August 7, 2026

Kansas Rural Health Transformation Plan
Evidence-Based Practice Program
Frequently Asked Questions – Clinical Performance Measures

Contents

1.0 Hospital Measures

1.1 Chest Pain - STEMI and NSTEMI Patients

For facilities with Cath Lab capabilities that do not transfer STEMI patients, should the performance goal be time to Cath Lab intervention rather than transfer time, and what is the expected target timeframe?

For facilities with Cath Lab capabilities, the focus is on timely cardiac catheterization rather than transfer time. The goal is to transfer the patient from the ED to cath lab within 90 min for STEMI. Patients without STEMI identified on arrival, but at higher risk—such as those with a HEART score ≥7 (TIMI 4 or higher), unstable conditions, refractory angina, or arrhythmias—should generally undergo catheterization within 6 hours, with some ACC benchmarks targeting approximately 4 hours. Facilities with Cath Lab capabilities are often well-positioned to meet these measures for STEMI and high-risk NSTEMI/UA. Even if performance is consistently at or near 100%, facilities should continue to track, report, and enter all eligible patients. Ongoing monitoring provides valuable data for performance assessment and quality improvement efforts.

Other sites, who don't have PCI capabilities, are not required to report the time the patient arrives at the PCI facility at this time. You should arrange to get these times so you can track whether the patient is arriving within 90 min from ED arrival at your facility or that the cath was done within the 120 min. national benchmark, as some direct transfer sites are switching to becoming lytic hospitals when the majority of their patients are not arriving at PCI at 90/Cath at 120.

We are using an ACS order set aligned with the new EBPP guidelines and have questions about the risk stratification criteria. The TIMI and HEART score thresholds used to determine the appropriate EBPP pathway appear to differ from those used in the order set to determine which NSTEMI patients should be transferred to a higher level of care within 6 hours of arrival. Should we update our order sets to align with the new EBPP guidelines, or should we continue using the existing order set criteria?

A TIMI score ≥4 identifies patients at intermediate to high risk for major adverse cardiac events, and current 2025 AHA/ACC guidance supports an early invasive strategy for NSTEMI patients with elevated troponin and high-risk TIMI or HEART scores. However, risk scores should be used alongside clinical judgment. Patients with persistent angina, hemodynamic instability, heart failure, or significant arrhythmias may require urgent transfer and catheterization regardless of their score. In short, use the scores to help assess risk, but let the patient's clinical presentation guide transfer and treatment decisions.

What if external factors prevent a hospital from transferring a patient who has received Lytic within 90 minutes?

In these cases, enter the reason for the delay in transferring the patient to identify later performance improvement opportunities (e.g., bed availability, transportation).

With NSTEMI, may a hospital establish different pathways for Type 1 and Type 2 given clinical differences?

A patient at a rural facility who remains symptomatic or are unstable should be transferred within 6 hours, whether Type 1 or Type 2. If the patient is not transferred within this period, enter the reason for the delay to identify later performance improvement opportunities.

1.2 Sepsis with Hypotension – Timely Vasopressor Utilization

The CMS proposed *Sepsis with Hypotension* quality measure requires vasopressor administration within 6 hours of time zero, while the RHTP EBPP QI measure specifies 2 hours. Will the EBPP QI measure align with the CMS sepsis guidelines, or will it continue to use the 2-hour requirement?

No. The EBPP QI Measure will continue to use the 2-hour vasopressor requirement and is based on Surviving Sepsis Campaign clinical guidelines, not CMS reporting criteria for their QI measures. The EBPP measure focuses on early sepsis management: protocol activation, IV fluid initiation, assessment of hypotension, administration of at least 600 cc of crystalloid within 2 hours, and vasopressor initiation if the patient remains hypotensive after fluid resuscitation. Unlike CMS SEP-1, the EBPP does not evaluate all the CMS sepsis quality bundle elements.

If a patient becomes hypotensive after the sepsis protocol has already been initiated, including within the first hour of ED arrival, how should the Sepsis with Hypotension measure be applied?

Yes. If a patient becomes hypotensive after the sepsis protocol is activated, the case still qualifies for reporting. The timing should start when hypotension is identified, and vasopressor administration should be measured from that point rather than from initial protocol activation.

Does a patient qualify based on a single hypotensive blood pressure reading, or is more than one reading required?

