ACO Measures Summary GPRO 2018

GPRO Measure	Measure Name	Age	Pt. Reported	Notes	Exclusions/Exceptions
CARE-1 ACO-12 (NQF 0097)	**Medication Reconciliation Post-Discharge**	18+	No	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility). Any of the following evidence meets criteria: (1) Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in meds since discharge, same meds at discharge, discontinue all discharge meds), (2) Documentation of the patient's current medications with a notation that the discharge medications were reviewed, (3) Documentation that the provider "reconciled the current and discharge meds," (4) Documentation of a current medication list, a discharge medication list and notation that the appropriate practitioner type reviewed both lists on the same date of service, (5) Notation that no medications were prescribed or ordered upon discharge, (6) Documentation that patient was seen for post-discharge follow-up with evidence of medication reconciliation or review, (7) Documentation in the discharge summary that the discharge medications were reconciled with the current medications; the discharge summary must be in the outpatient chart.	None
CARE-2 ACO-13 (NQF 0101)	**Falls: Screening for Future Fall Risk**	65+	No	Assessment of whether an individual has experienced a fall or problems with gait or balance during 2018. Specific screening tool is not required for this measure, however potential screening tools include the Morse Fall Scale, timed Get-Up-And-Go test, or other gait or balance assessment. Documentation of "No falls" is sufficient. Fall screening can occur any time during the measurement period.	Medical reasons may include: patient is not ambulatory - count as non- ambulatory only if non-ambulatory at the most recent encounter during 2018.
DM-2 ACO-27 (NQF 0059)	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)**	18-75	Yes- Must indicate date test was performed & most recent value	Active dx of Type 1 or 2 diabetes during 2018. Determine if patient had an HbA1c test performed during 2018. Use most recent in 2018 and use the lab report draw date. At a minimum, documentation in the medical record must include a note indicating the date (MM/DD/YY) on which the HbA1c test was performed and the result.	None
DM-7 ACO-41 (NQF 0055)	**Diabetes: Eye Exam**	18-75	Yes- Date (mm/yyyy) & Result/Finding	Screening for diabetic retinal disease: A retinal or dilated eye exam by an eye care professional during 2018 OR a negative retinal exam (no evidence of retinopathy) by an eye care professional in 2017. Must be reviewed by an ophthalmologist or optometrist if imaging performed in PCP office.	None
HTN-2 ACO-28 (NQF 0018)	**Controlling High Blood Pressure**	18-85	No	Determine if the patient has a documented diagnosis of essential or primary HTN within the first six months of 2018 or any time prior to 2018 but does not end before the start of 2018. Determine if the patient's most recent BP was documented during 2018. Use most recent in 2018. BP readings from the patient's home (including readings directly from monitoring devices) are not acceptable. Controlled = SBP <140mmHg and DBP <90mmHg. If multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.	Can start before or during 2018 but cannot end before 1/1/2018. Exclude ESRD, dialysis, CKD stage 5, or hx of renal transplant before or during 2018. Exclude pregnancy during 2018. Exclude 65 or older in nursing home or certain group homes/institutions anytime in 2018.
IVD-2 ACO-30 (NQF 0068)	**IVD: Use of Aspirin or Another Antiplatelet**	18+	Yes-For Aspirin or other Antiplatelet	Determine if the patient was discharged alive for acute myocardial infarction, coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) in the 12 months prior to 2018, or who had an active diagnosis of ischemic vascular disease (IVD) during 2018. Determine if the patient has documented use of aspirin or another antiplatelet during 2018. See Diagnosis and Medication Lists.	Patients who had documentation of use of anticoagulant medications any time in 2018. See Diagnosis and Medication Lists.
MH-1 ACO-40 (NQF 0710)	**Depression Remission at 12 Months**	18+	No	Determine if the patient had an active diagnosis of major depression or dysthymia AND one or more PHQ-9s administered during the **"Index Date" between 12/1/2016 and 11/30/2017**. If yes, determine if the patient had a PHQ-9 score greater than 9 between 12/1/2016 and 11/30/2017. If yes, determine if the patient had one or more PHQ-9s administered during the **Measurement Assessment Period (11-13 months from the Index Date)**. If yes, determine if the patient achieved remission with a follow-up PHQ-9 performed and a score less than 5 at 11-13 months from the initial "Index Date". PHQ-9 administration does not require a face-to-face visit.	Exclude patients who were permanent nursing home residents, or have an active diagnosis of bipolar disorder or personality disorder, or who received hospice or palliative care services in 2018.
PREV-5 ACO-20 (NQF 2372)	**Breast Cancer Screening**	50-74	Yes-Date, Type of Test AND Result/Finding	Determine if a mammogram to screen for breast cancer was performed between **10/1/2016 -12/31/2018**. Screening includes: screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography. MRI and Ultrasound are NOT considered breast cancer screening for this measure. Documentation in the medical record must include both of the following: A note indicating the date the breast cancer screening was performed and the result or findings. Documentation of 'normal' or 'abnormal' is acceptable.	Documentation of bilateral mastectomy or right and left unilateral mastectomies during or before 2018. Exclude 65 or older in nursing home or certain group homes/institutions anytime in 2018.
