

Minimum Documentation Requirements for Quality Measures

Measurement Year 2025

Quality Measure	Minimum Documentation Requirements
All Cancer Screenings	Breast (BCS), Colon (COL), Cervix (CCS): Name of screening, Date of Screening (as much of date as possible, at least the year). And brief result (Ex. Normal or Abnormal)
Control Blood Pressure	CBP and HTN-2: Notation in a chart note dated in measurement year of a blood pressure under 140/90. (most recent result)
Diabetes Eye Exam	EED: Notation of the date of eye exam in measurement year, Name of the eye test performed, and the Name of the Provider who performed the eye exam
Diabetes Blood Pressure	BPD: A notation in a chart note dated in the measurement year of a blood pressure under 140/90 (most recent result)
Diabetes Hemoglobin A1c Control	GSD: Documentation of A1c testing date and a result less than 9 during the measurement year. (most recent result) or the GMI (Glucose Management Index).
Diabetes Kidney Health	KED: Copy of the eGFR (estimated glomerular filtration rate) and the uACR (urine albumin-creatinine ration) lab results during the measurement year.
Care of Older Adults	COA – Functional Status Assessment (FSA): Documentation in a chart note during the measurement year that Assesses at least 5 ADL or 4 IDAL with the DOS included.
Care of Older Adults	COA- Medication Review: Indication in a chart note dated during the measurement year that the medications were reviewed, and a Med list is present. MUST HAVE BOTH.
Advance Care Planning	ACP: Notation in a chart note dated during the measurement year that an ACP discussion occurred or the presence of including but not limited to, POST, PQA Health, Living Will etc. Document time spent on this subject.
Depression Screening	Prev – 12: Notation of the completed depression screening and the date of the screening with a brief result. Do not need the PHQ-9 score. IF the provider diagnosis patient as Positive for depression must have a follow up plan documented in the chart note. (Does not need to be completed). IF Negative for depression state “negative no need for follow-up.”
Depression Remission at 12 Mo.	MH-1: Patient must have DX of major depression or dysthymia AND a PHQ-9 score of greater than 9 between 11.1.2023 to 10.31.2024. 12 later +/- 60 days have a PHQ-9 of less than 5. Need both PHQ-9 data to be compliant.
Post Discharge Med Reconciliation	TRC: In the hospital follow up note within 30 days of discharge must have a notation of the hospital stay and that the medications were reconciled at that visit.
Tobacco Screening & Cessation Intervention	PREV-10: Notation in the on a visit not during the measurement year, stating if the patient is a smoker or not a smoker. If the patient identifies as a smoker must have a notation that the clinician offered or attempted counsel the patient for tobacco cessation, then the intent of the measure is met.
Fall Screening	CARE-2: Date of Screening and a result of positive or negative for falls. If positive for falls document a brief, follow up plan. (Referrals to OT, PT, Meds, educations etc.)
Influenza Immunization	PREV-7: Documentation of a flu shot during flu season. Need documentation of the name of the vaccination and the date (Aug 1, 202 – March 31, 2025) or documentation of refusal reason.