A single hypotensive reading is sufficient if the patient is suspected of having sepsis and the sepsis protocol is activated. This includes SBP <90 mmHg, a 40 mmHg drop from baseline, or MAP <65 mmHg. While hypotension may improve with fluid resuscitation, it can be transient, so patients with sepsis and hypotension should still be considered for this measure.

Should IV fluids be initiated only for patients with hypotension, or also for patients with a lactate level greater than 4?

Correct. Elevated lactate (>4) should prompt fluid resuscitation, but it is not a reporting element of this QI measure. The measure focuses on hypotension, including timely fluids and vasopressors if hypotension persists. Patients with elevated lactate but no hypotension should receive fluids, while vasopressors are reserved for persistent hypotension despite fluid resuscitation.

There is concern this measure may be too restrictive for patients who meet sepsis protocols based on SIRS criteria but do not receive a diagnosis of sepsis (e.g., diagnosed with urosepsis instead). Would these cases be excluded from the measure, even though they met the sepsis protocol?

Yes. Only patients with sepsis and hypotension are eligible for this measure. The measure was intentionally designed to address a known performance gap that is not already tied to reimbursement. Hospitals with few or no eligible patients in a quarter may have no cases to report and should focus on reporting other qualifying QI measures to meet program requirements.

Our providers are concerned that patients with certain conditions (e.g., CHF, ESRD) may be overloaded if given 600-700cc within 1 hour of activation. Can these patients be excluded, provided the reason is documented in the medical record?

A hospital may exclude these patients from reporting. Evidence-based guidelines are just that – guidelines – and do not replace clinical judgement. Also, it is permissible to measure time from when the IV was started rather than when the protocol was activated. The measure goal is to have "at least" 600 cc of fluid administered within 2 hours and if still hypotensive starting the vasopressor (although that may be started earlier based on clinical judgement). As there is no easy way to determine how much fluid a patient receives in the first two hours, a hospital may calculate continuous IV rates and boluses and enter manually.

1.3 Hospital Discharge Checklists

Do eligible cases include only patients discharged home, and how should patients discharged to a swing bed and later discharged home be reported?

These measures apply to patients who are discharged home or back into the community, not to those discharged to long-term care, assisted living, rehabilitation facilities, or other institutional settings. Patients discharged from a swing bed to home are eligible, as are patients discharged home after a 23-hour observation stay, because they may have medication changes and require follow-up for their underlying diabetes or heart failure. QHI will allow facilities to identify the discharge type (acute inpatient, swing-bed, observation, SNF)

For the diabetes checklist measure, should all patients with a documented diabetes ICD-10 diagnosis be included, regardless of the reason for the admission, or only those admitted for a diabetes-related condition?

Any patient with a documented diabetes diagnosis should be included, regardless of the reason for the inpatient or swing bed admission or the 23-hour observation stay.

Is a formal checklist required at discharge, or is it sufficient to document that all required elements were addressed throughout the hospitalization and discharge process?

Each organization may choose the approach that works best for them. A paper checklist can help track completion of discharge elements and support auditing, while electronic workflows within the EHR may also be used. The key is to ensure all required elements are completed and documented, regardless of the format.

By what means can a hospital share a patient's most recent LVEF with other providers involved in the patient's care?

In addition to transmitting the LVEF to other providers, a hospital may provide the patient with a hard copy upon discharge or post the results to the patient portal, relying on the patient to deliver the information to other providers.

For the heart failure discharge checklist, if a patient has not had an echocardiogram within the past year and their LVEF is therefore unknown, can the requirement be met by scheduling an echocardiogram at discharge, or must the LVEF be available before discharge to count toward the checklist?

If an echocardiogram has been performed within the past year, the existing LVEF may be used. If a more current assessment is clinically indicated, scheduling an echocardiogram as part of the discharge plan is acceptable. In those cases, document the most recent available LVEF and note that a follow-up echocardiogram has been ordered or scheduled. For QHi reporting, this measure is an attestation, so documenting the available LVEF and planned follow-up is sufficient to meet the requirement. Additional reporting guidance will be provided to support consistent reporting when a recent echocardiogram is not available.

For the discharge checklists, does the follow-up appointment need to be scheduled within the specified time frame or does the appointment need to occur within the time frame?

Patients admitted for heart failure or for DKA/HHS should be contacted by telephone or be seen virtually or in person within 3 days of discharge. Discharged patients with a chronic diagnosis of heart failure (but not admitted for heart failure) should be seen within 7 days, while those with a chronic diagnosis of diabetes should be seen within 4 weeks.

