PRACTICE INNOVATION PROGRAM COLORADO
INNOVATION SUPPORT PROJECT

Innovation Support Project (ISP)
Clinical Quality Measure Guide

Adult Measures	Pediatric Measures
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan**
Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up Plan	**Maternal Depression Screening**
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	**Childhood Immunization Status**

Preventive Care and Screening: Screening for Depression and Follow-Up Plan
https://ecqi.healthit.gov/ecqm/ep/2020/cms002v9
CMS Measure ID CMS2v9
Version 9
NQF Number 0418e

Measure Description
Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to 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 eligible encounter

Initial Population
All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

Denominator Statement
Equals Initial Population

Denominator Exclusions
Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

Numerator Statement
Patients screened for depression on the date of the encounter or up to 14 days prior to 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 eligible encounter

Numerator Exclusions
Not Applicable

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 cognitive capacity, 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

Measure Steward
Centers for Medicare & Medicaid Services (CMS)

Domain
Community/Population Health

Previous Version
CMS2v8

Measure Scoring
Proportion

Measure Type
Process

Improvement Notation
Higher score indicates better quality

Guidance
A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the eligible encounter.
Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter based measure.
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. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.
* The screening should occur during a qualified encounter or up to 14 days prior to the date of the qualifying encounter.

* Standardized depression screening tools should be normalized and validated for the age appropriate patient population in which they are used
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."
Examples of a follow-up plan include but are not limited to:
* Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder
* Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale
* Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
* Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options
* Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Quality ID 134
Meaningful Measure Prevention, Treatment, and Management of Mental Health

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Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up Plan
https://ecqi.healthit.gov/ecqm/ep/2020/cms069v8
CMS Measure ID CMS69v8
Version 8
NQF Number 0421e

Measure Description
Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter
Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2

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

Denominator Statement
Equals Initial Population

Denominator Exclusions
Patients who are pregnant

Patients receiving palliative or hospice care
Patients who refuse measurement of height and/or weight

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

Numerator Exclusions
Not Applicable

Denominator Exceptions
Patients with a documented Medical Reason
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

Measure Steward
Centers for Medicare & Medicaid Services (CMS)

Domain
Community/Population Health

Previous Version
CMS69v7

Measure Scoring
Proportion

Measure Type
Process

Improvement Notation
Higher score indicates better quality

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 twelve 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 twelve 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 and exceptions 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 & Tonstad [2015]; 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

Quality ID 128
Meaningful Measure Preventive Care

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
https://ecqi.healthit.gov/ecqm/ep/2020/cms137v8
CMS Measure ID CMS137v8
Version 8
NQF Number Not Applicable

Measure Description
Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported.
a. Percentage of patients who initiated treatment including either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis

b. Percentage of patients who engaged in ongoing treatment including two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention.

Initial Population
Patients age 13 years of age and older who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency during a visit between January 1 and November 14 of the measurement period

Denominator Statement
Equals Initial Population

Denominator Exclusions
Patients with a previous active diagnosis of alcohol, opioid or other drug abuse or dependence in the 60 days prior to the first episode of alcohol or drug dependence
Exclude patients whose hospice care overlaps the measurement period.
Numerator Statement
Numerator 1: Initiation of treatment includes either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis
Numerator 2: Engagement in ongoing treatment includes two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention (i.e., engagement for these members cannot be satisfied with medication treatment alone).

Numerator Exclusions
Not Applicable

Denominator Exceptions
None

Measure Steward
National Committee for Quality Assurance

Domain
Effective Clinical Care

Previous Version
CMS137v7

Measure Scoring
Proportion

Measure Type
Process

Improvement Notation
Higher score indicates better quality

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.

Quality ID 305
Meaningful Measure Prevention and Treatment of Opioid and Substance Use Disorders

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Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
https://ecqi.healthit.gov/ecqm/ep/2020/cms122v8
CMS Measure ID CMS122v8
Version 8
NQF Number Not Applicable

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

Initial Population
Patients 18-75 years of age with diabetes with a visit during the measurement period

Denominator Statement
Equals Initial Population

Denominator Exclusions
Exclude patients whose hospice care overlaps the measurement period.
Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.

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

Numerator Exclusions
Not Applicable

Denominator Exceptions
None

Measure Steward
National Committee for Quality Assurance

Domain
Effective Clinical Care

Previous Version
CMS122v7

Measure Scoring
Proportion

Measure Type
Outcome

Improvement Notation
Lower score indicates better quality

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.

Quality ID 1

Meaningful Measure Management of Chronic Conditions

Preventive Care and Screening: Screening for Depression and Follow-Up Plan
https://ecqi.healthit.gov/ecqm/ep/2020/cms002v9
CMS Measure ID CMS2v9
Version 9
NQF Number 0418e

Measure Description
Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to 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 eligible encounter

Initial Population
All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

Denominator Statement
Equals Initial Population

Denominator Exclusions

Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

Numerator Statement
Patients screened for depression on the date of the encounter or up to 14 days prior to 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 eligible encounter

Numerator Exclusions
Not Applicable

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 cognitive capacity, 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

Measure Steward
Centers for Medicare & Medicaid Services (CMS)

Domain
Community/Population Health

Previous Version
CMS2v8

Measure Scoring
Proportion

Measure Type
Process

Improvement Notation
Higher score indicates better quality

Guidance
A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the eligible encounter.

Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter based measure.
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. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.
* The screening should occur during a qualified encounter or up to 14 days prior to the date of the qualifying encounter.
* Standardized depression screening tools should be normalized and validated for the age appropriate patient population in which they are used
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."
Examples of a follow-up plan include but are not limited to:
* Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder
* Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale
* Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
* Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options
* Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Quality ID 134
Meaningful Measure Prevention, Treatment, and Management of Mental Health

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Maternal Depression Screening
https://ecqi.healthit.gov/ecqm/ep/2019/cms082v6
CMS Measure ID CMS82v6
Version 6
NQF Number None

Measure 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

Initial Population
Children with a visit who turned 6 months of age in the measurement period

Denominator Statement
Equals Initial Population

Denominator Exclusions
None

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

Numerator Exclusions
Not Applicable

Denominator Exceptions
None

Measure Steward
National Committee for Quality Assurance

Domain
Community/Population Health

Previous Version
CMS82v5

Measure Scoring
Proportion

Measure Type
Process

Improvement Notation
Higher score indicates better quality

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. Information for the measure can be obtained from either the mother's or the baby's chart.

Quality ID 372

Meaningful Measure
Prevention, Treatment, and Management of Mental Health

PRACTICE INNOVATION PROGRAM COLORADO
INNOVATION SUPPORT PROJECT

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
https://ecqi.healthit.gov/ecqm/ep/2020/cms155v8
CMS Measure ID CMS155v8
Version 8
NQF Number Not Applicable

Measure Description
Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.
- Percentage of patients with height, weight, and body mass index (BMI) percentile documentation
- Percentage of patients with counseling for nutrition
- Percentage of patients with counseling for physical activity

Initial Population
Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period

Denominator Statement
Equals Initial Population

Denominator Exclusions
Patients who have a diagnosis of pregnancy during the measurement period.
Exclude patients whose hospice care overlaps the measurement period.

Numerator Statement
Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period
Numerator 2: Patients who had counseling for nutrition during the measurement period
Numerator 3: Patients who had counseling for physical activity during the measurement period

Numerator Exclusions
Not Applicable

Denominator Exceptions
None

Measure Steward
National Committee for Quality Assurance

Domain
Community/Population Health

Previous Version
CMS155v7

PRACTICE INNOVATION PROGRAM COLORADO
INNOVATION SUPPORT PROJECT

Measure Scoring
Proportion

Measure Type
Process

Improvement Notation
Higher score indicates better quality

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, rather than an absolute BMI value, is assessed.

Quality ID 239

Meaningful Measure
Preventive Care

Childhood Immunization Status
https://ecqi.healthit.gov/ecqm/ep/2020/cms117v8
CMS Measure ID CMS117v8
Version 8
NQF Number Not Applicable

Measure Description
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

Initial Population
Children who turn 2 years of age during the measurement period and who have a visit during the measurement period

Denominator Statement
Equals Initial Population

Denominator Exclusions
Exclude patients whose hospice care overlaps the measurement period

Numerator Statement
Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday

Numerator Exclusions
Not Applicable

Denominator Exceptions
None

Measure Steward
National Committee for Quality Assurance

Domain
Community/Population Health

Previous Version
CMS117v7

Measure Scoring
Proportion

Measure Type
Process

Improvement Notation
Higher score equals better quality

Guidance
For the MMR, hepatitis B, VZV and hepatitis A vaccines, numerator inclusion criteria include: evidence of receipt of the recommended vaccine; documented history of the illness; or, a seropositive test result for the antigen. For the DTaP, IPV, HiB, pneumococcal conjugate, rotavirus, and influenza vaccines, numerator inclusion criteria include only evidence of receipt of the recommended vaccine.
Patients may be included in the numerator for a particular antigen if they had an anaphylactic reaction to the vaccine. Patients may be included in the numerator for the DTaP vaccine if they have encephalopathy. Patients may be included in the numerator for the IPV vaccine if they have had an anaphylactic reaction to streptomycin, polymyxin B, or neomycin. Patients may be included in the numerator for the influenza, MMR, or VZV vaccines if they have cancer of lymphoreticular or histiocytic tissue, multiple myeloma, leukemia, have had an anaphylactic reaction to neomycin, have Immunodefiency, or have HIV. Patients may be included in the numerator for the hepatitis B vaccine if they have had an anaphylactic reaction to common baker's yeast.
The measure allows a grace period by measuring compliance with these recommendations between birth and age two.

Quality ID 240

Meaningful Measure
Preventive Care