NQF#: N/A
Measure Name: Effective Contraceptive Use Among Women at Risk of Unintended Pregnancy
Steward: Oregon Health Authority
Source of Specification: OHA 2017 CCO Measure Specifications

Description

The percentage of women (ages 15-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

Numerator

Women in the denominator with evidence of one of the following methods of contraception during the measurement period: sterilization, IUD, implant, contraception injection, contraceptive pills, patch, ring, or diaphragm.

Denominator

All women ages 15-50 as of December 31 of the measurement year who were continuously enrolled in a CCO for the 12-month measurement period.

Note: OHA will be measuring and reporting on adolescent and adult women separately, by ages 15-17 and ages 18-50. Only the adult rate will be tied to the CCO's incentive payment.

Exclusions

Remove from the denominator any women with history through December 31 of the measurement year for the following:

- Hysterectomy
- Bilateral oophorectomy
- Other female reproductive system removal, destruction, resection related to hysterectomy
- Natural menopause
- Premature menopause due to survey, radiation, or other factors
- Congenital anomalies of female genital organs
- Female infertility

Among women in the denominator who were not numerator compliant, exclude those with a pregnancy diagnosis from the measure.

NQF#: 0018
Measure Name: Controlling High Blood Pressure
Steward: NCQA
Source of Specification: NQF Website

Description

The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Numerator

The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.

Denominator

Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.

Exclusions

- Patients with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.
- Patients with a diagnosis of pregnancy during the measurement year.
- Patients who had an admission to a nonacute inpatient setting during the measurement year.

NQF#: N/A
Measure Name: Controlling High Blood Pressure
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

A single rate is reported and is the sum of all three groups.

Numerator

The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged with a diagnosis of diabetes and whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged with a diagnosis of diabetes and whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged as not having a diagnosis of diabetes and whose BP was <150/90 mm Hg.

Denominator

Members 18–85 years as of December 31 of the measurement year with at least one outpatient visit with a diagnosis of hypertension during the first six months of the measurement year.

Exclusions

- Members with evidence of end-stage renal disease (ESRD) or kidney transplant on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
- Female members with a diagnosis of pregnancy during the measurement year.
- Members who had a nonacute inpatient admission during the measurement year.

NQF#: N/A
Measure Name: Statin Therapy for Patients with Cardiovascular Disease (SPC)
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
2. *Statin Adherence 80%*. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Rate 1: Received Statin Therapy

Numerator
The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year

Denominator
Members (males 21-75 and females 40-75 years) as of December 31 of the measurement year identified as having clinical atherosclerotic cardiovascular disease (ASCVD).

Rate 2: Statin Adherence 80%

Numerator
The number of members who achieved a PDC of at least 80% during the treatment period

Denominator
Members (males 21-75 and females 40-75 years) as of December 31 of the measurement year identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who meet the numerator criteria for Rate 1.

Exclusions

- Female members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year.
- In vitro fertilization in the measurement year or year prior to the measurement year.
- Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year.
- ESRD during the measurement year or the year prior to the measurement year.
- Cirrhosis during the measurement year or the year prior to the measurement year.
- Myalgia, myositis, myopathy or rhabdomyolysis during the measurement year.

Notes

All members who are numerator compliant for Rate 1 must be used as the eligible population for Rate (regardless of the data source used to capture the Rate 1 numerator).

NQF#: 0066
Measure Name: Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)
Steward: American College of Cardiology
Source of Specification: NQF Website

Description

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.

Numerator

Patients who were prescribed ACE inhibitor or ARB therapy.

Denominator

All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have diabetes OR current or prior LVEF <40%.

Exclusions

- Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy (e.g., allergy, intolerance, pregnancy, renal failure due to ACE inhibitor, diseases of the aortic or mitral valve, other medical reasons).
- Documentation of patient reason(s) for not prescribing ACE inhibitor or ARB therapy (e.g., patient declined, other patient reasons).
- Documentation of system reason(s) for not prescribing ACE inhibitor or ARB therapy (e.g., lack of drug availability, other reasons attributable to the health care system).