For diabetes, should the follow-up be with an endocrinologist or with a primary care provider? For heart failure, should the follow-up be with a cardiologist or with a primary care provider?

Either a specialist or a primary care provider may provide follow-up. In rural communities, follow-up care will likely be the responsibility of the patient's primary care provider who manages all the patient's chronic conditions.

1.4 Discharge Medication Reconciliation Checklist

For the Medication Reconciliation measure, how many patients are required to be included in the sample for reporting purposes?

Medication reconciliation should be completed for all discharged patients as part of standard care. For reporting purposes, organizations submit up to 15 eligible cases/quarter in which medication reconciliation was completed, using random selection if more than 15 qualifying cases are available in a quarter to report. Rural Emergency Hospitals may have fewer eligible cases, but 23-hour observation patients may qualify when medication changes are made, and medication reconciliation is completed before discharge.

Should patients who transition from an inpatient stay to a swing-bed stay be included as eligible discharges, or does the measure apply only to patients discharged from the facility to another setting, such as home or community-based care?

Only patients discharged home are considered eligible. Patients transferred from acute care to a swing bed, skilled nursing facility, long-term care facility, or another healthcare setting should not be included. The measure is intended to evaluate medication reconciliation completed at the time of discharge home following an acute care or swing bed admission or 23-hour observation stay. Transfers to swing beds or other facilities are considered a continuation of care rather than a discharge home and therefore do not qualify for this measure.

What discharges qualify under the hospital discharge medication reconciliation measure?

Qualifying discharges include inpatient discharges (except for inpatients discharged to swing bed status or to a skilled nursing facility), swing bed discharges, and prolonged emergency room stays (up to 23-hour observation) that do not end with an admission or transfer.

If the medication list has been reviewed, validated, and reviewed with the patient through MyChart, would that be considered sufficient to meet this measure requirement?

Yes. If the medication list has been reviewed, validated, and confirmed with the patient through MyChart, it is considered acceptable for meeting this element of the measure. The intent is to ensure the medication list has been reconciled and verified with the patient following discharge.

What communication, if any, has been provided to retail pharmacies regarding the receipt of these documents?

The measure focuses on establishing a process for sharing updated medication lists with the patient's pharmacist to improve care coordination and ensure the care team has current medication information. While pharmacies may face practical and reimbursement limitations, the goal is communication and collaboration, not pharmacist action. This team-based approach helps identify medication discrepancies and improve patient safety.

Some pharmacies are pushing back on providers sending patient medication lists, claiming it will muddy up their faxes with information that pharmacies have not requested. Can a provider satisfy this measure by giving the patient a medication list the patient can share with the pharmacy?

The evidence-based practice to which the medication reconciliation measures are tied is communicating medication changes to the patient's care team – including pharmacists - to support safe, coordinated care. As a matter of best practice, the provider should send the updated medication list (not the historical medication list) to the patient's pharmacy of choice. If this is not feasible, the measure is satisfied if the patient can access the updated medication list from a portal to share with their pharmacist. The Care Collaborative will be meeting with the Kansas Pharmacist Association in a few weeks to have a conversation regarding how their membership would like to manage this.

1.5 ED Arrival to Contact with Qualified Medical Personnel (QMP)

Can contact with an AVEL Telehealth provider be used to meet the QMP response-time requirement, or should response time be measured only from contact with the on-site or admitting provider?

AVEL Telehealth can provide immediate clinical support before the on-call provider arrives. However, for this measure, response time is based on the arrival of the on-site provider in the emergency department, consistent with Critical Access Hospital requirements that the on-call provider be physically present within 30 minutes of being called. Telehealth support may enhance patient care, but it does not replace the provider arrival component being measured. Organizations should report cases based on the time from provider notification to the arrival of the on-call provider. Quality improvement data are used for learning and performance improvement and are not shared in a way that identifies individual organizations or providers.

2.0 Clinic Measures

2.1 Abnormal WtHR (Waist to Height Ratio) with Documented Action Plan AND Referral to Community Service Provider

How should the referral component of the measure be handled if a patient declines a referral or if a Community Health Worker (CHW) is not available in the local community?

