

2012 Physician Quality Reporting System
(Physician Quality Reporting)

Group Practice Reporting Option
(GPRO)

Narrative Measure Specifications

2012 Physician Quality Reporting GPRO Narrative Measure Specifications

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2012 Physician Quality Reporting GPRO Narrative Measure Specifications

Introduction

Group Practice Reporting Option (GPRO) is a reporting option for Physician Quality Reporting that incorporates some characteristics and methods from the demonstration projects, Medicare Care Management Performance (MCMP) and Physician Group Practice (PGP). In order to participate in the 2012 GPRO, practices are required to complete a self-nomination process and meet certain technical and other requirements.

For the purposes of 2012 GPRO, a "group practice" consists of a physician group practice as defined by a Tax Identification Number (TIN) with at least 25 or more individual eligible professionals [or as identified by individual National Provider Identifier (NPIs)] who have reassigned their billing rights to the TIN.

There are a total of 29 quality measures (27 which are National Quality Forum endorsed) included in GPRO targeting high-cost chronic conditions and preventive care. The measure specifications are grouped into seven disease modules: Care Coordination/Patient Safety (Care) (2 measures); Chronic Obstructive Pulmonary Disease (COPD) (1 measure); Coronary Artery Disease (CAD) (3 measures) Diabetes Mellitus (DM) (8 measures); Heart Failure (HF) (5 measures); Hypertension (HTN) (1 measure), Ischemic Vascular Disease (IVD) (2 measures) and Preventive Care measures (Prev) (7 measures).

A database pre-populated with an assigned beneficiary sample and the quality measures will serve as a data collection tool for groups to use in collecting and submitting data to the Centers for Medicare & Medicaid Services (CMS). The data collected will be based on services furnished during the January 1, 2012 through December 31, 2012 reporting period.

Group practices who satisfactorily submit data on quality measures via GPRO are eligible to earn an incentive of 0.5% of the group practice's Medicare Part B Physician Fee Schedule (PFS) total estimated allowed charges for covered professional services furnished by the group during the January 1, 2012 through December 31, 2012 reporting period. This incentive is in lieu of Physician Quality Reporting individual NPI's incentive payments.

Narrative measure specifications are being provided to allow group practices an opportunity to have a better understanding of each of the 29 quality measures included in 2012 GPRO.

Once a group practice is selected to participate in 2012 Physician Quality Reporting using the GPRO reporting option, additional detailed information will be provided.

Each Narrative Measure Specification Includes the Following Information:

- Symbol identifying measure developer and measure title
- NQF number
- Measure description
- Denominator statement
- Exclusions if applicable to measure
- Numerator statement
- Rationale statement(s)
- Clinical recommendations or evidence forming the basis for supporting criteria for the measure

2012 Physician Quality Reporting Care Coordination/Patient Safety Module

Narrative Measure Specification for GPRO Use ONLY

***GPRO Care-1 (NQF 0097): Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility**

DESCRIPTION:

Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented

DENOMINATOR:

All patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care

NUMERATOR:

Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

Definition:

Medical Record – Must indicate: The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.

RATIONALE:

Medications are often changed while a patient is hospitalized. Continuity between inpatient and on-going care is essential.

CLINICAL RECOMMENDATION STATEMENTS:

No trials of the effects of physician acknowledgment of medications post-discharge were found. However, patients are likely to have their medications changed during a hospitalization. One observational study showed that 1.5 new medications were initiated per patient during hospitalization, and 28% of chronic medications were canceled by the time of hospital discharge. Another observational study showed that at one week post-discharge, 72% of elderly patients were taking incorrectly at least one medication started in the inpatient setting, and 32% of medications were not being taken at all. One survey study faulted the quality of discharge communication as contributing to early hospital readmission, although this study did not implicate medication discontinuity as the cause. Assessing Care of Vulnerable Elders (ACOVE)

First, a medication list must be collected. It is important to know what medications the patient has been taking or receiving prior to the outpatient visit in order to provide quality care. This applies regardless of the setting from which the patient came — home, long-term care, assisted living, etc.

The medication list should include all medications (prescriptions, over-the-counter, herbals, supplements, etc.) with dose, frequency, route, and reason for taking it. It is also important to verify whether the patient is actually taking the medication as prescribed or instructed, as sometimes this is not the case.

At the end of the outpatient visit, a clinician needs to verify three questions:

1. Based on what occurred in the visit, should any medication that the patient was taking or receiving prior to the visit be discontinued or altered?
2. Based on what occurred in the visit, should any prior medication be suspended pending consultation with the prescriber?
3. Have any new prescriptions been added today?

These questions should be reviewed by the physician who completed the procedure, or the physician who evaluated and treated the patient.

- If the answer to ***all three questions*** is “no,” the process is complete.
- If the answer to ***any question*** is “yes,” the patient needs to receive clear instructions about what to do — all changes, holds, and discontinuations of medications should be specifically noted. Include any follow-up required, such as calling or making appointments with other practitioners and a timeframe for doing so. Institute for Healthcare Improvement (IHI)

2012 Physician Quality Reporting Care Coordination/Patient Safety Module

Narrative Measure Specification for GPRO Use ONLY

⌘ GPRO Care-2 (NQF 0101): Falls: Screening for Future Fall Risk

DESCRIPTION:

Percentage of patients aged 65 years and older who were screened for future fall risk at least once within 12 months

DENOMINATOR:

All patients aged 65 years and older

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusion only applied if patient was not screened for future fall risk)

- Documentation of medical reason(s) for not screening for future fall risk (e.g., patient is not ambulatory)

NUMERATOR:

Patients who were screened for future fall risk at least once within 12 months

Definition:

Fall - Is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.

NUMERATOR NOTE: *Patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year.*

RATIONALE:

Patients may not volunteer information regarding falls.

Data elements required for the measure can be captured and the measure is actionable by the physician.

CLINICAL RECOMMENDATION STATEMENTS:

All older persons who are under the care of a health professional (or their caregivers) should be asked at least once a year about falls. American Geriatrics Society/British Geriatrics Society/American Academy of Orthopaedic Surgeons (AGS/BGS/AAOS)

Older persons who present for medical attention because of a fall, report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should have a fall evaluation performed. This evaluation should be performed by a clinician with appropriate skills and experience, which may necessitate referral to a specialist (e.g., geriatrician). (AGS/BGS/AAOS)

Older people in contact with health care professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context, and characteristics of the falls. National Institute for Clinical Excellence (NICE) (Grade C)

Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. (NICE) (Grade C)

2012 Physician Quality Reporting COPD Disease Module

Narrative Measure Specification for GPRO Use ONLY

▲ GPRO COPD-1 (NQF 0102): Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV₁/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of COPD, who have an FEV₁/FVC < 70% and have symptoms (e.g., dyspnea, cough/sputum, wheezing)

NUMERATOR:

Patients who were prescribed an inhaled bronchodilator

Definition:

Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

RATIONALE:

Inhaled bronchodilator therapy is effective in treating and managing the symptoms of COPD, particularly, for those patients with moderate to very severe COPD, and improving a patient's quality of life.

CLINICAL RECOMMENDATION STATEMENTS:

Short-acting bronchodilators can increase exercise tolerance acutely in COPD. American Thoracic Society and European Respiratory Society (ATS and ERS)

Bronchodilator medications are central to the symptomatic management of COPD. (Evidence A) National Heart, Lung, and Blood Institute/World Health Organization (NHLBI/WHO)

A combination of a short-acting β_2 -agonist and an anticholinergic produces greater and more sustained improvements in FEV₁ than either alone and does not produce evidence of tachyphylaxis over 90 days of treatment. (Evidence A) (NHLBI/WHO)

In patients with Stage II: Moderate COPD to Stage IV: Very Severe COPD whose symptoms are not adequately controlled with as-needed short-acting bronchodilators, adding regular treatment with a long-acting inhaled bronchodilator is recommended. (Evidence A) (NHLBI/WHO)

Regular treatment with long-acting bronchodilators is more effective and convenient than treatment with short-acting bronchodilators, but more expensive. (Evidence A) (NHLBI/WHO)

2012 Physician Reporting Coronary Artery Disease Module

Narrative Measure Specification for GPRO I Use ONLY

► GPRO CAD-1 (NQF 0067): Coronary Artery Disease (CAD): Antiplatelet Therapy

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who were prescribed aspirin or clopidogrel

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusions only applied if patient was not prescribed aspirin or clopidogrel)

- Documentation of medical reason(s) for not prescribing aspirin or clopidogrel
- Documentation of patient reason(s) for not prescribing aspirin or clopidogrel
- Documentation of system reason(s) for not prescribing aspirin or clopidogrel

NUMERATOR:

Patients who were prescribed aspirin or clopidogrel

Definition:

Prescribed - May include prescription given to the patient for aspirin or clopidogrel at one or more visits in the measurement period OR patient already taking aspirin or clopidogrel as documented in current medication list.

RATIONALE:

Use of antiplatelet therapy has shown to reduce the occurrence of vascular events in patients with coronary artery disease, including myocardial infarction and death.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Aspirin should be started at 75 to 162 mg per day and continued indefinitely in all patients unless contraindicated (Class I Recommendation, Level A Evidence) American College of Cardiology/American Heart Association (ACC/AHA, 2007). Clopidogrel when aspirin is absolutely contraindicated. (Class IIa Recommendation; Level of Evidence B) (ACC/AHA, 2002)

2012 Physician Quality Reporting Coronary Artery Disease Module

Narrative Measure Specification for GPRO Use ONLY

► GPRO CAD-2 (NQF 0074): Coronary Artery Disease (CAD): Lipid Control

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result \geq 100 mg/dL and have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusions only applied if patient was not prescribed lipid-lowering therapy)

- Documentation of medical reason(s) for not prescribing lipid-lowering therapy
- Documentation of patient reason(s) for not prescribing lipid-lowering therapy
- Documentation of system reason(s) for not prescribing lipid-lowering therapy

NUMERATOR:

Patients who have a LDL-C < 100 mg/dL OR patients who have a LDL-C result \geq 100 mg/dL AND have a documented plan of care to achieve LDL-C < 100 mg/dL, including, at a minimum the prescription of a statin

Definitions:

Documented plan of care: Includes the prescription of a statin and may also include: documentation of discussion of lifestyle modifications (diet, exercise) or scheduled re-assessment of LDL-C.

