Trinity Health

Quality Playbook

Ambulatory Care User Manual

12/15/2025

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Preventive Care and Screening

Breast Cancer Screening

A. **Which patients are included?** Patients evaluated as female who are 40 through 74 years of age with a visit during the measurement period, starting 2026.

   Note: The measure's 27-month look back period applies to patients ages 42-74 (the numerator looks for a mammogram any time on or between October 1, 27 months prior to the measurement period, and December 31 of the measurement period to capture patients who have had a mammogram every 24 months per clinical guidelines, within a 3-month grace period). Therefore, patients aged 40-42 are included in the measure if they had a visit and a mammogram from age 40, but the look back only applies to patients aged 42-74.

B. **What do practices need to do?** Order and encourage the patient to have a screening mammogram once every 24 months. If the patient has mammograms done through a different office (i.e., gynecologist), ensure that we have a copy of the report. Ensure that health maintenance is updated. Note: ultrasounds, MRIs and biopsies do not satisfy the numerator.

C. **Who needs to do the documentation?** Providers order the appropriate test; rooming staff, nurses and/or providers may update health maintenance.

D. **What are we being measured on?** Patients evaluated as female who had one or more mammograms any time on or between October 1, 27 months prior to the measurement period, and December 31 of the measurement period, not to precede the patient's 40th birthday.

E. **Exclusions**: Patients who meet either of the following criteria:

   - Patients who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies. Documented in surgical history or problem list.
   - Exclude patients who are in hospice care for any part of the measurement period.
   - Exclude patients receiving palliative care.
   - Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
     - Advanced illness with two outpatient encounters during the measurement period or the year prior.
     - OR advanced illness with one inpatient encounter during the measurement period or the year prior
     - Or taking dementia medication during the measurement period or the year prior.

F. The order can be placed via the Overdue SmartSet on the patient storyboard, utilizing the well visit AMB Comprehensive Health Maintenance SmartSet or placing an order for screening mammogram in the visit task bar.

Job Aid: Health Maintenance Topics- Quick Tip Guide- **Health Maintenance Care Gap tracks breast cancer screening for women starting age 40-74 biannually.**

Reference appendix for hospice and palliative care documentation.

Metric is in the Quality Scorecard Ambulatory Rolling Calendar Dashboard, and Quality Measure Dashboard, department summary level only. This metric is retired for MIPs reporting.

Cervical Cancer Screening

A. **Which patients are included?** Women aged 21-64 years, except patients who have had their cervix removed (i.e., Total Hysterectomy).

B. **What do practices need to do?** Perform cervical cancer screening by USPSTF guidelines (see below). If the patient has pap smears done through a different office (i.e., gynecologist) ensure that we have a copy of the report. Ensure that health maintenance is updated.

- Women aged 21-64 years old – perform cervical cytology (pap smear) every 3 years.
- Women aged 30-64 years – perform cervical cytology (pap smear) with human papilloma virus (HPV) testing every 5 years.

C. **Who needs to do the documentation?** Providers perform/order the appropriate test; rooming staff, nurses and/or providers may update health maintenance.

D. **What are we being measured on?** The percentage of women aged 24-64 years that have had cervical cytology testing in the last 3 years OR (if over 30) have had cervical cytology and HPV co-testing in the last 5 years. Measurement starts at age 24 to allow for a 3-year look-back period.

E. **Exclusions for CMS measure:** Patients who meet either of the following criteria:

- Women who had a hysterectomy with no residual cervix or a congenital absence of cervix. The following surgical history procedures will count towards the exclusion:
  - SHX209 Total Abdominal Hysterectomy
  - SHX83 Total Abdominal Hysterectomy W/ Bilateral Salpingoophorectomy
  - SHX1934 Laparoscopic Radical Total Hysterectomy W/ Node Biopsy
  - SHX21005 Hysterectomy Total Cervix Removed (on rooming tab)
  - SHX21006 Laparoscopic Total Hysterectomy Cervix Removed
  - SHX2283 Radical Hysterectomy
  - SHX2548 Total Vaginal Hysterectomy
- The patient received hospice care during the measurement period, as indicated by a hospice encounter or hospice assessment.
- The patient received palliative care during the measurement year, as indicated by a diagnosis for a palliative care encounter.

Note: For **Health Maintenance** to exclude the patient from the topic the provider will need to add a health maintenance modifier- Not a candidate for Cervical Cancer Screening. This was a system office decision.

F. The order can be placed via the Overdue SmartSet on the storyboard, utilizing the well visit AMB Comprehensive Health Maintenance SmartSet or placing an order in the visit task bar.

Tip: The Last Menstrual Period date is a required field in the Pap Smear Order. Instruct rooming staff to update LMP in the vitals section/ OB/GYN status this will automatically flow to the Pap order.

Job aid:
Health Maintenance Topics- Quick Tip Guide
Cervical Cancer Screening (Pap Tracker) and Care Gaps

Metric is in the Quality Scorecard Ambulatory Rolling Calendar, MIPS Dashboard and Quality Measure Dashboard.

Reference appendix for hospice and palliative care documentation.

Colorectal Cancer Screening

A. **Which patients are included?** Patients aged 45-75 years.

B. **What do practices need to do?** The patient only needs to have had **one** of these screenings at the appropriate time. If the patient has already had one of these tests, ensure that we have a copy of the report. Ensure that health maintenance is updated.

- Colonoscopy - every 10 years OR
- Fecal occult blood test (FOBT or FIT) - annually OR
- Fecal Immunochemical DNA test (stool DNA or FIT-DNA) - every 3 years OR
- Flexible sigmoidoscopy - every 5 years OR
- CT colonography - every 5 years

C. **Who needs to do the documentation?** Providers order the appropriate test; rooming staff, nurses and/or providers may update health maintenance.

D. **What are we being measured on?** The percentage of patients 45-75 years that are up to date on colon cancer screening, either: colonoscopy in the last 10 years OR FOBT/FIT in the last year OR flexible sigmoidoscopy in the last 5 years OR CT colonography in the last 5 years OR stool DNA testing in the last 3 years.

E. **Exclusions:** Patients who meet either of the following criteria:

- Patients with a diagnosis or history of total colectomy or colorectal cancer.
- Patients who are in hospice care for any part of the measurement period
- Patients with a diagnosis or history of total colectomy or colorectal cancer
- Patients 66 and older with evidence of frailty and advanced illness or evidence of frailty and dementia
- Patients receiving palliative care overlapping with the measurement period.

F. The order can be placed via the Overdue SmartSet on the storyboard, utilizing the well visit AMB Comprehensive Health Maintenance SmartSet or placing an order in the visit task bar.

Job Aid: Health Maintenance Topics- Quick Tip Guide

Metric is in the Quality Scorecard Ambulatory Rolling Calendar Dashboard and Quality Measure Dashboard, department summary level only. This metric is retired for MIPs reporting.

Reference appendix for hospice and palliative care documentation.

