -- Apixaban -- Enoxaparin -- Argatroban -- Fondaparinux -- Bivalirudin -- Heparin -- Dabigatran -- Lepirudin -- Dalteparin -- Rivaroxaban -- Desirudin -- Tinzaparin -- Edoxaban -- Warfarin Oral antiplatelet meds include: -- ASA -- clopidogrel or combination of aspirin and extended-release dipyridamole -- Prasugrel -- Ticagrelor -- Ticlopidine Antiplatelet use documentation <u>can</u> be completed during a telehealth encounter
MH-1 Depression Remission at Twelve Months	Patients ≥ 18 yrs with: -- major depression or dysthymia AND -- an initial PHQ-9 > 9 documented between <u>12/1/2015</u> and <u>11/30/2016</u> AND -- demonstrate remission as evidenced by PHQ-9 < 5 at 12 months (+ or - 30 days) after index visit	<ul style="list-style-type: none"> Active diagnosis of bipolar disorder Active diagnosis of personality disorder Permanent Nursing Home Resident Deceased during CY 2017 In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 Moved out of country at anytime during CY 2017 Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> <i>Active Diagnosis</i> = a diagnosis that is: -- on the patient's problem list -- a diagnosis code on the encounter, or -- documented in a progress note indicating that the patient is being treated or managed for the disease or condition during CY 2017 CY = Calendar Year HMO = Health Maintenance Organization MP = Measurement Period = 01/01/2017-12/31/2017 MR = Medical Record <i>Permanent Nursing Home Resident</i> = a patient who is residing in a skilled nursing facility on a long-term basis. -- It does not include patients who are receiving short-term rehabilitative services following a hospital stay or patients residing in assisted-living or group-home settings WI = Web Interface 	<ol style="list-style-type: none"> Patient must be aged 18 years of age or older at Index Date Index PHQ-9 > 9 <u>must</u> be documented between <u>12/1/2015</u> and <u>11/30/2016</u>: -- <i>if more than one PHQ-9 result in present, use most recent</i> PHQ-9 can be administered via telephone, email, mail, e-visit, patient portal, iPad/tablet, or patient kiosk Remission PHQ-9 < 5 must be documented during 12 months post-index date, +/- 30 days

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Measure	Description	Exclusions	Definitions	Data Guidance
PREV-5 Breast Cancer Screening	<p>Patients 50 - 74 yrs who had:</p> <p>-- a mammogram screen for breast cancer between <u>10/01/2015 and 12/31/2017</u></p>	<ul style="list-style-type: none"> Bilateral mastectomy 2 unilateral mastectomies Patients ≥ 65 yrs in an Institutional SNP or residing in a long-term care facility with a POS code 32, 33, 34, 54, or 56 at anytime during CY 2017 Deceased during CY 2017 In hospice, including non-hospice with palliative goals or comfort care, at anytime during CY 2017 Moved out of country at anytime during CY 2017 Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> CY = Calendar Year HMO = Health Maintenance Organization MP = Measurement Period = 01/01/2017 - 12/31/2017 MR = Medical Record SNP = Special Needs Plan WI = Web Interface 	<ol style="list-style-type: none"> MR documentation must include date the breast cancer screening was performed and the result/findings Result of "normal" or "abnormal" is acceptable If patient reported, must include date, type of test, and result/finding Testing includes: Breast x-ray, diagnostic mammography, mammogram, screening mammography, and digital breast tomosynthesis, a.k.a. 3D mammography MRI and Ultrasound results are not acceptable Documentation of screening mammography <u>can</u> be completed during a telehealth encounter An order for breast cancer screening without documentation of test completion is not acceptable
PREV-6 Colorectal Cancer Screening	<p>Patients 50 - 75 yrs who had <u>one</u> of the following:</p> <p>-- FOBT during CY 2017</p> <p>-- Flexible sigmoidoscopy during <u>01/01/2013 - 12/31/2017</u></p> <p>-- Colonoscopy during <u>01/01/2008 - 12/31/2017</u></p> <p>-- CT colonography during <u>01/01/2013 - 12/31/2017</u></p> <p>-- FIT-DNA during <u>01/01/2015 - 12/31/2017</u></p>	<ul style="list-style-type: none"> Diagnosis or past history of total colectomy or colorectal cancer Patients ≥ 65 yrs in an Institutional SNP or residing in a long-term care facility with a POS code 32, 33, 34, 54, or 56 at anytime during CY 2017 Deceased during CY 2017 In hospice, including non-hospice with palliative goals