Prescribed: May include prescription given to the patient for a statin at one or more visits within the measurement period OR patient already taking a statin as documented in the current medication list.

RATIONALE:

Managing LDL-C to less than 100 mg/dL through use of statins reduces risk of cardiovascular events.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Recommended lipid management includes assessment of a fasting lipid profile (Class I Recommendation, Level A Evidence). American College of Cardiology/American Heart Association (ACC/AHA, 2007)

- a. LDL-C should be less than 100 mg/dL (Class I Recommendation, Level A Evidence)

- b. Reduction of LDL-C to less than 70 mg/dL or high-dose statin therapy is reasonable (Class IIa Recommendation, Level A Evidence).
- c. If baseline LDL-C is greater than or equal to 100 mg/dL, LDL-lowering medications are used in high-risk or moderately high-risk persons, it is recommended that intensity of the therapy be sufficient to achieve a 30% to 40% reduction in LDL-C levels (Class I Recommendation, Level A Evidence).
- d. If on-treatment LDL-C is greater than or equal to 100 mg/dL, LDL-lowering therapy should be intensified (Class I Recommendation, Level A Evidence).
- e. If baseline LDL-C is 70 to 100 mg/dL, it is reasonable to treat LDL-C to less than 70 mg/dL (Class IIa Recommendation, Level B Evidence).

Statins should be considered as first-line drugs when LDL-lowering drugs are indicated to achieve LDL treatment goals. (The Third Report of the National Cholesterol Education Program [NCEP] Adult Treatment Panel III [ATPIII], 2002)

2012 Physician Quality Reporting Coronary Artery Disease Module

Narrative Measure Specification for GPRO Use ONLY

► GPRO CAD-7 (NQF 0066): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a current or prior LVEF < 40%

OR

All patients aged 18 years and older with a diagnosis of CAD who also have a diagnosis of diabetes

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusions only applied if patient was not prescribed ACE or ARB therapy)

- Documentation of medical reason(s) for not prescribing ACE or ARB therapy
- Documentation of patient reason(s) for not prescribing ACE or ARB therapy
- Documentation of system reason(s) for not prescribing ACE or ARB therapy

NUMERATOR:

Patients who were prescribed ACE inhibitor or ARB therapy

Definition:

Prescribed – May include prescription given to the patient for ACE inhibitor or ARB therapy at one or more visits in the measurement period OR patient is already taking ACE inhibitor or ARB therapy as documented in current medication list.

RATIONALE:

Nonadherence to cardioprotective medications is prevalent among outpatients with coronary artery disease and can be associated with a broad range of adverse outcomes, including all-cause and cardiovascular mortality, cardiovascular hospitalizations, and the need for revascularization procedures.

In the absence of contraindications, ACE inhibitors or ARBs are recommended for all patients with a diagnosis of coronary artery disease and diabetes or reduced left ventricular systolic function. ACE inhibitors remain the first choice, but ARBs can now be considered a reasonable alternative. Both pharmacologic agents have been shown to decrease the risk of death, myocardial infarction, and stroke. Additional benefits of ACE inhibitors include the reduction of diabetic symptoms and complications for patients with diabetes.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

ACE inhibitors should be started and continued indefinitely in all patients with left ventricular ejection fraction less than or equal to 40% and in those with hypertension, diabetes, or chronic kidney disease, unless contraindicated. (Class I Recommendation, Level A Evidence). American College of Cardiology/American Heart Association (ACC/AHA, 2007)

Angiotensin receptor blockers are recommended for patients who have hypertension, have indicators for but are intolerant of ACE inhibitors, have heart failure, or have had a myocardial infarction with left ventricular ejection fraction less than or equal to 40%. (Class I Recommendation, Level A Evidence). (ACC/AHA, 2007)

2012 Physician Quality Reporting Diabetes Mellitus Disease Module

Narrative Measure Specification for GPRO Use ONLY

◆ GPRO DM-2 (NQF 0059): Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%

DENOMINATOR:

Patients aged 18 through 75 years with the diagnosis of diabetes

WITHOUT

Diagnosis of polycystic ovaries, gestational diabetes or steroid induced diabetes

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients with most recent hemoglobin A1c level > 9.0%

RATIONALE:

Intensive therapy of glycosylated hemoglobin (A1c) reduces the risk of microvascular complications.

CLINICAL RECOMMENDATION STATEMENTS:

A glycosylated hemoglobin should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals. American Association of Clinical Endocrinologists/American College of Endocrinology (AAACE/ACE)

The A1c should be universally adopted as the primary method of assessment of glycemic control. On the basis of data from multiple interventional trials, the target for attainment of glycemic control should be A1c values $\leq 6.5\%$. (AAACE/ACE)

Obtain a glycosylated hemoglobin during an initial assessment and then routinely as part of continuing care. In the absence of well-controlled studies that suggest a definite testing protocol, expert opinion recommends glycosylated hemoglobin be obtained at least twice a year in patients who are meeting treatment goals and who have stable glycemic control and more frequently (quarterly assessment) in patients whose therapy was changed or who are not meeting glycemic goals. (Level of Evidence: E) American Diabetes Association (ADA)

Because different assays can give varying glycated hemoglobin values, the ADA recommends that laboratories only use assay methods that are certified as traceable to the Diabetes Control and Complications Trial A1c reference method. The ADA's goal for glycemic control is A1c < 7%. (Level of Evidence: B) (ADA)

Monitor and treat hyperglycemia, with a target A1c of 7%, but less stringent goals for therapy may be appropriate once patient preferences, diabetes severity, life expectancy and functional status have been considered. American Geriatrics Society (AGS)

2012 Physician Quality Reporting Diabetes Mellitus Disease Module

Narrative Measure Specification for GPRO Use ONLY

◆ GPRO DM-3 (NQF 0061): Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg)

DENOMINATOR:

Patients aged 18 through 75 years with the diagnosis of diabetes

WITHOUT

Diagnosis of polycystic ovaries, gestational diabetes or steroid induced diabetes

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients whose most recent blood pressure < 140/90 mmHg

RATIONALE:

Intensive control of blood pressure in patients with diabetes reduces diabetes complications, diabetes-related deaths, strokes, heart failure, and microvascular complications.

CLINICAL RECOMMENDATION STATEMENTS:

Recommends that a blood pressure (BP) determination during the initial evaluation, including orthostatic evaluation, be included in the initial and every interim physical examination. American Association of Clinical Endocrinologists/American College of Endocrinology (AAACE/ACE)

Blood pressure control must be a priority in the management of persons with hypertension and type 2 diabetes. American College of Physicians (ACP)

Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure > 130 mmHg or diastolic > 80 mmHg should have blood pressure confirmed on a separate day. Orthostatic measurement of blood pressure should be performed to assess for the presence of autonomic neuropathy. (Level of Evidence: E) American Diabetes Association (ADA)

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction, therefore monitor and treat hypertension and dyslipidemias. American Geriatrics Society (AGS)

Measurement of blood pressure in the standing position is indicated periodically, especially in those at risk for postural hypotension. At least two measurements should be made and the average recorded. After BP is at goal and stable, follow-up visits can usually be at 3- to 6-month intervals. Comorbidities such as heart failure, associated diseases such as diabetes, and the need for laboratory tests influence the frequency of visits. Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC)

All individuals should be evaluated during health encounters to determine whether they are at increased risk of having or of developing chronic kidney disease. This evaluation of risk factors should include blood pressure measurement. National Kidney Foundation (NKF)

2012 Physician Quality Reporting Diabetes Mellitus Disease Module

Narrative Measure Specification for GPRO Use ONLY

♦ GPRO DM-5 (NQF 0064): Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)

DENOMINATOR:

Patients aged 18 through 75 years with the diagnosis of diabetes

WITHOUT

Diagnosis of polycystic ovaries, gestational diabetes or steroid induced diabetes

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients with most recent LDL-C < 100 mg/dL

RATIONALE:

Persons with diabetes are at increased risk for coronary heart disease (CHD). Lowering serum cholesterol levels can reduce the risk for CHD events.

CLINICAL RECOMMENDATION STATEMENTS:

A fasting lipid profile should be obtained during an initial assessment, each follow-up assessment, and annually as part of the cardiac-cerebrovascular-peripheral vascular module. American Association of Clinical Endocrinologists/American College of Endocrinology (AACE/ACE)

A fasting lipid profile should be obtained as part of an initial assessment. Adult patients with diabetes should be tested annually for lipid disorders with fasting serum cholesterol, triglycerides, HDL cholesterol, and calculated LDL cholesterol measurements. If values fall in lower-risk levels, assessments may be repeated every two years. (Level of Evidence: E) American Diabetes Association (ADA)

Patients who do not achieve lipid goals with lifestyle modifications require pharmacological therapy. Lowering LDL cholesterol with a statin is associated with a reduction in cardiovascular events. (Level of Evidence: A)

Lipid-lowering therapy should be used for secondary prevention of cardiovascular mortality and morbidity for all patients with known coronary artery disease and type 2 diabetes. American College of Physicians (ACP)

Statins should be used for primary prevention against macrovascular complications in patients with type 2 diabetes and other cardiovascular risk factors.

