

Chronic Disease Management Quality Improvement Program (CDM QIP) Indicators of Best Practice – 2024 update.

This document reflects the changes made in the revised 2024 CDM-QIP flowsheets. It contains information on the updated and newly introduced indicators for the four chronic diseases covered by CDM-QIP, including clear explanations of when each indicator must be met for payment and how physician compensation is evaluated. In the tables on the next 4 pages, changes from previous CDM QIP indicators are highlighted in yellow.

The CDM QIP indicators were selected to be process measures of some of the aspects of optimal chronic disease management, aligning with elements of care endorsed by Canadian clinical practice guidelines. They are not “perfect” and for some conditions there are other aspects of care that may be considered more important; for example, inquiring about hypoglycemia in a person with diabetes using insulin. However, with the recent changes to the CDM QIP flowsheets it is hoped that the indicators will promote best practice by prompting healthcare providers to ask appropriate questions, remind patients about screening, and ensure consideration of guideline recommended therapies or investigations. In addition, it is hoped that the collection of de-identified data for the four chronic diseases will facilitate the planning for enhanced health care delivery in Saskatchewan.

Since 2013, the CDM-QIP program has provided an annual Quality Improvement payment to physicians who participate in the program and submit patient data that satisfies all the indicators for each chronic condition on a per-patient, per-condition basis. The indicators are collected during patient visits over the course of twelve months. An additional 30-day "grace" period is available for the purpose of submitting the patient data. The 12-month payment anniversary period for a specific chronic condition commences with the export of the worksheet of the initial visit for that condition. Subsequently, each year, the same calendar date marks the commencement of the patient's next anniversary period for that condition. The minimum frequency of the completion of each indicator of best practice required for payment is outlined in the updated Indicator documents. For further details on payment requirements, please consult the ["Chronic Disease Management – Quality Improvement Program Payment Policy."](#)

Rationale for the frequency of the CDM-QIP indicators and why they are required at least once or twice within a 12-month period:

- Indicators of best practice recommended to be performed at least once every 6 months: *For optimal assessment and management, these clinical observations or 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 do CDM visits every 6 months. Therefore, these indicators are assessed for payment twice in a 12-month period.*
- Indicators of best practice recommended to be performed at least once every 12 months: *For clinically stable patients, it is acceptable to perform these observations, investigations or reviews at least once a year. Depending on clinical circumstances and disease stability, many of these reviews/observations/investigations will be performed more frequently; this is appropriate and encouraged for optimal patient care.*

CDM QIP indicators for revised flowsheets to be released in 2024.

Changes from 2016 document highlighted in yellow

DIABETES (DM)		
CDM indicators	CDM-QIP Indicator description (Indication of optimal clinical practice)	What the payment system looks for in a 12-month period for each patient (Based on indicator data exported from flowsheets or entered into EHR viewer)
Type of diabetes	Record whether patient has “type 1” or “type 2” or “other”	Type of diabetes needs to be noted in patient record and CDMQIP flowsheet <i>at least once for payment</i>
Blood pressure	Measurement of BP and recorded at least twice in 12 months	Presence of systolic and diastolic BP values on 2 separate dates
Monitoring of weight	Measurement of body weight at least once in 12 months (Height and BMI no longer required)	Presence of one weight value
Smoking status and smoking cessation advice	Smoking status reviewed and recorded at least twice in 12 months; cessation advice provided to smokers at least twice in 12 months	Presence of smoking status on 2 separate dates and presence of smoking cessation advice for patients who are smokers
Glycemic control	A1c performed and value recorded at least twice in 12 months	Presence of A1c value and test dates on 2 separate dates
Lipid screening	Lipid profile at least annually/as needed (testing influenced by age, duration of diabetes, CVD risk factors, treatment). LDL value recorded at least once in 12 months for patients aged 40-80 years	If patient age is 40-80 years, presence of 1 LDL cholesterol value and lipid test date
Nephropathy screening and monitoring	Urine ACR and eGFR recorded at least once in 12 months, and nephropathy status recorded (ACR not required if end-stage renal disease eGFR <15 mL/min)	Presence of 5 components: Urine ACR value and date of test, eGFR value and date of test, and nephropathy status. If eGFR value <15 mL/min the presence of 3 components is required: EGFR value and date and nephropathy status
Retinopathy screening and monitoring	Diabetic retinopathy status recorded at least once in 12 months	Presence of retinopathy status
Foot exam and peripheral neuropathy screening and monitoring	Diabetic foot exam completed at least once in 12 months, and peripheral neuropathy status recorded	Presence of diabetic foot exam and date and neuropathy status
Depression/psychosocial stress screening **	Depression/psychosocial stress evaluation performed at least once in 12 months	Presence of depression screening date and response of “Yes” or “No” to “experiencing low mood/anhedonia/anxiety”