You will be able to document patient refusal to community resources on this measure. CHW availability varies across Kansas and there is a goal with the KS RHT Plan to deploy more across communities specifically to assist with food-is-medicine efforts. Clinics do not need a formal CHW referral pathway to meet this measure. When a CHW is unavailable, organizations may refer patients to other appropriate community resources, such as community-based organizations, WIC, SNAP, food banks, extension offices, or nutrition assistance programs. The intent of the measure is to connect patients with appropriate support services, not only for access to healthy food, but for education and behavioral health approaches to weight loss and healthy lifestyles. Any documented referral or action supporting healthy eating, physical activity, or lifestyle improvement (e.g., dietitians, behavioral health, food banks, or other community resources) is acceptable.

Would provider counseling or the prescribing/adjustment of medication during the office visit satisfy the intervention/referral requirement, or is a separate referral still required?

Not typically. If that is your specialty or you have someone in your practice with obesity management training, that would suffice. Counseling or medication management alone would not generally satisfy the referral requirement unless it is part of a well-defined, evidence-based obesity management program. Such programs often include referrals to a dietitian, nutritionist, or other resources that support healthy eating, physical activity, and sustainable lifestyle changes. The intent of the measure is to connect patients with appropriate community or regional resources that can support long-term health improvement.

Is screening expected at every patient visit, or can it be limited to specific visit types such as annual wellness exams, well-child visits, chronic disease follow-ups, or other preventive care encounters? Providers have expressed concerns that performing this screening during acute visits, such as for a URI or UTI, may not be appropriate.

Providers are not expected to do the waist measurement at each visit. Opportunities to incorporate it can focus on Annual Wellness Visits (AWVs), well-child visits, chronic disease follow-ups, and patients with a BMI >25. Patients are not used to having the waist circumference measured, so developing talking points for staff to emphasize the value of this measure in assessing patient cardiometabolic risks will be necessary. It can help the patient focus less on their scales and more on reducing the abnormal adiposity that increases this cardiometabolic risk.

Measuring waist circumference in these settings can help identify patients with a WtHR >0.52, which qualifies for this measure in patients ages 6–70 years and places them at least in CKM Syndrome Stage 1. Screening is not expected at every visit, and providers may find it less appropriate to obtain this measurement during acute visits, such as those for a URI or UTI. The screening only needs to be completed once annually. More frequent monitoring may be appropriate in certain circumstances, but it would generally not be expected more than twice per year.

2.2 For pediatric practices, how should WrHR be applied?

The measure can be used for children age 6 and older. For reporting purposes, patients 18 years of age and older are considered adults, while pediatric measures apply to patients under 18. Recent updates developed with QHi will follow this standard approach. Although the distinction has minimal impact on reporting, facilities should follow the current measure specifications.

How should clinics document waist-to-height ratio screening and any related weight diagnoses to meet quality measure requirements without creating potential insurance reimbursement issues, particularly when some payers may deny claims that include weight-related diagnoses?

For patients with a WtHR >0.5, consider whether they meet criteria for E88.810 (Cardiometabolic Syndrome), which reflects increased cardiometabolic risk and became effective October 1, 2025. If not, E65 (Localized Excess Fat) may be an appropriate alternative. Document and track the patient's WtHR and continue to code related chronic conditions, such as dyslipidemia or hypertension, when present. For patients whose only finding is an elevated WtHR, clinics may want to consider a registry or tracking method that does not rely on obesity-related diagnosis codes. The impact of using E65 on insurance reimbursement is not currently known.

2.3 Lung Cancer Screening

For patients with a normal low-dose CT (LDCT) lung cancer screening result, should annual screening continue throughout the eligible screening age range as long as the patient continues to meet the screening criteria?

Under current recommendations, patients who continue to meet eligibility criteria should continue annual LDCT lung cancer screening, even if previous screening results have been normal. A normal result does not eliminate future risk, particularly for patients who continue to smoke or have a significant smoking history. Eligibility should be reassessed over time, as changes in smoking history, screening guidelines, or insurance coverage may affect whether screening should continue. However, the general principle is that patients who remain eligible should continue to receive annual LDCT screening to support early detection of lung cancer.

For lung cancer screening eligibility, should a patient's vaping history be considered equivalent to cigarette smoking, or are eligibility criteria based only on traditional cigarette smoking history?

At this time, vaping history alone is not a criterion for LDCT lung cancer screening. Current screening recommendations are based on age and cigarette smoking history, including pack-years of tobacco exposure. Therefore, individuals who have only used e-cigarettes or vaping products do not qualify for screening based solely on vaping history. While vaping is not considered risk-free, there is currently insufficient long-term evidence to support its use in lung cancer screening eligibility criteria. For quality improvement reporting and clinical screening decisions, organizations should continue to follow established guidelines based on cigarette smoking history, recognizing that recommendations may evolve as additional evidence becomes available.