Once lipid-lowering therapy is initiated, patients with type 2 diabetes mellitus should be taking at least moderate doses of a statin.

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction, therefore monitor and treat hypertension and dyslipidemias. American Geriatrics Society (AGS)

2012 Physician Quality Reporting Diabetes Mellitus Disease Module

Narrative Measure Specification for GPRO Use ONLY

◆ GPRO DM-7 (NQF 0055): Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient

DESCRIPTION:

Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam

DENOMINATOR:

All patients aged 18 through 75 years with a diagnosis of diabetes

WITHOUT

Diagnosis of polycystic ovaries, gestational diabetes or steroid induced diabetes

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients who had a dilated eye exam for diabetic retinal disease at least once within 12 months

RATIONALE:

Examination of the eyes is the first step in the treatment of any existing or developing conditions related to retinopathy and the first step in the prevention of blindness.

CLINICAL RECOMMENDATION STATEMENTS:

American Association of Clinical Endocrinologists/American College of Endocrinology (AACE/ACE), American Diabetes Association (ADA), and American Academy of Ophthalmology (AAO): Recommend that a dilated eye examination be performed on patients with diabetes during an initial assessment and at least annually thereafter. (AACE/ACE, 2002; ADA, 2004; AAO, 1998; Hammond, 1998)

American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE): Recommend that the annual eye examination be performed as part of a retinal module. The module includes test of visual acuity (Snellen chart); funduscopic examination and intraocular pressure (IOP) test. The AACE/ACE recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. AACE/ACE further believes that a dilated eye exam should only be done by an MD/DO. (AACE/ACE, 2002)

American Diabetes Association (ADA): Patients with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 3-5 years after the onset of diabetes. In general evaluation for diabetic eye disease is not necessary before 10 years of age. However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be used when applying these recommendations to individual patients. (Level of Evidence: B) Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after diabetes diagnosis. (Level of Evidence: B)

Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist who is knowledgeable and experienced in diagnosing the presence of diabetic retinopathy and is aware of its management. Examination will be required more frequently if retinopathy is progressing. This follow-up interval is recommended recognizing that there are limited data addressing this issue. (Level of Evidence: B)

Seven standard field stereoscopic 30° fundus photography is an accepted method for examining diabetic retinopathy. (ADA, 2004)

American Academy of Ophthalmology (AAO): Recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. Ophthalmologists with specialized knowledge and experience in managing the disease are best able to detect and treat serious disease. Stereoscopic photographs offer an advantage over nonstereoscopic photographs, and the traditional “seven stereo fields” provide the most complete coverage. (AAO, 1998; Hammond, 1996)

American Geriatrics Society (AGS): Dilated eye examinations should be performed every two years at a minimum, and more often if there are additional risk factors for diabetic eye disease or evidence of age-related eye disease. California Healthcare Foundation/American Geriatrics Society (CHF/AGS, 2003)

2012 Physician Reporting Diabetes Mellitus Disease Module

Narrative Measure Specification for GPRO I Use ONLY

♦ GPRO DM-8 (NQF 0056): Diabetes Mellitus: Foot Exam

DESCRIPTION:

The percentage of patients aged 18 through 75 years with diabetes who had a foot examination

DENOMINATOR:

Patients aged 18 through 75 years with a diagnosis of diabetes

WITHOUT

Diagnosis of polycystic ovaries, gestational diabetes or steroid induced diabetes

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusion only applied if patient did not receive a foot examination)

- Documentation of medical reason for not receiving foot exam (i.e., patient with bilateral foot/leg amputation)

NUMERATOR:

Patients who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam)

RATIONALE:

The most common consequences of diabetic neuropathy are amputation and foot ulceration American Diabetes Association (ADA, 2006). In developed countries, up to five percent of diabetic patients have foot ulcers International Diabetes Foundation (IDF, 2005). One in every six diabetics will have an ulcer during their lifetime (IDF, 2005). Amputation and foot ulceration are also major causes of morbidity and mortality. One half to 80% of all amputations are diabetes-related (Mayfield, 1998; Reiber, 1995; ADA, 2001; Unwin, 2000). The risk of ulcers or amputations increases the longer someone has diabetes. Early recognition and management of risk factors can prevent or delay adverse outcomes. (ADA, 2006)

CLINICAL RECOMMENDATION STATEMENTS:

American Association of Clinical Endocrinologists/American College of Endocrinology (AACE/ACE) and American Diabetes Association (ADA) recommend that a foot examination (visual inspection, sensory exam, and pulse exam) be performed during an initial assessment.

AACE/ACE (2002) recommends that a foot examination be a part of every follow-up assessment visit, which should occur quarterly.

ADA (2004) recommends that all individuals with diabetes should receive an annual foot examination to identify high-risk foot conditions. This examination should include assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity.

The ADA (2004) recommends that people with one or more high-risk foot conditions should be evaluated more frequently for the development of additional risk factors. People with neuropathy should have a visual inspection of their feet at every contact with a health care professional.

2012 Physician Quality Reporting Diabetes Mellitus Disease Module

Narrative Measure Specification for GPRO Use ONLY

◆ GPRO DM-10 (NQF 0575) Diabetes Mellitus: Hemoglobin A1c Control (< 8%)

DESCRIPTION:

The percentage of patients 18 through 75 years of age with a diagnosis of diabetes (type 1 or type 2) who had HbA1c < 8%

DENOMINATOR:

All patients 18 through 75 years of age with a diagnosis of diabetes (type 1 or type 2)

WITHOUT

Diagnosis of polycystic ovaries, gestational diabetes or steroid induced diabetes

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients with a most recent HbA1c test < 8%

RATIONALE:

This measure evaluates the percentage of patients in a specific age demographic who were diagnosed with type 1 or type 2 diabetes and who demonstrate adequate blood sugar control with an HbA1c level lower than 8 percent. Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including poor blood sugar control. Studies have shown that improved glycemic control is correlated with a 40% decline in the development of associated microvascular complications (i.e., eye, kidney and nerve diseases) American Diabetes Association (ADA 2009). Clinical guidelines recommend regular HbA1c testing to facilitate patients ability to improve and sustain acceptable levels (ADA 2009). This measure facilitates the maintenance and long-term management of adequate blood sugar levels for patients diagnosed with diabetes.

CLINICAL RECOMMENDATION STATEMENTS:

American Geriatric Society:

[1]For frail older adults, persons with life expectancy of less than 5 years, and others in whom the risks of intensive glycemic control appear to outweigh the benefits, a less stringent target such as 8% is appropriate. (Level III, Grade B)

[2]For older persons, target hemoglobin A1C should be individualized. A reasonable goal for A1C in relatively healthy adults with good functional status is 7% or lower. (Level III, Grade B)

American Diabetes Association:

[1]Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1C goal for nonpregnant adults in general is < 7%. (A)

[2]In type 1 and type 2 diabetes, randomized controlled trials of intensive versus standard glycemic control have not shown a significant reduction in cardiovascular disease (CVD) outcomes during the randomized portion of the trials. Long-term follow-up of the Diabetes Control and Complications Trial (DCCT) and UK Prospective Diabetes Study (UKPDS) cohorts suggests that treatment to A1C targets below or around 7% in the years soon after the diagnosis of diabetes is associated with long-term reduction in risk of macrovascular disease. Until more evidence becomes available, the general goal of < 7% appears reasonable for many adults for macrovascular risk reduction. (B)

[3]Subgroup analyses of clinical trials such as the DCCT and UKPDS and the microvascular evidence from the ADVANCE (Action in Diabetes and Vascular Disease: Preterax and Diamicon MR Controlled Evaluation) trial suggest a small but incremental benefit in microvascular outcomes with A1C values closer to normal. Therefore, for selected individual patients, providers might reasonably suggest even lower A1C goals than the general goal of < 7%, if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Such patients might include those with short duration of diabetes, long life expectancy, and no significant cardiovascular disease (CVD). (B)

[4]Conversely, less stringent A1C goals than the general goal of < 7% may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, and extensive comorbid conditions and those with longstanding diabetes in whom the general goal is difficult to attain despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple glucose lowering agents including insulin. (C)

2012 Physician Quality Reporting Diabetes Mellitus Disease Module

Narrative Measure Specification for GPRO Use ONLY

🎵 GPRO DM-11 (NQF 0729 as a composite): Diabetes Mellitus: Daily Aspirin Use for Patients with Diabetes and Ischemic Vascular Disease

DESCRIPTION:

Percentage of patients ages 18 to 75 years of age with diabetes mellitus and ischemic vascular disease with documented daily aspirin use during the measurement year unless contraindicated

DENOMINATOR:

Patients 18 to 75 years of age with a diagnosis of diabetes mellitus (established diabetic patient defined as two or more visits for diabetes in the last two years and at least one visit in the last 12 months) and a diagnosis of ischemic vascular disease

WITHOUT

Diagnosis of polycystic ovaries, gestational diabetes or steroid induced diabetes

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients with the diagnosis of diabetes and ischemic vascular disease with documentation of taking daily aspirin or have a documented contraindication in the measurement year

ACCEPTED CONTRAINDICATIONS:

- Anticoagulant use, Lovenox (Enoxaparin) or Coumadin (Warfarin)
- Any history of gastrointestinal (GI)* or intracranial bleed (ICB)
- Allergy to aspirin (ASA)

*Gastroesophageal reflux disease (GERD) is not automatically considered a contraindication but may be included if specifically documented as a contraindication by the physician.

