Suffolk Care Collaborative

Clinical Documentation Improvement Program

2017

Suffolk Care Collaborative
Office of Population Health
Stony Brook Medicine
1383 Veterans Memorial Highway, Suite 8
Hauppauge, NY 11778

dsrip@stonybrookmedicine.edu
www.suffolkcare.org

Measure Sections

	Access to Care
	Behavioral Health
	Asthma
	Cardiovascular
	Diabetes
	Survey (HEDIS & CGCAHPS)

Reference Sections

Medication Lists

Measure References

Key Terms

Measurement Year: July 1, 2016 – June 30, 2017

Year Prior to Measurement Year: July 1, 2015 – June 30, 2016

IPSD: Index Prescription Start Date

CPT Category II Codes – are a set of supplemental codes that can be used for performance measurement. The use of Category II codes for performance measurement decreases the need for record abstraction and chart review, thereby minimizing administrative burden on physicians, other health care professionals, hospitals and entities in measurement of the quality of patient care.

Reference: https://www.ama-assn.org/practice-management/cpt-category-ii-codes

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ACCESS TO CARE MEASURES

Adult Access to Preventive or Ambulatory Care

Measure Type: HEDIS (claims) / *Age Cohorts:* (20-44 years), (45-64 years), (65 years and older)

Measure Definition

Percentage of adults who had an ambulatory or preventive care visit during the measurement year.

Documentation Required

Ambulatory or preventive/wellness care visit

Applicable Visit CPT/HCPCS Codes: 92002, 92004, 92012, 92014, 99201 - 99205 99211 - 99215 99241 - 99245, 99304 - 99310, 99315 - 99316, 99318, 99324, 99325 - 99328, 99334 - 99337, 99341 - 99345, 99347 - 99350, 99381 - 99387, 99391 - 99397, 99401 – 99404, 99411 – 99412, 99420, 99429, G0402, G0438, G0439, G0463, S0620, S0621, T1015

Role of Care Management

- Patient/Family reminder calls
- Verification of last visit with patient
- Identify & Address barriers to adherence

Role of PCP Practice

- Outreach to patient & schedule visit

Children's Access to Primary Care

Measure Type: HEDIS (claims) / *Age Cohorts*: (12 months – 24 months), (25 months – 6 years), (7 -11 years), (12 -19 years)

Measure Definition

Percentage of children who had a visit with a primary care provider during the measurement year.

Documentation Required

Ambulatory or preventive/wellness care visit **with PCP (excludes specialist visits)**

Primary Care Practitioner (PCP): A Physician or nonphysician (e.g., NP, PA) who offers primary care medical services. Primary Care Providers include: Family Practice, Internal Medicine, OB/GYN and Pediatrics

Applicable Visit CPT/HCPCS Codes: 99201 - 99205 99211 - 99215 99241 - 99245, 99341 - 99345, 99347-99350, 99381 - 99387, 99391 - 99397, 99401 – 99404, 99411 – 99412, 99420, 99429, G0402, G0438, G0439, G0463, T1015

Role of Care Management

- Patient/Family reminder calls
- Verification of last visit with patient
- Identify & Address barriers to adherence

Role of PCP Practice

- Outreach to patient & schedule visit

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BEHAVIORAL HEALTH MEASURES

Antidepressant Medication Management – Effective Acute Phase Treatment

Measure Type: HEDIS (claims) / *Age Cohort:* 18 years and older

Measure Definition

Percent of patients who remained on antidepressant medication during the entire 12-week acute treatment phase.*

* **Patients** are identified as "new", dispensed an antidepressant medication for the first time or "existing", patient has a history of taking antidepressant medication but had no antidepressant medication dispensed in a period of 105 days or more.

Documentation Required

- Diagnosis of major depression (F32.0 – F32.4, F32.9 –F33.3, F33.41, F33.9)
- Dispensed an antidepressant medication (Medication List)
- At least 84 days (12 weeks) of continuous treatment with antidepressant medication

Role of Care Management

- Follow-up with patient to ensure monthly refill of prescription
- Identify & Address barriers to adherence

Role of PCP Practice

- Referral to behavioral health prescribing provider if applicable or prescribe antidepressant medication as appropriate
- Provide education and support

Antidepressant Medication Management – Effective Continuation Phase Treatment

Measure Type: HEDIS (claims) / *Age Cohort:* 18 years and older

Measure Definition

Percent of patients who remained on antidepressant medication for at least six months.