If a patient previously had a standard (full-dose) chest CT, can that study be used to meet the lung cancer screening measure, or is a LDCT specifically required?

Yes. If a full-dose CT scan was previously completed and meets the intent of lung cancer screening, it may be accepted for this measure. The goal is to ensure that eligible patients have received appropriate screening, regardless of whether it was performed using an LDCT or a previously completed full-dose CT.

Does a patient have to have ALL the lung cancer screening criteria to be included?

In general, patients should meet the established lung cancer screening criteria. However, patients screened because of other significant risk factors, such as radon exposure, occupational exposures, or other clinically appropriate high-risk factors, may also be included for reporting purposes.

Can providers receive additional reimbursement for lung cancer screenings?

CCA cannot advise providers on specific reimbursement-related questions. Please refer to this billing guide published by the American Lung Association for details regarding the use HCPCS G0296, counseling visit to discuss need for lung cancer screening using low dose CT.

2.4 Cardiovascular-Kidney Metabolic Syndrome

Are all actions listed on the reporting spreadsheet required for each patient, or is completion of a single appropriate action sufficient to meet the measure requirements?

At this time, the primary focus of the CKM Syndrome measure is to document the patient's CKM stage and any actions taken at the date of that encounter. Practices are not required to complete all actions listed on the spreadsheet. Acceptable actions may include medication adjustments, nutrition counseling referrals, weight management or lifestyle program referrals, or other interventions that address cardiovascular, kidney, or metabolic risk. Currently, reporting focuses on documenting the patient's CKM stage and associated clinical actions, with additional guidance expected as the measure continues to evolve toward a formal CMS quality measure.

Are cystatin C–based eGFR calculations acceptable for this measure, and does the measure require specific CKM-related treatments or focus primarily on identifying, staging, and managing patients with CKM syndrome and associated chronic conditions?

eGFR calculations that incorporate both cystatin C and creatinine are acceptable for this measure, and National Kidney Foundation guidance supports cystatin C as confirmatory testing in certain situations. While evidence-based therapies such as SGLT2 inhibitors and GLP-1 receptor agonists, or ns-MRA's may be important for patients with CKD, heart failure, and other cardiometabolic conditions, specific treatment requirements are not part of the measure criteria. The measure focuses on identifying patients with CKM syndrome, assessing disease stage, and recognizing associated chronic conditions to support appropriate risk stratification and goal-directed care.

For CKM Syndrome staging, the materials I have reviewed only describe Stages 1 and 2. Could you clarify the criteria for Stages 3 and 4 and where those stages can be found in the supporting resources?

Stages 3 and 4 of CKM Syndrome are described in greater detail in the accompanying flowchart. In general, Stage 3 is characterized by subclinical cardiovascular disease, while Stage 4 represents symptomatic cardiovascular disease. It is also important to recognize the connection between the CKM Syndrome and Elevated WtHR measures. Patients with a BMI >25 or WtHR >0.5 meet criteria for at least CKM Syndrome Stage 1 and may qualify for a higher stage depending on additional risk factors, comorbidities, and clinical findings. The goal of the measure is to identify the patient's current CKM stage and document appropriate interventions or management strategies.

What are the attestation requirements for eGFR testing, and when must the test be completed to meet measure requirements?

An eGFR completed within 12 months before the qualifying clinic visit meets the measure requirements. A repeat test is not required if a valid result is already available during that timeframe, helping avoid unnecessary duplicate testing and potential reimbursement issues.

For pediatric practices, how should the Cardiovascular-Kidney-Metabolic (CKM) Syndrome measures be applied, given that CKM syndrome is uncommon in children and pediatric clinics may not directly manage these conditions?

While CKM syndrome is uncommon in pediatric patients, an elevated BMI or abnormal waist-to-height ratio can identify children at increased future cardiometabolic risk. Clinics can meet the measure by identifying these risk factors and documenting appropriate interventions, such as counseling, education, referrals, or other preventive actions; direct management of the condition is not required. For reporting purposes, patients 18 years of age and older are considered adults, while pediatric measures apply to patients under age 18. Recent updates developed with QHi follow this standard approach. Although the distinction has minimal impact on reporting, facilities should follow the current measure specifications, which include 18-year-olds in the adult population.

