



2016 – 2017 Physician Practice Quality Improvement Award PROGRAM CRITERIA

Eligibility: Any physician practice in the state of Texas, Arkansas, Missouri, Oklahoma or the territory of Puerto Rico with one or more physicians licensed in that state or territory providing care for Medicare fee-for-service patients. All practicing provider(s) must not have been disciplined or excluded by any federal or state regulatory agency, licensing board or health care facility for a period of five years.

The 2016 – 2017 TMF Physician Practice Quality Improvement Award criteria consist of four major components:

- Exemplary performance on nationally recognized clinical outcome measures
- Regular use of population care management methods
- Participation in data reporting quality initiatives
- Implementation of tools and processes to promote patient engagement and improve the patient’s experience

TOP PERFORMANCE ON QUALITY MEASURES	<p><i>Top level of performance on at least three of the following quality measures:</i></p> <p>A practice must report levels of care above a threshold that is derived from various state and national data sources on at least three of the following commonly tracked quality measures. Practices are given the option to submit 12 months of data for the full year of 2016 if quarterly data reporting is not available for 12 months beginning April 1, 2016, and ending March 31, 2017. Primary care practices must meet or exceed the indicated threshold on three preventive measures to qualify for the award. Specialist practices must meet or exceed the indicated threshold on at least two of the preventive measures, plus one additional measure from the ‘other measure’ category. A practice must be able to describe the process they used to generate performance information and verify that the level of care provided is better than the target threshold.</p> <p>NOTE: The Physician Quality Reporting System (PQRS), National Quality Forum (NQF) and meaningful use clinical quality measure (MU CQM) numbers below are representative of one possible data point. Any other data reasonably representing the measure description may be accepted. Measures meeting the threshold with a denominator of 20 or greater are preferred.</p>
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Measure Description	PQRS #	NQF #	POPULATION	Final Threshold (%)
<i>Preventive Measures</i>				
Controlling High Blood Pressure	236	18	Adult	72
Preventive Care and Screening — Tobacco Use: Screening and Cessation Intervention	226	28	Adult	92
Preventive Care and Screening: Influenza Immunization (six months and older)	110	41	Pedi/Adult	83
Pneumonia Vaccination Status for Older Adults	111	43	Adult	82

Measure Description	PQRS #	NQF #	POPULATION	Final Threshold (%)
Herpes Zoster			Adult	30
Breast Cancer Screening	112	N/A	Adult	82
Cervical Cancer Screening	309	32	Adult	82
Colorectal Cancer Screening	113	34	Adult	77
Diabetes: Low Density Lipoprotein (LDL-C) Control (<100 mg/dL)	2	64	Adult	58
Diabetes: Eye Exam	117	55	Adult	82
Diabetes: Foot Exam ***	163	56	Adult	85
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (This references those referred for an eye exam) ***	19	89	Adult	75
Diabetes: Medical Attention for Nephropathy	119	62	Adult	95
Diabetes and Diabetes Self-Management Education (DSME): Percentage of patients 18–75 years with diabetes that have been referred to an accredited or recognized DSME/T program in the first 12 months since initial office referral. ***	N/A	N/A	Adult	80
Diabetes: Hemoglobin A1c (Please choose one of the following measures):				
• Poor Control (>9)	1	59	Adult	10
• Good Control Ex: In Control ≤7.0% Practice identifies standards or guidelines A. ADA Standards <7.0% but individualized to no greater than 8.0% OR B. AADE Guidelines ≤ 6.5% or >6.5% based on individualized needs			Adult	
Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed AND Risk-Stratified Fasting LDL-C ***	316	N/A	Adult	82.5
Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic ***	204	68	Adult	84*
Follow-Up after Hospitalization for Mental Illness (FUH)	391	N/A	Adult	73
Preventive Care and Screening: Unhealthy Alcohol Use — Screening ***	173	N/A	Adult	75
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan***	134	418	Adult	75
Other Clinical Measure: This measure is only applicable for Specialists. Only one “other” measure is permitted. To meet this measure, specialists must identify the benchmark measure and demonstrate that they are meeting or exceeding the 90 percent performance or 90th percentile of the benchmark rate.”				
<i>Optional: Please provide a description of how you are using your data to improve performance.</i>				

Calculating measures:

Please note that because reporting programs differ, the requirements for this criterion are designed to allow offices to report data that best matches the measurement definitions or guidelines on which they are already reporting (unless otherwise specified). Where available, please provide measure sponsor or measure number. If both are available, please submit both.