or comfort care, at anytime during CY 2017 Moved out of country at anytime during CY 2017 Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> CT = Computed tomography CY = Calendar Year DRE = Digital Rectal Exam FIT-DNA = Fecal immunochemical DNA test FOBT = Fecal Occult Blood Test HMO = Health Maintenance Organization MP = Measurement Period = 01/01/2017 - 12/31/2017 MR = Medical Record SNP = Special Needs Plan WI = Web Interface 	<ol style="list-style-type: none"> FOBT includes ColoCARE, Coloscreen, EZ Detect, FIT, flushable reagent pads, flushable reagent stool blood test, guiac smear test, Hemoccult, Seracult, stool occult blood test Do not count DRE or FOBT tests performed in the office Do not count FOBTs performed on a sample collected via DRE Documentation must include date of screening and result or findings <ul style="list-style-type: none"> Documentation of "normal" or "abnormal" is acceptable Patient-reported documentation requirement: date (year), type of test, and result/finding Documentation of colorectal cancer screening <u>can</u> be completed during a telehealth encounter
PREV-7 Influenza Immunization	<p>Patients ≥ 6 mos who:</p> <p>-- received an influenza immunization during an office visit <u>between</u> 10/01/2016 and 03/31/2017</p> <p style="text-align: center;">OR</p> <p>-- reported previously receiving an influenza immunization <u>between</u> 08/01/2016 and 03/31/2017</p>	<ul style="list-style-type: none"> Medical reason, i.e., allergy Patient reason, i.e., refused System reason, i.e., vaccine unavailable Deceased during CY 2017 In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 Moved out of country at anytime during CY 2017 Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> CY = Calendar Year HMO = Health Maintenance Organization MP = Measurement Period = 01/01/2017 - 12/31/2017 MR = Medical Record WI = Web Interface 	<ol style="list-style-type: none"> If WI is pre-filled with "Yes", <u>no further action is required</u> Documentation must include date of administration and type of vaccine administered Documented reason for not receiving influenza immunization: <ul style="list-style-type: none"> medical reason - e.g., patient allergy patient reason - e.g., patient declined system reason - e.g., vaccine unavailable Documentation of previously receiving the influenza immunization <u>can</u> be completed during a telehealth encounter
PREV-8 Pneumococcal Vaccination Status for Older Adults	<p>Patients ≥ 65 yrs who:</p> <p>-- have ever received a pneumococcal vaccine</p>	<ul style="list-style-type: none"> Deceased during CY 2017 In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 Moved out of country at anytime during CY 2017 Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> CY = Calendar Year HMO = Health Maintenance Organization MP = Measurement Period = 01/01/2017 - 12/31/2017 MR = Medical Record WI = Web Interface 	<ol style="list-style-type: none"> PCV13 and PPSV23, either alone or together, are acceptable Patient-reported results 2015 - Present: <u>Must</u> include the month, year, and type of vaccine received Patient-reported results prior to 2015: <u>Report alone is sufficient</u>, with date and vaccine type information being optional Documentation of pneumococcal vaccination status <u>can</u> be completed during a telehealth encounter

Measure	Description	Exclusions	Definitions	Data Guidance
PREV-9 Body Mass Index (BMI) Screening and Follow-Up Plan	<p>Patients ≥ 18 yrs with:</p> <ul style="list-style-type: none"> -- a documented BMI during the <u>current encounter</u> or if not calculated at the current encounter, use the most recent BMI calculated during the 6 months <u>prior to the current encounter</u> <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> -- for BMI <u>above or below</u> the normal range of ≥ 18.5 and $< 25 \text{ kg/m}^2$, a follow-up plan is documented either <u>during the current encounter</u> or during the <u>6 months prior</u> to the current encounter 	<ul style="list-style-type: none"> • Pregnancy • Receiving palliative care • Refusal of height/weight measurement or follow-up • Patients ≥ 65 yrs for whom weight loss/gain would complicate other underlying conditions, such as: <ul style="list-style-type: none"> -- Illness or physical disability -- Mental illness, dementia, confusion -- Nutritional or vitamin/mineral deficiency • Urgent or emergent patients where treatment