2014 Group Practice Reporting Option (GPRO)

Web Interface

Narrative Measure Specifications

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Table of Contents

2014 GPRO Web Interface
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Introduction

Group Practice Reporting Option (GPRO) Web Interface is a reporting option 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 2014 GPRO Web Interface, practices are required to complete a self-nomination process and meet certain technical requirements.

There are a total of 17 quality measures (22 individual measures when accounting for the two composite measures) included in GPRO targeting high-cost chronic conditions, preventive care and patient safety. The measure specifications are grouped into five disease modules and 10 patient care measures: Care Coordination/Patient Safety (CARE) (two measures); Coronary Artery Disease (CAD) (one composite consisting of two measures); Diabetes Mellitus (DM) (one measure and one composite consisting of five measures); Heart Failure (HF) (one measure); Hypertension (HTN) (one measure); Ischemic Vascular Disease (IVD) (two measures) and Preventive Care (PREV) (eight measures).

A pre-populated Web Interface 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, 2014 through December 31, 2014 reporting period. For purposes of the 2014 GPRO Web Interface reporting option, patient age is determined during the sampling process. Patients must meet each measure/module age denominator criteria by January 1 of the measurement period.

This manual contains specific guidance for reporting 2014 GPRO Web Interface measures. Only those measures defined in this document can be utilized when reporting the GPRO Web Interface option. This manual describes how to implement 2014 reporting of GPRO Web Interface measures to facilitate satisfactory reporting of quality-data by group practices who wish to participate under this reporting option. Supplementary documents which provide additional guidance and describe how to implement 2014 GPRO Web Interface reporting can be found on the CMS website in the GPRO Web Interface option: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html

Narrative Measure Specifications are being provided to allow group practices an opportunity to have a better understanding of each of the 17 quality measures (22 individual measures when accounting for the two composite measures) included in 2014 GPRO Web Interface. Once a group practice is selected to participate in the 2014 GPRO Web Interface 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 (if applicable to measure)
- Description
- Improvement Notation*
- Initial Patient Population
- Denominator

- Denominator Exclusions
- Denominator Exceptions**
- Numerator
- Numerator Exclusions
- Definition
- Guidance
- Rationale
- Clinical Recommendation Statements or evidence forming the basis for supporting criteria for the measure

NOTE: Specific definitions of data elements can be found in the Guide for Reading EP and EH eMeasures. This document is posted at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Guide_Reading_EP_Hospital_eCQMs.pdf

*For the purposes of the 2014 GPRO Narrative Specifications, the Improvement Notation is provided only when there is a corresponding eCQM. Conceptually the Improvement Notation is known for all measures and patient care modules within the GPRO Web Interface: A higher score indicates better quality in all measures and patient care modules with the sole exception of DM-2. DM-2 is considered an inverse measure and a lower score indicates better quality.

**Please note when exceptions (medical, patient, and/or system reasons for not achieving a quality action) are applicable to a module/measure, the exceptions are only applied when the quality action is not performed.

2014 GPRO Care Coordination/Patient Safety Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

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*GPRO CARE-1 (NQF 0097): Medication Reconciliation

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 30 days following discharge** in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

IMPROVEMENT NOTATION:
Not Available

INITIAL PATIENT POPULATION:
Not Available

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 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care

DENOMINATOR EXCLUSIONS:
Not Available

DENOMINATOR EXCEPTIONS:
Not Available

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

NUMERATOR EXCLUSIONS:
Not Available

DEFINITION:
Medical Record – Must indicate: The physician, prescribing practitioner, registered nurse, or clinical pharmacist providing ongoing care 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.

GUIDANCE:
Not Available

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)

2014 GPRO Care Coordination/Patient Safety Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

*GPRO CARE-2 (NQF 0101): Falls: Screening for Future Fall Risk

DESCRIPTION:
Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period

IMPROVEMENT NOTATION:
A higher score indicates better quality

INITIAL PATIENT POPULATION:
Patients aged 65 years and older with a visit during the measurement period

DENOMINATOR:
Equals Initial Patient Population

> DENOMINATOR EXCLUSIONS:
> None

> DENOMINATOR EXCEPTIONS:
> Documentation of medical reason(s) for not screening for fall risk (e.g., patient is not ambulatory)

NUMERATOR:
Patients who were screened for future fall risk at least once within the measurement period

> NUMERATOR EXCLUSIONS:
> Not Applicable

DEFINITION:
Future fall risk: 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.
Fall: 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 sudden onset of paralysis, epileptic seizure, or overwhelming external force.

GUIDANCE:
None

RATIONALE:
As the leading cause of both fatal and nonfatal injuries for older adults, falls are one of the most common and significant health issues facing people aged 65 years or older (Schneider, Shubert and Harmon 2010). Moreover, the rate of falls increases with age (Dykes et al. 2010). Older adults are five times more likely to be hospitalized for fall-related injuries than any other cause-related injury. It is estimated that one in every three adults over 65 will fall each year (Centers for Disease Control and Prevention 2012). In those over age 80, the rate of falls increases to fifty percent (Doherty et al. 2009). Falls are also associated with

substantial cost and resource use, approaching $30,000 per fall hospitalization (Woolcott et al. 2011). Identifying at-risk patients is the most important part of management, as applying preventive measures in this vulnerable population can have a profound effect on public health (al-Aama 2011). Family physicians have a pivotal role in screening older patients for risk of falls, and applying preventive strategies for patients at risk (al-Aama 2011).

The risk of falling is slightly greater in the inpatient setting (Clyburn and Heydemann 2011). A recent study found that specialized inpatient fall prevention initiatives were associated with a significant reduction in fall and fall-related injury rates (Weinberg et al. 2011). The results of this study show the importance of persistent quality improvement interventions with respect to falls. The authors stated that enhanced safety awareness and accountability were both instrumental in the success of the program (Weinberg et al. 2011). Another recent study calculated the number needed to treat (NNT) to prevent one fall as 32 for a single intervention compared with seven for a multidisciplinary intervention (Hanley, Silke and Murphy 2010). With such a low NNT, this measure has the opportunity to have high impact.

CLINICAL RECOMMENDATION STATEMENTS:
The American Geriatrics Society (AGS) along with the British Geriatrics Society (BGS) published clinical practice guidelines for the prevention of falls in older persons (Panel of Prevention of Falls in Older Persons 2011). In addition, the Assessing Care of Vulnerable Elders (ACOVE) indicators for fall assessment and management are in use (RAND 2008).

AGS/BGS Clinical Practice Guideline: Prevention of Falls in Older Persons (Panel on Prevention of Falls in Older Persons 2011)

Rating: A Recommendation
• The multifactorial fall risk assessment should be followed by direct interventions tailored to the identified risk factors, coupled with an appropriate exercise program.

Rating: A Recommendation
• A strategy to reduce the risk of falls should include multifactorial assessment of known fall risk factors and management of the risk factors identified.

Rating: A Recommendation
• The health professional or team conducting the fall risk assessment should directly implement the interventions or should assure that the interventions are carried out by other qualified healthcare professionals.

Rationale:
The goal of screening for falls and identifying fall risk is to prevent or reduce fall risk. A structured and standardized screening process can improve provider adherence to guideline recommendations. The AGS/BGS recommendations for fall risk assessment are based on epidemiological studies demonstrating an association between certain risk factors and falls and from experimental studies in which assessment followed by intervention demonstrated benefit. Assuming that the interventions are carried out, multifactorial falls risk assessment and management programs could be one of the most effective interventions for reducing both the risk for falling and the monthly rate of falling (Chang 2004).