Influenza Immunization

A. **Which patients are included?** Patients 6 months and older.

B. **What do practices need to do?** Administer an influenza vaccine if the patient has not had one yet during this flu season (see note). If the patient has had an influenza vaccine elsewhere document this in historical immunizations. If patients decline, update health maintenance to reflect this.

C. **Who needs to do the documentation**? Rooming staff, nursing, and/or providers.

D. **What are we being measured on?** The percentage of eligible patients 6 months and older that have received an influenza vaccine during the current flu season.

- **MIPs:** Patients are excluded if in hospice during the measurement period. There are no denominator exceptions such as medical reasons, allergies, or patient refusal.

E. **Exclusion:** Anaphylaxis due to the vaccine during or before the measurement period. Documented by adding Dx Anaphylaxis due to vaccine containing influenza virus antigen [T80.52XA, T50.B95A]

F. The order can be placed via the Overdue SmartSet on a storyboard, utilizing the well visit AMB Comprehensive Health Maintenance SmartSet, Pediatric Well Child SmartSets, or placing an order in the visit task bar.

G. For patients who choose to decline the vaccine: The Best practice workflow is to postpone the influenza health maintenance topic and document the reason as patient declined. This will allow the topic to reappear for the next flu season.

Job Aid: Health Maintenance Topics- Quick Tip Guide

Metric is in the Quality Scorecard Ambulatory Rolling Calendar Dashboard, Quality Measure Dashboard department summary level only. This metric is retired for MIPs reporting.

Pneumococcal Vaccination Status for Older Adults

A. **Which patients are included?** Patients aged 65 and older.

B. **What do practices need to do**? Administer a pneumonia vaccine if the patient has not had one yet. If the patient has had a pneumonia vaccine elsewhere document this in historical immunizations.

C. **Who needs to do the documentation?** Rooming staff, nursing, and/or providers.

D. **What are we being measured on?** The percentage of patients over 65 who have had at least one pneumonia vaccine. Health Maintenance updated to include PCV20 and PCV15.

E. The order can be placed via the Overdue SmartSet on the storyboard, utilizing the well visit AMB Comprehensive Health Maintenance SmartSet, Pediatric Well Child SmartSets, or placing an order in the visit task bar.

Job Aid: Health Maintenance Topics- Quick Tip Guide

Health Maintenance only, retired eCQM measure.

BMI Screening and Follow-Up Plan (18 and older)

A. **Which patients are included?** Patients aged eighteen and older.

B. **What do practices need to do?**

- Document BMI during the encounter or during the measurement period.

AND

- When the BMI is outside of normal parameters, a follow-up plan must be documented during the encounter or during the measurement period. The plan needs to clearly state that it is pertaining to the high or low BMI. example: “Patient referred to nutrition counseling for BMI above normal parameters.”
- This follow-up plan may include but is not limited to documentation of education, referral (for example, a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional specializing in weight management, or bariatric surgeon), pharmacological interventions, dietary supplements, exercise counseling and suggestions for an exercise plan or nutrition counseling.

C. **Who needs to do the documentation?** Rooming staff, nursing, and/or providers.

D. **What are we being measured on?** The percentage of patients older than 18 the BMI must be documented within the measurement period, and **any BMI documented during the measurement period can be used for the numerator instead of only the most recent BMI.** For any abnormal BMI in the measurement period a follow-up plan needs to be documented. Abnormal Parameters: < 18.5 or >= 25 will need a follow up plan documented.

E. A qualifying encounter cannot be a virtual visit.

F. **Documentation Guidelines**

- BMI must be interpreted as abnormal by using the SmartPhrase “. **BMIABOVE**” and “**. BMIBELOW OR** adding an appropriate diagnosis code. Examples: Underweight R63.6, Overweight with BMI 25-29.9 E66.3, Obesity (BMI30-39.9) E66.9.

- Adding Z Codes with a documented plan in the note will satisfy the measure.
  - Z71.3 Dietary counseling and surveillance
  - Z71.82 Exercise counseling.

- In Notes can utilize “**. BMIABOVE**” and “**. BMIBELOW”** SmartPhrases to document a quick plan. These phrases will satisfy the plan measure.

- To document Patient declines BMI assessment, you must utilize SmartPhrase “. **BMINOTASSESSEDMU**”

Metric is in the Quality Measure Dashboard at department summary level only, this measure has been retired for MIPs eCQM CMS 69.

Tobacco Use Screening and Cessation Intervention

A. **Which patients are included?** Patients aged 12 years and older.

B. **What do practices need to do?** Screen for tobacco at least once every 24 months AND if the patient IS a tobacco user, then tobacco cessation intervention must be documented. This may include brief counseling (3 minutes or less) and/or pharmacotherapy. Must also evaluate smokeless tobacco use.

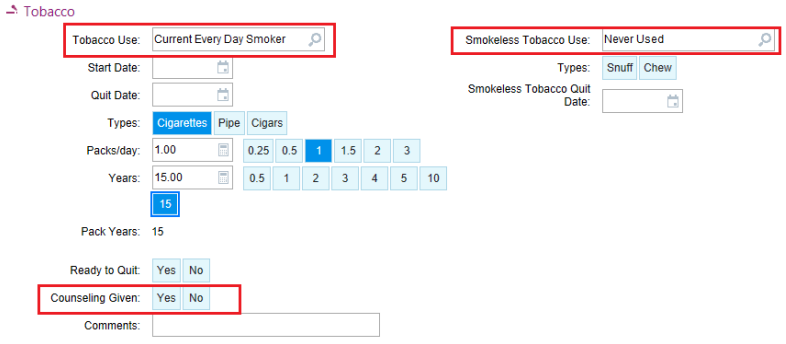
C. **Who needs to do the documentation?** Rooming staff, nursing, and/or providers

D. **What are we being measured on?** The percentage of patients 12 and older that have been screened for tobacco use AND, if a tobacco user, have documented tobacco cessation intervention done.

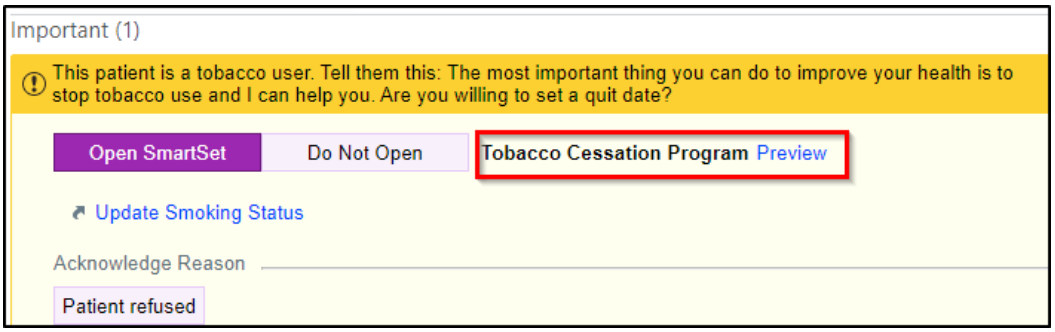
E. **Documentation Guidelines**

- Rooming or Provider must assess Tobacco Use and Smokeless Tobacco Use.
- E-cigarettes and vaping qualify as tobacco use. Previously, the measure did not evaluate e-cigarettes and vaping.
- Mark Counseling Given to satisfy the measure.
- Provider to document counseling in notes.