delay would jeopardize patient health • Deceased during CY 2017 • In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 • Moved out of country at anytime during CY 2017 • Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> • BMI - Body Mass Index • CY = Calendar Year • <i>Follow-Up Plan</i> = proposed outline of treatment for abnormal BMI • <i>Encounter</i> = patient visit where BMI is recorded • HMO = Health Maintenance Organization • MP = Measurement Period = 01/01/2017 - 12/31/2017 • MR = Medical Record • WI = Web Interface 	<ol style="list-style-type: none"> (1) Follow-Up Plan <u>may</u> include documentation of: <ul style="list-style-type: none"> -- Education -- Pharmacological interventions -- Dietary supplements -- Exercise counseling -- Nutrition counseling -- Referral to one of the following: <ul style="list-style-type: none"> • Registered dietician • Nutritionist • Occupational therapy • Physical therapy • Primary care Physician (PCP) • Exercise physiologist • Mental health professional • Surgeon (2) Self-reported weights <u>cannot</u> be used. (3) Height and weight may be obtained from separate encounters (4) If there is more than one BMI on the chart, <u>use most recent</u> (5) BMI calculation and recommended follow-up plan <u>cannot</u> be completed during a telehealth encounter
PREV-10 Tobacco Use - Screening and Cessation Intervention	<p>Patients ≥ 18 yrs who were:</p> <ul style="list-style-type: none"> -- screened for tobacco use one or more times during CY 2016 and CY 2017 <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> -- who received cessation counseling intervention if identified as a tobacco user 	<ul style="list-style-type: none"> • Documentation of medical reason for <u>not screening</u> for tobacco use, such as: <ul style="list-style-type: none"> -- limited life expectancy -- other medical reason • Only medical reason <u>excluding patient from receiving cessation intervention</u> is limited life expectancy • Deceased during CY 2017 • In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 • Moved out of country at anytime during CY 2017 • Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> • CY = Calendar Year • HMO = Health Maintenance Organization • MP = Measurement Period = 01/01/2017 - 12/31/2017 • MR = Medical Record • <i>Tobacco Use</i> = Includes any type of tobacco, e.g., smoke and smokeless • <i>Tobacco Cessation Intervention</i> = Includes brief counseling (≤ 3 mins) and/or pharmacotherapy • WI = Web Interface 	<ol style="list-style-type: none"> (1) Confirm patient screened for tobacco at least once between 01/01/2016 and 12/31/2017 (2) If more than one Tobacco Use Screening is on the chart, use most recent (3) Tobacco Use Screening and the Tobacco Cessation Intervention can occur at different encounters however they both must have occurred between 01/01/2016 and 12/31/2017 (4) <u>Both</u> the Tobacco Screening <u>and</u> the Tobacco Cessation Intervention <u>can</u> be completed during a telehealth encounter (5) Electronic Nicotine Delivery Systems (ENDS) <u>are not considered evidence of tobacco use and cannot be used as a tobacco cessation aid</u>
PREV-12 Screening for Depression and Follow-Up Plan	<p>Patients ≥ 12 yrs who were:</p> <ul style="list-style-type: none"> -- <u>screened for depression on the date of encounter</u> using an age appropriate standardized depression screening tool <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> -- if positive, <u>a follow-up plan</u> is documented on the date of the positive screen 	<ul style="list-style-type: none"> • Active diagnosis of depression • Active diagnosis of bipolar disorder • Patient refusal to participate • Urgent or emergent patients where treatment delay would jeopardize patient health • Patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools • Deceased during CY 2017 • In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 • Moved out of country at anytime during CY 2017 • Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> • <i>Active Diagnosis</i> = a diagnosis that is: <ul style="list-style-type: none"> -- on the patient's problem list -- a diagnosis code on the encounter, or -- documented in a progress note indicating that the patient is being treated or managed for the disease or condition during CY 2017 • CY = Calendar Year • HMO = Health Maintenance Organization • MP = Measurement Period = 01/01/2017 - 12/31/2017 • MR = Medical Record • <i>Standardized Depression Screening Tool</i> = a normalized and validated depression screening tool developed for the patient population in which it is being utilized • WI = Web Interface 	<ol style="list-style-type: none"> (1) Adolescent Screening Tools (12 - 17 yrs) - see POM ACO website for suggestions (2) Adult Screening Tools (≥ 18 yrs) - see POM ACO website for suggestions (3) Name of the standardized depression screening tool used must be documented in the medical record (4) The depression screening must be reviewed and addressed in the office of the provider filing the code, on the date of the encounter (5) The screening and encounter must occur on the same date (6) Follow-Up Plan <u>must include one or more of the following</u>: <ul style="list-style-type: none"> -- 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 (7) Follow-up plan must be related to the positive depression screening, e.g., "Patient referred for psychiatric evaluation due to positive depression screening." (8) Screening for depression <u>can</u> be completed during a telehealth encounter however the results <u>must</u> be reviewed/verified <u>and</u> documented by the eligible professional in the medical record <u>on the date of the encounter</u> to meet the screening portion of this measure (9) Documentation of recommended follow-up plan for a positive depression screen <u>can</u> be completed during a telehealth encounter

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Measure	Description	Exclusions	Definitions	Data Guidance
<p>PREV-13 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</p>	<p>Patients ≥ 21 yrs at beginning of CY 2017 who:</p> <ul style="list-style-type: none"> -- have an active diagnosis or history of ASCVD <p style="text-align: center;">OR</p> <p>Patients ≥ 21 yrs at beginning of CY 2017 who:</p> <ul style="list-style-type: none"> -- have ever had a fasting or direct LDL-C ≥ 190 mg/dL at <i>anytime during CY 2017</i> or -- were previously diagnosed or have an active diagnosis of familial / pure hypercholesterolemia <p style="text-align: center;">OR</p> <p>Patients 40 - 75 yrs at beginning of CY 2017 with:</p> <ul style="list-style-type: none"> -- a diagnosis of Type 1 or 2 DM and -- a fasting or direct LDL-C of 70 - 189 mg/dL recorded as the <i>highest result</i> during CY 2015, CY 2016, or CY 2017 	<ul style="list-style-type: none"> • Active diagnosis of pregnancy • Breastfeeding • Diagnosis of rhabdomyolysis • History of adverse effect, allergy, or intolerance to statin medication • Palliative care • Active liver disease or hepatic disease or insufficiency • ESRD • DM diagnosis with most recent fasting or direct LDL-C < 70 mg/dL and are not taking statin therapy • Deceased during CY 2017 • In hospice, including non-hospice with palliative goals or comfort care at anytime during CY 2017 • Moved out of country at anytime during CY 2017 • Enrolled in HMO at any time during CY 2017 	<ul style="list-style-type: none"> • <i>Active Diagnosis</i> = a diagnosis that is: <ul style="list-style-type: none"> -- on the patient's problem list -- a diagnosis code on the encounter, or -- documented in a progress note indicating that the patient is being treated or managed for the disease or condition during CY 2017 • ASCVD = Clinical Atherosclerotic Cardiovascular Disease includes: <ul style="list-style-type: none"> -- Acute coronary syndromes -- History of myocardial infarction -- Stable or unstable angina -- Coronary or other arterial revascularization -- Stroke or transient ischemic attack (TIA) -- Peripheral arterial disease of atherosclerotic origin • CY = Calendar Year • DM = Diabetes mellitus • ESRD = End-stage renal disease • HMO = Health Maintenance Organization • LDL-C = Low-Density Lipoprotein Cholesterol • MP = Measurement Period = 01/01/2017 - 12/31/2017 • MR = Medical Record • WI = Web Interface 	<ul style="list-style-type: none"> (1) Adherence to statin therapy is not part of this measure (2) If laboratory unable to calculate LDL-C value due to high triglycerides, select "No". (3) If the test result is labeled "unreliable" and a result is provided, select "No" (4) Diabetes history is defined as any history of diabetes, prior to or during the measurement period (5) Documentation of statin therapy prescribed or being taken during the measurement period <u>cannot</u> be completed during a telehealth encounter