2.5 Dementia Screening and Alzheimer's Blood Biomarker Selection

Which cognitive screening tools are acceptable for identifying mild cognitive impairment (MCI), and can tools such as the Mini-Mental State Examination (MMSE), Saint Louis University Mental Status (SLUMS), Short Test of Mental Status (STMS), or other validated cognitive assessments be used to meet the measure requirements?

No single cognitive screening tool is required. STMS, SLUMS, MOCA, MMSE, and Mini-Cog are all acceptable for reporting purposes. While some tools may be more sensitive for identifying early cognitive impairment, practices should use the tool that best fits their workflow and clinical experience. Screening results should always be interpreted in the broader clinical context. Cognitive screening scores alone do not establish a diagnosis. Input from the patient, family members, caregivers, and others familiar with the patient can provide important insight into changes in memory, thinking, judgment, and daily functioning. The goal is not simply to identify an abnormal score, but to recognize patients who may benefit from further evaluation, monitoring, or intervention based on both screening results and the overall clinical picture.

How can cognitive screening and assessment be incorporated into routine clinical practice when cognitive concerns are identified during a standard office visit, and what additional evaluation or follow-up steps should be considered when screening results or clinical observations suggest possible cognitive impairment?

When patients or family members express concerns about memory loss or cognitive changes, an initial cognitive screening can be performed during the visit. However, a comprehensive cognitive evaluation (CPT 99483) often requires additional time to obtain a detailed history, assess symptoms, gather input from family or caregivers, and perform further testing. Many practices address this by scheduling dedicated cognitive assessment visits or developing structured workflows for follow-up evaluation. These visits allow providers to focus on cognitive concerns, assess functional changes, determine whether additional testing is needed, and facilitate referral or specialist consultation when appropriate. Patients with persistent cognitive symptoms, concerning screening results, or functional decline may benefit from additional evaluation, including biomarker testing or specialty referral. The goal is to support earlier identification of cognitive disorders and ensure appropriate follow-up and treatment.

For patients undergoing evaluation for cognitive impairment or Alzheimer's disease, are blood-based biomarker tests covered by insurance, and if so, which biomarker tests are currently preferred or recommended for clinical use?

Several commercial laboratories offer blood-based biomarker testing for cognitive impairment and Alzheimer's disease, including p-tau217 and p-tau181 assays. P-tau217 is generally preferred because of its stronger sensitivity and specificity for amyloid-related pathology. Coverage varies by payer, test ordered, and individual patient circumstances. Documentation that secondary causes have been ruled out, the patient has abnormal screening tests, and additional cognitive and functional history has been corroborated by family members will likely be requested as part of prior authorization – it varies, so you will likely need to check.

When out-of-pocket costs apply, they are generally reported to be a few hundred dollars. These tests are expected to play an increasing role in the evaluation of cognitive impairment as evidence and clinical guidelines continue to evolve, and they may be ordered when clinically appropriate.

How should blood-based biomarker results for cognitive impairment and Alzheimer's disease be interpreted when values are only mildly elevated versus markedly elevated, and how should the degree of elevation influence clinical evaluation, diagnosis, and follow-up decisions?

Laboratory reports may include an indeterminate range that is not automatically flagged as abnormal, so clinicians should review the actual cutoff values and reference ranges rather than relying solely on laboratory flags. Blood-based biomarkers are primarily used to increase diagnostic confidence in patients with suspected Alzheimer's disease and to identify potential candidates for anti-amyloid therapy. When results are near the cutoff or the clinical picture is unclear, additional evaluation, such as specialist consultation or amyloid PET imaging, may be appropriate. When biomarker levels are clearly elevated and the clinical presentation is consistent with Alzheimer's disease, the results can provide additional diagnostic confidence. However, biomarkers are supportive evidence, not a standalone diagnosis, and false-positive and false-negative results can occur. Results should be interpreted alongside the patient's history, cognitive testing, functional changes, and overall clinical presentation. For patients being considered for anti-amyloid therapy, confirmatory imaging often remains part of the evaluation process.

On the Dementia Screening and Alzheimer's Blood Biomarker Selection flowchart, what is meant by "consult for advanced treatment" following an abnormal blood biomarker result?

The purpose of this measure is to promote cognitive screening, structured evaluation, and appropriate follow-up for patients with cognitive concerns. The reporting fields are intended for tracking purposes, not to require a specific workup or treatment pathway. Following a positive screening result, practices may perform additional evaluation, schedule a dedicated cognitive assessment visit, order laboratory tests, imaging, or blood biomarkers, and refer to a specialist when appropriate. Organizations should simply document the steps taken for that patient. The long-term goal is to support primary care practices in managing cognitive evaluations locally while reserving specialist referral for more complex cases or consideration of newer therapies.