Individuals who have experienced two or more falls in the last year or who have gait or balance issues have an increased likelihood of falling, therefore would benefit from multifactorial falls risk assessment. Although

evidence is lacking, AGS believes there is also a potential benefit for individuals who have reported only a single fall in the last year and who do not have gait and balance issues.

Several individual studies have shown that a multifactorial risk assessment that was not tied to intervention was not effective in reducing falls. Multifactorial falls risk assessment and management programs may be the most effective intervention for reducing both the risk for falling and the monthly rate of falling, assuming that those interventions are properly carried out (Chang 2004). Recent trials of multifactorial risk assessment followed by referral without assurance of completion of the intervention have not been proven effective.

ACOVE (RAND 2008).
Quality Indicators
• Inquiring about Falls. ALL vulnerable elders should have documentation that they were asked at least annually about the occurrence of recent falls.
• Detecting Balance and Gait Disturbances. ALL vulnerable elders should have documentation that they were asked about or examined for the presence of balance or gait disturbances at least once.
• Basic Fall Evaluation. IF a vulnerable elder reported two or more falls in the past year, or a single fall with injury requiring treatment, THEN there should be documentation that a basic fall evaluation was performed that resulted in specific diagnostic and therapeutic recommendations.
• Gait-Mobility and Balance Evaluation. IF a vulnerable elder reports or is found to have new or worsening difficulty with ambulation, balance, or mobility, THEN there should be documentation that a basic gait, mobility, and balance evaluation was performed within 6 months that resulted in specific diagnostic and therapeutic recommendations.
• Exercise and Assistive-Device Prescription for Balance problems. IF a vulnerable elder demonstrates decreased balance or proprioception, or increased postural sway, THEN an appropriate exercise program should be offered and an evaluation for an assistive device performed.
• Exercise Prescription for Gait Problems and Weakness. IF a vulnerable elder is found to have problems with gait, strength (for example, 4 out of 5 on manual muscle testing, or the need to use his or her arms to rise from a chair), or endurance (for example, dyspnea on mild exertion), THEN an exercise program should be offered (Rubenstein 2001).

Rationale: There are a number of clinical approaches in addressing the serious and complex concerns involving fall risk and mobility problems in older adults. The ACOVE quality indicators can be categorized into three categories: 1) detection of the problem(s); 2) diagnosis or evaluation of the problem(s); and 3) treatment while focusing on how to prevent reoccurrence. These indicators are based on literature review and expert panel consideration (Rubenstein 2001).

Falls and mobility problems oftentimes result from multiple, diverse and overlapping causes. Falls and gait or balance disorders represent an underlying pathologic condition that could response well to treatment but could have life threatening consequences if unrecognized. These six quality indicators were judged sufficiently valid for use as measures of the quality of fall management for the vulnerable population and could potentially serve as a basis for comparison for care provided by different health care delivery systems and the change in care for the older population over time (Rubenstein 2001).

2014 Coronary Artery Disease Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

❯❯ GPRO CAD-2 (NQF 0074): Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Lipid Control

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The CAD Composite measure consists of CAD-2 and CAD-7.

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 ≥ 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

IMPROVEMENT NOTATION:
Not Available

INITIAL PATIENT POPULATION:
Not Available

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

DENOMINATOR EXCLUSIONS:
Not Available

DENOMINATOR EXCEPTIONS:
Documentation of medical reason(s) for statin therapy not prescribed or currently being taken (eg, allergy, intolerance to statin medication(s), other medical reasons)

Documentation of patient reason(s) for statin therapy not prescribed or currently being taken (eg, patient declined, other patient reasons)

Documentation of system reason(s) for statin therapy not prescribed or currently being taken (eg, financial reasons, other system reasons)

NUMERATOR:
Patients who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result ≥ 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

NUMERATOR EXCLUSIONS:
Not Available

DEFINITION:

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 current medication list

GUIDANCE:
Not Available

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) (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 [ATPII], 2002)

2014 Coronary Artery Disease Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

➤ GPRO CAD-7 (NQF 0066): Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)

The CAD Composite measure consists of CAD-2 and CAD-7.

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

IMPROVEMENT NOTATION:
Not Available

INITIAL PATIENT POPULATION:
Not Available

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 coronary artery disease seen within a 12 month period who also have diabetes

DENOMINATOR EXCLUSIONS:
Not Available

DENOMINATOR EXCEPTIONS:
Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, allergy, intolerance, pregnancy, renal failure due to ACE inhibitor, diseases of the aortic or mitral valve, other medical reasons)

Documentation of patient reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, patient declined, other patient reasons)

Documentation of system reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, lack of drug availability, other reasons attributable to the healthcare system)

NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy

NUMERATOR EXCLUSIONS:

Not Available

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

GUIDANCE:

For the purposes of this measure, a qualitative finding of 'moderately or severely depressed' Left Ventricular Systolic Function is equal to a quantitative LVEF result < 40%.

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) (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)

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

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

IMPROVEMENT NOTATION:
Lower score indicates better quality

INITIAL PATIENT POPULATION:
Patients 18 - 75 years of age with diabetes with a visit during the measurement period

DENOMINATOR:
Equals Initial Patient Population

> **DENOMINATOR EXCLUSIONS:**
> Patients with a diagnosis of gestational diabetes during the measurement period

> **DENOMINATOR EXCEPTIONS:**
> None

NUMERATOR:
Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

> **NUMERATOR EXCLUSIONS:**
> Not Applicable

DEFINITION:
None

GUIDANCE:
Patient is numerator compliant if most recent HbA1c level is > 9% or is missing a result or if an HbA1c test was not done during the measurement year.

Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.

RATIONALE:
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 may cause life-threatening, life ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60-70 percent of diabetics suffer from mild or severe nervous system damage (American Diabetes Association 2009).

Randomized clinical trials have demonstrated that improved glycemic control, as evidenced by reduced levels of glycohemoglobin, correlates with a reduction in the development of microvascular complications in both Type 1 and Type 2 diabetes (Diabetes Control and Complications Trial Research Group 1993; Ohkubo 1995). In particular, the Diabetes Control and Complications Trial (DCCT) showed that for patients with Type 1 diabetes mellitus, important clinical outcomes such as retinopathy (an important precursor to blindness), nephropathy (which precedes renal failure), and neuropathy (a significant cause of foot ulcers and amputation in patients with diabetes) are directly related to level of glycemic control (Diabetes Control and Complications Trial Research Group 1993). Similar reductions in complications were noted in a smaller study of intensive therapy of patients with Type 2 diabetes by Ohkubo and co-workers, which was conducted in the Japanese population (Ohkubo et al. 1995).

CLINICAL RECOMMENDATION STATEMENTS:
American Geriatrics Society (Brown et al. 2003):

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. (Quality of Evidence: Level III; Strength of Evidence: Grade B)

American Diabetes Association (2009):

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 non-pregnant adults in general is <7%. (Level of Evidence: A)

In type 1 and type 2 diabetes, randomized controlled trials of intensive versus standard glycemic control have not shown a significant reduction in 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. (Level of Evidence: B)

Subgroup analyses of clinical trials such as the DCCT and UKPDS and the microvascular evidence from the Action in Diabetes and Vascular Disease: Preterax and Diamicron MR Controlled Evaluation (ADVANCE) 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 CVD. (Level of Evidence: B)

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. (Level of Evidence: C)

2014 Diabetes Mellitus Disease Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

♪ **GPRO DM-13 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: High Blood Pressure Control**

The DM Composite measure consists of DM-13, DM-14, DM-15, DM-16 and DM-17.