Access Tobacco history on the Rooming Navigator under history, or History Navigator > Substance Use section:



F. **OPA Alert for Providers:** Can utilize Tobacco Cessation Smart Set



Metric is in the MIPS Dashboard and Quality Measure Dashboard eCQM CMS 138.

Depression Screening and Follow-Up Plan

A. **Which patients are included?** Patients aged 12 years and older, except patients who have an active diagnosis of bipolar disorder.

B. **What do practices need to do?** Annually, complete a PHQ-2 depression screening during an encounter. If the patient's score is positive on the PHQ-2, the patient should continue to the PHQ-9. If the patient's score is positive on the PHQ-9 (i.e., the score is 5 or higher), the provider must document a follow-up plan that includes one or more of the following: 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.

   - (It is acceptable defer screening for patients who refuse or patients whose functional capacity or motivation may impact the accuracy of results. It is also acceptable not to screen in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. Make sure to document why the screening was not done.)

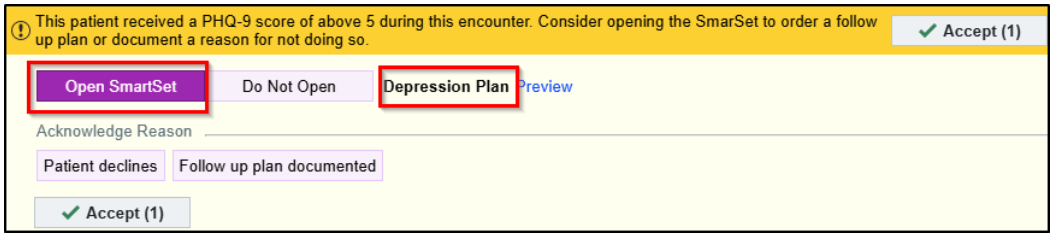
C. **Who needs to do the documentation?** Nurses and/or providers document a follow-up plan.

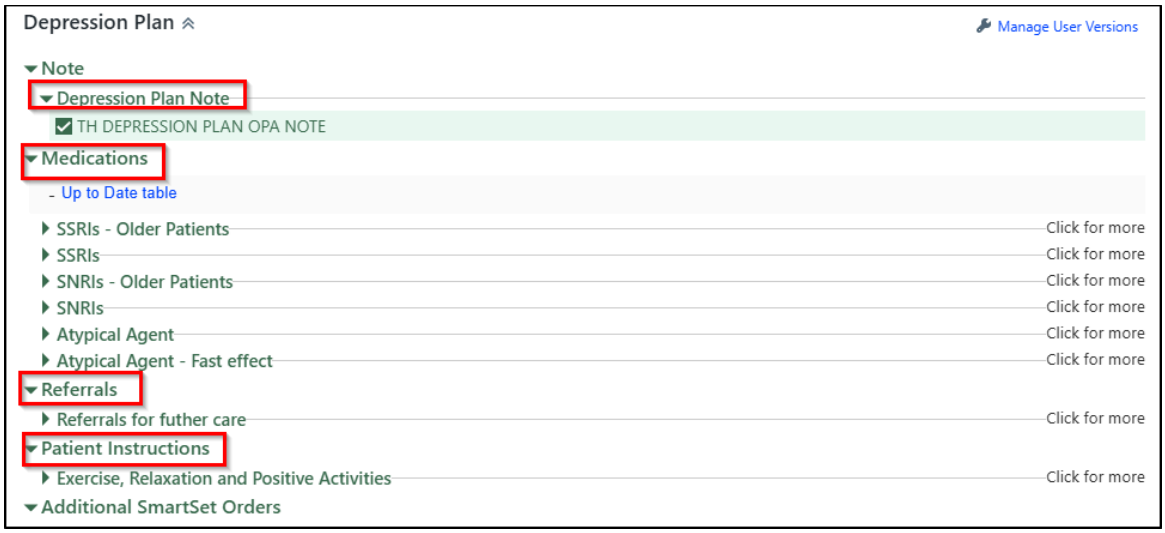
D. **What are we being measured on?** The percentage of patients 12 and older that have been screened for depression in the last year. If depression screening is positive this measurement will also include whether the patient has a follow-up plan documented.

   a. *Starting in 2026 Patients with positive screening now count toward the measure numerator if they have an active depression medication that overlaps with the qualifying encounter.*

E. **Documentation of follow-up plan**:

   - **OPA documentation:** If the Depression Risk Score row has a value of 5 or higher, an OPA will be triggered for the patient to indicate that follow-up is needed. The user should Open the SmartSet to meet the follow up plan documentation.



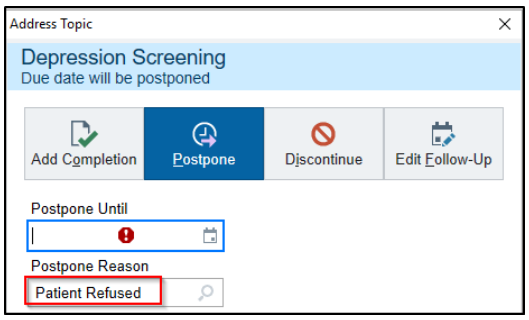


- **Pharmacologic Depression Treatment:** Certain Medication Orders can also meet the follow-up requirements for this measure. The list of these medications is quite extensive and varies slightly between adolescent patients and adult patients. These are listed in the SmartSet.

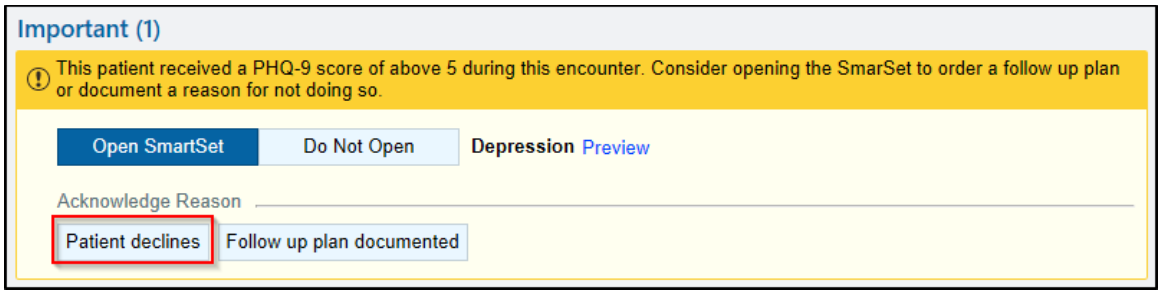
- **Referrals:** Below are Referral orders that count towards the measure for depression follow-up.
  AMB REFERRAL TO BEHAVIORAL HEALTH [REF8]
  AMB REFERRAL TO PEDIATRIC PSYCHIATRY [REF80]
  AMB REFERRAL TO PEDIATRIC PSYCHOLOGY [REF81]
  AMB REFERRAL TO PSYCHIATRY [REF91]
  AMB REFERRAL TO PSYCHOLOGY [REF92]
  AMB REFERRAL TO SOCIAL WORK [REF98]
  AMB REFERRAL TO ADOLESCENT MEDICINE [REF3]
  AMB REFERRAL TO COGNITIVE BEHAVIORAL THERAPY [REF138]
  AMB REFERRAL TO INTERNAL MEDICINE [REF40]
  AMB REFERRAL TO FAMILY MEDICINE [REF24]
  AMB REFERRAL TO CARE MANAGEMENT [REF2100]
  AMB REFERRAL TO SOCIAL WORKER CARE MANAGER [REF21002]
  AMB REFERRAL TO CARE CORRDINATION [REF558]