Documentation Required

- Diagnosis of major depression (F32.0 – F32.4, F32.9 –F33.3, F33.41, F33.9)
- Dispensed an antidepressant medication (Medication List)
- At least 180 days (6 months) of continuous treatment with antidepressant medication

Role of Care Management

- Follow-up with patient to ensure monthly refill of prescription
- Identify & Address barriers to adherence

Role of PCP Practice

- Referral to behavioral health prescribing provider if applicable or prescribe antidepressant medication as appropriate
- Provide education and support

Antipsychotic Medication Adherence

Measure Type: HEDIS (claims) / *Age Cohort:* 19-64 years

Measure Definition

Percent of patients with **schizophrenia** who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Documentation Required

- Diagnosis of schizophrenia (F20.0 – F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9)
- Dispensed an antipsychotic medication (Medication List)
- Prescriptions are filled at least 80% of the time

Role of Care Management

- Follow-up with patient to ensure monthly refill of prescription
- Identify & Address barriers to adherence

Role of PCP Practice

- Referral to behavioral health prescribing provider if applicable or prescribe antipsychotic medication as appropriate
- Provide education and support

Child ADHD Medication Follow-up *(Initiation)*

Measure Type: HEDIS (claims) / *Age Cohort:* 6–12 years of age as of the Index Prescription Start Date (IPSD)

Measure Definition

Percent of patients* with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority** during the 30-day Initiation Phase

* **Patients** are identified as "new", dispensed an ADHD medication for the first time or "existing", patient has a history of taking ADHD medication but had no ADHD medication dispensed for either new or refill prescription in a period of 120 days or more.

****Prescribing Authority**: A practitioner with prescribing privileges, including physicians, nurse practitioners, physician assistants who have the authority to prescribe medications

Documentation Required

Index visit resulting with ADHD diagnosis and ADHD medication prescribed (Medication List)

- Follow-up visit within 30 days of the index visit

Applicable Follow-up Visit CPT/HCPCS Codes: 90791 – 90792, 90801 – 90829, 90832 – 90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 96150 – 96154, 98960 – 98962, 99078, 99201-99205, 99211 – 99215, 99217 – 99223, 99231 – 99233, 99238 – 99239, 99241 – 99245, 99251 – 99255, 99341 – 99350, 33891 – 99394, 99401 – 99404, 99411 – 99412, 99510

Role of Care Management

- Ensure prescription fill
- Ensure follow-up visit within 30 days
- Identify & address barriers to adherence

Role of PCP Practice

- Schedule follow-up visit within 30 days of index visit OR referral to behavioral health prescribing provider
- Visit reminder message to the patient

Child ADHD Medication Follow-up (*Continuation)*

Measure Type: HEDIS (claims) / *Age Cohort:* 6–12 years of age as of the Index Prescription Start Date (IPSD)

Measure Definition

Percent of patients with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the first follow-up visit in the Initiation Phase, had at **least two follow-up** visits **with a practitioner** within 270 days (9 months) after the Initiation Phase ended.

Documentation Required

Index visit resulting with ADHD diagnosis and ADHD medication prescribed (Medication List)

- One follow-up visit within 30 days of the index visit
- Two follow-up visits after the initiation phase but within 270 days
- Refill of prescriptions

Applicable Follow-up Visit CPT/HCPCS Codes: 90791 – 90792, 90801 – 90829, 90832 – 90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 96150 – 96154, 98960 – 98962, 99078, 99201-99205, 99211 – 99215, 99217 – 99223, 99231 – 99233, 99238 – 99239, 99241 – 99245, 99251 – 99255, 99341 – 99350, 33891 – 99394, 99401 – 99404, 99411 – 99412, 98966 – 98968, 99441 – 99443, 99510, G0155, G0176, G0177, G0409 – G0411, G0463, H0002, H0004, H0031, H0034 – H0037, H0039, H0040, H2000, H2001, H2010 – H2020, M0064, S0201, S9480, S9484, S9485, T1015

Role of Care Management

- Verify diagnosis with patient
- Ensure consistent refills
- Ensure follow-up visits
- Identify & address barriers to adherence

Role of PCP Practice

- Schedule two additional follow-up visits within 270 days OR ensure two additional follow-up visits with behavioral health provider
- Visit reminder message to the patient

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

Measure Type: HEDIS (claims) / *Age Cohort:* 18-64 years

Measure Definition

Percent of patients with **schizophrenia and cardiovascular disease**, who had an **LDL-C test** during the measurement year

Documentation Required

- Diagnosis of schizophrenia: (F20.0 – F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9)
- **AND** diagnosis of cardiovascular disease:
  - Patient had AMI or CABG (Inpatient Visit only) or PCI (in any setting) during prior year
  - Patient had ischemic vascular disease (IVD) during both the measurement year and year prior (I20.0 – I20.9, I24.0 – I24.9, I25.10 – I25.119, I25.5 – I25.9, I63.00 – I66.9, I67.2, I70.0 –I70.92, I74.01 – I75.89)
- Lab test for LDL-C test during the measurement year

Applicable LDL-C Test CPT Codes: 80061, 83700, 83701, 83704, 83721
CPT Category II Codes: 3048F – 3050F