DESCRIPTION:
Percentage of patients 18 to 75 years of age with diabetes mellitus who had a blood pressure < 140/90 mmHg

IMPROVEMENT NOTATION:
Not Available

INITIAL PATIENT POPULATION:
Not Available

DENOMINATOR:
Patients 18 to 75 years of age with a diagnosis of diabetes mellitus (type 1 or type 2) with two or more face-to-face visits for diabetes in the last two years and at least one visit for any reason in the last 12 months

DENOMINATOR EXCLUSIONS:
Patient was a permanent nursing home resident during the measurement period
Patient was pregnant during the measurement period

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Patients with most recent blood pressure < 140/90 mmHg

NUMERATOR EXCLUSIONS:
Not Available

DEFINITION:
Not Available

GUIDANCE:
Not Available

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 intermediate physiological and biochemical outcomes included in this composite measure are modifiable lifestyle risk factors that can ultimately decrease the incidence of long term catastrophic events and chronic illness associated with diabetes. 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. ICSI Diabetes Guidelines April 2012 (American Diabetes Association, 2010; Duckworth, 2009; Gaede, 2008 [A]; Holman, 2008a [A])

Two sets of guidelines are referenced in the development and maintenance of this measure.

- The Institute for Clinical Systems Improvement (ICSI) Guidelines for the Diagnosis and Management of Type 2 Diabetes Mellitus Fifteenth Edition April 2012 This includes a comprehensive literature review and some of the articles quoted within the guideline are also included as references. References will be referred to as ICSI Diabetes Guideline or ICSI. Detailed guidelines are available at https://www.icsi.org/_asset/3rrm36/Diabetes-Interactive0412.pdf
- The American Diabetes Association 2013 Standards of Medical Care. Will be referred to as American Diabetes Association or ADA. Detailed standards of medical care are available at http://www.diabetes.org under the "For Professionals" tab.

Hypertension is a major cardiovascular risk factor for patients with diabetes. According to ICSI Diabetes guidelines, aggressive blood pressure control is just as important as glycemic control. Systolic blood pressure level should be the major factor for detection, evaluation and treatment of hypertension. The use of two or more blood pressure lowering agents is often required to meet blood pressure goal.

CLINICAL RECOMMENDATION STATEMENTS:
Current guidelines are in a state of flux in terms of recommendations for a target blood pressure for patients with diabetes and hypertension in general. The hypertension guidelines produced by the National Heart Lung and Blood Institute are currently undergoing revision (JNC8) and not yet available for use. On the recommendation of the National Quality Forum's Cardiovascular Steering Committee, whose membership included cardiologists privy to development discussions with JNC8, MN Community Measurement selected a blood pressure target of less than 140/90. This target is also in alignment with the proposed Meaningful Use of HIT measure Diabetes: Blood Pressure Management (< 140/90).

ICSI Diabetes Guideline:

Goals for blood pressure control: blood pressure less than 140/90 mmHg

Uncontrolled hypertension is a major cardiovascular risk factor that also accelerates the progression of diabetic nephropathy *(Morrish, 1991 [Low Quality Evidence])*. When hypertension is identified, it

should be aggressively treated to achieve a target blood pressure of less than 140/90 mmHg. In many patients with diabetes, two or three or more antihypertensive agents may be needed to achieve this goal. The use of generic combination tablets (such as ACE plus calcium-channel blocker, or beta-blocker plus diuretic) can reduce the complexity of the regimen and out-of-pocket costs.

The UKPDS, HOT, ADVANCE and ACCORD trials are all large randomized clinical trials that allow comparison of more stringent versus less stringent blood pressure levels on major cardiovascular outcomes *(ACCORD Study Group, The, 2010a [High Quality Evidence]; ADVANCE Collaborative Group, 2008 [High Quality Evidence]; Hansson, 1998 [Moderate Quality Evidence]; United Kingdom Prospective Diabetes Study Group (UKPDS), 1993e [High Quality Evidence]).* The UKPDS, HOT and ADVANCE trials all found reduced cardiovascular outcomes with lower achieved blood pressure levels. However, none of these trials achieved average systolic blood pressure levels below 130 mmHg (Table 2). The ACCORD trial found no difference in major cardiovascular outcomes between a more intensive blood pressure intervention targeting systolic blood pressure < 120 mmHg compared to a more standard intervention targeting systolic blood pressure between 130 and 139 mmHg (Table 2). The more intensive blood pressure regimen was associated with a small reduction in the rate of stroke, greater medication use and more serious adverse events *(ACCORD Study Group, The, 2010a [High Quality Evidence]).*

The above studies support a systolic blood pressure goal < 140 mmHg for people with type 2 diabetes. We would estimate that targeting a systolic blood pressure < 140 mmHg would result in an achieved blood pressure around 135 mmHg for most people.

Only the HOT trial specifically targeted diastolic blood pressure. In the HOT trial, targeting a lower diastolic blood pressure was associated with fewer cardiovascular events in subjects with type 2 diabetes. The average achieved diastolic blood pressure values in the three HOT intervention arms ranged from 81-85 mmHg (Table 2). Based on results from the ADVANCE and ACCORD trials, it appears likely that achieved systolic blood pressure values in the mid-130 range will be associated with diastolic blood pressure values well below 80 mmHg.

The work group acknowledges that the evidence is not definitive for any particular general blood pressure goal for patients with diabetes. The work group feels that a blood pressure goal of< 140/90 mmHg is reasonable and defensible based on the evidence previously presented. This goal is also consistent with the current blood pressure measure for people with diabetes specified by the Physician Quality Reporting System. See https://www.cms.gov/PQRS for more information. The work group will continue to review the blood pressure goal to consider any new evidence and the recommendations of other national practice guidelines (e.g., ADA and JNC8) that are expected to announce revisions. The general recommendation of blood pressure < 140/90 mmHg does not preclude setting individual patient goals lower than that based on patient characteristics, comorbidities, risks or the preference of an informed patient.

2014 Diabetes Mellitus Disease Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

<div style="border:1px solid black; background:#d3d3d3; padding:5px;">

🎼 GPRO DM-14 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control

</div>

The DM Composite measure consists of DM-13, DM-14, DM-15, DM-16 and DM-17.

DESCRIPTION:
Percentage of patients 18 to 75 years of age with diabetes mellitus who had LDL-C < 100 mg/dL

IMPROVEMENT NOTATION:
Not Available

INITIAL PATIENT POPULATION:
Not Available

DENOMINATOR:
Patients 18 to 75 years of age with a diagnosis of diabetes mellitus (type 1 or type 2) with two or more face-to-face visits for diabetes in the last two years and at least one visit for any reason in the last 12 months

> DENOMINATOR EXCLUSIONS:
> Patient was a permanent nursing home resident during the measurement period
> Patient was pregnant during the measurement period

> DENOMINATOR EXCEPTIONS:
> None

NUMERATOR:
Patients with most recent low density lipoprotein < 100 mg/dL

> NUMERATOR EXCLUSIONS:
> Not Available

DEFINITION:
Not Available

GUIDANCE:
Not Available

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 intermediate physiological and biochemical outcomes included in this composite measure are modifiable lifestyle risk factors that can ultimately decrease the incidence of long term catastrophic events and chronic illness associated with diabetes. 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. ICSI Diabetes Guidelines April 2012 (American Diabetes Association, 2010; Duckworth, 2009; Gaede, 2008 [A]; Holman, 2008a [A])

Two sets of guidelines are referenced in the development and maintenance of this measure.
- The Institute for Clinical Systems Improvement (ICSI) Guidelines for the Diagnosis and Management of Type 2 Diabetes Mellitus Fifteenth Edition April 2012. This includes a comprehensive literature review and some of the articles quoted within the guideline are also included as references. References will be referred to as ICSI Diabetes Guideline or ICSI. Detailed guidelines are available at https://www.icsi.org/_asset/3rrm36/Diabetes-Interactive0412.pdf.
- The American Diabetes Association 2013 Standards of Medical Care. Will be referred to as American Diabetes Association or ADA. Detailed standards of medical care are available at http://www.diabetes.org under the "For Professionals" tab.