The following may be exclusions if specifically documented by the physician:

- Use of non-steroidal anti-inflammatory agents
- Documented risk for drug interaction
- Uncontrolled hypertension defined as > 180 systolic, > 110 diastolic
- Other provider documented reason for not being on ASA therapy

RATIONALE:

According to the MN Department of Health, diabetes is a high impact clinical condition in Minnesota. More than 1 in 3 adults and 1 in 6 youth in Minnesota have diabetes or are at high risk of developing it. Each year more than 20,000 Minnesotans are newly diagnosed with diabetes. Diabetes is the sixth leading cause of death in Minnesota and is a significant risk factor in developing cardiovascular disease and stroke, non-traumatic lower extremity amputations, blindness, and end-stage renal disease. Diabetes costs Minnesota almost \$2.7 billion annually, including medical care, lost productivity and premature mortality. According to the American Diabetes Association, an estimated 23.6 million American children and adults have diabetes. Most people with diabetes have other risk factors, such as high blood pressure and cholesterol that

increase the risk for heart disease and stroke. In fact, more than 65% of people with diabetes die from these complications.

The most recent American Diabetes Association (ADA) Guideline published in January 2011 concludes that aspirin has been shown to be effective in reducing cardiovascular morbidity and mortality in high-risk patients with previous myocardial infarction or stroke (secondary prevention). Its net benefit in primary prevention among patients with no previous cardiovascular events is more controversial, both for patients with and without a history of diabetes. Two recent randomized controlled trials of aspirin specifically in patients with diabetes failed to show a significant reduction in cardiovascular disease (CVD) end points, raising further questions about the efficacy of aspirin for primary prevention in people with diabetes.


CLINICAL RECOMMENDATION STATEMENTS:

According to the 2011 ADA guidelines, the clinical recommendations for aspirin/ anti-platelet use included the following:

- Use aspirin therapy (75–162 mg/day) as a secondary prevention strategy in those with diabetes with a history of CVD
- Consider aspirin therapy (75–162 mg/day) as a primary prevention strategy in those with type 1 or type 2 diabetes at increased cardiovascular risk (10-year risk > 10%). This includes most men > 50 years of age or women > 60 years of age who have at least one additional major risk factor (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria).
- Aspirin should not be recommended for CVD prevention for adults with diabetes at low CVD risk (10-year CVD risk < 5%, such as in men < 50 and women < 60 years of age with no major additional CVD risk factors), since the potential adverse effects from bleeding likely offset the potential benefits.

2012 Physician Quality Reporting Diabetes Mellitus Disease Module

Narrative Measure Specification for GPRO Use ONLY

 GPRO DM-12 (NQF 0729 as a composite): Diabetes Mellitus: Tobacco Non Use

DESCRIPTION:

Percentage of patients with a diagnosis of diabetes who indicated they were tobacco non-users

DENOMINATOR:

Patients 18 through 75 years of age with a diagnosis of diabetes mellitus with two or more visits for diabetes during the current year or year prior and one visit within the measurement year

WITHOUT

Diagnosis of polycystic ovaries, gestational diabetes or steroid induced diabetes

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients 18 through 75 years of age with a diagnosis of diabetes who were identified as non-users of tobacco

RATIONALE:

There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in the primary care setting is successful in helping tobacco users quit U.S. Preventive Services Task Force (USPSTF, 2003). Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke (USPSTF, 2003).

Tobacco smoking increases risk of macrovascular complications about 4%-400% in adult with type 2 diabetes, and also increases risk of macrovascular complications. Although only about 14% of adult with diabetes in Minnesota are current smokers, in these patients, smoking cessation is very likely to be the single most beneficial intervention that is available (Institutes for Clinical Systems Improvement (ICSI) Diabetes Guideline pages 28 and 29).

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (USPSTF, 2003) During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. National Quality Forum ([NQF],2007). All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008) Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

In 2010 the American Diabetes Association recommended that a physician and patient should discuss and document specific treatment goals and develop a plan to achieve all desired goals pertaining to diabetes care. A multifactorial approach to diabetes care that includes emphasis on blood pressure, lipids, glucose, aspirin use, and non-use of tobacco will maximize health outcomes far more than a strategy that is limited to just one or two of these clinical domains. (American Diabetes Association, 2010 [R]; Duckworth, 2009 [A]; Gaede, 2008 [A]; Holman, 2008a [A])

2012 Physician Quality Reporting Heart Failure Disease Module

Narrative Measure Specification for GPRO Use ONLY

► GPRO HF-1 (NQF 0079): Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure for whom the quantitative or qualitative result (of a recent or prior [any time in the past] LVEF assessment) is documented within a 12 month period

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of heart failure

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients for whom the quantitative or qualitative result (of a recent or prior [any time in the past] LVEF assessment) is documented within a 12 month period

Instructions: Documentation must include documentation in a progress note of the results of an LVEF assessment, regardless of when the evaluation of ejection fraction was performed.

Definitions:

Qualitative results correspond to numeric equivalents as follows:

- Hyperdynamic: corresponds to LVEF greater than 70%
- Normal: corresponds to LVEF 50% to 70% (midpoint 60%)
- Mild dysfunction: corresponds to LVEF 40% to 49% (midpoint 45%)
- Moderate dysfunction: corresponds to LVEF 30% to 39% (midpoint 35%)
- Severe dysfunction: corresponds to LVEF less than 30%

RATIONALE:

Evaluation of LVEF in patients with heart failure provides important information that is required to appropriately direct treatment. Several pharmacologic therapies have demonstrated efficacy in slowing disease progression and improving outcomes in patients with left ventricular systolic dysfunction. LVEF assessed during the initial evaluation of patients presenting with heart failure can be considered valid unless the patient has demonstrated a major change in clinical status, experienced or recovered from a clinical event, or received therapy that might have a significant effect on cardiac function.

A comprehensive 2-dimensional echocardiogram with Doppler flow studies has been identified as the single most useful diagnostic test in the evaluation of patients with heart failure.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Two-dimensional echocardiography with Doppler should be performed during initial evaluation of patients presenting with HF to assess LVEF, LV size, wall thickness, and valve function. Radionuclide ventriculography can be performed to assess LVEF and volumes. Radionuclide ventriculography can be

performed to assess LVEF and volumes. (Class I, Level of Evidence: C) American College of Cardiology/American Heart Association (ACC/AHA, 2009)

Magnetic resonance imaging or computed tomography may be useful in evaluating chamber size and ventricular mass, detecting right ventricular dysplasia, or recognizing the presence of pericardial disease, as well as in assessing cardiac function and wall motion. American College of Cardiology Foundation/American Heart Association (ACCF/AHA, 2009)

2012 Physician Reporting Heart Failure Disease Module

Narrative Measure Specification for GPRO I Use ONLY



GPRO HF-2 (NQF N/A): Heart Failure (HF): Left Ventricular Function (LVF) Testing

DESCRIPTION:

Percentage of patients 18 years and older with LVF testing performed during the measurement period for patients hospitalized with a principal diagnosis of HF during the reporting period

DENOMINATOR:

All patients aged 18 years and older with a principal diagnosis of HF hospitalized during the reporting period

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusions only applied if patient did not receive LVF testing during the measurement period if patient was hospitalized for HF)

- Documentation of medical reason(s) for not obtaining LVF testing during the measurement period if patient was hospitalized for HF
- Documentation of patient reason(s) for not obtaining LVF testing during the measurement period if patient was hospitalized for HF

NUMERATOR:

Patients with LVF testing performed during the measurement period

RATIONALE:

Appropriate selection of medications to reduce morbidity and mortality in heart failure requires the identification of patients with impaired left ventricular systolic function. National guidelines advocate the evaluation of left ventricular systolic function as the single most important diagnostic test in the management of all patients with heart failure (Hunt, 2005). Despite these recommendations, left ventricular systolic function is not evaluated in a substantial proportion of eligible older patients hospitalized with heart failure. (Jencks, 2000)

CLINICAL RECOMMENDATION STATEMENTS:

In patients with HF, an assessment of left ventricular systolic function with 2-dimensional echocardiography or radionuclide ventriculography is recommended. (Class 1 Recommendation, Level-C Evidence) American College of Cardiology/American Heart Association (ACC/AHA)

In patients with a change in clinical status or clinical event/treatment with significant effect on cardiac function, repeat measurement of ejection fraction is recommended. (Level-C Evidence) (ACC/AHA)

2012 Physician Reporting Heart Failure Disease Module

Narrative Measure Specification for GPRO I Use ONLY



GPRO HF-5 (NQF 0082): Heart Failure: Patient Education

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure who were provided with patient education on disease management and health behavior changes during one or more visit(s) within 12 months

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of heart failure who were seen at least twice for any visits within 12 months

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients who were provided with patient education on disease management and health behavior changes* during one or more visits within 12 months

Definition: *Patient education should include one or more of the following: Weight monitoring; Diet (sodium restriction); Symptom management; Physical activity; Smoking cessation; Medication instruction; Minimizing or avoiding use of non-steroidal anti-inflammatory drugs (NSAIDs); Referral for visiting nurse, or specific educational or management programs; Prognosis/end-of-life issues.

RATIONALE:

Patient education is an essential nonpharmacological component to heart failure care. It may reduce the likelihood of noncompliance with recommended therapeutic strategies and lead to early identification of worsening clinical status and subsequent treatment. Heart failure disease management programs, in which patient education is an integral component, have been shown to be effective in improving self-care and reducing readmissions.