Role of Care Management

- Patient/Family reminder calls
- Chronic Disease Education
- Identify & Address barriers to adherence

Role of PCP Practice

- Outreach to patient & schedule visit
- Visit reminder message to the patient
- Order LDL-C test
- Review test result with patient
- Consider assigning CPT Category II Code when reviewing test results with patient

Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication

Measure Type: HEDIS (claims) / *Age Cohort:*18–64 years

Measure Definition

Percent of patients with **schizophrenia or bipolar disorder who are using antipsychotic medication** who had a **glucose test or HbA1c test** during the measurement year

Documentation Required

- Diagnosis of schizophrenia (F20.0 – F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9)
- **OR** diagnosis of bipolar disorder (F30.10 – F31.9)
- Prescribed an Antipsychotic Medication (Medication List)
- Lab test for either a Glucose Test **or** a HbA1c test during the measurement year as identified by claim/encounter or automated laboratory data.

Applicable Glucose Test CPT Codes: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 (leave it if done at office, delete if not in office)
Applicable HbA1c Test CPT Codes: 83036, 83037 / CPT Category II Codes: 3048F – 3050F

Role of Care Management

- Verify if a patient has been prescribed antipsychotic medications
- Patient/Family reminder calls
- Chronic disease education
- Identify & Address barriers to adherence

Role of PCP Practice

- Outreach to patient & schedule visit
- Visit reminder message to the patient
- Order glucose test or HbA1c test
- Review test result with patient
- Consider assigning CPT Category II Code when reviewing test results with patient

Diabetes Monitoring for People with Diabetes and Schizophrenia

Measure Type: HEDIS (claims) / *Age Cohort:* 18-64 years

Measure Definition

Percent of patients diagnosed with both **schizophrenia and diabetes** receive **both** an **LDL-C test AND HBA1c test** during the measurement year

Documentation Required

- Diagnosis of schizophrenia: (F20.0 – F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9)
- **AND** diagnosis of diabetes: (E10.10 – E10.351, E10.359, E10.36, E10.39 – E11.351, E11.359, E11.36, E11.39 – E13.351, E13.359, E13.36, E13.39 – E13.9, O24.011 – O24.33, O24.811 – O24.83)
- Lab test for both a LDL-C test **and** a HbA1c test during the measurement year

Applicable LDL-C Test CPT Codes: 80061, 83700, 83701, 83704, 83721 / CPT Category II Codes: 3048F – 3050F

Applicable HbA1c Test CPT Codes: 83036, 83037 / CPT Category II Codes: 3044F – 3046F

Role of Care Management

- Patient/Family reminder calls
- Chronic Disease Education
- Identify & Address barriers to adherence

Role of PCP Practice

- Outreach to patient & schedule visit
- Visit reminder message to the patient
- Order LDL-C test and HbA1c test
- Consider assigning CPT Category II Code

Initiation of Alcohol and Other Drug Dependence Treatment

Measure Type: HEDIS (claims) / *Age Cohort:* 13 years and older

Measure Definition

Number of people who initiated treatment through an inpatient alcohol and other drugs (AOD) admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode*

Documentation Required

Index Episode resulting with AOD diagnosis (F10.10 – F10.20, F10.220 – F11.20, F11.220 – F13.20, F13.220 – F14.20, F14.220 – F15.20, F15.220 – F16.20, F16.220 – F16.99, F18.10 – F18.20, F18.220 – F19.20, F19.220 – F19.99)

- **One follow-up visit within 14 days** of the index episode (**Index Episode:* The initial AOD diagnosis may be established during an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED visit.)

Applicable Follow-up Visit CPT/HCPCS Codes: 90791, 90792, 90832 – 90845, 90847 – 90853, 90875, 90876, 98960 – 98962, 99078, 99201 – 99220, 99241 – 99245, 99341 – 99350, 99384 – 99387, 99394 – 99404, 99408 – 99412, 99510, G0155, G0176, G0177, G0396, G0397, G0409 - G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034 – H0037, H0039, H0040, H2000, H2001, H2010 – H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015
Applicable Follow-up Visit CPT Codes (for only these service locations: Psychiatric Facility-Partial Hospitalization/Community Mental Health Center): 99221 – 99223, 99231 – 99233, 99238, 99239, 99251 - 99255

Role of Care Management

- Verify recent AOD utilization
- Ensure follow-up visit within 14 days of initial AOD event
- Provide support for sober living
- Identify & Address barriers to adherence

Role of PCP Practice

- Ensure patient has scheduled visit with provider within 14 days of index episode

Engagement of Alcohol and Other Drug Dependence Treatment

Measure Type: HEDIS (claims) / *Age Cohort:* 13 years and older

Measure Definition

Number of people who initiated treatment AND had two or more additional services with a diagnosis of alcohol and other drugs (AOD) within 30 days of the initiation visit