** Screening for depression/stress has been modified; HCP now responds to the question “Patient experiencing low mood/anhedonia/anxiety?” with “Yes” or “No”. If response left blank or “Not asked” checked, the indicator will not be considered for QIP payment.

CORONARY ARTERY DISEASE (CAD)		
CDM indicators	CDM-QIP Indicator description (Indication of optimal clinical practice)	What the payment system looks for in a 12-month period for each patient (Based on indicator data exported from flowsheets or entered into EHR viewer)
Blood pressure	Measurement of BP and recorded at least twice in 12 months	Presence of systolic and diastolic BP values on 2 separate dates
Smoking status and smoking cessation advice	Smoking status reviewed and recorded at least twice in 12 months; cessation advice provided to smokers at least twice in 12 months	Presence of smoking status on 2 separate dates and presence of smoking cessation advice for patients who are smokers
Monitoring of weight	Measurement of body weight at least once in 12 months (Height and BMI no longer required)	Presence of one weight value
Lipid screening	Lipid profile at least annually/as needed. LDL value recorded at least once in 12 months	Presence on 1 LDL cholesterol value and lipid test date
Diabetes screening for patients who do not have diabetes	Fasting blood glucose or A1c tests performed at least once in 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 diabetes “flag” in the payment system, one fasting glucose value and test date or one A1c value and test date must be present
Statin therapy/use	Statin therapy/use assessed and recorded at least once in 12 months	Presence of 1 of the statin therapy responses
ACE inhibitor or ARB therapy/use	ACE inhibitor or ARB therapy/use assessed and recorded at least once in 12 months	Presence of 1 of the ACE inhibitor or ARB therapy responses
Beta-blocker therapy/use	Beta-blocker therapy/use assessed and recorded at least once in 12 months	Presence of 1 of beta-blocker therapy responses
Antiplatelet agent therapy/use	Antiplatelet therapy/use assessed and recorded at least once in 12 months	Presence of 1 of the antiplatelet therapy responses
Depression/psychosocial stress screening **	Depression/psychosocial stress evaluation performed at least once in 12 months	Presence of depression screening date and response of “Yes” or “No” to “experiencing low mood/anhedonia/anxiety”

** Screening for depression/stress has been modified; HCP now responds to the question “Patient experiencing low mood/anhedonia/anxiety?” with “Yes” or “No”. If response left blank or “Not asked” checked, the indicator will not be considered for QIP payment.