CLINICAL RECOMMENDATION STATEMENTS:

Patients at high risk for developing HF should be counseled to avoid behaviors that may increase the risk of heart failure (HF) (e.g., smoking, excessive alcohol consumption, and illicit drug use). (Class I, Level of Evidence: C) American College of Cardiology/American Heart Association (ACC/AHA, 2009)

It is recommended that patients with HF and their family members or caregivers receive individualized education and counseling that emphasizes self-care. (Strength of Evidence=B) Heart Failure Society of America (HFSA, 2006)

Essential Elements of Patient Education With Associated Skills and Target Behaviors (HFSA, 2006)

Elements of Education	Skill Building and Critical Target Behaviors
Definition of HF (linking disease, symptoms, and treatment) and cause of patient's HF	<ul style="list-style-type: none"> • Discuss basic HF information, cause of patient's HF, and how symptoms are related
Recognition of escalating symptoms and selection of appropriate treatments in response to particular symptoms	<ul style="list-style-type: none"> • Monitor for specific signs and symptoms (e.g., increasing fatigue doing usual activities, increasing shortness of breath with activity, shortness of breath at rest, need to sleep with increasing number of pillows, waking at night with shortness of breath, edema) • Perform and document daily weights • Develop action plan for how and when to notify the provider • Institute flexible diuretic regimen, if appropriate
Indications and use of each medication	<ul style="list-style-type: none"> • Reiterate medication dosing schedule, basic reason for specific medications, and what to do if a dose is missed
Importance of risk factor modification	<ul style="list-style-type: none"> • Smoking cessation • State blood pressure goal and know own blood pressure from recent measurement • Maintain normal HgA1c, if diabetic • Maintain specific body weight
Specific diet recommendations: individualized low-sodium diet; recommendation for alcohol intake	<ul style="list-style-type: none"> • Reiterate recommended sodium intake • Demonstrate how to read a food label to check sodium amount per serving and sort foods into high-and low-sodium groups • Reiterate limits for alcohol consumption or need for abstinence if history of alcohol abuse
Specific activity/exercise recommendations	<ul style="list-style-type: none"> • Reiterate goals for exercise and plan for achieving • Reiterate ways to increase activity level
Importance of treatment adherence and behavioral strategies to promote	<ul style="list-style-type: none"> • Plan and use a medication system that promotes routine adherence • Plan for refills

2012 Physician Quality Reporting Heart Failure Disease Module

Narrative Measure Specification for GPRO Use ONLY

► GPRO HF-6 (NQF 0083): Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%

DENOMINATOR NOTE: *LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe left ventricular systolic dysfunction*

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusions only applied if patient was not prescribed beta-blocker therapy)

- Documentation of medical reason(s) for not prescribing beta-blocker therapy
- Documentation of patient reason(s) for not prescribing beta-blocker therapy
- Documentation of system reason(s) for not prescribing beta-blocker therapy

NUMERATOR:

Patients who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at hospital discharge

Definition:

Prescribed – May include prescription given to the patient for beta-blocker therapy at one or more visits in the measurement period OR patient already taking beta-blocker therapy as documented in current medication list.

Beta-blocker therapy – should include bisoprolol, carvedilol, or sustained release metoprolol succinate.

RATIONALE:

Beta-blockers are recommended for all patients with stable heart failure and left ventricular systolic dysfunction, unless contraindicated. Treatment should be initiated as soon as a patient is diagnosed with left ventricular systolic dysfunction and does not have low blood pressure, fluid overload, or recent treatment with an intravenous positive inotropic agent. Beta-blockers have been shown to lessen the symptoms of heart failure, improve the clinical status of patients, reduce future clinical deterioration, and decrease the risk of mortality and the combined risk of mortality and hospitalization.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Beta-blockers (using 1 of the 3 proven to reduce mortality, i.e., bisoprolol, carvedilol, and sustained release metoprolol succinate) are recommended for all stable patients with current or prior symptoms of [heart failure] and reduced LVEF, unless contraindicated. (Class I, Level of Evidence: A) American College of Cardiology Foundation/American Heart Association (ACCF/AHA, 2009)

Treatment with a beta blocker should be initiated at very low doses [see excerpt from guideline table below], followed by gradual increments in dose if lower doses have been well tolerated... physicians, especially cardiologists and primary care physicians, should make every effort to achieve the target doses of the beta blockers shown to be effective in major clinical trials. (ACCF/AHA, 2009)

Beta Blockers Commonly Used for the Treatment of Patients with [Heart Failure] with Low Ejection Fraction

Drug	Initial Daily Dose(s)	Maximum Doses(s)
Beta Blockers		
Bisoprolol	1.25 mg once	10 mg once
Carvedilol	3.125 mg twice	25 mg twice 50 mg twice for patients > 85 kg
Metoprolol succinate extended release (metoprolol CR/XL)	12.5 to 25 mg once	200 mg once

For the hospitalized patient:

- In patients with reduced ejection fraction experiencing a symptomatic exacerbation of [heart failure] requiring hospitalization during chronic maintenance treatment with oral therapies known to improve outcomes, particularly [ACE inhibitors] or ARBs and beta-blocker therapy, it is recommended that these therapies be continued in most patients in the absence of hemodynamic instability or contraindications. (Class I, Level of Evidence: C) (ACCF/AHA, 2009)
- In patients hospitalized with [heart failure] with reduced ejection fraction not treated with oral therapies known to improve outcomes, particularly [ACE inhibitors] or ARBs and beta-blocker therapy, initiation of these therapies is recommended in stable patients prior to hospital discharge. (Class I, Level of Evidence: B) (ACCF/AHA, 2009)
- Initiation of beta-blocker therapy is recommended after optimization of volume status and successful discontinuation of intravenous diuretics, vasodilators, and inotropic agents. Beta-blocker therapy should be initiated at a low dose and only in stable patients. Particular caution should be used when initiating beta blockers in patients who have required inotropes during their hospital course. (Class I, Level of Evidence: B) (ACCF/AHA, 2009)

2012 Physician Quality Reporting Heart Failure Disease Module

Narrative Measure Specification for GPRO Use ONLY

► GPRO HF-7 (NQF 0081): Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%

DENOMINATOR NOTE: *LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction*

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusions only applied if patient was not prescribed ACE or ARB therapy)

- Documentation of medical reason(s) for not prescribing ACE or ARB therapy
- Documentation of patient reason(s) for not prescribing ACE or ARB therapy
- Documentation of system reason(s) for not prescribing ACE or ARB therapy

NUMERATOR:

Patients who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge

Definition:

Prescribed – May include prescription given to the patient for ACE inhibitor or ARB therapy at one or more visits in the measurement period OR patient already taking ACE inhibitor or ARB therapy as documented in current medication list.

RATIONALE:

In the absence of contraindications, ACE inhibitors or ARBs are recommended for all patients with symptoms of heart failure and reduced left ventricular systolic function. ACE inhibitors remain the first choice for inhibition of the renin-angiotensin system in chronic heart failure, but ARBs can now be considered a reasonable alternative. Both pharmacologic agents have been shown to decrease the risk of death and hospitalization. Additional benefits of ACE inhibitors include the alleviation of symptoms and the improvement of clinical status and overall sense of well-being of patients with heart failure.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Angiotensin converting enzyme inhibitors are recommended for all patients with current or prior symptoms of [heart failure] and reduced LVEF, unless contraindicated. (Class I, Level of Evidence: A) American College of Cardiology Foundation/American Heart Association (ACCF/AHA, 2009)

Treatment with an [ACE inhibitor] should be initiated at low doses [see excerpt from guideline table below], followed by gradual increments in dose if lower doses have been well tolerated... Clinicians should attempt to use doses that have been shown to reduce the risk of cardiovascular events in clinical trials. If these target doses of an [ACE inhibitor] cannot be used or are poorly tolerated, intermediate doses should be used with the expectation that there are likely to be only small differences in efficacy between low and high doses. (ACCF/AHA, 2009)

Inhibitors of the Renin-Angiotensin-Aldosterone System...Commonly Used for the Treatment of Patients with [Heart Failure] with Low Ejection Fraction

Drug	Initial Daily Dose(s)	Maximum Doses(s)
ACE Inhibitors		
Captopril	6.25 mg 3 times	50 mg 3 times
Enalapril	2.5 mg twice	10 to 20 mg twice
Fosinopril	5 to 10 mg once	40 mg once
Lisinopril	2.5 to 5 mg once	20 to 40 mg once
Perindopril	2 mg once	8 to 16 mg once
Quinapril	5 mg twice	20 mg twice
Ramipril	1.25 to 2.5 mg once	10 mg once
Trandolapril	1 mg once	4 mg once
Angiotensin Receptor Blockers		
Candesartan	4 to 8 mg once	32 mg once
Losartan**	25 to 50 mg once	50 to 100 mg once
Valsartan	20 to 40 mg twice	160 mg twice

**[Note: *Among ARBs, losartan has the weakest evidence supporting its value in heart failure patients.*]

An ARB should be administered to post-[myocardial infarction (MI)] patients without [heart failure] who are intolerant of [ACE inhibitors] and have a low LVEF. (Class I, Level of Evidence: B) (ACCF/AHA, 2009)

Angiotensin II receptor blockers are reasonable to use as alternatives to [ACE inhibitors] as first-line therapy for patients with mild to moderate [heart failure] and reduced LVEF, especially for patients already taking ARBs for other indications. (Class IIa, Level of Evidence: A) (ACCF/AHA, 2009)

For the hospitalized patient:

In patients with reduced ejection fraction experiencing a symptomatic exacerbation of [heart failure] requiring hospitalization during chronic maintenance treatment with oral therapies known to improve outcomes, particularly ACE inhibitors or ARBs and beta-blocker therapy, it is recommended that these therapies be continued in most patients in the absence of hemodynamic instability or contraindications. (Class I, Level of Evidence: C) (ACCF/AHA, 2009)