Can providers receive additional reimbursement for dementia screenings?

CCA cannot advise providers on specific reimbursement-related questions. Screening for cognitive impairment is considered part of an annual wellness or office visit. Based on the screening results, a provider may perform a more detailed cognitive assessment and care plan which may be reimbursable under CPT 99483. More information is available here.

2.6 Starting Prenatal Care in First Trimester

Should reporting be based on confirmation that the patient completed a prenatal care visit during the first trimester, or is a referral or scheduled appointment sufficient to meet the measure requirements?

The primary intent of this measure is to document how patients identified as pregnant in the first trimester are connected to prenatal care. Acceptable actions include making a referral, scheduling an appointment, providing prenatal care resources, or otherwise assisting the patient in accessing services. For reporting, the focus is on documenting the actions taken to support timely entry into prenatal care and demonstrating appropriate care coordination, not on confirming that the patient completed a prenatal visit during the first trimester. A case remains eligible even if the patient is not seen by a prenatal provider during that timeframe. The measure is intended to evaluate and improve the processes used to identify pregnant patients, facilitate access to care, and support positive maternal and fetal outcomes.

Does the measure apply to patients who are currently pregnant, or can it also be reported retrospectively for patients who have already delivered based on when prenatal care was initiated during the pregnancy?

This measure applies to patients who are currently pregnant and in their first trimester at the time of the encounter. The focus is on early identification, referral, and care coordination to help patients access prenatal care as soon as possible. Appropriate actions may include referring the patient to a prenatal care provider, scheduling an obstetrical appointment, providing information about prenatal services, or connecting the patient with maternal health resources. For reporting purposes, the emphasis is on documenting these actions, rather than providing prenatal care directly.

What tests are accepted to confirm pregnancy?

A variety of methods may be used to confirm pregnancy for this measure, including a patient-reported positive home pregnancy test, a patient report that they are already receiving prenatal care, or a pregnancy test performed by the clinic, if available.

2.7 Postpartum Depression Screening

For patients with a positive postpartum depression screening, is there a required timeframe for completing a behavioral health consultation or is the expectation simply that appropriate follow-up and referral processes are initiated?

At present, there is no required timeframe for completing a behavioral health consultation after a positive EPDS or PHQ-9 screening. Patients with severe symptoms, suicidal ideation, or other urgent concerns should be managed according to the organization's emergency behavioral health processes. For patients who are not in crisis, the focus is on establishing a follow-up plan that may include counseling, behavioral health consultation, medication management, or other supportive services. For reporting purposes, the emphasis is on documenting the patient's follow-up and ongoing management, rather than meeting a specific referral or consultation deadline.

Does postpartum depression screening completed during well-child visits within the infant's first 12 months qualify for reporting under this measure, or must the screening be conducted during a maternal postpartum visit?

Yes. Postpartum depression screening completed during well-child visits within the infant's first year of life is acceptable for this measure. This aligns with the American Academy of Pediatrics' recommendations supporting postpartum depression screening throughout the first year after delivery. Well-child visits provide opportunities to identify postpartum depression, monitor symptoms, and connect patients with appropriate follow-up care. For reporting purposes, screenings completed during these visits qualify for the measure and may be used to identify patients who need further evaluation, treatment, or referral.

For the Postpartum Depression measure, will the PHQ-9 continue to be accepted, and if so, what score will be considered abnormal for reporting purposes?

Yes, the PHQ-9 may be used as an accepted screening tool for this measure. A PHQ-9 score of 10 or higher is considered abnormal and should prompt appropriate follow-up, assessment, or intervention. The expectation is that elevated scores are recognized and addressed as part of the patient's care plan.

If a patient was screened for postpartum depression using the EPDS at a 6-week postpartum OB/GYN visit, should they be screened again if they are seen by a primary care provider later during the first year after delivery?

Yes. Even if a patient was screened at a 6-week postpartum OB/GYN visit, additional screening during the first year after delivery is appropriate. Postpartum depression can develop at any point during the first 12 months, even when earlier screenings were normal. For clinics that routinely use depression screening tools, such as the PHQ-9, continued screening during postpartum visits is reasonable and may help identify new or worsening symptoms. For reporting purposes, screening performed during any encounter within the first year postpartum aligns with the intent of the measure and supports early identification, intervention, and follow-up.