NQF#: 0059
Measure Name: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

Numerator

The most recent HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review.

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

Denominator

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Exclusions

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
- Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

NQF#: 0055
Measure Name: Comprehensive Diabetes Care: Eye Exam
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Measure Description:

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.

Numerator

Screening or monitoring for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
- Bilateral eye enucleation anytime during the member's history through December 31 of the measurement year.

Denominator

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Exclusions

- Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

NQF#: 0057
Measure Name: Comprehensive Diabetes Care: Hemoglobin A1c Testing
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year

Numerator

An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

Denominator

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Exclusions

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
- Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Notes

For Hybrid reporting, search the medical record for required exclusions and apply them before determining if the member has a numerator hit. Organizations are not required to search for required exclusions if a member has an administrative hit for the indicator, but must exclude these members if they are discovered during medical record review.

NQF#: 1799 (no longer endorsed)
Measure Name: Medication Management for People with Asthma (MMA)
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. *Medication Compliance 50%*. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
2. *Medication Compliance 75%*. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

Numerator

Medication Compliance 50%

The number of members who achieved a proportion of days covered (PDC) of at least 50% for their asthma controller medications during the measurement year.

Medication Compliance 75%

The number of members who achieved a PDC of at least 75% for their asthma controller medications during the measurement year.

Calculate the member's PDC using the following equation. Round (using the .5 rule) to two decimal places.

$$\frac{\text{Total Days Covered by a Controller Medication in the Treatment Period}}{\text{Total Days in Treatment Period}}$$

Denominator

Members ages 5-64 as of December 31 of the measurement year who have persistent asthma and met at least one of the criteria during both the measurement year and the year prior to the measurement year:

- At least one ED visit, with a principal diagnosis of asthma.
- At least one acute inpatient encounter, with a principal diagnosis of asthma.
- At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events for any controller medication or reliever medication. Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events for any controller medication or reliever medication.

Exclusions

Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:

    - Emphysema.
    - COPD.
    - Obstructive Chronic Bronchitis.
    - Chronic Respiratory Conditions Due to Fumes/Vapors.
    - Cystic Fibrosis.
    - Acute Respiratory Failure.
- Members who had no asthma controller medications dispensed during the measurement year.

NQF#: 0053
Measure Name: Osteoporosis Management in Women Who Had a Fracture
Steward: NCQA HEDIS
Source of Specification: HEDIS 2017 Technical Specifications

Description

The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Numerator

Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria:

- A BMD test, in any setting, on the index episode start date (IESD) or in the 180-day (6-month) period after the IESD.
- If the IESD was an inpatient stay, a BMD during the inpatient stay.
- Osteoporosis therapy on the IESD or in the 180-day (6-month) period after the IESD.
- If the IESD was an inpatient stay, long-acting osteoporosis therapy during the inpatient stay.
- A dispensed prescription to treat osteoporosis on the IESD or in the 180-day (6-month) period after the IESD.

Denominator

Women who experienced a fracture, except fractures of the finger, toe, face or skull. Three denominator age strata are reported for this measure:

- Women age 50-64
- Women age 65-85
- Women age 50-85

Exclusions

Exclude members who met any of the following criteria:

- Members who had a BMD test during the 730 days (24 months) prior to the IESD.
- Members who had a claim/encounter for osteoporosis therapy during the 365 days (12 months) prior to the IESD.
- Members who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days (12 months) prior to the IESD.
- Members who are enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
- Members living long-term in an institution any time during the measurement year.
    - Organizations may use the LTI flag in the Medicare Part C monthly membership file

NQF#: 0576
Measure Name: Follow-Up After Hospitalization for Mental Illness
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

1. *30-Day Follow-Up.* The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. *7-Day Follow-Up.* The percentage of discharges for which the member received follow-up within 7 days after discharge.