In patients hospitalized with [heart failure] with reduced ejection fraction not treated with oral therapies known to improve outcomes, particularly ACE inhibitors or ARBs and beta-blocker therapy, initiation of these therapies is recommended in stable patients prior to hospital discharge. Initiation of beta-blocker therapy is recommended after optimization of volume status and successful discontinuation of intravenous diuretics, vasodilators, and inotropic agents. Beta-blocker therapy should be initiated at a low dose and only in stable patients. Particular caution should be used when initiating beta-blockers in patients who have required inotropes during their hospital course. (Class I, Level of Evidence: B) (ACCF/AHA, 2009)

2012 Physician Quality Reporting Hypertension Disease Module

Narrative Measure Specification for GPRO Use ONLY

◆ GPRO HTN-2 (NQF 0018): Hypertension (HTN): Controlling High Blood Pressure

DESCRIPTION:

Percentage of patients aged 18 through 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90 mmHg) during the measurement year

DENOMINATOR:

Patients aged 18 through 85 years with the diagnosis of hypertension

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusions only applied if patient did not receive a blood pressure measurement)

- Documentation of medical reason(s) for not recording a blood pressure measurement (diagnosis for End-Stage Renal Disease [ESRD] and pregnancy are the only acceptable exclusions)

NUMERATOR:

Patients whose most recent blood pressure < 140/90 mmHg

RATIONALE:

This measure assesses the percentage of patients demonstrating adequate control of systolic and diastolic blood pressure levels. Over 50 million Americans warrant treatment for high blood pressure, according to the National Health and Nutrition Examination Survey (NHANES) survey Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-7 2003). Financially, hypertension and associated disorders and health complications, such as coronary heart disease and congestive heart failure, cost the U.S. economy more than \$100 billion each year. The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen adults 18 and older for high blood pressure (2007). This guideline is further endorsed by research studies and clinical trials that have demonstrated decline in costly health outcomes as a direct result of improved blood pressure control. This measure is important in efforts to promote blood pressure control and improve quality of life.

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. JNC-7: Treating systolic blood pressure (SBP) and diastolic blood pressure (DBP) to targets that are < 140/90 mmHg is associated with a decrease in cardiovascular disease (CVD) complications.

2012 Physician Quality Reporting Ischemic Vascular Disease Module

Narrative Measure Specification for GPRO Use ONLY

♦ GPRO IVD-1 (NQF 0075): Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control

DESCRIPTION:

Percentage of patients aged 18 years and older with ischemic vascular disease (IVD) who received at least one lipid profile within 12 months and whose most recent LDL-C level was in control (less than 100 mg/dL)

DENOMINATOR:

Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients who received at least one lipid profile (or ALL component tests) with most recent LDL-C < 100 mg/dL

RATIONALE:

There is general agreement in the literature that individuals with existing coronary artery disease can reduce their risk of subsequent morbidity and premature mortality by management of cholesterol levels. Total cholesterol in general and LDL level specifically, is the leading indicator for management of these patients. Treatments include limits on dietary fat and cholesterol, or in certain cases, cholesterol lowering medications.

A 10% decrease in total cholesterol levels (population wide) may result in an estimated 30% reduction in the incidence of coronary heart disease (CHD) Centers for Disease Control (CDC, 2000). Based on data from the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults:

- Less than half of persons who qualify for any kind of lipid-modifying treatment for CHD risk reduction are receiving it.
- Less than half of even the highest-risk persons, those who have symptomatic CHD, are receiving lipid-lowering treatment.
- Only about a third of treated patients are achieving their LDL goal; less than 20% of CHD patients are at their LDL goal. (2002)

Several studies have shown that reducing high lipid levels will reduce cardiovascular morbidity and mortality. These studies include the Coronary Primary Prevention Trial, the Framingham Heart Study, the Oslo Study Diet and Anti-smoking Trial, the Helsinki Heart Study, the Coronary Drug Project, the Stockholm Ischemic Heart Study, the Scandinavian Simvastatin Survival Study, the West of Scotland Coronary Prevention Study, the Program on the Surgical Control of the Hyperlipidemias, and Cholesterol and Recurrent Events trial.

CLINICAL RECOMMENDATION STATEMENTS:

Third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). (2001) AND Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines. (2004)

In high-risk persons, the recommended LDL-C goal is < 100 mg/dL.

- An LDL-C goal of < 70 mg/dL is a therapeutic option on the basis of available clinical trial evidence, especially for patients at very high risk.
- If LDL-C is > 100 mg/dL, an LDL-lowering drug is indicated simultaneously with lifestyle changes.
- If baseline LDL-C is < 100 mg/dL, institution of an LDL-lowering drug to achieve an LDL-C level < 70 mg/dL is a therapeutic option on the basis of available clinical trial evidence.
- If a high-risk person has high triglycerides or low HDL-C, consideration can be given to combining a fibrate or nicotinic acid with an LDL-lowering drug. When triglycerides are > 200 mg/dL, non-HDL-C is a secondary target of therapy, with a goal 30 mg/dL higher than the identified LDL-C goal.

The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders and recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. The USPSTF also strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease and recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.

2012 Physician Quality Reporting Ischemic Vascular Disease Module

Narrative Measure Specification for GPRO Use ONLY

♦ GPRO IVD-2 (NQF 0068): Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

DESCRIPTION:

Percentage of patients aged 18 years and older with ischemic vascular disease (IVD) with documented use of aspirin or other antithrombotic

DENOMINATOR:

Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)

THERE ARE NO PERFORMANCE EXCLUSIONS FOR THIS MEASURE

NUMERATOR:

Patients who are using aspirin or another antithrombotic therapy

RATIONALE:

Aspirin therapy has been shown to directly reduce 14% of the odds of cardiovascular events among men and 12% of the odds for women (Berger, 2006). Aspirin use reduced the number of strokes by 20%, myocardial infarction (MI) by 30%, and other vascular events by 30% (Weisman, 2002). Also, aspirin treatments have been shown to prevent 1 cardiovascular event over an average follow-up of 6.4 years. This means that on average in a 6.4 year time period the use of aspirin therapy results in a benefit of 3 cardiovascular events prevented per 1000 women and 4 events prevented per 1000 men (Berger, 2006). Even for patients with peripheral arterial disease, aspirin has been shown to reduce coronary heart disease (CHD) in people. (Kikano, 2007)

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians discuss aspirin chemoprevention with adults who are at increased risk (5-year risk of greater than or equal to 3 percent) for coronary heart disease (CHD). Discussions with patients should address both the potential benefits and harms of aspirin therapy.

The USPSTF found good evidence that aspirin decreases the incidence of coronary heart disease in adults who are at increased risk for heart disease. They also found good evidence that aspirin increases the incidence of gastrointestinal bleeding and fair evidence that aspirin increases the incidence of hemorrhagic strokes. The USPSTF concluded that the balance of benefits and harms is most favorable in patients at high risk of CHD (5-year risk of greater than or equal to 3 percent) but is also influenced by patient preferences.

USPSTF encourages men age 45 to 79 years to use aspirin when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage. They

encourage women age 55 to 79 years to use aspirin when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.

The American Diabetes Association (ADA) recommends use aspirin therapy (75-162 mg/day) as a primary prevention strategy in those with type 1 or 2 diabetes at increased cardiovascular risk, including those who are 40 years of age or who have additional risk factors (family history of cardiovascular disease (CVD), hypertension, smoking, dyslipidemia, or albuminuria).

American Heart Association/American College of Cardiology (AHA/ACC): Start aspirin 75 to 162 mg/day and continue indefinitely in all patients with coronary and other vascular disease unless contraindicated.

Institute for Clinical Systems Improvement (ICSI): Aspirin should be prescribed to all patients with stable coronary disease. If a patient is aspirin intolerant, then use clopidogrel.

Veterans Affairs/Department of Defense (VA/DoD): Ensure that all patients with ischemic heart disease or angina symptoms receive antiplatelet therapy (aspirin 81-325 mg/day). For patients who require warfarin therapy, aspirin may be safely used at a dose of 80 mg/day. If use of aspirin is contraindicated, clopidogrel (75 mg/day) may be used.

American Heart Association/American Stroke Association (AHA/ASA): The use of aspirin is recommended for cardiovascular (including but not specific to stroke) prophylaxis among persons whose risk is sufficiently high for the benefits to outweigh the risks associated with treatment (a 10-year risk of cardiovascular events of 6% to 10%).

American College of Chest Physicians (ACCP): For long-term treatment after percutaneous coronary intervention (PCI), the guideline developers recommend aspirin, 75 to 162 mg/day. For long-term treatment after PCI in patients who receive antithrombotic agents such as clopidogrel or warfarin, the guideline developers recommend lower-dose aspirin, 75 to 100 mg/day. For patients with ischemic stroke who are not receiving thrombolysis, the guideline developers recommend early aspirin therapy, 160 to 325 mg/day.