PREV-6 ACO-19 (NQF 0034)	**Colorectal Cancer Screening**	50-75	Yes-Date (year), type of test, AND Result/Finding	Determine if colorectal cancer screening is current during 2018. Current colorectal cancer screening is defined as performing any of the following: Fecal occult blood test (FOBT) during 2018; flexible sigmoidoscopy 1/1/2014- 12/31/2018; colonoscopy 1/1/2009-12/31/2018; CT colonography 1/1/2014-12/31/2018; FIT-DNA (Cologuard) 1/1/2016-12/31/2018. Documentation must include both of the following: A note indicating the date the colorectal cancer screening was performed AND the result or findings. Documentation of 'normal' or 'abnormal' is acceptable.	Documentation of diagnosis or past history of total colectomy or colorectal cancer. Exclude 65 or older in nursing home or certain group homes/institutions anytime in 2018.

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PREV-7 ACO-14 (NQF 0041)	**Preventive Care and Screening: Influenza Immunization**	6mo+	Yes- Month of receipt	Determine if the patient was seen for a visit **between October 1, 2017 and March 31, 2018** AND received an influenza immunization OR reported previous receipt of an influenza immunization between August 1, 2017 through March 31, 2018. ***Documentation of "Patient Refused" will pass this measure***	Medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons). Patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons). System reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons).
PREV-8 ACO-15 (NQF 0043)	**Pneumonia Vaccination Status for Older Adults**	65+	Yes- Date (year) & type of vaccine	Determine if the patient has **EVER** received a pneumococcal vaccination. Measure provides credit for adults 65+ and older who have ever received either the PCV13 or PPSV23 vaccine (or both).	None
PREV-9 ACO-16 (NQF 0421)	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan**	18+	No	Determine if the patient had a BMI documented during the most recent visit in 2018 or in the last 12 months prior to the most recent visit. If the patient had a BMI calculated, determine if the most recent BMI is within normal parameters. Both height and weight must be measured within 12 months of the current encounter and may be obtained from separate encounters. If more than one BMI, use most recent. **Normal Parameters for BMI: ≥ 18.5 and < 25**. If the most recent documented BMI is outside of normal parameters: A follow-up plan must be documented during the encounter or during the previous 12 months of the current encounter. The documented follow-up plan must be based on the most recent BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters". A 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, or surgeon), pharmacological interventions, dietary supplements, exercise counseling or nutrition counseling. Proposed outline of treatment to be conducted must be a result of the most recent BMI outside of normal parameters. ***Documentation of "Patient Refused" will pass this measure***	Exclude Pregnancy (cannot end before start of 2018). Medical reasons may include: patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status OR patient 65 or older for whom weight reduction/weight gain would complicate other underlying health conditions (including dementia, confusion). Patient reasons may include: Patient refuses BMI measurement or refuses measurement of height and/or weight or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.
PREV-10 ACO-17 (NQF 0028)	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**	18+	Yes- For Tobacco Use Status	Determine if the patient was screened for tobacco use at least once between **1/1/2017-12/31/2018** AND identified as a tobacco user.Use the most recent screen. Includes any type of tobacco. If tobacco user, determine if tobacco cessation intervention was received at least once between 1/1/2017-12/31/2018. Screening for tobacco use and cessation intervention do not have to occur on the same encounter. Tobacco Cessation Intervention - Includes brief counseling (3 minutes or less), and/or pharmacotherapy. Electronic nicotine delivery systems (e-cigarettes, vapes) are not currently classified as tobacco use nor a cessation aid.	Medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason).
PREV-12 ACO-18 (NQF 0418)	**Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan**	12+	No	Determine if the patient was screened for clinical depression using an age appropriate standardized tool during 2018 (use most recent). The results must be reviewed/verified and documented by the eligible professional in the medical record on the date of the encounter. If the depression screening is positive, a follow up plan must be documented and must include one or more of the following: additional evaluation for depression, Suicide Risk Assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression. The name of the standardized screening tool must be documented in the medical record. Examples but not limited to: PHQ-9, BDI-PC, BDI, BDI-II (Becks), CES-D, DEPS, DADS, GDS, Cornell Scale Screening, MFQ, PHQ-A and PRIME MD-PHQ-2. ***Documentation of "Patient Refused" will pass this measure***	Documentation of an active diagnosis for depression or bipolar disorder diagnosed prior to 1/1/2018. Not screened for medical reasons may include: Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of the standardized depression assessment tools (i.e cases of delirium or court-appointed cases). Not screened for patient reasons may include: Patient refuses to participate.
PREV-13 ACO-42 (NQF: None)	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**	21+	Yes- For the Statin	Determine if the patient has a diagnosis of ASCVD (active or history of) at any time up through 12/31/2018. Determine if the patient has ever had a fasting or direct LDL-C ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia. Determine if the patient is aged 40-75 and has a diagnosis of Type I or Type 2 Diabetes. Determine if the patient has an LDL-C level of 70-189 mg/dL during 1/1/2016- 12/31/2018 (Use highest result). If yes, determine if the patient was taking or prescribed statin therapy during 2018. Only statin therapy is included. Samples count as current statin therapy if documented in medication list. See Diagnosis and Medication Lists.	Exclude pregnancy, breastfeeding, or rhabdomyolysis. Not screened for medical reasons may include: documented adverse effect, allergy, or statin intolerance, receiving palliative care, active liver or hepatic disease or insufficiency, ESRD OR diabetics whose most recent fasting/direct LDL-C lab test was <70 mg/dL. *See Diagnosis and Medication Lists.*