Seventy to seventy-five percent of adult patients with diabetes die of macrovascular disease, specifically coronary, carotid and/or peripheral vascular disease. Diabetes is considered a coronary artery disease equivalent and dyslipidemia is a known risk factor for macrovascular disease. Patients with diabetes develop more atherosclerosis than patients without diabetes with the same quantitative lipoprotein profiles. High triglycerides and low high-density lipoprotein cholesterol levels are independent risk factors for cardiovascular disease in the patient with diabetes. (ICSI,Pyorola, 1997 [High Quality Evidence])

<u>CLINICAL RECOMMENDATION STATEMENTS:</u>
American Diabetes Association 2013 Standards of Medical Care:
- Lifestyle modification focusing on the reduction of saturated fat, *trans* fat, and cholesterol intake; increase of n-3 fatty acids, viscous fiber, and plant stanols/sterols; weight loss (if indicated); and increased physical activity should be recommended to improve the lipid profile in patients with diabetes. (A).
- Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients:
  - with overt CVD (A)
  - without CVD who are over the age of 40 years and have one or more other CVD risk factors (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria) (A)
- For lower-risk patients than the above (e.g., without overt CVD and under the age of 40 years), statin therapy should be considered in addition to lifestyle therapy if LDL cholesterol remains above 100 mg/dL or in those with multiple CVD risk factors. (C)
- In individuals without overt CVD, the goal is LDL cholesterol <100 mg/dL (2.6 mmol/L). (B)

- In individuals with overt CVD, a lower LDL cholesterol goal of <70 mg/dL (1.8 mmol/L), using a high dose of a statin, is an option. (B)
- If drug-treated patients do not reach the above targets on maximal tolerated statin therapy, a reduction in LDL cholesterol of ~30–40% from baseline is an alternative therapeutic goal. (B)
- Triglycerides levels <150 mg/dL (1.7 mmol/L) and HDL cholesterol >40 mg/dL (1.0 mmol/L) in men and >50 mg/dL (1.3 mmol/L) in women are desirable (C). However, LDL cholesterol–targeted statin therapy remains the preferred strategy. (A)
- Combination therapy has been shown not to provide additional cardiovascular benefit above statin therapy alone and is not generally recommended. (A)
- Statin therapy is contraindicated in pregnancy. (B)

ICSI Diabetes Guideline:
Cardiovascular risk factor treatment goals for patients <u>with</u> cardiovascular disease recommendation:
- Use of statins if tolerated; to achieve low-density lipoprotein (LDL) cholesterol of less than 70 mg/dL
- Blood pressure less than 140/90 mmHg
- Tobacco cessation if indicated
- Daily aspirin use is recommended in patients with cardiovascular disease.

Cardiovascular risk factor treatment goals for patients <u>without</u> cardiovascular disease recommendation:

- Use of statins in all adult type 2 diabetes patients if tolerated; statins should be titrated to achieve low-density lipoprotein cholesterol of less than 100 mg/dL.
- Blood pressure less than 140/90 mmHg.
- Smoking cessation if indicated.
- Daily aspirin use is optional for primary prevention of cardiovascular events.

2014 Diabetes Mellitus Disease Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

> ♬ GPRO DM-15 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Hemoglobin A1c Control (< 8%)

The DM Composite measure consists of DM-13, DM-14, DM-15, DM-16 and DM-17.

DESCRIPTION:
Percentage of patients 18 to 75 years of age with diabetes mellitus who had HbA1c < 8.0 percent

IMPROVEMENT NOTATION:
Not Available

INITIAL PATIENT POPULATION:
Not Available

DENOMINATOR:
Patients 18 to 75 years of age with a diagnosis of diabetes mellitus (type 1 or type 2) with two or more face-to-face visits for diabetes in the last two years and at least one visit for any reason in the last 12 months

> DENOMINATOR EXCLUSIONS:
> Patient was a permanent nursing home resident during the measurement period
> Patient was pregnant during the measurement period

> DENOMINATOR EXCEPTIONS:
> None

NUMERATOR:
Patients with most recent hemoglobin A1c < 8.0 percent

> NUMERATOR EXCLUSIONS:
> Not Available

DEFINITION:
Not Available

GUIDANCE:
Not Available

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 intermediate physiological and biochemical outcomes included in this composite measure are modifiable lifestyle risk factors that can ultimately decrease the incidence of long term catastrophic events and chronic illness associated with diabetes. 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. ICSI Diabetes Guidelines April 2012 (American Diabetes Association, 2010; Duckworth, 2009; Gaede, 2008 [A]; Holman, 2008a [A])

Two sets of guidelines are referenced in the development and maintenance of this measure.
- The Institute for Clinical Systems Improvement (ICSI) Guidelines for the Diagnosis and Management of Type 2 Diabetes Mellitus Fifteenth Edition April 2012. This includes a comprehensive literature review and some of the articles quoted within the guideline are also included as references. References will be referred to as ICSI Diabetes Guideline or ICSI. Detailed guidelines are available at https://www.icsi.org/_asset/3rrm36/Diabetes-Interactive0412.pdf
- The American Diabetes Association 2013 Standards of Medical Care. Will be referred to as American Diabetes Association or ADA. Detailed standards of medical care are available at http://www.diabetes.org under the "For Professionals" tab.

CLINICAL RECOMMENDATION STATEMENTS:
ICSI Diabetes Guideline:
Recommends setting a personalized goal to less than 7% or less than 8% based on the risks and benefits for each patient. This recommendation places high value on trying to optimize the balance of risks versus benefits of more intensive glycemic control for each individual. Potential risks of< 7% may include higher mortality rates, hypoglycemia and weight gain. Potential benefits may include lower risk of diabetes complications such as retinopathy, nephropathy and heart disease. Individual patient factors that may increase risks include known cardiovascular disease, history of severe hypoglycemia, polypharmacy-related challenges, limited life expectancy, cognitive impairment and extensive comorbid conditions.

A1c target in type 2 diabetes is aimed at reducing microvascular complications while not increasing risk of morbidity or mortality. All patients with type 2 diabetes should aim to achieve an A1c less than 8%. This will reduce microvasuclar disease and not increase risk substantially. Many patients with type 2 diabetes may derive additional benefit in reduction of microvasuclar disease by reaching a target A1c less than 7% and not increase risks as long as the target is not A1c less than 6%. For patients with type 2 diabetes and the following factors, an A1c goal of less than 8% may be more appropriate than an A1c goal of less than 7% *(Action to Control Cardiovascular Risk in Diabetes Study Group, The, 2008 [High Quality Evidence]; ADVANCE Collaborative Group, The, 2008 [High Quality Evidence]; Duckworth, 2009 [Moderate Quality Evidence])*

American Diabetes Association 2013 Standards of Medical Care state:
- Lowering A1C to below or around 7.0% has been shown to reduce microvascular complications of diabetes and, if implemented soon after the diagnosis of diabetes, is

associated with long-term reduction in macrovascular disease. Therefore, a reasonable A1C goal for many nonpregnant adults is less than 7.0%.