Documentation Required

Index Episode resulting with AOD diagnosis (F10.10 – F10.20, F10.220 – F11.20, F11.220 – F13.20, F13.220 – F14.20, F14.220 – F15.20, F15.220 – F16.20, F16.220 – F16.99, F18.10 – F18.20, F18.220 – F19.20, F19.220 – F19.99)

One follow-up visit (initiation visit) within 14 days of the index visit

- **Two follow-up visits** within 30 days of the initiation visit

Applicable Follow-up Visit CPT/HCPCS Codes: 90791, 90792, 90832 – 90845, 90847 – 90853, 90875, 90876, 98960 – 98962, 99078, 99201 – 99220, 99241 – 99245, 99341 – 99350, 99384 – 99387, 99394 – 99404, 99408 – 99412, 99510, G0155, G0176, G0177, G0396, G0397, G0409 - G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034 – H0037, H0039, H0040, H2000, H2001, H2010 – H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015

Applicable Follow-up Visit CPT Codes (for only these service locations: Psychiatric Facility-Partial Hospitalization/Community Mental Health Center): 99221 – 99223, 99231 – 99233, 99238, 99239, 99251 – 99255

Role of Care Management

- Ensure continuity of AOD treatment
- Provide support for sober living
- Identify & Address barriers to adherence

Role of PCP Practice

- Ensure patient has scheduled two follow-up visits with provider within 30 days of initiation visit

Follow-up after Hospitalization for Mental Illness (7 days & 30 days)

Measure Type: HEDIS (claims) / *Age Cohort:* 6 years and older

Measure Definition

An outpatient visit, intensive outpatient visit or partial hospitalization with a **mental health practitioner***. First measure is within 7 days after discharge** the second measure is within 30 days after discharge**. A visit within 7 days fulfills both measures**. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge**.**

*Mental health practitioner: (Reference List)

**An acute inpatient discharge with a principal diagnosis of mental illness (F20.0 – F39, F42 – F43.9, F44.89, F53, F60.0 – F63.9, F68.10 – F68.8, F84.0 – F84.9, F90.0 – F94.9)

Documentation Required

- Follow-up visit within 7 days
- *Note:* **A visit within 7 days fulfills both measures**. If visit occurs within 8 - 30 days of discharge this fulfills only the 30 day measure.

Applicable Follow-up Visit CPT/HCPCS Codes: 90791, 90792, 90832 – 90845, 90847 – 90853, 90867 – 90876, 98960 – 98962, 99078, 99201 – 99220, 99241 – 99245, 99341 – 99350, 99383 – 99387, 99393 – 99404, 99411, 99412, 99495 (this code only for 30-day indicator) 99496, 99510, G0155, G0176, G0177, G0409 – G0411, G0463, H0002, H0004, H0031, H0034 – H0037, H0039, H0040, H2000, H2001, H2010 – H2020, M0064, S0201, S9480, S9484, S9485, T1015

Role of Care Management

- Verify recent mental health admission and discharge with patient
- Ensure follow-up visit within 7 days of inpatient mental health admission with mental health practitioner
- Provide support for recovery process
- Identify & Address barriers to adherence

Role of PCP Practice

- Ensure patient has scheduled visit with mental health provider within 7 days of discharge

Screening for Clinical Depression and follow-up

Measure Type: HEDIS **(medical record abstraction)** / *Age Cohort:* 18 years and older

Measure Definition

Number of people screened for clinical depression using a standardized depression screening tool, and if positive, with follow-up plan within 30 days.

Documentation Required

- Completed Standardized depression screening with positive result (Depression Screening Tools: PHQ-2, PHQ-9)
- Documentation of follow up must include **one or more of the following** in the 30 day period following the initial positive screen (inclusive of the screening visit date):
  - Recommend/prescribe antidepressant medication;
  - Recommend/refer for follow up visit with behavioral health provider
  - Recommend/schedule follow up outpatient visit with any provider, including the PCP or other provider administering the original screen, for further assessment;
  - Further assessment on the same day of the positive screen including documentation of additional depression assessment indicating no depression (such as positive score from PHQ2 with a negative PHQ9 or documented negative findings after further evaluation);
  - Referral to emergency department for crisis services on the same day of the positive screen;
  - Arrangement for inpatient admission for mental health diagnosis on the same day as the positive screen.

