Government of Saskatchewan
Ministry of Health

SMA Saskatchewan Medical Association

eHealth Saskatchewan

Chronic Disease Management – Quality Improvement Program:
Indicators of Best Practice

This January 2016 document will provide details of the indicators for the four chronic diseases included in CDM-QIP with clarification of when each indicator is required for payment and how payment to physicians is assessed.

An **annual Quality Improvement Payment** will be issued on a per-patient, per-condition basis to physicians who are enrolled in the CDM-QIP program and submit patient observations that meet **all** of the indicators for each chronic condition. These process indicators were selected by members of the CDM-QIP Clinical Expert Group. They align with best practice indicators developed by the Canadian Institute of Health Information (CIHI – 2012) and reflect aspects of care recommended by current clinical practice guidelines.

The patient assessment window for payment is 12 months, with an additional 30 days "grace". A patient's 12 month payment review period for a particular chronic condition starts with the first visit for that condition when indicators are exported/entered into the CDM-QIP repository; that calendar date each subsequent year would be the start of that patient's next review period for that condition. The minimum frequency of each indicator required for payment is indicated below. The indicators apply to patients 18 years of age (or turning 18 during the 12 month data collection window). For more information about payment requirements, please refer to "Chronic Disease Management – Quality Improvement Program Payment Policy."

Rationale for the frequency of some of the CDM-QIP indicators and why they are required "at least once" every 6 or every 12 months:

- Indicators recommended to be performed at least once every 6 months: *For optimal clinical care these clinical interventions/investigations should be performed at every CDM clinic visit. So for some patients they may be performed as often as every 3-4 months. However, for patients with stable and well controlled chronic diseases it is acceptable to provide CDM visits every 6 months. Therefore, these indicators are assessed for payment twice in a 12 month period.*
- Indicators recommended to be performed at least once every 12 months: *For clinically stable patients, or diabetic patients undergoing screening for complications, it is acceptable to perform these investigations/reviews once a year. However some indicators such as review of CPG-recommended medications may be performed as frequently as every CDM visit, and some indicators for Diabetes, such as Nephropathy, Retinopathy and Neuropathy screening and monitoring, should be performed more frequently once a patient has these complications.*

DIABETES		
CDM Indicators	**CDM QIP Indicator Description (based on optimal clinical practice)**	**What the Payment System Looks For in the 12 month period for each patient (based on indicator data exported from EMR flow sheets or entered into eHR Viewer)**
Type of diabetes	Record whether patient has Type 1, Type 2 or "other"	Presence of Type 1, Type 2 or "other" in the patient profile or the patient history of problems in EMR, or once in the eHR Viewer for non-EMR users (required only once for payment)
Blood Pressure Measurement	Blood pressure measured and recorded at least once every 6 months	Presence of systolic and diastolic values on 2 separate dates
Smoking Status and Smoking Cessation Advice	Smoking status reviewed and recorded at least once every 6 months. Smoking cessation advice provided to smokers and recorded at least once every 6 months	Presence of smoking status on 2 separate dates *and* presence of smoking cessation advice dates for patients who are smokers
Obesity/Overweight Screening	Obesity/overweight screening completed at least once every 12 months, with height and weight values recorded	Presence of one height and one weight value
Glycemic control - A1c	A1c performed and value recorded at least once every 6 months	Presence of A1c value *and* test date on 2 separate dates
Nephropathy Screening and Monitoring	Urine ACR and eGFR recorded at least once every 12 months, and nephropathy status (whether patient has nephropathy or not) recorded. Urine ACR not required if significant CKD (eGFR <15ml/min).	Presence of 5 components: Urine ACR value *and* date, eGFR value *and* date, *and* nephropathy status. If eGFR value is ≤ 15 ml/min, the presence of 3 components is required: eGFR value *and* date *and* a nephropathy status
Retinopathy Screening and Monitoring	Dilated eye exam performed every 12-24 months (date not evaluated for payment) and diabetic retinopathy status (whether patient has retinopathy or not) recorded at least once every 12 months	Presence of one retinopathy status
Foot Exam and Peripheral Neuropathy Screening and Monitoring	Diabetic foot exam completed at least once every 12 months and peripheral neuropathy status (whether patient has neuropathy or not) recorded	Presence of one foot exam date *and* neuropathy status
Full Lipid Profile Screening	Full lipid profile annually/as needed (testing influenced by age, duration DM, CVD risk factors); LDL value recorded at least once every 12 months for patients age 40 to 80 years	If the patient age is ≥ 40 and ≤ 80 years, presence of one LDL-cholesterol value *and* one full lipid test date
Depression/Psychosocial Stress Screening	Depression/psychosocial stress screening performed at least once every 12 months	Presence of a depression screening date *and* a "Yes" response to Screened for depression/anxiety