- Providers might reasonably suggest more stringent A1C goals (such as <6.5%) for selected individual patients, if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Appropriate patients might include those with short duration of diabetes, long life expectancy, and no significant CVD. (C)
- Providers might reasonably suggest more stringent A1C goals (such as <6.5%) for selected individual patients, if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Appropriate patients might include those with short duration of diabetes, long life expectancy, and no significant CVD. (C)
- Less stringent A1C goals may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, extensive comorbid conditions, and those with longstanding diabetes in whom the general goal is difficult to attain despite DSME, appropriate glucose monitoring, and effective doses of multiple glucose-lowering agents including insulin. (B)

2014 Diabetes Mellitus Disease Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

𝄞 **GPRO DM-16 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease**

The DM Composite measure consists of DM-13, DM-14, DM-15, DM-16 and DM-17.

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

IMPROVEMENT NOTATION:
Not Available

INITIAL PATIENT POPULATION:
Not Available

DENOMINATOR:
Patients 18 to 75 years of age with a diagnosis of diabetes mellitus (type 1 or type 2) with two or more face-to-face visits for diabetes in the last two years and at least one visit for any reason in the last 12 months **and** a diagnosis of ischemic vascular disease

> DENOMINATOR EXCLUSIONS:
> Patient was a permanent nursing home resident during the measurement period
> Patient was pregnant during the measurement period
>
> DENOMINATOR EXCEPTIONS:
> Documentation of medical reason(s) for not prescribing daily aspirin or antiplatelet medication
>
> Note: As a stand-alone measure the following exclusions would also be applicable if the patient was not using daily aspirin or anti-platelet medication:
> - Anticoagulant use, such as Lovenox (enoxaparin), Coumadin (warfarin) or Xarelto (rivaroxaban)
> - Any history of gastrointestinal (GI)* or intracranial bleed (ICB)
> - Allergy to aspirin (ASA)
> - Documentation by a provider of medical reason(s) for not prescribing daily aspirin or antiplatelet medication. Examples include:
>   - 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

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

<u>NUMERATOR EXCLUSIONS:</u>
Not Available

<u>DEFINITION:</u>
Not Available

<u>GUIDANCE:</u>
Not Available

<u>RATIONALE:</u>
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 2013 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.

<u>CLINICAL RECOMMENDATION STATEMENTS:</u>
According to the 2013 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

2014 Diabetes Mellitus Disease Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

🎼 **GPRO DM-17 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Tobacco Non-Use**

The DM Composite measure consists of DM-13, DM-14, DM-15, DM-16 and DM-17.

DESCRIPTION:
Percentage of patients 18 to 75 years of age with a diagnosis of diabetes who indicated they were tobacco non-users

IMPROVEMENT NOTATION:
Not Available

INITIAL PATIENT POPULATION:
Not Available

DENOMINATOR:
Patients 18 to 75 years of age with a diagnosis of diabetes mellitus (type 1 or type 2) with two or more face-to-face visits for diabetes in the last two years and at least one visit for any reason in the last 12 months

DENOMINATOR EXCLUSIONS:
Patient was a permanent nursing home resident during the measurement period
Patient was pregnant during the measurement period

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Patients who were identified as non-users of tobacco

NUMERATOR EXCLUSIONS:
Not Available

DEFINITION:
Not Available

GUIDANCE:
Not Available

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 adults 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 2013 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])

2014 Heart Failure Disease Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

➤ **GPRO HF-6 (NQF 0083): Heart Failure (HF): 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 each hospital discharge

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL PATIENT POPULATION:
All patients aged 18 years and older with a diagnosis of heart failure

DENOMINATOR:
Equals Initial Patient Population with a current or prior LVEF < 40%

DENOMINATOR EXCLUSIONS:
None

DENOMINATOR EXCEPTIONS:
Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons)

Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons)

Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the healthcare system)

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

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
Outpatient setting: 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

Inpatient setting: Prescription given to the patient for beta-blocker therapy at discharge OR beta-blocker therapy to be continued after discharge as documented in the discharge medication list

<u>GUIDANCE</u>:
LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction.

To meet this measure, it must be reported for all heart failure patients a minimum of once during the measurement period when seen in the outpatient setting and also reported at each hospital discharge during the measurement period.

Beta-blocker therapy:
- For patients with prior LVEF < 40%, beta-blocker therapy should include bisoprolol, carvedilol, or sustained release metoprolol succinate.

<u>RATIONALE</u>:
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.

<u>CLINICAL RECOMMENDATION STATEMENTS:</u>
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) (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

<u>For the hospitalized patient:</u>
- 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)

2014 GPRO Hypertension Disease Module
Narrative Measure Specification for GPRO Web Interface Use ONLY

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

DESCRIPTION:
Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL PATIENT POPULATION:
Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period

DENOMINATOR:
Equals Initial Patient Population

> **DENOMINATOR EXCLUSIONS:**
> Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.
>
> **DENOMINATOR EXCEPTIONS:**
> None

NUMERATOR:
Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

> **NUMERATOR EXCLUSIONS:**
> Not Applicable

DEFINITION:
None

GUIDANCE:
In reference to the numerator element, only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient's home (including readings directly from monitoring devices) are not acceptable.

If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled".

<u>RATIONALE</u>:
Hypertension is a very significant health issue in the United States. Fifty million or more Americans have high blood pressure that warrants treatment, according to the National Health and Nutrition Examination Survey (NHANES) survey (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003). The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen adults aged 18 and older for high blood pressure (United States Preventive Services Task Force 2007).

The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. The increased risks of hypertension are present in individuals ranging from 40 to 89 years of age. For every 20 mmHg systolic or 10 mmHg diastolic increase in blood pressure, there is a doubling of mortality from both ischemic heart disease and stroke (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).

Better control of blood pressure has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. The relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40 percent), myocardial infarction incidence (20-25 percent) and heart failure incidence (>50 percent) (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).

<u>CLINICAL RECOMMENDATION STATEMENTS</u>:
The United States Preventive Services Task Force (2007) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (2003): Treating systolic blood pressure and diastolic blood pressure to targets that are <140/90 mmHg is associated with a decrease in cardiovascular disease complications.

> ◆ GPRO IVD-1 (NQF 0075): Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control

DESCRIPTION:
Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL)

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL PATIENT POPULATION:
Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) during the measurement period, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period

DENOMINATOR:
Equals Initial Patient Population

DENOMINATOR EXCLUSIONS:
Not Applicable

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Patients with a complete lipid profile performed during the measurement period and whose most recent LDL-C level performed during the measurement period is <100 mg/dL

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
None

GUIDANCE:
CMS182v3 Guidance is not consistent with the denominator and description for 2014 GPRO Web Interface reporting

RATIONALE:
A 10 percent decrease in total cholesterol levels (population wide) may result in an estimated 30 percent reduction in the incidence of coronary heart disease (CHD) (Centers for Disease Control and Prevention

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 percent of CHD patients are at their LDL goal (National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Pressure 2002)

According to data from the Behavioral Risk Factor Surveillance System (BRFSS) from 1991–2003, the prevalence of cholesterol screening during the preceding 5 years increased from 67.3 percent in 1991 to 73.1 percent in 2003 (Centers for Disease Control and Prevention 2005).

Between 1988–94 and 1999–2002, the age-adjusted mean total serum cholesterol level of adults 20 years of age and older decreased from 206 mg/dL to 203 mg/dL, and LDL cholesterol levels decreased from 129 mg/dL to 123 mg/dL. The mean level of LDL cholesterol for American adults age 20 and older is 123 mg/dL (Carroll et al. 2005). However, even given this decrease, there is still a significant amount of room for improvement.