Applicable Initial Outpatient Visit CPT/HCPCS Codes: - 96150, 96151, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402, G0438, G0439, G0444

Applicable Screening HCPCS Codes: G8431 (Screening for clinical depression is documented as positive and follow up plan is documented), G8510 (Screening for clinical depression is documented as negative; a follow up plan is not required)

Role of Care Management

- Ensure appropriate follow-up as indicated
- Identify & Address barriers to adherence

Role of PCP Practice

- Ensure documentation of follow-up plan for patient screened with positive result.
- Consider assigning HCPCS Code

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ASTHMA MEASURES

Asthma Medication Ratio

Measure Type: HEDIS (claims) / *Age Cohort:* 5-64 years

Measure Definition

Number of people with a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Documentation Required

- Diagnosis of asthma: (J45.20 – J45.998)
- Dispensed an asthma reliever medication (Medication List)
- Dispensed an asthma controller medication (Medication List)
- ***Note:*** *A higher percentage of controller medication indicates better performance for this metric*

Role of Care Management

- Reinforce patient and family education regarding chronic disease and medication adherence
- Identify & Address barriers to adherence

Role of PCP Practice

- Ensure diagnosis / severity of asthma accurately reflects need for controller medication
- Prescribe controlling medication as appropriate
- Provide education on medication and adherence
- If applicable, refer to the Asthma Home-Based Self-Management Program

Medication Management for People with Asthma (50% of Treatment Days Covered)

Measure Type: HEDIS (claims) / *Age Cohort:* 5-64 years

Measure Definition

Number of people who filled prescriptions for asthma controller medications during at least 50% of their treatment period.

Documentation Required

- Diagnosis of asthma: (J45.20 – J45.998)
- Dispensed an asthma controller medication (Medication List)
- Prescriptions are filled at least 50% of the time

Role of Care Management

- Follow-up with patient to ensure monthly refill of prescription
- Reinforce patient and family education regarding chronic disease and medication adherence
- Identify & Address barriers to adherence

Role of PCP Practice

- Prescribe controlling medication as appropriate and authorize monthly refills
- Provide education on medication and adherence
- If applicable, refer to the Asthma Home-Based Self-Management Program

Medication Management for People with Asthma (75% of Treatment Days Covered)

Measure Type: HEDIS (claims) / *Age Cohort:* 5-64 years

Measure Definition

Number of people who filled prescriptions for asthma controller medications during at least 75% of their treatment period.

Documentation Required

- Diagnosis of asthma: (J45.20 – J45.998)
- Dispensed an asthma controller medications (Medication List)
- Prescriptions are filled at least 75% of the time

Role of Care Management

- Follow-up with patient to ensure monthly refill of prescription
- Reinforce patient and family education regarding chronic disease and medication adherence
- Identify & Address barriers to adherence

Role of PCP Practice

- Prescribe controlling medication as appropriate and authorize monthly refills
- Provide education on medication and adherence
- If applicable, refer to the Asthma Home-Based Self-Management Program

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CARDIOVASCULAR MEASURES

Controlling High Blood Pressure

Measure Type: HEDIS **(medical record abstraction)** / *Age Cohort:* 18-85 years

Measure Definition

Number of people whose blood pressure was adequately controlled as follows: below 140/90 if ages 18-59; below 140/90 for ages 60 to 85 with diabetes* diagnosis; or below 150/90 ages 60 to 85 without a diagnosis of diabetes

*Diabetes Diagnosis (E10.10 – E10.351, E10.359, E10.36, E10.39 – E11.351, E11.359, E11.36, E11.39 – E13.351, E13.359, E13.36, E13.39 – E13.9, O24.011 – O24.33, O24.811 – O24.83)

Documentation Required

- Diagnosis of HTN **(I10)** and a dated BP measurement
- Diagnosis can be documented as: HTN, Borderline HTN, Elevated blood pressure, high blood pressure

Statements such as "rule out hypertension", "possible hypertension", "white coat hypertension", "questionable hypertension", and "consistent with hypertension" are ***not*** sufficient to confirm a diagnosis of hypertension.

CPT Category II Codes (Blood Pressure): 3074F (systolic less than 130), 3075F (systolic 130 - 139), 3077F (systolic greater than/equal to 140), 3078F (diastolic less than 80), 3079F (diastolic 80-89), 3080F (diastolic greater than/equal to 90)

Role of Care Management

- Reinforce patient education regarding chronic disease, medication adherence and life-style/behavior modification
- Identify & Address barriers to adherence

Role of PCP Practice

- Ensure documentation of diagnosis and measurement
- Prescribe medication and/or provide education to patient on diagnosis and symptom management
- Consider assigning CPT Category II Code

Statin Therapy for Patients with Cardiovascular Disease – Received Statin Therapy

Measure Type: HEDIS (claims) / *Age Cohort:* 21-75 years (males); 40-75 years (females)

Measure Definition

Number of people who have had an MI, CABG or PCI in the year prior or a diagnosis of ischemic vascular disease in both the measurement year and year prior and who were dispensed at least one high or moderate-intensity statin medication