2012 Physician Quality Reporting Preventive Care Disease Measure

Narrative Measure Specification for GPRO Use ONLY

◆ GPRO Prev-5 (NQF 0031): Preventive Care and Screening: Screening Mammography

DESCRIPTION:

Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months

DENOMINATOR:

All female patients aged 40 through 69 years

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusion only applied if mammogram not performed within 24 months)

- Documentation of medical reason(s) for not performing a mammogram within 24 months (i.e., women who had a bilateral mastectomy or two unilateral mastectomies)

NUMERATOR:

Patients who had a mammogram at least once within 24 months

RATIONALE:

Breast cancer ranks as the second leading cause of death in women. For women 40 to 49 years of age mammography can reduce mortality by 17 percent. American Medical Association (AMA, 2003)

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older. (USPSTF, 2002)

- The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women aged 50-69, the age group generally included in screening trials. (USPSTF, 2002)
- For women aged 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50. (USPSTF, 2002)
- The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. (USPSTF, 2002)

The USPSTF concluded that the evidence is also generalizable to women aged 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increases along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminishes from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable

as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. (USPSTF, 2002)

American Cancer Society: Yearly Mammograms starting at age 40 and continuing for as long as a woman is in good health. (Smith, 2003)

American College of Preventive Medicine (ACPM):

- Low-risk women (no family history, familial cancer syndrome, or prior cancer). There is inadequate evidence for or against mammography screening of women under the age of 50. Women between the ages of 50-69 should have annual or biennial, high-quality, two-view mammography. Women aged 70 and older should continue undergoing mammography screening provided their health status permits breast cancer treatment. (Ferrini, 1996)
- Higher-risk women: Women with a family history of pre-menopausal breast cancer in a first-degree relative or those with a history of breast and/or gynecologic cancer may warrant more aggressive screening. Women with these histories often begin screening at an earlier age, although there is no direct evidence of effectiveness to support this practice. The future availability of genetic screening may define new recommendations for screening high-risk women. (Ferrini, 1996)

The American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Radiology (ACR), all support screening with mammography and CBE beginning at age 40. (AMA, 1999; ACOG, 2000; Feig, 1998)

The Canadian Task Force on Preventive Health Care (CTFPHC), and the American Academy of Family Physicians (AAFP), recommends beginning mammography for average-risk women at age 50. (Canadian Task Force on the Periodic Health Examination, 1999; AAFP, 2005)

AAFP recommends that mammography in high-risk women begin at age 40, and recommends that all women aged 40-49 be counseled about the risks and benefits of mammography before making decisions about screening. (AAFP, 2005)

2012 Physician Quality Reporting Preventive Care Measure

Narrative Measure Specification for GPRO Use ONLY

♦ GPRO Prev-6 (NQF 0034): Preventive Care and Screening: Colorectal Cancer Screening

DESCRIPTION:

Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening

DENOMINATOR:

All patients aged 50 through 75 years

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusion only applied if colorectal cancer screening not performed)

- Documentation of medical reason(s) for not performing colorectal cancer screening (i.e., total colectomy)

NUMERATOR:

Patients who had at least one or more screenings for colorectal cancer during or prior to the reporting period

Numerator Instructions: Patients are considered to have appropriate screening for colorectal cancer if any of the following are documented:

- Fecal occult blood test (FOBT) within the last 12 months
- Flexible sigmoidoscopy during the reporting period or the four years prior to the reporting period
- Colonoscopy during the reporting period or the nine years prior to the reporting period

RATIONALE:

Colorectal cancer is the second leading cause of cancer-related death in the United States. There were an estimated 135,400 new cases and 56,700 deaths from the disease during 2001. Colorectal cancer (CRC) places significant economic burden on the society as well with treatment costs over \$6.5 billion per year and, among malignancies, is second only to breast cancer at \$6.6 billion per year. (Schrag, 1999)

Colorectal cancer screening can detect pre-malignant polyps and early stage cancers. Unlike other screening tests that only detect disease, colorectal cancer screening can guide removal of pre-malignant polyps, which in theory can prevent development of colon cancer. Three tests are currently recommended for screening: fecal occult blood testing (FOBT), flexible sigmoidoscopy, and colonoscopy.

CLINICAL RECOMMENDATION STATEMENTS:

During the past decade, compelling evidence has accumulated that systematic screening of the population can reduce mortality from colorectal cancer. Three randomized, controlled trials demonstrated that fecal occult blood testing (FOBT), followed by complete diagnostic evaluation of the colon for a positive test, reduced colorectal cancer mortality (Hardcastle et al., 1996; Mandel & Oken, 1998; Kronborg; 1996). One of these randomized trials (Mandel et al., 1993) compared annual FOBT screening to biennial FOBT screening, and found that annual screening resulted in greater reduction in colorectal cancer mortality. Two case control studies have provided evidence that sigmoidoscopy reduces colorectal cancer mortality (Selby

et al., 1992; Newcomb et al., 1992). Approximately 75% of all colorectal cancers arise sporadically (Stephenson et al., 1991). Part of the effectiveness of colorectal cancer screening is mediated by the removal of the precursor lesion—an adenomatous polyp (Vogtelstein et al., 1988). It has been shown that removal of polyps in a population can reduce the incidence of colorectal cancer (Winawer, 1993). Colorectal screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective (Kavanaugh, 1998).

The U.S. Preventive Services Task Force (USPSTF) published an updated recommendation for colorectal cancer screening in 2008. The guideline strongly recommends that clinicians screen men and women ages 50 to 75 years of age for colorectal cancer (A recommendation). The USPSTF recommends not screening adults age 85 and older due to possible harms (D recommendation). The appropriateness of colorectal cancer screening for men and women aged 76 to 85 years old should be considered on an individual basis (C recommendation). While the approved modalities vary for patients 50 to 75 years old, the USPSTF found there is insufficient evidence to assess the benefits and harms of computed tomographic colonography (CTC) and fecal DNA (fDNA) testing as screening modalities for colorectal cancer for all patients. (I statement)

2012 Physician Quality Reporting Preventive Care Measure

Narrative Measure Specification for GPRO Use ONLY

▲ GPRO Prev-7 (NQF 0041): Preventive Care and Screening: Influenza Immunization

DESCRIPTION:

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 of the one-year measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization

DENOMINATOR:

All patients aged 6 months and older seen for a visit between October 1 and March 31

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusions only applied if patient did not receive influenza immunization during the flu season)

- Documentation of medical reason(s) for not receiving an influenza immunization during the flu season
- Documentation of patient reason(s) for not receiving an influenza immunization during the flu season
- Documentation of system reason(s) for not receiving an influenza immunization during the flu season

NUMERATOR:

Patients who have received an influenza immunization OR who reported previous receipt of influenza immunization

Definition:

Previous Receipt – May include: receipt of influenza immunization from another provider OR receipt of influenza immunization from same provider during a visit prior to October 1.

RATIONALE:

Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza vaccine is recommended for all persons aged ≥ 6 months who do not have contraindications to vaccination.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Routine annual influenza is recommended for all persons aged ≥ 6 months. Centers for Disease Control/Advisory Committee on Immunization Practices (CDC/ACIP, 2011).

2012 Physician Quality Reporting Preventive Care Measure

Narrative Measure Specification for GPRO Use ONLY

♦ GPRO Prev-8 (NQF 0043): Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older

DESCRIPTION:

Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine

DENOMINATOR:

All patients 65 years and older

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusion only applied if patient did not ever receive a pneumococcal immunization)

- Documentation of medical reason(s) for not ever receiving pneumococcal vaccination

NUMERATOR:

Patients who have ever received a pneumococcal vaccination

RATIONALE:

The elderly have a much higher mortality from community-acquired pneumonia due to increased risk factors such as comorbidities, an increase in the number of medications taken and weaknesses or disease of lung tissue. Pneumonia accounts for an estimated 20 percent of nosocomial infections among the elderly, second only to urinary tract infections. The disease burden is large for older adults and the potential for prevention is high. (Ely, E., 1997)

Drugs such as penicillin were once effective in treating these infections; but the disease has become more resistant, making treatment of pneumococcal infections more difficult. This makes prevention of the disease through vaccination even more important. Centers for Disease Control (CDC. National Immunization Program—*Pneumococcal Disease*, 2005)

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services* recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but may be appropriate in immunocompetent individuals at high risk for morbidity and mortality from pneumococcal disease (e.g., persons ≥ 75 years of age or with severe chronic disease) who were vaccinated more than five years previously. Medicare Part B fully covers the cost of the vaccine and its administration every five years. (United States Preventive Services Task Force, 1998) Pneumococcal infection is a common cause of illness and death in the elderly and persons with certain underlying conditions. In 1998, an estimated 3,400 adults aged ≥ 65 years died as a result of invasive pneumococcal disease. Pneumococcal infection accounts for more deaths than any other vaccine-preventable bacterial disease. (CDC, 2002; Pneumococcal Pneumonia, National Institute of Allergy and Infectious Diseases (NIAID) Fact Sheet, December 2004.)

One of the *Healthy People 2010* objectives is to increase pneumococcal immunization levels for the non-institutionalized, high-risk populations to at least 90 percent (objective no. 14.29). While the percent of persons 65 years and older receiving the pneumococcal vaccine has increased, it still remains considerably below the *Health People 2010* objective. According to the National Health Interview Survey (NHIS), which is used to track performance on year 2010 objectives, in 1998 only 46 percent of adults age 65 years and older report receiving the vaccine. The figure was 45 percent based on the 1997 Behavioral Risk Factor Surveillance System (BRFSS) survey. (National Center for Health Statistics., 2005; CDC, 1997)

A particular strength of this measure is that it provides an opportunity to compare performance against national, state and/or regional benchmarks, which are collected through nationally organized and administered surveys.

At the physician practice level where a patient survey may not be feasible, data collection on pneumonia vaccination status through chart abstraction is a viable option.