Numerator

30-Day Follow-Up

A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up

A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit:

- A visit with a mental health practitioner, with or without a telehealth modifier.
- A visit with a mental health practitioner, with or without a telehealth modifier.
- A visit with a mental health practitioner, with or without a telehealth modifier.
- A visit in a behavioral healthcare setting.
- A visit in a nonbehavioral healthcare with a mental health practitioner.
- A visit in a nonbehavioral healthcare setting with a diagnosis of mental illness.
- Transitional care management services, with or without a telehealth modifier.

The following meets criteria for only the *30-Day Follow-Up* indicator:

- Transitional care management services, with or without a telehealth modifier.

Denominator

Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.

Exclusions

- Discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
- Discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health

NQF#: 0418
Measure Name: Screening for Clinical Depression and Follow-Up Plan
Steward: CMS
Source of Specification: eCQM Specifications

Description

Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Numerator

Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Denominator

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

Exclusions

- Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder.

Exceptions

- Patient Reason(s)
- Patient refuses to participate, or
- Medical Reason(s), or
- 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 standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

NQF#: 0105
Measure Name: Antidepressant Medication Management
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Numerator

Effective Acute Phase Treatment

At least 84 days (12 weeks) of treatment with antidepressant medication, beginning on the index prescription start date (IPSD) through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Effective Continuation Phase Treatment

At least 180 days (6 months) of treatment with antidepressant medication, beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Denominator

Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.

Exclusions

- Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.
- Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

NQF#: NA
Measure Name: Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT)
Steward: OHA
Source of Specification: OHA Specifications

Description

The percentage of members (ages 12 and older) who received appropriate "screening, brief intervention, and referral to treatment" (SBIRT) for alcohol or other substance abuse.

Numerator

Unique counts of members age 12 years as of December 31 of the measurement year with one or more screening, brief intervention, and referral to treatment (SBIRT) services. SBIRT services are defined by the following codes:

CPT	HCPCS	ICD-9	ICD-10
99408, 99409, 99420*	G0442, G0443, G0396, G0397	V79.1**, V82.9	Z13.89**, Z13.9

*99420 must be used in combination with one of the listed diagnosis codes for inclusion in the measure.

**V79.1 and Z13.89 may be used as standalone codes, i.e., they do not need to be paired with CPT 99420 for inclusion in the numerator.

Denominator

Unique count of members age 12 years as of December 31 of the measurement year who received an outpatient service between January 1- December 31 of the measurement year.

Exclusions

Exclude SBIRT screening and/or brief intervention services provided in emergency department settings.

NQF#: 0028
Measure Name: Tobacco Use: Screening and Cessation Intervention
Steward: American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)
Source of Specification: eCQM Specifications

Description

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

Numerator

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

Denominator

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.

Exclusions

None.

Exceptions

Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason).

NQF#: NA
Measure Name: Cigarette Smoking Prevalence
Steward: OHA
Source of Specification: OHA Specifications

Description

Measure has three separately reported rates.

1. Of all patients with a qualifying visit, how many have their cigarette smoking or tobacco use status recorded?
2. Of all patients with their cigarette smoking or tobacco use status recorded, how many are cigarette smokers?
3. Of all patients with their cigarette smoking or tobacco use status recorded, how many are smokers *and/or* tobacco users?

Rate 1

Numerator

Unique members age 13 years or older who had a qualifying visit with the provider during the measurement period, who have their smoking and/or tobacco use status recorded as structured data.

Denominator

Unique Medicaid members 13 years old or older by the beginning of the measurement year, who had a qualifying visit with the provider during the measurement period. If a patient is seen by the provider more than once during the measurement period, for the purposes of measurement, the patient is only counted once in the denominator.

Rate 2

Numerator

Of patients in the Rate 2 denominator, those who are cigarette smokers. See below for additional information on identifying cigarette smoking in the numerator.

Denominator

Unique Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

Rate 3

Numerator

Of patients in the Rate 3 denominator, those who are cigarette smokers *and/or* tobacco users.

Denominator

Unique Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

Notes
OHA developed these specifications based on the Meaningful Use standards required for electronic health records in 2014, as well as the clinical practice guidelines for treating tobacco use and dependence and the ACA-recommended tobacco cessation benefits.