Documentation Required

- Diagnosis of cardiovascular disease:
  - Patient had MI or CABG (Inpatient Visit only) or PCI (in any setting) during year prior to measurement year.
  - Patient had ischemic vascular disease (IVD) during both measurement year and year prior (I20.0 – I20.9, I24.0 – I24.9, I25.10 – I25.119, I25.5 – I25.9, I63.00 – I66.9, I67.2, I70.0 –I70.92, I74.01 – I75.89)
- Dispensed at least one high or moderate-intensity statin medication (Medication List)

Note: Patients who meet any of the following criteria during measurement year or year prior are excluded from this metric: ESRD, cirrhosis, myalgia, myositis, myopathy, rhabdomyolysis, pregnancy, in vitro fertilization or were dispensed at least one prescription for clomiphene

Role of Care Management

- Ensure medication fill
- Reinforce patient education regarding chronic disease, medication adherence
- Identify & Address barriers to adherence

Role of PCP Practice

- Prescribe Statin Medication as appropriate
- Provide education to patient on diagnosis and symptom management

Statin Therapy for Patients with Cardiovascular Disease – Statin Adherence 80%

Measure Type: HEDIS (claims) / *Age Cohort:* 21-75 years (males); 40-75 years (females)

Measure Definition

Number of people who had an MI, CABG or PCI in the year prior or a diagnosis of ischemic vascular disease (IVD) in both the measurement year and year prior and who achieved a proportion of days covered of 80% for the treatment period

Documentation Required

- Diagnosis of cardiovascular disease:
  - Patient had MI or CABG (Inpatient Visit only) or PCI (in any setting) during year prior to measurement year.
  - Patient had IVD during both measurement year and year prior (I20.0 – I20.9, I24.0 – I24.9, I25.10 – I25.119, I25.5 – I25.9, I63.00 – I66.9, I67.2, I70.0 –I70.92, I74.01 – I75.89)
- Dispensed at least one high or moderate-intensity statin medication (Medication List)
- Prescriptions are filled at least 80% of the time

Note: Patients who meet any of the following criteria during measurement year or year prior are excluded from this metric: ESRD, cirrhosis, myalgia, myositis, myopathy, rhabdomyolysis, pregnancy, in vitro fertilization or were dispensed at least one prescription for clomiphene

Role of Care Management

- Ensure monthly refills
- Reinforce patient education regarding chronic disease, medication adherence
- Identify & Address barriers to adherence

Role of PCP Practice

- Prescribe statin medication as appropriate and authorize monthly refills
- Provide education to patient on diagnosis and symptom management

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DIABETES MEASURES

Comprehensive Diabetes Care:
Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Measure Type: HEDIS **(medical record abstraction)** / *Age Cohort:* 18-75 years

Measure Definition

Number of people with diabetes whose most recent HbA1c level indicated poor control (>9.0 percent), or was missing or did not have a HbA1c test.

Documentation Required

- Diagnosis of diabetes: (E10.10 – E10.351, E10.359, E10.36, E10.39 – E11.351, E11.359, E11.36, E11.39 – E13.351, E13.359, E13.36, E13.39 – E13.9, O24.011 – O24.33, O24.811 – O24.83)
- Document the HbA1c Test**,** the dates of service **and results** for the **LAST** HbA1c test identified by end of measurement year.

Note: *A lower rate indicates better performance for this metric (i.e., low rates of poor control indicate better care).*

CPT Category II Codes (HbA1c Test Result): 3044F (HbA1c Level Less than 7.0), 3045F (HbA1c Level 7.0-9.0), 3046F (HbA1c Level Greater than 9.0)

Role of Care Management

- Reinforce patient education regarding chronic disease, medication adherence and life-style/behavior modification
- Ensure lab work is current and assist with making appointment as needed
- Identify & address barriers to adherence

Role of PCP Practice

- Provide education to patient on chronic disease, medication adherence and lifestyle/behavior modification
- Ensure lab work is current and make appointment for repeat labs as needed
- Consider assigning CPT Category II Code

Comprehensive Diabetes Screening – All three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)

Measure Type: HEDIS **(medical record abstraction)** / *Age Cohort:* 18-75 years

Measure Definition

Number of people with diabetes who received **all of the following tests: HbA1c test, diabetes eye exam, and medical attention for nephropathy.**

Documentation Required

Diagnosis of diabetes: (E10.10 – E10.351, E10.359, E10.36, E10.39 – E11.351, E11.359, E11.36, E11.39 – E13.351, E13.359, E13.36, E13.39 – E13.9, O24.011 – O24.33, O24.811 – O24.83)

HbA1c: Document the HbA1c Test**,** the dates of service **and results** for the **LAST** HbA1c test identified by end of measurement year.