HEART FAILURE (HF)		
CDM indicators	CDM-QIP Indicator description (Indication of optimal clinical practice)	What the payment system looks for in a 12-month period for each patient (Based on indicator data exported from flowsheets or entered into EHR viewer)
Type of heart failure	Record whether patient has HFrEF, HFpEF or HFmEF	Type of HF needs to be noted in patient record and CDMQIP flowsheet <i>at least once for payment</i>
Assessment of HF functional status	NYHA functional class assessed and recorded at least twice in 12 months	Presence of NYHA functional class value on 2 separate dates
Blood pressure	Measurement of BP and recorded at least twice in 12 months	Presence of systolic and diastolic BP values on 2 separate dates
Volume assessment	Volume /fluid status assessed and recorded at least twice in 12 months	Presence of volume status response (euvolemic, hypovolemic, fluid overload) on 2 separate dates
Monitoring of weight	Measurement of body weight at least twice in 12 months	Presence of weight value on 2 separate dates
Smoking status and smoking cessation advice	Smoking status reviewed and recorded at least twice in 12 months; cessation advice provided to smokers at least twice in 12 months	Presence of smoking status on 2 separate dates and presence of smoking cessation advice for patients who are smokers
Diabetes screening for patients who do not have diabetes	Fasting blood glucose or A1c tests performed at least once in 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 diabetes “flag” in the payment system, 1 fasting glucose value and test date or 1 A1c value and test date must be present
Obstructive sleep apnea (OSA) screening	Screen for OSA at least once in 12 months	Presence of 1 of the OSA screening responses
ACE inhibitor or ARB or ARNI therapy/use	ACE inhibitor, ARB or ARNI therapy/use assessed and recorded at least once in 12 months	Presence of 1 of the ACE inhibitor, ARB or ARNI therapy responses
Beta-blocker therapy/use	Beta-blocker therapy/use assessed and recorded at least once in 12 months	Presence of 1 of the beta-blocker therapy responses
MRA therapy/use	MRA therapy/use assessed and recorded at least once in 12 months	Presence of 1 of the MRA therapy responses
Depression/psychosocial stress screening **	Depression/psychosocial stress evaluation performed at least once in 12 months	Presence of depression screening date and response of “Yes” or “No” to “experiencing low mood/anhedonia/anxiety”

** Screening for depression/stress has been modified; HCP now responds to the question “Patient experiencing low mood/anhedonia/anxiety?” with “Yes” or “No”. If response left blank or “Not asked” checked, the indicator will not be considered for QIP payment.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)		
CDM indicators	CDM-QIP Indicator description (Indication of optimal clinical practice)	What the payment system looks for in a 12-month period for each patient (Based on indicator data exported from flowsheets or entered into EHR viewer)
Confirmed diagnosis of COPD FEV1 no longer an indicator but confirmation of COPD by spirometry/PFT recommended. This indicator reassessed annually to align with CPGs.	Assess and record spirometry confirmation of COPD diagnosis and/or reason why spirometry/PFT not done. This should be done at least once in 12 months. (Spirometry/PFT confirmation of diagnosis is recommended unless patient too frail to perform this test)	Presence of Yes or No response to “spirometry confirmation of diagnosis” and 1 of the additional 4 response options: *Spirometry done FEV1/FVC < 0.7 *Confirmed by specialist/in hospital *Clinically suspected, patient too frail for spirometry *Spirometry not done, will refer
Smoking status and smoking cessation advice	Smoking status reviewed and recorded at least twice in 12 months; cessation advice provided to smokers at least twice in 12 months	Presence of smoking status on 2 separate dates and presence of smoking cessation advice for patients who are smokers
Depression/psychosocial stress screening **	Depression/psychosocial stress evaluation performed at least once in 12 months	Presence of depression screening date and response of “Yes” or “No” to “experiencing low mood/anhedonia/anxiety”
Assessment of COPD functional status	mMRC dyspnea scale assessed and recorded at least twice in 12 months	Presence of mMRC dyspnea scale value on 2 separate dates
COPD exacerbations	Record number of exacerbations and whether or not patient has an action plan at least once in 12 months	Presence of responses for both number of exacerbations and “patient has action plan”
Oxygen saturation	Oxygen saturation measured and recorded at least twice in 12 months	Presence of oxygen saturation value on 2 separate dates
Obstructive sleep apnea (OSA) screening	Screen for OSA at least once in 12 months	Presence of 1 of the OSA screening responses
LABA therapy/use	LABA therapy/use assessed and recorded at least once in 12 months	Presence of 1 of the responses for LABA therapy or LABA+LAMA therapy or ICS+LABA or ICS+LABA+LAMA therapy
LAMA therapy/use	LAMA therapy/use assessed and recorded at least once in 12 months	Presence of 1 of the responses for LAMA therapy or LABA+LAMA therapy or ICS+LABA+LAMA therapy
Assessment of need for ICS (inhaled corticosteroid)	Assess and record ongoing indication /clinical need for ICS at least once in 12 months	Presence of 1 of the responses for “review ongoing need for ICS”
Optimal inhaler device and technique	Inhaler device and technique reviewed and recorded at least once in 12 months	Presence of 1 of the optimal inhaler device/technique responses

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