CORONARY ARTERY DISEASE

CDM Indicators	CDM QIP Indicator Description (based on optimal clinical practice)	What the Payment System Looks For in the 12 month period for each patient (based on indicator data exported from EMR flow sheets or entered into eHR Viewer)
Blood Pressure Measurement	Blood pressure measured and recorded at least once every 6 months	Presence of systolic and diastolic values on 2 separate dates
Smoking Status and Smoking Cessation Advice	Smoking status reviewed and recorded at least once every 6 months. Smoking cessation advice provided to smokers and recorded at least once every 6 months	Presence of smoking status on 2 separate dates *and* presence of smoking cessation advice date for patients who are smokers
Obesity/Overweight Screening	Obesity/overweight screening completed at least once every 12 months, with height and weight values recorded	Presence of one height and one weight value
Diabetes Screening (for patients who do not have diabetes)	Fasting Plasma Glucose or A1c test performed at least once every 12 months	If the patient exists in the payment system database as already having Diabetes, this indicator is ignored. If the patient does not have a Diabetes "flag" in the payment system, one Fasting Glucose value *and* test date ***or*** one A1c value *and* test date must be present
Full Lipid Profile Screening	Full lipid profile screening annually/as needed; LDL value recorded at least once every 12 months for patients > 40 years of age and as appropriate for patients <40 years	If the patient age ≥ 40 years, presence of one LDL-cholesterol value *and* one full lipid test date
Statin Indication/Use	Statin indication and use assessed and recorded at least once every 12 months	Presence of one of the statin indication responses
Beta Blocker Indication/Use	Beta blocker indication and use assessed and recorded at least once every 12 months	Presence of one of the beta blocker indication responses
ACE Inhibitor or ARB Indication/Use	ACE Inhibitor or ARB indication and use assessed and recorded at least once every 12 months	Presence of one of the ACE/ARB indication responses
Antiplatelet Agent Indication/Use	Anti-platelet indication and use assessed and recorded at least once every 12 months	Presence of one of the anti-platelet indication responses
Depression/Psychosocial Stress Screening	Depression/psychosocial stress screening at least once every 12 months	Presence of a depression screening date *and* a "Yes" response to Screened for depression/anxiety