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) (2002)

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

[1]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.

[2]If LDL-C is > 100 mg/dL, an LDL-lowering drug is indicated simultaneously with lifestyle changes.

[3]If baseline LDL-C is < 100 mg/dL, institution of an LDL-lowering drug to achieve an LDL-C level of < 70 mg/dL is a therapeutic option on the basis of available clinical trial evidence.

[4]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. This is a grade A recommendation.

The USPSTF recommends screening men 20 to 25 years of age for lipid disorders if they are at increased risk for coronary heart disease. This is a grade B recommendation.
The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease. This is a grade A recommendation.

The USPSTF recommends screening women 20 to 45 years of age for lipid disorders if they are at increased risk for coronary heart disease. This is a grade B recommendation (U.S. Preventive Services Task Force 2008).

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

<u>DESCRIPTION:</u>
Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period

<u>IMPROVEMENT NOTATION:</u>
Higher score indicates better quality

<u>INITIAL PATIENT POPULATION:</u>
Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period

<u>DENOMINATOR:</u>
Equals Initial Patient Population

<u>DENOMINATOR EXCLUSIONS:</u>
Not Applicable

<u>DENOMINATOR EXCEPTIONS:</u>
None

<u>NUMERATOR:</u>
Patients who have documentation of use of aspirin or another antithrombotic during the measurement period

<u>NUMERATOR EXCLUSIONS:</u>
Not Applicable

<u>DEFINITION:</u>
None

<u>GUIDANCE:</u>
CMS164v2 Guidance is not consistent with the denominator and description for 2014 GPRO Web Interface reporting

<u>RATIONALE:</u>
Coronary heart disease (CHD) is a major cause of death in the United States – in 2004, it was an underlying or contributing cause of death for 451,300 people (1 of every 5 deaths). Acute myocardial

infarction (AMI) was as an underlying or contributing cause of death for 156,000 people (American Heart Association 2008). In addition, nearly 16 million people (or 7.3 percent of the American population) had CHD in 2005 (American Heart Association 2008). The cost of cardiovascular diseases and stroke in the United States for 2008 was estimated at $448.5 billion (American Heart Association 2008). This figure includes health expenditures (direct costs such as the cost of physicians and healthcare practitioners, hospital and nursing home services, medications, home health care and other medical durables) and lost productivity resulting from morbidity and mortality (indirect costs). AMI accounts for 18 percent of hospital discharges and 28 percent of deaths due to heart disease (National Heart, Lung, and Blood Institute 2000). Research has shown that costs associated with cardiovascular disease for hospitals are easily $156 billion (American Heart Association 2008).

Aspirin treatments reduce MI in men (127 events per 100,000 person-years) and women (17 events per 100,000 person-years) (Grieving et al. 2008). While studies have shown warfarin to be more effective, aspirin is a safer, more convenient, and less expensive form of therapy (Patrono et al. 2004). Aspirin therapy has been shown to directly reduce the odds of cardiovascular events among men by 14 percent and among women by 12 percent (Berger et al. 2006). Aspirin use has been shown to reduce the number of strokes by 20 percent, MI by 30 percent, and other vascular events by 30 percent (Weisman and Graham 2002).

CLINICAL RECOMMENDATION STATEMENTS:
U.S. Preventive Services Task Force (2009):
The 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. ('A' recommendation) The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. ('A' recommendation) The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic stroke outweighs the potential harm of an increase in gastrointestinal hemorrhage. ('A' recommendation)

American Diabetes Association (2008):
Use aspirin therapy (75-162 mg/day) as a secondary prevention strategy in those with diabetes with a history of CVD. (Level A) 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 CVD, hypertension, smoking, dyslipidemia or albuminuria). (Level of Evidence: Level A)

American Heart Association/American Stroke Association (2006):
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 percent). (Class I: Level A)

American College of Clinical Pharmacy (2004):
For long-term treatment after PCI, the guideline developers recommend aspirin, 75 to 162 mg/day. (Grade 1A) 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. (Grade 1C+) For patients with ischemic stroke who are not receiving thrombolysis, the guideline developers recommend early aspirin therapy, 160 to 325 mg/day. (Grade 1A)

♦ GPRO PREV-5 (NQF N/A): Breast Cancer Screening

DESCRIPTION:
Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months

IMPROVEMENT NOTATION:
Higher score equals better quality

INITIAL PATIENT POPULATION:
Women 50 through 74 years of age with a visit during the measurement period

DENOMINATOR:
Equals Initial Patient Population

> *DENOMINATOR NOTE: The measure's 27-month look back period applies to women ages 52-74 (the numerator looks for a mammogram any time on or between October 1, 27 months prior to the measurement period, and December 31 of the measurement period in order to capture women who have had a mammogram every 24 months per clinical guidelines, with a 3-month grace period). Therefore, women ages 50-52 are included in the measure if they had a visit and a mammogram since age 50, but the look back only applies to patients age 52-74.*

DENOMINATOR EXCLUSIONS:
Women who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Patients who had one or more mammograms any time on or between October 1, 27 months prior to December 31 of the measurement period, not to precede the patient's 50th birthday

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
None

GUIDANCE:
None

RATIONALE:
Breast cancer ranks as the second leading cause of cancer-related death in women, accounting for nearly 40,000 estimated deaths in 2011 (American Cancer Society, 2011). Deaths from breast cancer have

decreased over the years, in part due to early detection using mammography. About 85 percent of breast cancers occur in women who have no family history of breast cancer. Mammography is particularly valuable to the patients, detecting on average about 80-90 percent of breast cancers in women with no symptoms. (BreastCancer.Org, 2012)

CLINICAL RECOMMENDATION STATEMENTS:
U.S. Preventive Services Task Force (2009)
Grade: B recommendation. The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.
Grade: C recommendation. The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.
Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older.
Grade: D recommendation. The USPSTF recommends against teaching breast self-examination (BSE).
Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older.
Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of either digital mammography or magnetic resonance imaging (MRI) instead of film mammography as screening modalities for breast cancer.

◆ GPRO PREV-6 (NQF 0034): Colorectal Cancer Screening

DESCRIPTION:
Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL PATIENT POPULATION:
Patients 50-75 years of age with a visit during the measurement period

DENOMINATOR:
Equals Initial Patient Population

> **DENOMINATOR EXCLUSIONS:**
> Patients with a diagnosis or past history of total colectomy or colorectal cancer

> **DENOMINATOR EXCEPTIONS:**
> None

NUMERATOR:
Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria below:
- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period

> **NUMERATOR EXCLUSIONS:**
> Not Applicable

DEFINITION:
None

GUIDANCE:
None

RATIONALE:
An estimated 142,570 men and women were diagnosed with colon cancer in 2010. In the same year, 51,370 were estimated to have died from the disease, making colorectal cancer the third leading cause of cancer death in the United States (American Cancer Society 2010).

Screening for colorectal cancer is extremely important as there are no signs or symptoms of the cancer in the early stages. If the disease is caught in its earliest stages, it has a five-year survival rate of 91%;

however, the disease is often not caught this early. While screening is extremely effective in detecting colorectal cancer, it remains underutilized (American Cancer Society 2010).

Fecal occult blood tests, colonoscopy, and flexible sigmoidoscopy are shown to be effective screening methods (United States Preventive Services Task Force, 2008). Colorectal screening of individuals with no symptoms can identify polyps whose removal can prevent more than 90% of colorectal cancers (Rozen 2004).

Studies have shown that the cost-effectiveness of colorectal cancer screening is $40,000 per life year gained, which is similar to the cost-effectiveness of mammography for breast cancer screening (Hawk and Levin 2005).