If a postpartum depression screening is completed in a pediatric or OB clinic that is not enrolled in the program, can that screening be counted as completed for reporting purposes, or must the screening be performed within the clinic participating in the program?

For a screening to be counted as an eligible case for reporting, it must be performed within the clinic that is registered and participating in the program. Screenings completed at a pediatric, OB, or other clinic that is not enrolled in the program cannot be reported by a different participating clinic. The reporting clinic may only count screenings completed within its own registered clinic.

Can providers receive additional reimbursement for post-partum depression screenings?

CCA cannot advise providers on specific reimbursement-related questions. For information regarding KanCare coverage for PPD screening under CPT 96160 and 96161, refer to this Billing and Policy Guidance. Some payers reimburse PPD screenings under CPT 96127, brief emotional and behavioral assessments (e.g., PHQ-9, GAD-7), including scoring and documentation, per standardized instrument. If the mother is screened during an infant's well-child visit, some payers will reimburse under CPT 96161 or specific G-codes. Other payers include PPD screening in the global fee for obstetrical services for the immediate period following delivery. Note, however, the American Medical Association is discontinuing global maternity codes effective January 1, 2027, necessitating a change to these payers' policies.

2.8 Medication Reconciliation Less Than 30 Days Post-Discharge

When a primary care provider sees a patient after an inpatient stay and has already shared the updated medication list with the pharmacy, who should receive the medication reconciliation information to meet the measure requirements?

The appropriate recipients of medication reconciliation information depend on the patient's care team and clinical needs. In addition to the pharmacy, providers should consider whether medication changes need to be shared with specialists or other clinicians involved in the patient's care, particularly for patients with complex conditions, multiple comorbidities, or recent medication adjustments. The measure does not require communication with specific providers or every member of the care team. Rather, the focus is on ensuring medication changes are communicated appropriately to support safe, coordinated care. For reporting purposes, the emphasis is on completing and documenting the medication reconciliation process, with communication guided by what is most clinically appropriate for the individual patient.

Does this measure apply only to patients whose discharge the practice is aware of and has identified for follow-up, or are practices expected to capture all discharged patients regardless of how the discharge is identified?

Yes. This measure applies to patients whose discharge the practice is aware of and has identified for follow-up. Practices are not currently expected to capture every discharged patient; the focus is on identifying eligible patients and completing the measure requirements for those patients. Additional guidance may be forthcoming as KDHE evaluates approaches to improve post-discharge patient identification and tracking.

Some pharmacies are pushing back on providers sending patient medication lists, claiming it will muddy up their faxes with information that pharmacies have not requested. Can a provider satisfy this measure by giving the patient a medication list the patient can share with the pharmacy?

The evidence-based practice to which the medication reconciliation measures are tied is communicating medication changes to the patient's care team – including pharmacists - to support safe, coordinated care. As a matter of best practice, the provider should send the updated medication list (not the historical medication list) to the patient's pharmacy of choice. If this is not feasible, the measure is satisfied if the patient can access the updated medication list from a portal to share with their pharmacist. The Care Collaborative will be meeting with the Kansas Pharmacist Association in a few weeks to have a conversation regarding how their membership would like to manage this.

2.9 Medication Reconciliation Between Primary Care and Behavioral Health

How should organizations address medication reconciliation and care coordination when discharge summaries, medication lists, and care plans from behavioral health or psychiatric facilities—particularly for pediatric patients—are not readily available at the time of discharge?

Timely communication between behavioral health facilities and community providers is essential for safe, coordinated care, particularly when psychiatric medications require ongoing monitoring and management. When discharge summaries, medication lists, or care plans are not readily available, organizations should document these barriers as part of their quality improvement efforts. Identifying challenges such as delayed discharge communication and incomplete medication information can help inform broader efforts to improve care transitions and support more coordinated, informed care after discharge.

When behavioral health and primary care services are provided within the same organization and providers share access to a common medical record, what documentation is required to meet the medication reconciliation and care coordination measure requirements?

When behavioral health and primary care providers share the same medical record, separate notifications or duplicate documentation are generally not necessary. The focus is on documenting the appropriate action that occurred, such as a referral, consultation, follow-up, care team notification, or involvement of an internal behavioral health provider. For reporting purposes, documenting the completed referral or behavioral health involvement in the shared electronic health record is generally sufficient to demonstrate that the measure requirements have been met.