F. **Documentation of Patient Declines**:

- If the patient declines the depression screening, postpone the health maintenance topic with reason Patient Refused.



- If the patient declines the follow up plan after a positive PHQ9 click on “Patient declines” in the Acknowledge Reason in the OPA.



G. **Exclusions:** Patients who have been diagnosed with bipolar disorder.

Metric is in the Quality Scorecard Ambulatory Rolling Calendar Dashboard, MIPs Dashboard, Quality Measure Dashboard and MSSP ACO Web Interface & eCQM Management Dashboard. eCQM CMS 2.

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

A. **Which patients are included?** Patients who meet at least one of the following criteria:

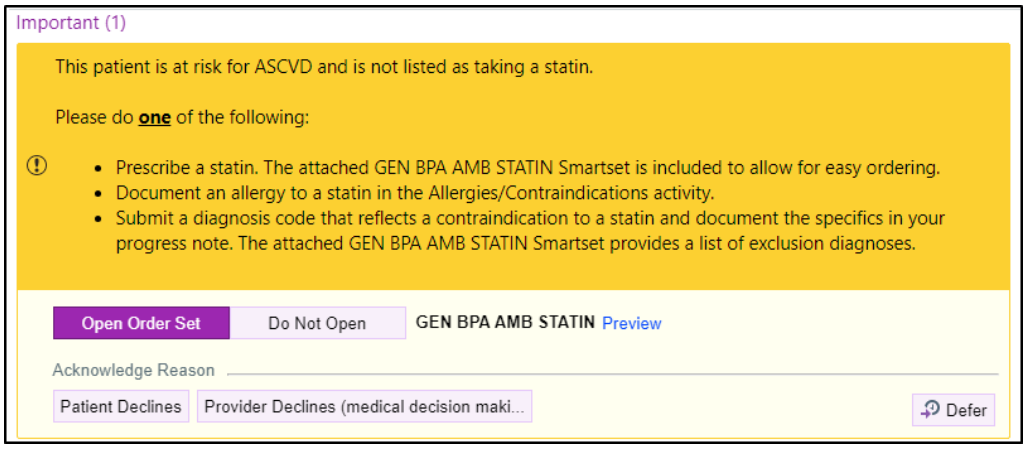
- Who were previously diagnosed with or have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD)
- Are age 20 -75 years or older at the beginning of the measurement period and either:
    - Have ever had an LDL cholesterol result of greater than or equal to 190 mg/dL.
    - Who were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia.
- Are age 40-75 years at the beginning of the measurement period and have Type 1 or Type 2 diabetes.
- Are age 40-75 with a 10-year ACSVD risk score of greater than or equal to 20%.

B. **What do practices need to do?** Review the patient's chart to determine if the patient is included in this measure and approach statin therapy according to clinical recommendations. If a specialist is prescribing a statin, ensure that this is accurately recorded on the medication list.

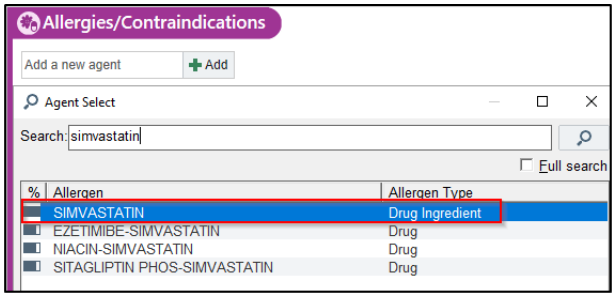
C. **Who needs to do the documentation?** Providers order appropriate statin therapy, rooming staff, nurses, and/or providers may record patient reported medications.

D. **What are we being measured on?** The percentage of patients (in the categories above) at high risk of cardiovascular events that have a statin medication currently documented on their medication list.

E. **OPA alert for providers:**



F. To document Statin Allergy, the ACO Value set requires the use of Drug Ingredient allergens: **Lovastatin, Simvastatin, Fluvastatin, Pravastatin, Atorvastatin, Rosuvastatin, or Pitavastatin.**



G. **Exclusions**: Patients who meet either of the following criteria:
- Are breastfeeding at any time during the measurement period.
- Or have rhabdomyolysis.

H. **Exceptions:** Patients who meet one or more of the following criteria:
- Have an adverse effect, allergy, or intolerance to statin medication.
- Have active liver disease or hepatic disease or insufficiency.
- Have end-stage renal disease (ESRD).
- Have diabetes and a most recent fasting or direct LDL-C result of less than 70 mg/dL and is not taking statin therapy.
- Have documentation of a medical reason for not being prescribed statin therapy.

Metric is in the MIPs and Quality Measure Dashboard. eCQM CMS 347.

Childhood Immunizations

A. **Which patients are included?** Patients who are turning 2 years old in the calendar year, excluding those who have contraindications to any antigen in any of the below vaccines.

B. **What do practices need to do?** Ensure that patients have received the following vaccines by their 2nd birthday:

   1. 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 conjugates (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccine

C. **Who needs to do the documentation?** Rooming staff, nursing, and/or providers

D. **What are we being measured on**? The percentage of patients aged 2 that have had **all** the above vaccines on or before their 2nd birthday.

E. The order can be placed via the Pediatric Well Child SmartSets, Overdue SmartSet on the storyboard, or placing an order in the visit task bar.

Note: For a patient to be included in the numerator because they have previously had the relevant disease instead of receiving immunization, a diagnosis is required instead of a positive antibody est. This change applies to the following immunizations:

- Hepatitis A
- Hepatitis B
- MMR
- Varicella Zoster.

As a result, clinicians need to document diagnoses for these conditions but no longer need to order antibody tests.

