SIM C3 Objectives, Measures, and Data Map

Objective 1: Identify target population by risk						
Required Tactic		**Measure**				
		Measure	Description	Method of Collection	Frequency	Baseline & Method of Collection
1.1	Develop or improve systems to identify high-risk patients (HbgA1C>9) - Educate and equip providers to address diabetes risk factors and screening with patients (2.3-B*)	NQF 0059 [Quality ID 001]	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.	Clinics may directly import measures into the SIM data portal, or provide measures to the C3 to enter into the portal on their behalf	Monthly	February 1 – April 30, 2017
1.2	Identify comorbidities including vascular diseases, tobacco use, etc. (2.2-A)	NQF 0729 NQF 0028 If not collecting 0729, the following measures: NQF 0064 NQF 0061 NQF 0028 & NQF 0059	Optimal Diabetes Care: The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this	Clinics may directly import measures into the SIM data portal, or provide measures to the C3 to enter into the portal on their behalf	Monthly	February 1 – April 30, 2017

			composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.			
1.3	Promote the implementation of AssessMyHealth, a comprehensive and high quality health risk assessment (HRA) that identifies patient clinical, social, and community needs (Care Coordination – 1.1-F)	Completed HRAs	Total number of HRAs completed by C3 partners	Collected by IME (submission process to SIM Data Portal to be determined; to be built into the SIM data portal once AssessMyHealth details are determined)	When available	TBD
Objective 2: Improve diabetes management						
Required Tactic		**Measure**				
		Measure	Description	Method of Collection	Frequency	Baseline & Method of Collection
2.1	Implement evidence-based interventions to enhance diabetes management (3.1-A)	NQF 0729 NQF 0028 If not collecting 0729, the following measures: NQF 0064 NQF 0061	Optimal Diabetes Care: The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing	Clinics may directly import measures into the SIM data portal, or provide measures to the C3 to enter into the portal on their behalf	Monthly	February 1 – April 30, 2017

		NQF 0028 & NQF 0059 *Duplicate from NQF measures in Objective 1*	or reducing future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.			
		Adverse Drug Events	Adverse Drug Event Rate/Observation Patient Days	Collected through the Hospital Innovation and Improvement Network (HIIN) by IHC and entered into the data portal for each community	Monthly	Calendar year 2014
		Adverse Drug Events Blood Glucose Less than 50	Number of blood glucose measurements (per lab reports, POCT, EMR, Charge Data etc.) for Acute Care, Skilled Nursing Facility, Swing Bed and Observation patients where blood glucose <50 / Number of blood glucose measurements (per lab reports, POCT, EMR, Charge Data etc.) for Acute Care, Skilled Nursing Facility, Swing Bed and Observation patients	Collected through the Hospital Innovation and Improvement Network (HIIN) by IHC and entered into the data portal for each community (beginning July 2017)	Monthly	Calendar year 2014

		Readmission (Potentially Preventable Readmissions - PPR) ED Visits (Potentially Preventable ED Visits - PPV)	A PPR is a readmission (return hospitalization within a 30-day time interval) that is clinically-related to the initial hospital admission. Clinically-related is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission PPVs are emergency room visits that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory sensitive conditions (e.g., asthma) which adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate	Collected by IME (submission process to SIM Data Portal to be determined; to be built into the SIM data portal once submission details are determined)	Monthly (when available)	TBD
Objective 3: Link to Community Resources and Clinical-Community Programs and Services						
Required Tactic		**Measure**				
		Measure	Description	Method of Collection	Frequency	Baseline & Method of Collection
3.1	Maximize effectiveness and use of diabetes self-management education and training (DSME), and the Stanford Chronic	DSME programs offered	Total number of times state certified DSME curriculum series, covering the required topic areas, was delivered in the service area [count]	Collected by the Department	Annual	Calendar Year 2016

