C3 Data Collection Requirements and Instructions

Table Information:

1. "FY2017" refers to the first C3 project period: March 7, 2016 - April 30, 2017 (clinic data was only collected through January of 2017)
2. "Quarterly" reporting periods are based on the SIM project period quarters:
    a. May 1 - July 31, 2017
    b. August 1 - October 31, 2017
    c. November 1, 2017 - January 31, 2018
    d. February 1 - April 30, 2018
3. Data must be submitted within 45 days of the end of the reporting month
4. Not all measures will be included in the data portal. The following measures will be collected by IDPH and included separately in the Community Scorecards. Data that is collected by the C3s (DSME only) will be provided in the quarterly report in the "Supporting Documentation" upload fields (can be a separate document or added as a tab to the SDH process measure report:
    a. Number of hospitals in the service area connected to and using the IHIN
    b. Number of LPH agencies in the service area using the IHIN for direct secure messaging
    c. Number of eligible hospitals utilizing SWAN alerts for care coordination (provided by the Department)
    d. Number of hospitals sending ADT data to the SWAN
    e. Number of DSME programs offered
5. **NQF Measures**: Multiple clinics within a C3 can be entered into the SIM data portal as separate facilities. Clinics entering directly can only see their own data. The SIM data portal will aggregate clinic data at the C3 community level automatically.

a. **NQF 0028 will be collected for all reporting clinics - even if the clinic is reporting NQF 0729 - as it is a required core metric for the state SIM data reporting.** The original assumption was that NQF 0028 could be extracted from clinics submitting 0729; however it cannot and therefore needs to be submitted in addition to 0729. Clinics submitting the separate measures for the composite 0729 will already be submitting 0028 as it is an individual measure of 0729.

6. **Adverse Drug Events**: Hospitals in the Hospital Innovation and Improvement Network (HIIN) currently use 2014 self-reported data as a baseline for this measure. To maintain consistency, the same baseline will be used in the SIM Data Portal. This measure only includes hospitals participating in the HIIN, and may not include all hospitals within a C3 service area.

7. **SWAN Measures:**

    a. "Utilization" is defined as having process in place at the hospital/clinic level to use the alerts for care coordination

    b. "Eligible" hospitals include hospitals that are in an ACO that is receiving SWAN alerts

    c. All hospitals can send ADT (admissions, discharge, transfer) data from emergency department visits to the SWAN

8. **DSME and NDPP/YDPP measures**:

    a. These programs report to federal programs and/or at the state level and may consider sharing data with C3s to be burdensome. The Department will work with each C3 to determine what data will be available for process improvement.

    b. DSME data can be collected by the Department annually. Annual program data will be used for performance measure incentive and can be provided to the C3 if local program data is unavailable. C3s are encouraged to collect data directly from the program on a quarterly basis (if available) to use for process improvement.

        i. To be counted as "complete", individuals must complete all DSME sessions as defined by each local state certified DSME program

            1. The rate for this measure is calculated as the total number completing in the current quarter out of the total number individuals signed up for or starting the same DSME

        ii. DSME includes only state-certified programs, and, for the purposes of this document, includes both diabetes education and support (DSME/S)

c. NDPP data can be collected by the Department quarterly but is currently only available statewide, not be individual county. NDPP will no longer be included as a performance measure for the incentive payment. YDPP data, if not a CDC-recognized program or pending CDC-recognition), is not available to the Department. C3s are encouraged to collect data directly from the program on a quarterly basis (if available) to use for process improvement.

   i. Total number of referrals may include self-referral or other community-based organization referral

   ii. “Testing” is defined as blood glucose testing; “Screening” is defined as the written screening tool; (note: some providers may refer to blood glucose testing as “screening”)

   iii. To be counted as “complete”, individuals must complete a minimum of four NDPP/YDPP classes

   iv. Completions are counted in the quarter in which the course ends

   v. If there are questions about CDC pending or recognized programs, contact IDPH for clarification on data collection processes

Individual measures of composite 0729:

NQF 0064	Comprehensive Diabetes Care: LDL-C Control <100 mg/dL: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent LDL-C test is <100 mg/dL during the measurement year.
NQF 0061	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg): The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is <140/90 mm Hg during the measurement year.
NQF 0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: the 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. ****NQF 0028 will be submitted to CMMI as a core SIM metric**
NQF 0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%): 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.

SDH Process Measures:

- Categorized based on HealthyPeople 2020: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
- "Number of referrals" includes TOTAL referrals and can include duplicate clients (i.e. the same client receiving food assistance within the quarter). Clients may be duplicated across types of referrals as well (i.e. the same client receiving food assistance and transportation assistance at the same or separate visits).

Category (measure)	Subcategory	Description
Economic Stability	Food assistance	Examples: having access to grocery stores, food pantries, food assistance and healthy food nutrition information
	Housing/rent	Examples: rent/mortgage assistance

	Other economic issues	Examples: ability to acquire assistance for job placement, clothing, personal items
Education		Includes: Language & Literacy – opportunities and assistance to learn if English is not first language, or if unable to read and write Early Childhood Education & Development/Childcare – education/assistance on parenting and childcare, access to affordable childcare in order to maintain employment. Other (high school education, enrollment in higher education etc.) – assistance in higher education to improve career marketability; assistance to apply for colleges or getting GED
Health and health care		Includes: Insurance – access to medical care, education/assistance on availability of children programs (Hawk-i), Medicaid/Medicare, waivers, healthcare marketplace, guidance/assistance for under insured, newly insured Pharmacy – medication assistance, voucher program Mental Health – substance abuse, mental health, cognitive impairment, support groups Dental – education in oral hygiene, assistance on locating a dental home, guidance for finding assistance or dental insurance Other Health Care Referrals (primary care, vision, podiatry, etc.) – education/ assistance for tobacco cessation programs, home health, hospice, immunizations, medical home, medical specialists, cultural barriers to health system, hours available, treatments/alternatives for new diagnosed condition
Transportation		Examples: mobility issues around neighborhood and businesses (ADA compliance), ability to access transportation to and from healthcare and needed services, transportation voucher programs
Social and community context		Includes issues faced by elderly population, isolation, lack of social support/network
Number of closed referrals to providers		Number of referrals to any of the community supports outlined above in which the provider received a follow up communication (through IHIN Direct Secure Messaging or other existing communication process such as fax, community care coordination IT system, etc.)