Job Aid:
Health Maintenance Topics- Quick Tip Guide
SmartSets: Well Child Check

Metric is in the MIPs and Quality Measure Dashboards, eCQM CMS 117.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

A. **Which patients are included?** Patients aged 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.

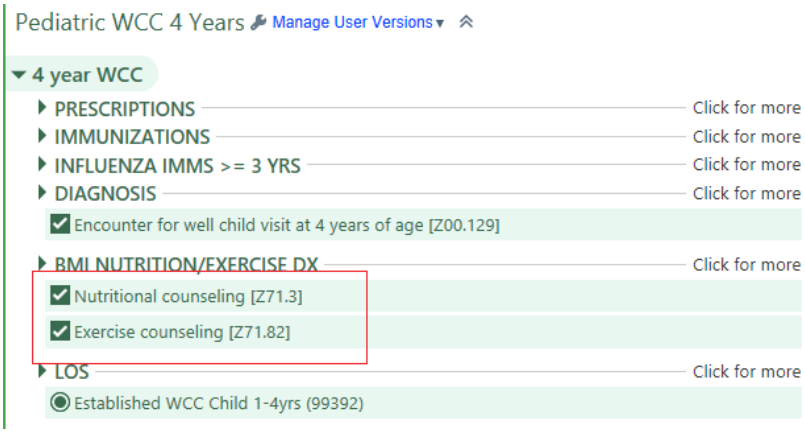
B. **What do practices need to do?** Document height and weight at every visit. The BMI percentile is automatically calculated when height and weight entered. Document Counseling for Nutrition and Physical Activity. Adding exercise and nutrition counseling codes will satisfy the measure.

C. **Who needs to do the documentation?** Rooming staff, nursing, and/or providers.

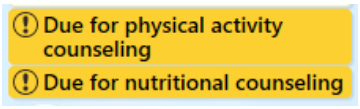
D. **What are we being measured on?** The following three metrics:

   1. Percentage of patients with height, weight, and body mass index (BMI) percentile documentation
   2. Percentage of patients with counseling for nutrition
   3. Percentage of patients with counseling for physical activity

E. Documentation utilizing Pediatric Wellness SmartSets. BMI Nutrition and Exercise counseling codes automatically defaulted for ages 3 to 17.



F. OPA alert reminder for providers: Appears to providers when children are due for physical activity counseling and nutritional counseling. Informational alert only. Add the counseling codes from the SmartSet.



Job Aid: SmartSets: Well Child Check

Metric is in the MIPs and Quality Measure Dashboards, eCQM CMS155.

Advanced Care Planning CPT

A. **Which patients are included?** Patients aged 65 and greater.

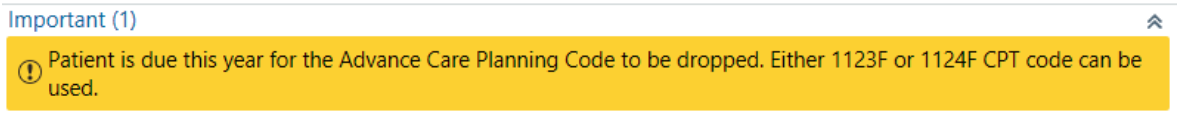
B. **What do practices need to do?** Ensure that patients have a well visit once per calendar year. Schedule future appointments or place recalls whenever possible.

C. **Who needs to do the documentation?** Provider, Advance Practices Providers need to manually add the CPTII codes on charge capture.

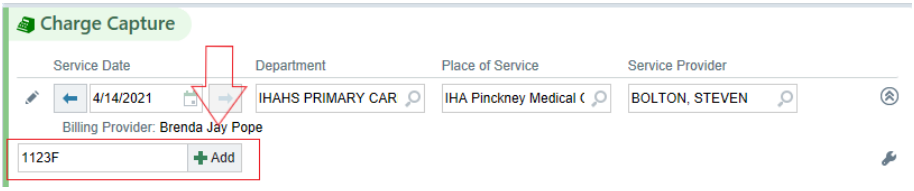
- **1123F-** Advance Care Planning, discussed and documented ACP or surrogate decision maker documented in medical record.
- **1124F-** Advance Care Planning, patient did not wish or was not able to name a surrogate decision make or provide an advance care plan.

D. **What are we being measured on?** This measure calculates the percentage of patients 65 or greater who had at least one Advance Care Planning CPT2 code drop during current year.

E. **OPA alert for providers:** Appears to providers when the patient is eligible for the Advance Care Planning Code to be added to the encounter.



F. On Wrap Up tab > Charge Capture manually add the appropriate code. Tip: mark these codes as favorites, so they are easier to add.



Note: The measure looks at the last service date on the claim. If the CPTII code is deleted from the claim it will not count towards the measure.

Job aid:
Advance Care Planning Activity
Creating Favorites in Charge Capture

Metric is in the Quality Scorecard Ambulatory Rolling Calendar Dashboard.

Well Care Visits

Medicare Annual Well Check

A. **Which patients are included?** Patients aged 65 and older.

B. **What do practices need to do?** Ensure that patients have a well visit once per calendar year. Schedule future appointments or place recalls whenever possible.

C. **Who needs to do the documentation?** N/A

D. **What are we being measured on?** The percentage of patients aged 65 and older that have had a well visit during the calendar year.

E. LOS codes satisfy the measure and Health Maintenance topic: G0438**, G0439, G0402.**

Job Aid:
Health Maintenance Topics- Quick Tip Guide
Medicare Annual Wellness Visit Documentation

Metric is in the Quality Scorecard Ambulatory Rolling Calendar Dashboard.

Well-Child Visits 3-6 Years Old

A. **Which patients are included?** Patients turning 3 years of age up to 6 years of age in the calendar year.

B. **What do practices need to do?** Ensure that patients have well child visit once per calendar year. Schedule future appointments or place recalls whenever possible.

C. **Who needs to do the documentation?** N/A

D. **What are we being measured on?** The percentage of patients aged 3-6 that have had a well child visit during the calendar year.

E. LOS codes satisfy the measure and Health Maintenance topic.

- For age 1-4 Initial 99382 and 99392 established
- For age 5-11 Initial 99383 and 99393 established

Job Aid: Health Maintenance Topics- Quick Tip Guide

Metric is in the Quality Scorecard Ambulatory Rolling Calendar Dashboard.

Well Child Visits in the First 15 Months of Life

A. **Which patients are included?** Patients who turn 15 months of age in the calendar year.

B. **What do practices need to do?** Ensure that patients come in for all their routine well child visits by their 15-month birthdate. Schedule future appointments whenever possible. Follow the AAP/Bright Futures schedule when possible, scheduling visits during these times:

2-5 days old	6 months old
1 month old	9 months old
2 months old	12 months old
4 months old	

C. **Who needs to do the documentation?** N/A

D. **What are we being measured on?** The percentage of patients aged 15 months has had at least 6 well child visits before turning 15 months.

E. LOS codes satisfy the measure and Health Maintenance topic.

- For age <1 Initial 99381 and 99391 established
- For age 1-4 Initial 99382 and 99392 established

Job Aid: Health Maintenance Topics- Quick Tip Guide

Metric is in the Quality Scorecard Ambulatory Rolling Calendar Dashboard.