	Disease Self-Management Program (CDSMP) (3.4-B)					
		Total referrals to DSME	Total number of individuals referred to a state certified DSME [count]	Collected by the C3 from the DSME program	Quarterly	February – April 2017
		Total number of individuals completing DSME	Total number of individuals completing a state certified DSME in the current quarter out of the total number of individuals who started the state certified DSME [rate: Numerator: individuals completing DSMEs; Denominator: all individuals starting/signed up for the DSME education ending in the current quarter] (see notes at the end of this table for the definition of “completed” DSME)	Collected by the C3 from the DSME program	Quarterly	February – April 2017
		Total number of individuals completing CDSMP	Total number of individuals completing CDSMP [count]	Collected by the C3 from the CDSMP program	Quarterly	February – April 2017

3.2	Promote care coordination across a community of providers (3.2-A)	Total referrals for social needs	Number of referrals to:
			● Economic Stability
			  ● Food assistance
			  ● Housing/rent
			  ● Other economic issues
			● Education
			● Health and health care
				Collected by the C3 for all referrals for social needs for the target population and submitted to IDPH through each Quarterly Progress Report; IDPH to categorize and enter	Quarterly (broken down by month)	July – September 2016

3.3	Ensure providers are aware of and refer patients to appropriate resources to address social determinants of health barriers to management and treatment (3.2-C and 3.2-D) (includes tactics 1.3-A and 1.3-B from the Care Coordination statewide strategy plan)		● Health care access (including insurance, pharmacy, mental health, dental) ● Transportation ● Social and community context ● Number of closed referrals to providers [rate: Numerator: type of referral; Denominator: total number of SDH referrals] Total number of unduplicated clients [rate: Numerator: total clients served; Denominator: service area population]	into the SIM Data Portal on behalf of each C3 (submitted to IDPH to ensure method of categorization is standardized across all C3s, as several C3s use different software systems to track referrals)		
Objective 4: Improve healthcare transitions						
Required Tactic		**Measure**				
		Measure	Description	Method of Collection	Frequency	Baseline & Method of Collection
4.1	Designate defined care coordination roles and/or responsibilities within the clinic, practice, or organization (Care Coordination – 1.2-C)	Process Measures	To be determined in Quality Improvement Plan	Collected by the C3 and entered into the SIM Data Portal	Quarterly	QI Plan (May – July 2016)
4.2	Engage providers and patients in glycemic management and best practices (3.1-B)	NQF 0059 *Duplicate from NQF measures in Objective 1*	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%): The percentage of members 18-75 years of age with diabetes (type	Clinics may directly import measures into the SIM data portal, or provide measures to the	Monthly	February 1 – April 30, 2017

			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.	C3 to enter into the portal on their behalf		
		Readmission (Potentially Preventable Readmissions - PPR) ED Visits (Potentially Preventable ED Visits - PPV) *Duplicate from measures in Objective 2*	A PPR is a readmission (return hospitalization within a 30-day time interval) that is clinically-related to the initial hospital admission. Clinically-related is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission PPVs are emergency room visits that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory sensitive conditions (e.g., asthma) which adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate	Collected by IME (submission process to SIM Data Portal to be determined)	Monthly (when available)	TBD
4.3	Promote use of available HIT resources to allow mutual access to patient care information from all	Use of the IHIN	Number of hospitals in the service area connected to and using the IHIN Number of LPH agencies in the service area using the IHIN for direct secure messaging	Collected by IDPH	Quarterly	Total as of April 30, 2017

	appropriate members of the patient care team, i.e. Iowa Health Information Network (IHIN), shared Electronic Health Records (EHR) view and messaging functionalities (Care Coordination – 2.2-A)					
		Use of SWAN alerts	Number of eligible hospitals utilizing SWAN alerts for care coordination (provided by the Department) [rate: Numerator: hospitals utilizing SWAN alerts for care coordination; Denominator: number of eligible hospitals in the service area] (refer to the notes section for information on utilization and eligible hospitals)	Collected by IDPH and entered into the SIM data portal on behalf of each C3	Quarterly	February – April 30, 2017
		Hospitals sending Admissions, Discharge, and Transfer (ADT) data to the SWAN	Number of hospitals sending ADT data to the SWAN [rate: Numerator: number of hospitals sending ADTs; Denominator: total number of hospitals in the service area]	Collected by IDPH and entered into the data portal on behalf of each C3	Quarterly	February 1 – April 30, 2017
4.4	Align coordination among organizations that share responsibility for assuring or overseeing Healthcare Associated Infection	Identification or development of a protocol	Protocol exists or is under development by the end of the contract period	C3 to provide directly to IDPH through one of the Quarterly Progress Reports (upload once available - may be included in any quarterly	Annual	N/A