Diabetes Eye Exam: must meet one of the criteria below to qualify meeting an eye exam

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement time frame OR a negative retinal exam by an eye care professional in the year prior to the measurement time frame.
- A note or letter with date of ophthalmoscopic exam and results completed by an eye care professional
- Chart or photograph of retinal abnormalities, dated and evidence that an eye care professional reviewed the results.

Medical Attention for Nephropathy: must meet one of the criteria below to qualify meeting medical attention to Nephropathy

- Urine protein test performed (positive or negative) during the measurement year
- Evidence of any of the following: Visits to a nephrologist (for any diagnosis), Diabetic nephropathy (A diagnosis of nephropathy does not have to be noted by a nephrologist), End-stage renal disease (ESRD), Chronic renal failure (CRF), Chronic Kidney disease (CKD), Renal insufficiency, Proteinuria, Albuminuria, Renal dysfunction , Acute renal failure (ARF), Dialysis, hemodialysis, or peritoneal dialysis, renal transplant or positive result for urine microalbuminuria.
- A note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs within the measurement year. (Medication List)

Applicable Codes: HbA1c Test CPT Codes: 83036, 83037 CPT Category II Codes: 3044F – 3046F; Diabetic Retinal Screening CPT Category II Codes : 2022F, 2024F, 2026F, 3072F (negative for retinopathy), Optometrist/Ophthalmologist CPT/HCPCS Codes: 67028 – 67113, 67121 – 67221, 67227, 67228, 92002 – 92014, 92018, 92019, 92134, 92225 – 92260, 99203 – 99205, 99213 – 99215, 99242 – 99245, S0620, S0621, S3000; Screening for Nephropathy - Urine Protein CPT Codes: 81000 – 81005, 82042 – 82044, 84156, CPT Category II Codes: 3060F – 3062F, CPT Category II Codes (Nephropathy Treatment): 3066F, 4010F

Role of Care Management

- Educate patient on chronic disease, medication adherence and lifestyle/behavior modification
- Ensure lab work and screenings are current and assist with making appointment as needed
- Identify & Address barriers to adherence

Role of PCP Practice

- Provide education to patient on chronic disease, medication adherence and lifestyle/behavior modification
- Prescribe medication as appropriate
- Ensure lab work is current and make appointment for repeat labs as needed
- Refer as appropriate for eye exams and nephrology consults and track results of referrals
- Consider assigning CPT Category II Code

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SURVEY MEASURES (HEDIS & CGCAHPS)

CGCHAPS Measure	Definition
Care Coordination	Number responses ‘Usually’ or ‘Always’ that provider seemed to know important history, follow-up to give results from tests, and talked about all prescription medicines
Getting Timely Appointments, Care and information	Number responses ‘Usually’ or ‘Always’ got appointment for urgent care or routine care as soon as needed , and got answers the same day if called during the day
Health Literacy – Instructions Easy to Understand	Number of responses ‘Usually’ or ‘Always’ that instructions for caring for condition were easy to understand
Health Literacy – Describing How to Follow Instructions	Number of responses ‘Usually’ or ‘Always’ that provider asked patient to describe how the instruction would be followed
Health Literacy – Explained What to do if Illness Got Worse	Number of responses ‘Usually’ or ‘Always’ that provider explained what to do if illness/condition got worse or came back
Primary Care – Length of Relationship	Percent of Responses at least 1 year or longer
Primary Care - Usual Source of Care	Percent of Reponses Yes

HEDIS Survey Measure	Definition
Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit	Number of responses 'Sometimes', 'Usually' or 'Always' were advised to quit
Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Medication	Number of responses 'Sometimes', 'Usually' or 'Always 'discussed Cessation Medication
Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Strategies	Number of responses 'Sometimes', 'Usually' or 'Always' discussed cessation methods or strategies
Aspirin Use	Number of responses ‘Usually’ or ‘Always’ that provider explained what to do if illness/condition got worse or came back
Discussion of Risks and Benefits of Aspirin Use	Number of respondents who discussed the risks and benefits of using aspirin with a doctor or health provider
Flu Shots for Adults Ages 18 – 64	Number of respondents who have had a flu shot

Physician Office Visits – Patient Satisfaction Improvement Strategies

Role of Office Staff

- Ensure patients get appointments for urgent care or routine care as soon as needed
- Be helpful, courteous and respectful to patients
- Answer patient questions the same day if patient called during the day
- Check for flu shot prior to patient visit
- **Recommendation:** Log in to applicable registries prior to patient visit and check for other services patient may need

Patient – Provider Conversation

Recommendation: The SHARE Approach—Using the Teach-Back Technique

- Provider explains care instructions and what to do if illness/condition got worse or came back (includes tobacco cessation counseling & risks and benefits of aspirin use)
- Provider ask patient to describe how the care instruction would be followed (Teach-Back)