CLINICAL RECOMMENDATION STATEMENTS:
The United States Preventive Services Task Force (2008):

[1]The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years (A recommendation).
[2]The USPSTF concludes that the evidence is insufficient to assess the benefits and harms of computed tomographic (CT) colonography and fecal DNA testing as screening modalities for colorectal cancer (I statement).

The American Cancer Society, The American College of Radiology, and the U.S. Multi-Society Task Force on Colorectal Cancer (Levin et al. 2008):

Tests that Detect Adenomatous Polyps and Cancer
[1]Colonoscopy (every 10 yrs)
[2]Flexible sigmoidoscopy (every 5 yrs)
[3]Fecal occult blood tests (fecal occult blood test (FOBT))
[4]Double contrast barium enema (DCBE) (every 5 yrs)
[5]Computed tomographic colonography (CTC) (every 5 years)

Tests that Primarily Detect Cancer:
[1] Guaiac fecal occult blood test (gFOBT) with high sensitivity for cancer (annually)
[2] Fecal immunochemical test (FIT) with high sensitivity for cancer (annually)
[3] Stool DNA (sDNA) with high sensitivity for cancer (interval uncertain)

Modalities not approved:
[1] Single digital rectal examination fecal occult blood test (FOBT) has a poor sensitivity for CRC and should not be performed as a primary screening method
[2] Studies evaluating virtual colonoscopy and fecal DNA testing for CRC screening have yielded conflicting results and therefore cannot be recommended

2014 Preventive Care Measure
Narrative Measure Specification for GPRO Web Interface 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 who received an influenza immunization OR who reported previous receipt of an influenza immunization

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL PATIENT POPULATION:
All patients aged 6 months and older

DENOMINATOR:
Equals Initial Patient Population and seen for a visit between October 1 and March 31

> DENOMINATOR EXCLUSIONS:
> None

> DENOMINATOR EXCEPTIONS:
> Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons)
>
> Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons)
>
> Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)

NUMERATOR:
Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

> NUMERATOR EXCLUSIONS:
> Not Applicable

DEFINITION:
Previous Receipt – receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st)

GUIDANCE:
The timeframe for the visit refers to the influenza season as defined by the measure: October through March (October 1 for the year prior to the start of the reporting period through March 31 during the reporting period). This measure will *only* assess the influenza season that ends in March of the reporting period. The

subsequent influenza season (beginning in October of the reporting period and ending in March of the following year) will be measured and reported in the following year.

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:
Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months. To permit time for production of protective antibody levels, vaccination should optimally occur before onset of influenza activity in the community, and providers should offer vaccination as soon as vaccine is available. Vaccination also should continue to be offered throughout the influenza season. (CDC/ACIP, 2011)

2014 GPRO Preventive Care Measure
Narrative Measure Specification for GPRO Web Interface Use ONLY

♦ GPRO PREV-8 (NQF 0043): Pneumonia Vaccination Status for Older Adults

DESCRIPTION:
Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL PATIENT POPULATION:
Patients 65 years of age and older with a visit during the measurement period

DENOMINATOR:
Equals Initial Patient Population

> DENOMINATOR EXCLUSIONS:
> None

> DENOMINATOR EXCEPTIONS:
> None

NUMERATOR:
Patients who have ever received a pneumococcal vaccination

> NUMERATOR EXCLUSIONS:
> Not Applicable

DEFINITION:
None

GUIDANCE:
Pneumococcal vaccination is expected once ever for patients 65 years of age and older

RATIONALE:
Pneumonia is a common cause of illness and death in the elderly and persons with certain underlying conditions such as heart failure, diabetes, cystic fibrosis, asthma, sickle cell anemia, or chronic obstructive pulmonary disease. (NHLBI, 2011) In 1998, an estimated 3,400 adults aged > 65 years died as a result of invasive pneumococcal disease. (IPD) (CDC, 2003)

Among the 91.5 million US adults aged > 50 years, 29,500 cases of IPD, 502,600 cases of nonbacteremic pneumococcal pneumonia and 25,400 pneumococcal-related deaths are estimated to occur yearly; annual direct and indirect costs are estimated to total $3.7 billion and $1.8 billion, respectively. Pneumococcal disease remains a substantial burden among older US adults, despite increased coverage with 23-valent pneumococcal polysaccharide vaccine, (PPV23) and indirect benefits afforded by PCV7 vaccination of young children. (Weycker, et al., 2011)

Vaccination has been found to be effective against bacteremic cases (OR: 0.34; 95% CI: 0.27–0.66) as well as nonbacteremic cases (OR: 0.58; 95% CI: 0.39–0.86). Vaccine effectiveness was highest against bacteremic infections caused by vaccine types (OR: 0.24; 95% CI: 0.09–0.66). (Vila-Corcoles, et al., 2009)

CLINICAL RECOMMENDATION STATEMENTS:

The Advisory Committee on Immunization Practices' (ACIP) Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine (2010)

ACIP recommends pneumococcal vaccine for all immune competent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but a second dose is appropriate for those who received PPV23 before age 65 years for any indication if at least 5 years have passed since their previous dose (USPSTF, 1989; ACIP, 2010). The major updates for the 2010 update are: 1) the indications for which PPSV23 vaccination is recommended now include smoking and asthma, and 2) routine use of PPSV23 is no longer recommended for Alaska Natives or American Indians aged <65 years unless they have medical or other indications for PPV23.

2014 GPRO Preventive Care Measure
Narrative Measure Specification for GPRO Web Interface 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 documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter

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

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL PATIENT POPULATION:
Not Available

DENOMINATOR:
All patients aged 18 years and older at the beginning of the measurement period

DENOMINATOR EXCLUSIONS:
Patients who are pregnant

DENOMINATOR EXCEPTIONS:
Documentation of medical reason(s) for not having a BMI measurement performed during the measurement period (e.g., patient is receiving palliative care, patient is pregnant or 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)

Documentation of patient reason(s) for not having a BMI measurement performed during the measurement period (e.g., patient refuses BMI measurement (height or weight) or if there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate)

NUMERATOR:
Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
BMI – Body mass index (BMI) is a number calculated using the Quetelet index: weight divided by height squared (W/H2) and is commonly used to classify weight categories. BMI can be calculated using:

Metric Units: BMI = Weight (kg) / (Height (m) x Height (m))
OR
English Units: BMI = Weight (lb) / (Height (in) x Height (in)) x 703

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up may include but is not limited to: documentation of education, referral (e.g., a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling or nutrition counseling.

GUIDANCE:

There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. The BMI documented in the medical record may be reported if done in the provider's office/facility or if a BMI is documented within the previous six months in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan must be documented within six months of the abnormal BMI. An eligible professional or their staff is required to measure both height and weight. Both the height and the weight must be measured within the same six months. Self-reported values cannot be used. The documented follow-up interventions must be related to the BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters".

RATIONALE:

BMI Above Upper Parameters

Obesity continues to be a costly public health concern in the United States. The Centers for Disease Control and Prevention (CDC, 2010) reported that in 2009, no state met the Healthy People 2010 obesity target of 15 percent and the self reported overall prevalence of obesity among adults had increased 1.1 percentage points in 2007 to 26.7 percent Flegal, Carroll, Kit and Ogden (2012) reported the prevalence of BMI-defined obesity in adults is high and continues to exceed 30% in most sex-age groups. In addition to the continued high prevalence rate for adults in general, there has been a significant increase for men and for non-Hispanic black and Mexican American women over the 12-year period from 1999 through 2010 . Moyer (2012) reported: Obesity is associated with such health problems as an increased risk for coronary artery disease, type 2 diabetes, various types of cancer, gallstones and disability. These comorbid medical conditions are associated with higher use of health care services and costs among obese patients (p. 373). Obesity is also associated with an increased risk of death, particularly in adults younger than age 65 years and has been shown to reduce life expectancy by 6 to 20 years depending on age and race (LeBlanc et al., 2011).

