Northeast
Physician Hospital Organization

2019 ACO/MEDICARE QUALITY MEASURES

Measures	Population	Required Services	Tips
Patient Safety: Screening for future fall risk	**Patients 65+**	*Screened for future falls risk documented during calendar year 2019* • ***1. Have you had two or more falls in the past year?*** • ***2. Are you being seen here today because of a fall?*** • ***3. Do you have difficulty with balance or walking?***	Document medical reasons for not screening fall risk (i.e. pt is not ambulatory)
At Risk Population: Diabetes: Hemoglobin A1c Poor Control (>9%)	**Patients 18 – 75** w/documented DM in 2018 or 2019	HbA1c during 2018-2019 and most recent A1c value should be less than 9.0% to be compliant with measure	Members with missing results or no test are **Non-Compliant**
At Risk Population: Hypertension- Controlling High Blood Pressure	**Patients 18-85** who have a Dx of hypertension	Blood pressure measured and documented during 2019. The most recent recorded blood pressure must be **less than** 140/90.	The patient should be seated comfortable with the back supported, feet on the floor and the upper arm bare without constrictive clothing. The legs should not be crossed**.** **Repeat BP reading in 5 minutes if 1st reading is elevated.**
At Risk Population: Depression Remission at 12 Months	**Patients 18+** w/DX of major depression or Dysthymia **AND** at least one PHQ-9 score>9 from 12/1/2017 – 11/30/18 (index date)	At least one PHQ-9 < 5 during the assessment period, from 10/01/2018 through 12/31/2019 (11-13 months from the index date)	The patients PHQ-9 score has decreased since the initial test
Preventive Health: Colorectal Cancer Screen	**Patients 50-75**	• One or more of the following screenings: • FIT - Hemoglobin every year • FIT- DNA (Cologuard) every 3 years • Flexible Sigmoidoscopy every 5 years • Colonoscopy every 10 years • **Exclusion: Hospice**	Documentation in the EMR must include both of the following: A note indicating the date of colorectal screening was performed AND the result or findings – document of both normal & abnormal is acceptable. Digital rectal exams (DRE), FOBT tests performed in an office setting are not acceptable
Preventive Health: Influenza Immunization	**Patients 6 mos.+** visit Oct 2018 – March 2019	• Measure Time Period: Oct. 1, 2018 - Mar 31, 2019 • Documentation that the patient received/reported receiving the Flu shot	**Exclusions:** Medical contradictions, patient refusal, vaccine out of stock **Always Document**
Preventive Health: Tobacco Use: Screening and Cessation Intervention	**Patients 18+**	Screened at least once for tobacco use **within 2 years** (2017 or 2018) Document advise to quit if identified as a tobacco user (includes any type of tobacco)	**Document** a medical reason(s) for not screening for tobacco use (e.g. limited life expectancy, other medical reason) **Exceptions only apply to the screening part of the measure; once a patient has been screened, there are no allowable exceptions for not providing the intervention**
Preventive Health: Screening for Clinical Depression and Follow Up Plan	**Patients 12 years and older**	Perform depression screening with age appropriate standardized tool at least once during the measurement period. Examples of screening tools include **but are not limited to**: **Adult Screening Tools** (18 and older): Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, PHQ-2 and PRIME MD-PHQ-2 **Adolescent Screening Tools** (12-17): PHQ-A, BDI-PC, MFQ, CES-D, PHQ-2 & PRIME MD-PHQ2; If POSITIVE, document follow-up (see tips)	**Documented follow-up plan** as a result of positive clinical depression screening MUST include one (1) or more of the following: * Additional evaluation for depression * Suicide Risk Assessment * Referral to a practitioner who is qualified to diagnosis & treat depression
Preventative Health: Screening for Breast Cancer	**Women 51 – 74 years of age**	The intent of this measure is that starting at age 50 women should have one or more mammograms every 24 months	Documentation in the EMR must include both of the following: A note indicating the date the breast cancer screening was performed AND the result or findings
Preventive Health: Statin Therapy for Prevention & Treatment of Cardiovascular Disease	**Adults >=21 w/ASCVD**	Patients with ASCVD (past or present) OR adults >=21 who have ever had a LDL-C level >=190 mg/dL or were diagnosed with hypercholesterolemia (past or present) OR adults 40-75 with a diagnosis of diabetes with a fasting or direct LCL-C level of 70-189 mg/dL recorded as the highest fasting or direct lab test result in the MY or during the two years prior to the beginning of the MP, who were prescribed or were on statin therapy during the MP	**There are 3 reporting criteria for this measure: all are considered "high risk" for cardiovascular events under 2013 ACC/AHA guidelines. Pts should only be counted in one of the denominator populations.**