Care Coordination/ Patient Safety

Screening for Future Fall Risk

A. **Which patients are included?** Patients aged 65 years and older.

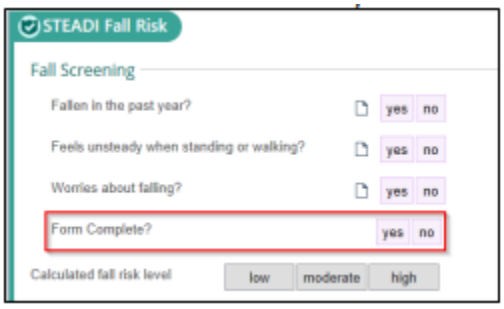
B. **What do practices need to do?** Document falls screening at least once every 12 months. Documentation of no falls or documentation of the reason the falls screening is not performed due to an exception (for example: patient is bed-ridden, or wheelchair bound, documented in the problem list).

C. **Who needs to do the documentation?** Rooming staff, nurses, and/or providers.

D. **What are we being measured on?** The percentage of patients 65 and older that have been screened for falls in the last year.

E. **Documentation:** STEADI Fall Risk Form. This form is available on the rooming tab > screenings. The form is on the "All Screenings" activity found in more menu items that providers can favorite. This form is also on the Annual Wellness Activity Navigator. F

F. The **Form Complete** question needs to be completed to satisfy the CMS measure.



Job Aid: Medicare Annual Wellness Visit Documentation

Metric is in the Mips Dashboard and Quality Measure Dashboard, eCQM CMS 139.

Diabetes

Glycemic Status Assessment Greater than 9%

A. **Which patients are included?** Patients 18-75 years with diabetes (Type 1, Type 2, or diagnosis of secondary diabetes due to another condition).

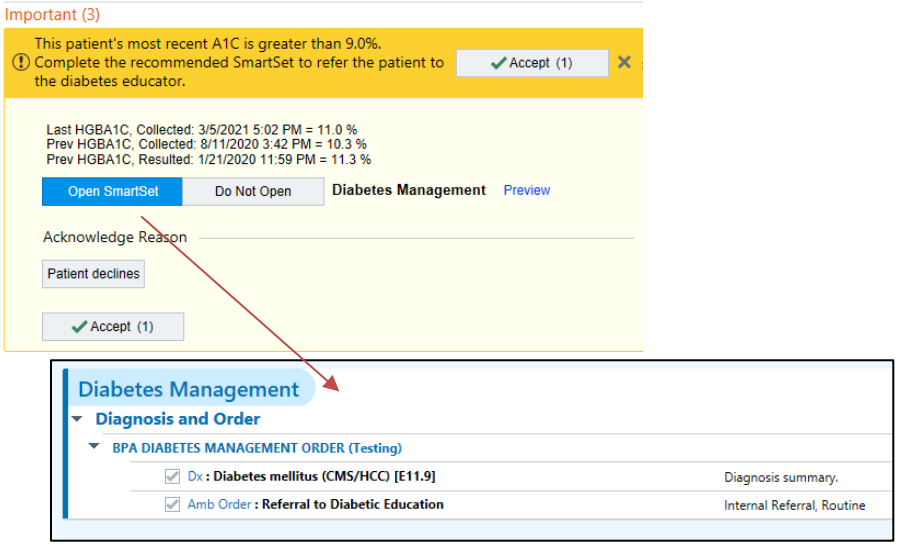
B. **What do practices need to do?** Order routine Hemoglobin A1C tests at least once a year. Encourage the patient to have this test done. Consider scheduling appointments more frequently and/or rechecking an A1C sooner if the results are greater than 8.

C. **Who needs to do the documentation?** Providers order hemoglobin A1C testing.

D. **What are we being measured on?** The percentage of diabetic patients aged 18-75 who had a hemoglobin A1C level greater than 9 this year. This is an inverse measure. The patients that meet the measure either have not had an A1C in the measurement period or the A1C is >9. The lower the percentage the better you are doing on controlling your diabetic population.

E. There is a Health Maintenance Topic to track Hemoglobin A1c every 6 months for patients with diabetes and every 3 months for A1c > 7.0 The order can be placed via the Overdue SmartSet in storyboard or placing an order in the visit task bar.

F. OPA alert for providers: Appears to providers when the patient's most recent A1C is greater than 9.0%. This does not satisfy the measure but is an alert to the provider that the patient's most recent A1C is greater than 9.0%.



Job Aid: Health Maintenance Topics- Quick Tip Guide

Metric is in the Quality Scorecard Ambulatory Rolling Calendar Dashboard, MIPS, and Quality Measure Dashboards and MSSP ACO Web Interface & eCQM Management Dashboard. eCQM CMS 122.

Diabetes Eye Exam

A. **Which patients are included?** Patients aged 18-75 years with diabetes.

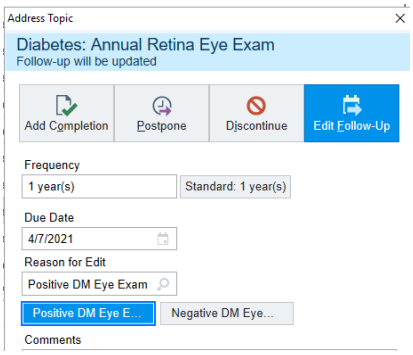
B. **What do practices need to do?** Review patient's chart for yearly diabetes eye exams and encourage the patient to have these exams done. The exam must be a retinal exam or a dilated eye exam to qualify. Ensure that we have a copy of the exam from their ophthalmologist or optometrist and that this is documented in health maintenance.

C. **Who needs to do the documentation?** Nurses and/or providers.

D. **What are we being measured on?** The percentage of diabetic patients aged 18-75 that have an eye exam documented this year OR a negative eye exam documented for last year.

E. Place an order for Ambulatory referral to Ophthalmology. The order can be placed via Overdue SmartSet on the storyboard or place an order in the visit task bar.

F. The Health Maintenance topic will be satisfied with a result coming back from a referral order. When addressing the topic, the frequency and result can be documented.



Job Aid: Health Maintenance Topics- Quick Tip Guide

Metric is in the MIPS Dashboard and Quality Measure Dashboard, eCQM CMS 131.

Kidney Health Evaluation for Diabetics

A. **Which patients are included?** Patients 18-85 years with diabetes who received a kidney health evaluation defined by and Estimated Glomerular Filtration Rate (eGFR) AND Urine Albumin-Creatinine Ratio (uACR), within the measurement period.

B. **What do practices need to do?** Order annually eGFR and Urine Albumin-Creatinine Ratio for your diabetic patients.

C. Who needs to do the documentation? Nurses and/or providers.

D. **What are we being measured on?** The percentage of diabetic patients aged 18-85 who have had the Kidney Health Evaluation panel (eGFR and uACR)

E. **Exclusions**: Patients who meet either of the following criteria:
   - Have CKD stage 5 or ESRD diagnosis in the measurement period.
   - Have Hospice or Palliative care in the measurement period.