NQF#: 1391 (no longer endorsed)
Measure Name: Frequency of Ongoing Prenatal Care
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of Medicaid deliveries on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits:

- <21 percent of expected visits.
- 21 percent–40 percent of expected visits.
- 41 percent–60 percent of expected visits.
- 61 percent–80 percent of expected visits.
- ≥81 percent of expected visits.

This measure uses the same denominator as the Prenatal and Postpartum Care measure.

Numerator

Women who had an unduplicated count of <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent or ≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age.

Denominator

The number of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.

Exclusions

Non-live births.

NQF#: N/A
Measure Name: Pregnant Women That Had HBsAg Testing
Steward: OptumInsight
Source of Specification: eCQM 2018 Measure Specifications

Description

The percentage of pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.

Numerator

The number of patients who were tested for hepatitis B surface antigen (HBsAg) during pregnancy within 280 days prior to delivery.

Denominator

All female patients aged 12 and older who had a live birth or delivery during the measurement period.

Exclusions

Patients with a diagnosis of hepatitis B that started or ended within 365 days prior to delivery.

NQF#: 1517 (no longer endorsed)
Measure Name: Prenatal & Postpartum Care – Postpartum Care
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Numerator

A postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

Denominator

The number of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.

Exclusions

Non-live births.

NQF#: N/A
Measure Name: Maternity Care: Post-Partum Follow-Up and Care Coordination
Steward: CMS
Source of Specification: MIPS 2017 Registry Measure Specifications

Description

Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for post-partum care within 8 weeks of giving birth who received a breast feeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning.

Numerator

Patients receiving the following at a post-partum visit:

- Breast feeding evaluation and education, including patient-reported breast feeding
- Post-partum depression screening
- Post-partum glucose screening for gestational diabetes patients and
- Family and contraceptive planning

Denominator

All patients, regardless of age, who gave birth during a 12-month period seen for post-partum care visit before or at 8 weeks of giving birth.

Exclusions

None.

NQF#: 0067
Measure Name: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
Steward: American College of Cardiology
Source of Specification: NQF Website

Description:

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who were prescribed aspirin or clopidogrel.

Numerator

Patients who were prescribed* aspirin or clopidogrel within a 12-month period.

*Prescribed may include prescription given to the patient for aspirin or clopidogrel at one or more visits in the measurement period OR patient already taking aspirin or clopidogrel as documented in current medication list.

Denominator

All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period.

Exclusions:

- Documentation of medical reason(s) for not prescribing aspirin or clopidogrel (e.g., allergy, intolerance, receiving other thienopyridine therapy, receiving warfarin therapy, bleeding coagulation disorders, other medical reasons).
- Documentation of patient reason(s) for not prescribing aspirin or clopidogrel (e.g., patient declined, other patient reasons).
- Documentation of system reason(s) for not prescribing aspirin or clopidogrel (e.g., lack of drug availability, other reasons attributable to the health care system).

NQF#: 0070
Measure Name: Coronary Artery Disease (CAD): Beta-Blocker Therapy — Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
Steward: AMA-PCPI
Source of Specification: MIPS 2017 Registry Measure Specifications

Description:

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF < 40% who were prescribed beta-blocker therapy. Two rates are reported:

1. Patients who are 18 years and older with a diagnosis of CAD or history of cardiac surgery who have a current or prior LVEF < 40%
2. Patients who are 18 years and older with a diagnosis of CAD or history of cardiac surgery who have a prior myocardial infarction

Rate 1

Numerator
Patients who were prescribed beta-blocker therapy

Denominator
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a current or prior LVEF < 40%

Rate 2

Numerator
Patients who were prescribed beta-blocker therapy

Denominator
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior (within the past 3 years) MI

Exceptions

- Documentation of medical reason(s) for not prescribing beta-blocker therapy (e.g., allergy, intolerance, other medical reasons)
- Documentation of patient reason(s) for not prescribing beta-blocker therapy (e.g., patient declined, other patient reasons)
- Documentation of system reason(s) for not prescribing beta-blocker therapy (e.g., other reasons attributable to the health care system)

NQF#: 0277
Measure Name: Congestive Heart Failure Admission Rate (PQI-08)
Steward: AHRQ
Source of Specification: AHRQ Specifications

Description

Admissions with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older. Excludes cardiac procedure admissions, obstetric admissions, and transfers from other institutions.