	(HAI) surveillance, prevention, and control (Healthcare Associated Infections, 1.1-A). Includes promoting better foot care to decrease infection rates in diabetes and assuring education and referral flow process for providers on preventing foot infections			report as long as it is received by IDPH by the 4th quarterly report)		
Objective 5: Decrease the incidence of diabetes						
Required Tactic		**Measure**				
		Measure	Description	Method of Collection	Frequency	Baseline & Method of Collection
5.1	Implement evidence-based interventions to enhance overweight and obesity identification and treatment, such as established treatment algorithms (Obesity – 3.2-A)	NQF 0421 [PQRS 128]	Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan. Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.	Clinics may directly import measures into the SIM data portal, or provide measures to the C3 to enter into the portal on their behalf	Monthly	February 1 – April 30, 2017

		NQF 0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: - Body mass index (BMI) percentile documentation* - Counseling for nutrition - Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	Clinics may directly import measures into the SIM data portal, or provide measures to the C3 to enter into the portal on their behalf	Monthly	February 1 – April 30, 2017
5.2	Increase participation in diabetes primary prevention programs, including National Diabetes Primary Program (NDPP) and YMCA Diabetes Prevention Program (YDPP) (1.2-B)	Total number of available programs	Number of CDC pending or recognized NDPP/YDPPs [count]	Collected in partnership by IDPH and the C3	Quarterly	Total as of April 30, 2017
		Referrals to a Diabetes Prevention Program	Number of individuals tested and referred to NDPP/YDPP by primary care providers out of all referrals to NDPP/YDPP [rate: Numerator: number	Collected by the C3 from the NDPP/YDPP and/or referring provider and	Quarterly	February – April 2017

			of patients who receive a blood glucose test and referral to NDPP/YDPP by their primary care provider; Denominator: total number of referrals to NDPP/YDPP, including self-referrals and referrals from other community-based organizations]	entered into the SIM Data Portal		
		Total number of patients completing an NDPP/YDPP	Number of patients who complete NDPP/YDPP out of the total number of referrals [rate: Numerator: number of patients who attend a minimum of four sessions; Denominator: total number of referrals to NDPP/YDPP, including provider referrals, self-referrals, and referrals from other community-based organizations]	Collected by the C3 and entered into the SIM Data Portal by the C3	Quarterly	February – April 2017
Objective 6: Address Community-Wide Prevention						
Required Tactic		**Measure**				
		Measure	Description	Method of Collection	Frequency	Baseline & Method of Collection
6.1	Include a minimum of one tactic and supporting activity(ies) from the Diabetes or Obesity Statewide Strategy Plan to address Bucket 3: Community-Wide Prevention	Determined by Applicant - process measures for Objective 6 will be driven by Quality Improvement Work Plan development with SIM Quality Improvement Advisor.				
Objective 7: Develop and maintain the C3 structure						

Required Tactic		Measure				
		Measure	Description	Method of Collection	Frequency	Baseline & Method of Collection
7.1	Ensure C3 alignment with the Accountable Communities of Health model	Process Measure	● Number of Steering Committee meetings ● Meeting attendance by required members [rate: number of required **members** attending each meeting; Denominator: number of required **members**] ● Total number of coalition partners attending coalition meetings (unique) [count]	Determined by applicant and submitted to the SIM data portal	Quarterly	February 1 – April 30, 2017 Coalition – no baseline
7.2	Align the hospital and Local LBOH CHNA/HIP	Process Measures	● Number of same or similar priorities in each CHNA ● Number of shared roles in each HIP	Submitted to IDPH in the 4th quarterly report for contract monitoring.	Annual	N/A
7.3	Prepare the delivery system for payment reform, including accessing VIS scores, etc.	Process Measures	Determined by applicant	Determined by applicant and submitted to IDPH	Determined by applicant based on activities	N/A
7.4	Participate in quality improvement activities, including performance improvement, participation in required trainings and evaluation	Process Measure	Completion of or update to a Quality Improvement Plan by June 30, 2018	Determined by applicant and submitted to the SIM data portal	Quarterly	N/A