2012 Physician Quality Reporting Preventive Care Measure

Narrative Measure Specification for GPRO Use ONLY

🌟 GPRO Prev-9 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

DESCRIPTION:

Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented

Normal Parameters: Age 65 and older BMI ≥ 23 and < 30
Age 18 – 64 BMI ≥ 18.5 and < 25

DENOMINATOR:

All patients aged 18 years and older

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusion only applied if a calculated BMI was not documented as normal OR was outside parameters with a follow-up not performed during the measurement period)

- Documentation of medical reason(s) for not having a BMI measurement performed during the measurement period
- Documentation of patient reason(s) for not having a BMI measurement performed during the measurement period
- Documentation of system reason(s) for not having a BMI measurement performed during the measurement period

NUMERATOR:

Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters

Definitions:

BMI – Body mass index (BMI), expressed as weight/height (BMI; kg/m²), is commonly used to classify overweight (BMI 25.0-29.9), obesity (BMI greater than or equal to 30.0) and extreme obesity (BMI greater than or equal to 40) among adults. Centers for Disease Control (CDC). BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared.

Elderly BMI – Most experts suggest use of a higher BMI threshold for underweight elderly individuals, compared to what is used for the general population. *International Dietetics and Nutrition Terminology* defines underweight in persons > 65 years of age as a BMI of < 23. This BMI value is one indicator of malnutrition when forming a nutrition diagnosis for the elderly population. A BMI of < 23 classifies an older adult (older than age 65) as underweight and may require nutrition intervention.

Calculated BMI – Requires that both the height and weight are actually measured by an eligible professional or by their staff. Self-reported values cannot be used.

Follow-up Plan – Proposed outline of treatment to be conducted as a result of abnormal BMI measurement. Such follow-up can include documentation of a future appointment, education, referral (such as, a registered dietician, nutritionist, occupational therapy, primary care physician, exercise physiologist, mental health professional, surgeon, etc.), prescription/administration of medications/dietary supplements, exercise counseling, nutrition counseling, etc.

Not Eligible/Not Appropriate for BMI Measurement – Patients can be considered not eligible in the following situations:

- There is documentation in the medical record that the patient is over or under weight and is being managed by another provider
- If the patient has a terminal illness – life expectancy less than 6 months
- If the patient is pregnant
- If the patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate
- If the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

RATIONALE:

BMI Above Upper Parameter

In 2009, no U.S. state met the *Healthy People 2010* adult obesity prevalence target of 15 percent, and the number of states with an obesity prevalence ≥ 30 increased from zero in 2000 to 9 in 2009 (CDC, 2010). Further, the report revealed that the overall self-reported obesity prevalence in the United States was 26.7 percent, an increase of 1.1 percentage points from 2007 to 2009 among adults aged 18 years or older.

Obesity continues to be a public health concern in the United States and throughout the world. In the United States, obesity prevalence doubled among adults between 1980 and 2004 (Flegal, et al, 2002; Ogden, et al, 2006). Obesity is associated with increased risk of a number of conditions, including diabetes mellitus, cardiovascular disease, hypertension, and certain cancers, and with increased risk of disability and a modestly elevated risk of all-cause mortality. With obesity on the rise, the medical community anticipates an increase in the complications of obesity, including type 2 diabetes mellitus, hypertension, dyslipidemia, cardiovascular disease, obstructive sleep apnea, degenerative arthritis, non-alcoholic steatohepatitis, gallbladder disease and others.

Results from the 2005-2006 National Health and Nutrition Examination Survey (NHANES) indicate that an estimated 32.7 percent of U.S. adults 20 years and older are overweight, 34.3 percent are obese and 5.9 percent are extremely obese. Although the prevalence of adults in the U.S. who are obese is still high with about one-third of adults obese in 2007-2008, new data suggest that the rate of increase for obesity in the U.S. in recent decades may be slowing (Flegal, et al, 2010).

Finkelstein, et al. (2009), found increased prevalence of obesity is responsible for almost \$40 billion of increased medical spending through 2006, including \$7 billion in Medicare prescription drug costs. We estimate the medical costs of obesity may raise to \$147 billion per year by 2008.

Ma, et al (2009) performed a retrospective, cross-sectional analysis of ambulatory visits in the National Ambulatory Medical Care Survey from 2005 and 2006. The study findings on obesity and office-based quality of care concluded the evidence is compelling that obesity is underappreciated in office-based physician practices across the United States. Many opportunities are missed for obesity screening and

diagnosis, as well as for the prevention and treatment of obesity and related health risks, regardless of patient and provider characteristics.

BMI Below Normal Parameter

Poor nutrition or underlying health conditions can result in underweight. Results from the 2003-2006 National Health and Nutrition Examination Survey (NHANES, 2009), using measured heights and weights, indicate an estimated 1.8% of U.S. adults are underweight. A tremendous gap still exists between our knowledge of malnutrition, its sequelae and our actions in preventing and treating malnutrition. To date professionals in various disciplines have applied their own approaches to solving the problem. Yet the causes of malnutrition are multi-factorial and the solutions demand an integration of knowledge and expertise from the many different disciplines involved in geriatric care. Older people have special nutritional needs due to age and disease processes.

Elderly patients with unintentional weight loss are at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases. Medications that may cause nausea and vomiting, dysphagia, dysgeusia and anorexia have been implicated. Polypharmacy can cause unintended weight loss, as can psychotropic medication reduction (e.g., by unmasking problems such as anxiety). In one study it was found that a BMI of less than 22 kg per m² in women and less than 23.5 in men is associated with increased mortality. The optimal BMI in the elderly is 24 to 29 kg per m². (In an observational study, Ranhoff, et al. (2005) identified using a BMI < 23, resulted in a positive screen for malnutrition (sensitivity 0.86, specificity 0.71), giving 0.75 correctly classified subjects, thus leading to the recommendation that a score of BMI < 23 should be followed by Mini Nutritional Assessment short-form (MNA-SF) when the aim is to identify poor nutritional status in elderly.

CLINICAL RECOMMENDATION STATEMENTS:

Although multiple clinical recommendations addressing obesity have been developed by professional organizations, societies and associations, two recommendations, which exemplify the intent of the measure and address the numerator and denominator, have been identified.

The US Preventive Health Services Task Force (USPSTF) (2003) recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (Level Evidence B).

Institute for Clinical Systems Improvement (ICSI, 2009) Prevention and Management of Obesity (Mature Adolescents and Adults) provides the following guidance:

- Calculate the body mass index; classify the individual based on the body mass index categories. Educate patients about their body mass index and their associated risks.
- Weight management requires a team approach. Be aware of clinical and community resources. The patient needs to have an ongoing therapeutic relationship and follow-up with a health care team.
- Weight control is a lifelong commitment, and the health care team can assist with setting specific goals with the patient

2012 Physician Quality Reporting Preventive Care Measure

Narrative Measure Specification for GPRO Use ONLY

▲ GPRO Prev-10 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

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

DENOMINATOR:

All patients aged 18 years and older

NUMERATOR:

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:

Tobacco Use – Includes any type of tobacco

Cessation Counseling Intervention – Includes counseling or pharmacotherapy

RATIONALE:

There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in the primary care setting is successful in helping tobacco users quit U.S. Preventive Services Task Force (USPSTF, 2003). Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke (USPSTF, 2003).

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (USPSTF, 2003)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. National Quality Foundation (NQF, 2007)

All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

All *physicians* should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

2012 Physician Quality Reporting Preventive Care Measure
Narrative Measure Specification for GPRO Use ONLY

♣ GPRO Prev-11 (NQF N/A): Preventive Care and Screening: Screening for High Blood Pressure

DESCRIPTION:

Percentage of patients aged 18 and older who are screened for high blood pressure

DENOMINATOR:

Percentage of patients aged 18 years and older who are screened for high blood pressure

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:

(Exclusions only applied if patient did not receive screening for high blood pressure during the current year or year prior)

- Documentation of medical reason(s) for not receiving screening for high blood pressure (i.e., diagnosis of hypertension)

NUMERATOR:

Patients who were screened for high blood pressure according to defined recommended screening intervals

NUMERATOR NOTE: *For the purposes of Physician Quality Reporting, this measure only needs to be reported once per reporting period*

Definitions:

Recommended screening intervals

- Patients with the most recent blood pressure < 120/80 mmHg should be screened every 2 years
- Patients with a most recent systolic blood pressure of 120-139 mmHg or diastolic blood pressure of 80-90 mmHg should be screened every year
- Patients with 1 elevated readings of ≥ 140 mmHg or > 90 mmHg should be re-screened in a month

Not Eligible

- Previous diagnosis with hypertension at any time in the patient's history OR whose two most recent systolic blood pressure ≥ 140 mmHg or diastolic blood pressure > 90 mmHg
- Patient refuses blood pressure measurement
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

RATIONALE:

This measure assesses the percentage of patients aged 18 and older without known hypertension who were screened for high blood pressure. Hypertension is a prevalent condition that contributes to important adverse health outcomes, including premature death, heart attack, renal insufficiency and stroke. The United States Preventive Services Task Force (USPSTF) found good evidence that blood pressure

measurement can identify adults at increased risk for cardiovascular disease from high blood pressure. The relationship between systolic blood pressure and diastolic blood pressure and cardiovascular risk is continuous and graded. The actual level of blood pressure elevation should not be the sole factor in determining treatment. Clinicians should consider the patient's overall cardiovascular risk profile, including smoking, diabetes, abnormal blood lipid values, age, sex, sedentary lifestyle, and obesity, when making treatment decisions. The seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) recommends screening every 2 years in person with blood pressure less than 120/80 mmHg and every year in persons with systolic blood pressure of 120 to 139 mmHg or diastolic blood pressure of 80 to 90 mmHg.

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

Reference: U.S. Preventive Services Task Force. Screening for high blood pressure: U.S. Preventive Services Task Force reaffirmation recommendation statement. *Ann Intern Med* 2007 Dec 4;147(11):783-6. [6 references]

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