F. There is a Health Maintenance Topic to track Diabetes: Annual GFR and Diabetes: Annual Urine Albumin Creatinine ration. The order can be placed via Overdue SmartSet on the storyboard or place an order in the visit task bar.

Job Aid: Health Maintenance Topics- Quick Tip Guide

Reference appendix for hospice and palliative care documentation.

Metric is on the MIPs and Quality Measure Dashboards, eCQM CMS 951.

Hypertension

Controlling High Blood Pressure

A. **Which patients are included?** Patients aged 18-85 years with a diagnosis of essential hypertension, except patients who also have an active diagnosis of pregnancy, end stage renal disease (ESRD), dialysis, or renal transplant.

B. **What do practices need to do?** Check patients' blood pressure during each visit. Consider rechecking if blood pressure is 140/90 or greater. Consider scheduling appointments more frequently if blood pressure results remain high. Document in vital signs.

C. **Who needs to do the documentation?** Rooming staff**,** nurses, and/or providers.

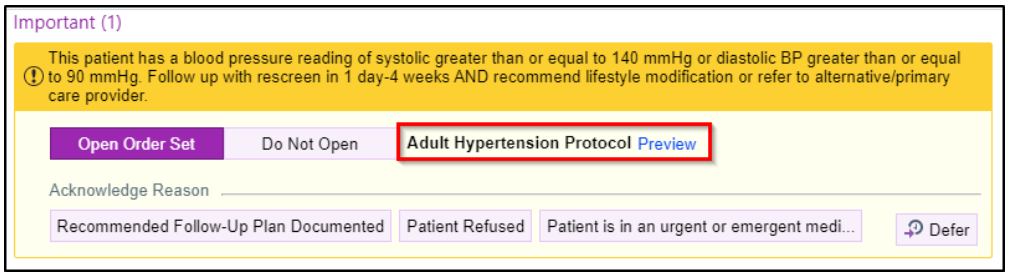
D. **What are we being measured on?** The percentage of patients 18-85 that have a last recorded blood pressure under 140/90.

E. **Exclusions:** Patients who meet either of the following criteria:

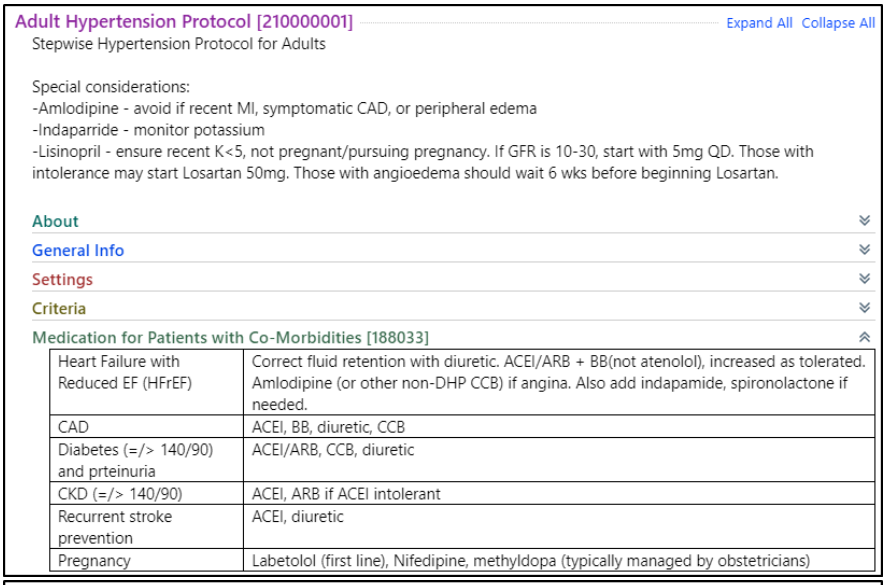
   - Exclude patients who are in hospice care for any part of the measurement period.
   - Exclude patients receiving palliative care.
   - Exclude patients 81 and older by the end of the measurement period with an indication of frailty for any part of the measurement period.
   - Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
     - Advanced illness with two outpatient encounters during the measurement period or the year prior.
     - OR advanced illness with one inpatient encounter during the measurement period or the year prior
     - OR taking dementia medications during the measurement period or the year prior.

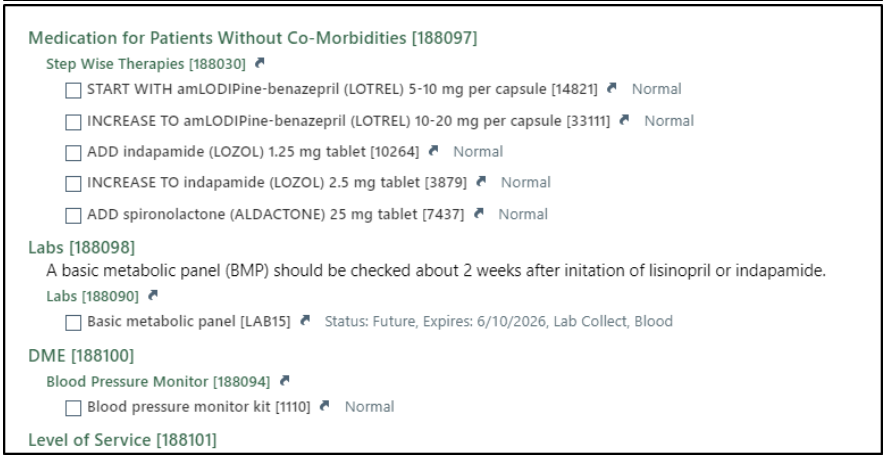
F. **OPA alert for providers**: Appears to a provider when a patient has a systolic BP greater than or equal to 140 mmHg or a diastolic BP greater than or equal to 90 mmHg. There is an Adult Hypertension Protocol SmartSet

that can be utilized for medications for patients with and without co morbidities, labs, referral, DME order, level of service and follow up order.



G. Providers can open the order set from the OPA or search in SmartSets: Adult Hypertension Protocol





Metric is in the Quality Scorecard Ambulatory Rolling Calendar Dashboard, MIPs, and Quality Measure Dashboards, and MSSP ACO Web Interface & eCQM Management Dashboard. eCQM CMS 165.

Reference appendix for hospice and palliative care documentation.

Mental Health

Depression Remission at Twelve Months: Adults Aged 18 and Older

A. **Which patients are included?** Patients aged 18 and older with a new or existing diagnosis of major depression or dysthymia and a PHQ-9 score greater than 9. Excludes: permanent nursing home residents, patients with active bipolar or personality disorder or patients receiving hospice or palliative care services.

B. **What do practices need to do?** Reassess any patients who had a PHQ-9 score greater than 9 within 12 months (plus or minus 30 days). This measure applies to both patients with newly diagnosed and existing depression whose PHQ-9 score indicates a need for treatment.