Numerator

Discharges, for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for heart failure.

Denominator

Population ages 18 years and older in metropolitan area[1] or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.

Exclusions

Cases with:

- any-listed ICD-10-PCS procedure codes for cardiac procedure
- transfer from a hospital (different facility)
- transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- transfer from another health care facility
- missing gender, age, quarter, year, principal diagnosis, or county

[1] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area.

NQF#: 0063 (no longer endorsed)
Measure Name: Comprehensive Diabetes Care: LDL-C Screening
Steward: NCQA
Source of Specification: NQF Website

Description:

The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an LDL-C test during the measurement year.

Numerator:

Members who had an LDL-C test performed during the measurement year.

Denominator:

Members 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Exclusions:

- Members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year.
- Members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year.

NQF#: 0575
Measure Name: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description:

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).

Numerator

Patients whose most recent HbA1c level (performed during the measurement year) is <8.0%.

Denominator

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Exclusions

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
- Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

NQF#: 0272
Measure Name: Diabetes Short-term Complications (PQI-01)
Steward: AHRQ
Source of Specification: AHRQ Specifications

Description

Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions.

Numerator

Discharges, for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma).

Denominator

Population ages 18 years and older in the metropolitan area[2] or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence,not the metropolitan area or county of the hospital where the discharge occurred.[3] May be combined with uncontrolled diabetes as a single indicator as a simple sum of the rates to form the Healthy People 2010 indicator.

Exclusions

Cases with:

- transfer from a hospital (different facility)
- transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- transfer from another health care facility
- missing gender, age, quarter, year, principal diagnosis, or county

[2] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area, or 4) 2003 OMB Metropolitan Statistical Area.

[3] The denominator can be specified with the diabetic population only and calculated with the SAS QI software through the condition-specific denominator at the state-level feature.

NQF#: 0275
Measure Name: Chronic Obstructive Pulmonary Disease (PQI-05)
Steward: AHRQ
Source of Specification: AHRQ Specifications

Description

Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.

Numerator

Discharges, for patients ages 40 years and older, with either:

- a principal ICD-10-CM diagnosis code for COPD; or
- a principal ICD-10-CM diagnosis code for asthma

Denominator

Population ages 40 years and older in metropolitan area[4] or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.

Exclusions

Cases with:

- any listed ICD-10-CM diagnostic codes for cystic fibrosis and anomalies of the respiratory system
- transfer from a hospital (different facility)
- transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- transfer from another health care facility
- missing gender, age, quarter, year, principal diagnosis, or county

[4] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area, or 4) 2003 OMB Metropolitan Statistical Area.

NQF#: 0283
Measure Name: Asthma in Younger Adults Admission Rate (PQI-15)
Steward: AHRQ
Source of Specification: AHRQ Specifications

Description

Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.

Numerator

Discharges, for patients ages 18 through 39 years, with a principal ICD-9-CM or ICD-10-CM/PCS diagnosis code for asthma.

Denominator

Population ages 18 through 39 years in metropolitan area[5] or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.

Exclusions

Cases with:

- transfer from a hospital (different facility)
- transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- transfer from another health care facility
- missing gender, age, quarter, year, principal diagnosis, or county

[5] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area, or 4) 2003 OMB Metropolitan Statistical Area.

NQF# 0036 (no longer endorsed)
Measure Name: Use of Appropriate Medications for Asthma
Steward: NCQA
Source of Specification: NQF Website

Description:

The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Numerator:

The number of patients who were dispensed at least one prescription for an asthma controller medication during the measurement year.

Denominator:

Patients 5–64 years of age by the end of the measurement year who were identified as having persistent asthma.