(Provider needs to watch for **red flags** which may indicate health literacy challenges: patient nodding politely without asking questions; patient' questions not aligned with the explanation provided; patient joking they have a terrible memory about their medical conditions; patient asking the provider to read something for them; patient starring blankly or not paying attention during discussion)

- Screen patient for depression

Reference: https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/tool-6/index.html

Role of Care Management

- Identify & Address barriers to adherence
- Reinforce patient education
- Ensure follow-up visits

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MEASURE MEDICATION LISTS

Measure	Medication List
Antidepressant Medication Management – Effective Acute Phase Treatment **&** Effective Continuation Phase Treatment Back to Measure – Acute Back to Measure - Continuation	Bupropion, Vilazodone, Vortioxetinem, Isocarboxazid, Phenelzine, Selegiline , Tranylcypromine, Nefazodone, Trazodone, Amitriptyline-chlordiazepoxide, Amitriptyline-Perphenazine, Fluoxetine-olanzapine, Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine, Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine , Sertraline, Maprotiline, Mirtazapine, Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6 mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine
Antipsychotic Medication Adherence Back to Measure	Aripiprazole, Asenapine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone, Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline, Prochlorperazine, Thioridazine, Trifluoperazine, Fluoxetine-olanzapine, Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Paliperidone palmitate
Child ADHD Medication Follow-up Back to Measure – Initiation Back to Measure – Continuation	Amphetamine-dextroamphetamine, Dexmethylphenidate, Dextroamphetamine, Lisdexamfetamine, Methylphenidate, Methamphetamine, Clonidine, Guanfacine, Atomoxetine
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication Back to Measure	Aripiprazole, Asenapine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone, Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline, Prochlorperazine, Thioridazine, Trifluoperazine, Fluoxetine-olanzapine, Thiothixene, Fluphenazine decanoate, Haloperidol decanoate, Paliperidone palmitate

Measure	Medication List
Statin Therapy for Patients with Cardiovascular Disease – Received Statin Therapy **&** Statin Adherence 80% Back to Measure - Received Statin Therapy Back to Measure – Statin Adherence 80%	Atorvastatin (10-20 mg) (40–80 mg), Amlodipine-atorvastatin (10-20 mg) (40–80 mg), Ezetimibe-atorvastatin (10-20 mg) (40–80 mg), Rosuvastatin (5-10 mg) (20–40 mg), Simvastatin (20–40 mg) (80 mg), Ezetimibe-simvastatin (20–40 mg) (80 mg), Niacin-simvastatin 20-40 mg, Sitagliptin-simvastatin 20-40 mg, Pravastatin 40–80 mg, Aspirin-pravastatin 40-80 mg, Lovastatin 40 mg, Niacin-lovastatin 40 mg, Fluvastatin XL 80 mg, Fluvastatin 40 mg bid, Pitavastatin 2–4 mg
Asthma Controller Medication: • Asthma Medication Ratio • Medication Management for People with Asthma (50% **&** 75% of Treatment Days Covered) Back to Measure – Medication Ratio Back to Measure – 50% Back to Measure – 75%	Dyphylline-guaifenesin, Guaifenesin-theophylline, Omalizumab, Budesonide-formoterol, Mometasone-formoterol, Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone CFC free, Mometasone, Montelukast, Zafirlukast, Zileuton, Cromolyn, Aminophylline, Dyphylline, Theophylline
Asthma Reliever Medication: • Asthma Medication Ratio Back to Measure	Albuterol, Levalbuterol, Pirbuterol

Measure	Medication List
ACE Inhibitors/ARBs (Attention for Nephropathy) • Comprehensive Diabetes Screening Back to Measure	Benazepril , Captopril , Enalapril, Fosinopril, Lisinopril , Moexipril, Perindopril, Quinapril, Ramipril, Trandolapril, Azilsartan, Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan , Valsartan, Aliskiren-valsartan, Amlodipine-benazepril, Amlodipine-hydrochlorothiazide-valsartan, Amlodipine-hydrochlorothiazide-olmesartan, Amlodipine-olmesartan, Amlodipine-telmisartan, Amlodipine-valsartan, Azilsartan-chlorthalidone, Benazepril-hydrochlorothiazide, Candesartan-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Eprosartan-hydrochlorothiazide, Fosinopril-hydrochlorothiazide, Hydrochlorothiazide-irbesartan, Hydrochlorothiazide-Lisinopril, Hydrochlorothiazide-losartan, Hydrochlorothiazide-moexipril, Hydrochlorothiazide-olmesartan, Hydrochlorothiazide-quinapril, Hydrochlorothiazide-telmisartan, Hydrochlorothiazide-valsartan, Trandolapril-verapamil

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MEASURE REFERENCES

Measure References

Measure: Follow-up after Hospitalization for Mental Illness (7 days & 30 days) Back to Measure

Mental Health Practitioner:

- An MD or DO who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.