CHRONIC OBSTRUCTIVE PULMONARY DISEASE		
CDM Indicators	**CDM QIP Indicator Description (based on optimal clinical practice)**	**What the Payment System Looks For in the 12 month period for each patient (based on indicator data exported from EMR flow sheets or entered into eHR Viewer)**
Spirometry Confirmed Diagnosis of COPD	Date of Spirometry and FEV1 value or "NTP" (Not Technically Possible – e.g. patient not able to perform test) recorded at least once. (Spirometry/ PFT is essential to confirm diagnosis of COPD)	Presence of one Spirometry date *and* FEV1 value ***or*** presence of a Yes response to "Not Technically Possible" (required only once for payment)
Smoking Status and Smoking Cessation Advice	Smoking status reviewed and recorded at least once every 6 months. Smoking cessation advice provided to smokers and recorded at least once every 6 months	Presence of smoking status on 2 separate dates *and* presence of smoking cessation advice dates for patients who are smokers
Depression/Psychosocial Stress Screening	Depression/psychosocial stress screening at least once every 12 months	Presence of a depression screening date *and* a "Yes" response to Screened for depression/anxiety
Functional Status	mMRC Dyspnea Scale assessed and recorded at least once every 6 months	Presence of functional status value on 2 separate dates
Exacerbations	Record the average number of exacerbations and whether or not the patient has an action plan at least once every 6 months	Presence of responses for *both* average number of exacerbations *and* patient has action plan on 2 separate dates
Oxygen Sat	Oxygen Sat measured and recorded at least once every 6 months	Presence of Oxygen Saturation value on 2 separate dates
LABA Indication/Use	LABA indication and use assessed and recorded at least once every 6 months	Presence of one of the LABA indication responses on 2 separate dates
LAAC (LAMA) Indication/Use	LAAC indication and use assessed and recorded at least once every 6 months	Presence of one of the LAAC indication responses on 2 separate dates
Inhaler Technique	Correct Inhaler technique reviewed and recorded at least once every 12 months	Presence of one of the correct inhaler technique responses
Obstructive Sleep Apnea (OSA) Screening	Screen for obstructive sleep apnea at least once every 12 months	Presence of one of the OSA screening responses
Referral to pulmonary rehab program	Consider referral to Pulmonary Rehab Program at least once every 12 months	Presence of one of the Pulmonary Rehab Referral responses

HEART FAILURE		
CDM Indicators	**CDM QIP Indicator Description (based on optimal clinical practice)**	**What the Payment System Looks For in the 12 month period for each patient (based on indicator data exported from EMR flow sheets or entered into eHR Viewer)**
Type of HF	Record whether patient has HF-REF, HF-PEF, or Combined HF	Presence of one HF type (required only once for payment)
Assessment of Functional/Clinical Status	NYHA Functional Class assessed and recorded at least once every 6 months	Presence of NYHA functional class value on 2 separate dates
Smoking Status and Smoking Cessation Advice	Smoking status reviewed and recorded at least once every 6 months. Smoking cessation advice provided to smokers and recorded at least once every 6 months	Presence of smoking status on 2 separate dates *and* presence of smoking cessation advice dates for patients who are smokers
Blood Pressure Measurement	Blood pressure measured and recorded at least once every 6 months	Presence of systolic and diastolic values on 2 separate dates
Volume Assessment	Volume status assessed and recorded at least once every 6 months	Presence of volume assessment value on 2 separate dates
Echocardiogram	Echo performed every 3-5 years; frequency determined by clinical history/stability	Not required for payment *(Access to Echocardiography is a limiting factor, so while regular Echo's are recommended for optimal clinical care, this indicator will not be assessed for payment)*
Weight Monitoring	Weight measured and recorded at least once every 6 months (monitoring change in weight is required for volume status assessment)	Presence of weight value on 2 separate dates
Diabetes Screening (for patients who do not have diabetes)	Fasting Plasma Glucose or A1c test completed at least once every 12 months	If the patient exists in the payment system database as already having Diabetes, this indicator is ignored. If the patient does not have a Diabetes "flag" in the payment system, one Fasting Glucose value *and* test date ***or*** one A1c value *and* test date must be present
ACE Inhibitor or ARB Indication/Use	ACE Inhibitor or ARB indication and use assessed and recorded at least once every 6 months	Presence of one of the ACE/ARB indication responses on 2 separate dates
Beta Blocker Indication/Use	Beta blocker indication and use assessed and recorded at least once every 6 months	Presence of one of the beta blocker indication responses on 2 separate dates
Aldosterone Antagonist Indication/Use	Aldosterone Antagonist indication and use assessed and recorded at least once every 6 months	Presence of one of the aldosterone antagonist indication responses on 2 separate dates
Obstructive Sleep Apnea (OSA) Screening	Screen for Obstructive Sleep Apnea at least once every 12 months	Presence of one of the OSA screening responses
Depression/Psychosocial Stress Screening	Depression/psychosocial stress screening at least once every 12 months	Presence of a depression screening date *and* a "Yes" response to Screened for depression/anxiety