Exclusions:

Patients who had any diagnosis of Emphysema, COPD, Chronic Bronchitis, Cystic Fibrosis or Acute Respiratory Failure any time during the patient's history through the end of the measurement year (e.g., December 31).

NQF#: 2371
Measure Name: Annual Monitoring for Patients on Persistent Medications (MPM)
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the three rates separately and as a total rate.

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Annual monitoring for members on digoxin.
- Annual monitoring for members on diuretics.
- Total rate (the sum of the three numerators divided by the sum of the three denominators).

For each product line, report each of the three rates separately and as a combined rate. The total rate is the sum of the three numerators divided by the sum of the three denominators.

Rate 1: Annual Monitoring for Members on ACE Inhibitors or ARBs

Numerator

At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test.
- A serum potassium test ***and*** a serum creatinine test on the same date of service or on different dates of service

Denominator

Members age 18 and older as of December 31st of the measurement year who are on selected persistent medications (at least 180 treatment days of ACE inhibitors or ARBs) during the measurement year.

Rate 2: Annual Monitoring for Members on Digoxin

Numerator

At least one serum potassium, at least one serum creatinine ***and*** at least one serum digoxin therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test and a serum digoxin test on the same date of service or on different dates of service.
- A serum potassium test and a serum creatinine test and a serum digoxin test on the same date of service or on different dates of service.

Denominator
Members age 18 and older as of December 31st of the measurement year who are on selected persistent medications (at least 180 treatment days of digoxin) during the measurement year.

Rate 3: Annual Monitoring for Members on Diuretics

Numerator
At least one serum potassium *and* a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test.
- A serum potassium test and a serum creatinine test on the same date of service or on different dates of service.

Denominator
Members age 18 and older as of December 31st of the measurement year who are on selected persistent medications (at least 180 treatment days of a diuretic) during the measurement year.

Exclusions

Members from each eligible population who had an acute inpatient encounter or nonacute inpatient encounter during the measurement year.

NQF#: NA
Measure Name: Overall Composite (PQI-90)
Steward: AHRQ
Source of Specification: AHRQ Specifications

Description

Prevention Quality Indicators (PQI) overall composite per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, dehydration, bacterial pneumonia, or urinary tract infection.

Numerator

Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

- PQI #1 Diabetes Short-Term Complications Admission Rate
- PQI #3 Diabetes Long-Term Complications Admission Rate
- PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
- PQI #7 Hypertension Admission Rate
- PQI #8 Heart Failure Admission Rate
- PQI #10 Dehydration Admission Rate
- PQI #11 Bacterial Pneumonia Admission Rate
- PQI #12 Urinary Tract Infection Admission Rate
- PQI #14 Uncontrolled Diabetes Admission Rate
- PQI #15 Asthma in Younger Adults Admission Rate
- PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.

Denominator

Population ages 18 years and older in metropolitan area[6] or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.

Exclusions

None.

[6] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area, or 4) 2003 OMB Metropolitan Statistical Area.

NQF#: NA
Measure Name: Acute Conditions Composite (PQI-91)
Steward: AHRQ
Source of Specification: AHRQ Specifications

Description

Prevention Quality Indicators (PQI) composite of acute conditions per 100,000 population, ages 18 years and older. Includes admissions with a principal diagnosis of one of the following conditions: dehydration, bacterial pneumonia, or urinary tract infection.

Numerator

Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

- PQI #10 Dehydration Admission Rate
- PQI #11 Bacterial Pneumonia Admission Rate
- PQI #12 Urinary Tract Infection Admission Rate

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.

Denominator

Population ages 18 years and older in metropolitan area[7] or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.

Exclusions

None.

[7] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area, or 4) 2003 OMB Metropolitan Statistical Area.

NQF#: NA
Measure Name: Chronic Conditions Composite (PQI-92)
Steward: AHRQ
Source of Specification: AHRQ Specifications

Description

Prevention Quality Indicators (PQI) composite of chronic conditions per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short- term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure.