<p>CARE MANAGEMENT METHODS</p>	<p>Employment of at least ONE of the following population care management methods:</p> <ul style="list-style-type: none"> • Public health registry • Attainment of Medical Home Recognition • Attainment of certified Diabetes Education Centers by the American Association of Diabetes Educators (AADE) or the American Diabetes Association (ADA) • Use certified electronic health record (EHR) technology to complete certain improvement activities • Care management teams, including risk stratification and management of high-risk patients • Use of a Health Information Exchange— (Bi-directional interface) • American Osteopathic Association Clinical Assessment Program • Performance Improvement — Continuing Medical Education— Cardiac/Diabetes
<p>DATA REPORTING QUALITY INITIATIVES</p>	<p>Currently participating in at least ONE of the following data reporting quality initiatives:</p> <ul style="list-style-type: none"> • 2017 Merit-based Incentive Payment System (MIPS) • 2017 Alternative Payment Models (APMs) • 2016 Physician Quality Reporting System (PQRS) • The Million Hearts initiative focusing on taking aspirin, blood pressure control, cholesterol management and smoking cessation • Quality Programs as a Requirement of Maintenance of Certification • Other recognized physician office quality data reporting initiatives (please provide details) Example: Bridges to Excellence Clinical Modules
<p>PATIENT ENGAGEMENT AND EXPERIENCE</p>	<p>Adoption of at least TWO of the following patient engagement and experience tools and strategies:</p> <ul style="list-style-type: none"> • Practices have completed the minimal sample size of Clinician Group Consumer Assessment of Healthcare Providers (CG-CAHPS) surveys per number of providers. Practices with fewer than 100 patients and not participating in the CG-CAHPS may use a customized survey that shows real time patient satisfaction feedback. • Establish an electronic connection (patient portal) • Shared decision-making (specify conditions, provide documentation of process) Examples are: Effective Health Care Programs by the Agency for Healthcare Research and Quality (AHRQ); Share Approach by AHRQ; Choosing Wisely; Million Hearts; etc. • Chronic care management/Care coordination • Mobile health tools/Applications • Shared medical visit model for self-management education and needs (i.e., group visits) • Promoting patient education programs (Establishing or incorporating into the workflow) • Tele-medicine • Use of language assistive devices or services • Assessment of health literacy of each patient and use of educational materials • Patient members of quality team or advisory board

How do I demonstrate that my practice meets the award criteria?

Top Performance on Quality Measures:

Please provide documentation of recent clinical outcome performance in any of the following formats: a report generated from an EHR, a third-party quality report or a claims-based data report. Please provide the number of patients used in the denominator of each outcome.

Care Management Methods:

If EHR-based, please provide a screen shot of electronic mechanisms used and describe the nature of when and how they are used. For other care management methods, please provide a screen shot or, alternatively, a copy of any policy, procedure, certificate or other written document that demonstrates the nature of the method.

Data Reporting Quality Initiatives:

Please provide certificates of submission/completion with the name of the initiative, the nature of the practice involvement and a link to a website that describes the program. If participating in the Million Hearts initiative with a TMF QIN-QIO consultant, engagement will be validated by the TMF QIN-QIO.

Patient Engagement and Experience:

Please provide a short description and requested documentation, as outlined on the application, of the process or system being use in your practice.



**Threshold established using data from the TMF Quality Innovation Network's Cardiovascular Health and Million Hearts Learning and Action Network Data Portal.*

***Performance benchmarks are based on Healthy People 2020, published by the Healthcare Effectiveness Data and Information Set and National Committee for Quality Assurance rates, unless otherwise specified.*

****Threshold established using TMF's contract goals.*