C. **Who needs to do the documentation?** Nurse and/ or Provider will need to reach out 11-13 months (after the positive PHQ-9) to administer a PHQ-9 questionnaire via telephone or office visit.

D. **What are we being measured on?** The percentage of patients 18 and over with major depression OR dysthymia AND an initial PHQ-9 score greater than 9 who demonstrate remission at 12 months (+/- 30 days) defined as a PHQ-9 score less than 5.

Metric is in the MIPs and Quality Measure Dashboard, eCQM CMS 159.

Appendix

Hospice & Palliative Care Documentation

- Hospice
    - Dx code Z51.5 Encounter for Hospice
    - Encounter for Hospice- Hospice billing CPT Codes
    - Intervention-Amb Referral to Home Hospice
- Palliative Care
    - Dx Code Z51.5 Encounter for Palliative Care
    - IP Consult to Palliative Care
    - Intervention- AMB Referral to Palliative Care

Advanced Illness & Frailty

G. Requires <u>one</u> of the following during performance year or year prior.
    - At least 2 outpatient events on different dates of services.
    - At least 1 inpatient event.
    - Dispensed dementia medication.

- Can be diagnosed via face-to-face or telehealth visits.
- Examples: Malignancy, dementia, Parkinson, Alzheimer's, Heart Failure, Emphysema, and ESRD.

B. Frailty
    - Must have two indications of frailty on different dates of service during the measurement year. Includes:
        - Frailty Diagnosis (e.g., failure to thrive, pressure ulcers)
        - Frailty Symptoms- Physical exam: Constitutional – frail cachectic, Musculoskeletal – gait problem. Review of symptoms- Neurological weakness, Musculoskeletal- gait problem

Galaxy Guides to MSSP ACO and eCQM Measures

- Galaxy - Outpatient Quality Measures Reporting for Promoting Interoperability (Meaningful Use) and MIPS (Green Book) (epic.com)

Quality Summary

Dash board	Measure	Age	Risk Group	Frequency	Action Needed	Notes
QS QMD Retired for MIPS MSSP	**Breast Cancer Screening**	40-74	Women	Every 2 years	Order screening mammogram	Health maintenance Obtain report if done via GYN
QS MIPS QMD	**Cervical Cancer Screening**	21-64	Women	Every 3-5 years	Order pap smear (age 21-64) or pap smear with HPV co-testing (age 30-64)	Health maintenance topic Obtain report if done via GYN. Manage via Pap Tracker
QS QMD Retired for MIPS MSSP	**Colorectal Cancer Screening**	45-75	All patients	Every 10 years or per clinical guideline	Order colonoscopy, FOBT, sigmoidoscopy, CT colonography or FIT-DNA testing.	Health maintenance Obtain report from GI

QS QMD	**Influenza Immunization**	6m+	All patients	Annually, during flu season	Administer influenza vaccine	Health maintenance topic
HM only	**Pneumonia Vaccination Status for Older Adults**	65+	All patients	Once	Administer pneumonia vaccine	Health maintenance topic
Retired 2024 for MIPS QMD	**Body Mass Index (BMI) Screening and Follow-Up Plan**	18+	All Patients	Every visit	Plan can include adding Z Codes with a documented plan in the note will satisfy the measure. Z71.3 Dietary counseling and surveillance Z71.82 Exercise counseling.	Abnormal Parameters: <18.5 or >=25
MIPS QMD	**Tobacco Use Screening and Cessation Intervention**	12+	All Patients	Every Year	Assess tobacco use; For smokers or smokeless tobacco users document counseling by clicking "Counseling Given" button.	Both smoking status and smokeless tobacco use must be addressed
QS MIPS QMD MSSP	**Depression Screening and Follow-Up Plan**	12+	All patients	Every 12 months	If phq score is 5 or greater document follow-up plan in note. Utilize Follow Up plan documented within the OPA alert.	Health maintenance topic
MIPS QMD	**Statin Therapy for Prevention and Treatment of Cardiovascular Disease**	21+	Patients ASCVD or patients 20-75 with an LDL level >190; Diabetic patients 40-75: or patients 40-75 with 10-year ASCVD Risk score > +20%	Ongoing	Prescribe statin therapy	OPA alert
MIPS QMD	**Childhood Immunizations**	By age 2	All patients	n/a	Administer (according to ACIP schedule): 4 DTaP, 3 IPV, 1 MMR, 3ir 4 HiB, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV, and two Flu	Health maintenance Must be given on or before 2nd birthday

MIPS QMD	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children**	Age 3-17	All patients	Every visit	Document Height and Weight Utilize Pediatric SmartSets to add Nutrition and Exercise counseling codes	OPA alert
QS	**Advance Care Planning CPT2 Code**	65+	All Patients	Annually	Manually add appropriate code **1123F-** Advance Care Planning, discussed and documented. **1124F-** Advance Care Planning, patient did not wish to discuss	OPA alert
QS	**Medicare Annual Well Check**	65+	All Patients	Annually	See patient annually for Medicare Wellness Visit	Health maintenance topic
QS	**Adolescent Well Care**	12-21	All patients	Annually	See patient annually for a well care visit	Health maintenance topic
QS	**Well Care Visits 3-6 Years Old**	Age 3 to 6	All patients	Annually	See patients annually for Well Child Visit	Health maintenance topic
QS	**Well Care Visits First 15 Month**	By age 15m	All patients	At least 6 visits by age 15m	See patient routinely for Well Child Visits	Health maintenance topic
MIPS QMD	**Falls: Screening for Future Fall Risk**	65+	All patients	Annually	Complete **STEADI Fall Risk** Screening Smartform from Annual Medicare Wellness activity.	Health maintenance topic
QS MIPS MSSP	**Diabetes Care: Hemoglobin A1C Poor Control (>9%)**	18-75	Diabetics	Every 6 months	Order A1C testing, order more frequently is level is greater than 8	Health maintenance topic
MIPS QMD	**Diabetes: Eye Exam**	18-75	Diabetics	Yearly	Encourage patients to go for eye exams	Health maintenance topic Obtain report from optometrist or ophthalmologist
MIPS QMD	**Kidney Health Evaluation**	18-85	Diabetics	Yearly	eGFR and uACR	Health Maintenance

ACO QS MIPS	**Hypertension: Blood Pressure Control**	18-85	Patients w/ essential hypertension	Every visit	Check blood pressure: recheck if last BP was 140/90 or greater. Follow up visit for pre hypertensive or hypertensive reading	OPA alert
ACO QMD	**Depression Remission at 12 Months**	12-17 and 18 +	Patients with positive PHQ-9 screen	Once, 12 months after positive PHQ9	Providers to conduct follow-up PHQ-9 at appropriate time	

QS - Quality Scorecard Ambulatory Rolling Calendar Dashboard
MIPS - MIPS Dashboard
QMD- Quality Measure Dashboard
MSSP- MSSP ACO Quality Measure Dashboard