Numerator

Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

- PQI #1 Diabetes Short-Term Complications Admission Rate
- PQI #3 Diabetes Long-Term Complications Admission Rate
- PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
- PQI #7 Hypertension Admission Rate
- PQI #8 Heart Failure Admission Rate
- PQI #14 Uncontrolled Diabetes Admission Rate
- PQI #15 Asthma in Younger Adults Admission Rate
- PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.

Denominator

Population ages 18 years and older in metropolitan area[8] or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.

Exclusions

None.

[8] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area, or 4) 2003 OMB Metropolitan Statistical Area.

NQF#: 0108
Measure Name: Follow-Up Care for Children Prescribed ADHD Medication
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

- *Initiation Phase.* The percentage of members 6–12 years of age as of the IPSD 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.
- *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the 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.

Numerator

Initiation Phase

An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD.

Continuation and Maintenance (C&M) Phase

Members who are numerator compliant for *Rate 1 – Initiation Phase,* ***and*** have

- At least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD.
- Only one of the two visits (during days 31–300) may be a telephone visit or a telehealth visit. Identify telehealth visits using the code combinations below in conjunction with a telehealth modifier

Denominator

Children 6-12 years of age newly prescribed ADHD medication

Exclusions

Initiation Phase

Members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD. Any of the following meet criteria:

- An acute inpatient encounter with a principal mental health diagnosis.
- An acute inpatient encounter with a principal diagnosis of chemical dependency.

Continuation and Maintenance (C&M) Phase

Members who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the IPSD. Any of the following meet criteria:

- An acute inpatient encounter with a principal mental health diagnosis.

NQF#: 0004
Measure Name: Initiation and Engagement of Alcohol & Other Drug Dependence Treatment (IET)
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following.

- *Initiation of AOD Treatment.* The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis.
- *Engagement of AOD Treatment.* The percentage of members who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.

Numerator

Initiation of AOD Treatment

Initiation of AOD treatment through an inpatient admission, outpatient visit, telehealth, intensive outpatient encounter or partial hospitalization or MAT within 14 days of the index episode start date

Engagement of AOD Treatment

Members who are numerator compliant for the Initiation of AOD Treatment numerator ***and*** have:

3. Two or more inpatient admissions, outpatient visits, telehealth, intensive outpatient encounters or partial hospitalizations with a diagnosis matching the IESD diagnosis, beginning on the day after the initiation encounter through 29 days after the initiation event (29 total days). Multiple engagement visits may occur on the same day, but they must be with different providers in order to count.
4. If the Initiation of AOD treatment was not a MAT dispensing event, one or more of the MAT dispensing events beginning on the day after the initiation encounter through 33 days after the initiation event (total of 34 days).
5. If the Initiation of AOD treatment was a MAT dispensing event, two or more engagement events where at least one meets criteria for 1. For example, two engagement events from criteria 2 do not meet numerator compliance

Denominator

Members age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).

Exclusions

- Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence, Medication Assisted Treatment Value Set or a MAT dispensing event during the 60 days (2 months) before the IESD.
- Exclude the member from the denominator for both indicators if the initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.

NQF#: 0027
Measure Name: Medical Assistance with Smoking and Tobacco Use Cessation (MSC)
Steward: NCQA HEDIS
Source of Specification: HEDIS 2018 Technical Specifications

Description

The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation.

1. *Advising Smokers and Tobacco Users to Quit.* A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year
2. *Discussing Cessation Medications.* A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year
3. *Discussing Cessation Strategies.* A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

This measure is collected as part of the CAHPS Health Plan Survey 5.0H, Adult Version (commercial, Medicaid) or by Centers for Medicare & Medicaid Services (CMS) using the Medicare CAHPS Survey (Medicare).

Numerator

Percentage of members 18 years of age and older who were current smokers or tobacco users who received advice to quit during the measurement year
The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider.

Percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year
The number of members in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications.

Percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year
The number of members in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies.

Denominator

The number of eligible members who responded to the survey and indicated that they were current smokers or tobacco users.

Exclusions

None.