Finkelstein, Trogdon, Cohen and Dietz (2009) found that in 2006 across all payers, per capita medical spending for the obese is $1,429 higher per year (42 percent) than for someone of normal weight. Using 2008 dollars, this was estimated to be equivalent to $147 billion dollars in medical care costs related to obesity.

In addition to a high prevalence rate of obesity, less than 50% of obese adults in 2010 received advice to exercise or perform physical activity (Barnes & Schoenborn, 2012).

BMI Below Normal Parameters

In the National Center for Health Statistics Health E-Stat, Fryer and Ogden reported that poor nutrition or underlying health conditions can result in underweight. Results from the 2007-2010 National Health and Nutrition Examination Survey (NHANES), using measured heights and weights, indicate an estimated 1.7% of U.S. adults are underweight with women more likely to be underweight than men (2012).

Ranhoff, Gjoen and Mowe (2005) identified using a BMI < 23 for the elderly to identify positive results with malnutrition screens and poor nutritional status.

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

The US Preventive Health Services Task Force (USPSTF) recommends screen all adults (aged 18 years and older) for obesity. Clinicians should offer or refer patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions. This is a B recommendation (Moyer, 2012).

As cited in Wilkinson et al. (2012), the Institute for Clinical Systems Improvement (ICSI) Preventive Services for Adults, Obesity Screening (Level II) Recommendation provides the following guidance:
- Record height, weight and calculate body mass index at least annually
- A BMI greater or equal to 30 is defined as obese
- A BMI of 25-29 is defined as overweight
- Intensive intervention for obese individuals, based on BMI, is recommended by the U.S. Preventive Services to help control weight.

2014 Preventive Care Measure
Narrative Measure Specification for GPRO Web Interface 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

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL PATIENT POPULATION:
All patients aged 18 years and older

DENOMINATOR:
Equals Initial Patient Population

DENOMINATOR EXCLUSIONS:
None

DENOMINATOR EXCEPTIONS:
Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)

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

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
Tobacco Use – Includes any type of tobacco
Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy

GUIDANCE:
If tobacco use status of a patient is unknown, the patient cannot be counted in the numerator and should be considered a measure failure. Instances where tobacco use status of "unknown" is recorded include: 1) the patient was not screened; or 2) the patient was screened and the patient (or caregiver) was unable to provide a definitive answer. If tobacco use status of "unknown" is recorded but the patient has an allowable medical exception, then the patient should be removed from the denominator of the measure and reported as a valid exception.

If a patient uses any type of tobacco (ie, smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation: either counseling and/or pharmacotherapy.

RATIONALE:
This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:
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 use 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 and 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 and 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 and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (U.S. Preventive Services Task Force, 2009)

2014 GPRO Preventive Care Measure
Narrative Measure Specification for GPRO Web Interface Use ONLY

♠ GPRO PREV-11 (NQF N/A): Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

DESCRIPTION:
Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL PATIENT POPULATION:
Percentage of patients aged 18 years and older before the start of the measurement period

DENOMINATOR:
Equals Initial Patient Population

DENOMINATOR EXCLUSIONS:
Patient has an active diagnosis of hypertension

DENOMINATOR EXCEPTIONS:
Patient Reason(s): Patient refuses to participate
OR
Medical Reason(s): 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. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated.

NUMERATOR:
Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
Blood Pressure (BP) Classification: BP is defined by four (4) BP reading classifications: Normal, Pre-Hypertensive, First Hypertensive, and Second Hypertensive Readings.

Recommended BP Follow-Up: The current Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC) recommends BP screening intervals, lifestyle modifications and interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow-Up Interventions" listed below.
Recommended Lifestyle Modifications: The current JNC report outlines lifestyle modifications which **must** include one or more of the following as indicated:

- Weight Reduction
- DASH Eating Plan
- Dietary Sodium Restriction
- Increased Physical Activity
- Moderation in Alcohol (ETOH) Consumption

Second Hypertensive Reading: Requires a BP reading of Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg during the current encounter AND a most recent BP reading within the last 12 months Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg.

Second Hypertensive Reading BP Interventions: The current JNC report outlines BP follow-up interventions for a second hypertensive BP reading and **must** include one or more of the following as indicated:
- Anti-Hypertensive Pharmacologic Therapy
- Laboratory Tests
- Electrocardiogram (ECG)

Recommended Blood Pressure Follow-Up Interventions:
- Normal BP: No follow-up required for Systolic BP < 120 mmHg AND Diastolic BP < 80 mmHg
- Pre-Hypertensive BP: Follow-up with rescreen every year with systolic BP of 120-139 mmHg OR diastolic BP of 80-89 mmHg AND recommend lifestyle modifications OR referral to Alternative/Primary Care Provider
- First Hypertensive BP Reading: Patients with one elevated reading of systolic BP ≥ 140 mmHg OR diastolic BP ≥ 90 mmHg: Follow-up with rescreen > 1 day and < 4 weeks AND recommend lifestyle modifications OR referral to Alternative/Primary Care Provider
- Second Hypertensive BP Reading: Patients with second elevated reading of systolic BP ≥140 mmHg OR diastolic BP ≥ 90 mmHg: Follow-up with Recommended lifestyle modifcations AND one or more of the Second Hypertensive Reading Interventions OR referral to Alternative/Primary Care Provider

<u>GUIDANCE:</u>
Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple blood pressures on the same date of service,use the lowest systolic and diastolic blood pressure on that date as the representative blood pressure.

Eligible professionals who report the measure must perform the blood pressure screening at the time of a qualifying visit and may not obtain measurements from external sources.

The documented follow up plan must be related to the current BP reading as indicated, example: "Patient referred to primary care provider for BP management."

<u>RATIONALE:</u>
Hypertension is a prevalent condition that affects approximately 66.9 million people in the United States. It is estimated that about 20-40% of the adult population has hypertension; the majority of people over age 65 have a hypertension diagnosis (Appleton SL, et. al., 2012 and Luehr D, et. al., 2012). Winter (2013) noted that 1 in 3 American adults have hypertension and the lifetime risk of developing hypertension is 90% (Winter KH, et. al., 2013). The African American population or non-Hispanic Blacks, the elderly, diabetics and those with chronic kidney disease are at increased risk of stroke, myocardial infarction and renal

disease. Non-Hispanic Blacks have the highest prevalence at 38.6% (Winter KH, et. al., 2013). Hypertension is a major risk factor for ischemic heart disease, left ventricular hypertrophy, renal failure, stroke and dementia (Luehr D, et. al., 2012).

Hypertension is the most common reason for adult office visits other than pregnancy. Garrison (2013) stated that in 2007, 42 million ambulatory visits were attributed to hypertension (Garrison GM and Oberhelman S, 2013). It also has the highest utilization of prescription drugs. Numerous resources and treatment options are available, yet only about 40-50% of the hypertensive patients have their blood pressure under control (<140/90) (Appleton SL, et. al., 2012, Luehr D, et. al., 2012). In addition to medication non-compliance, poor outcomes are also attributed to poor adherence to lifestyle changes such as a low-sodium diet, weight loss, increased exercise and limiting alcohol intake. Many adults find it difficult to continue medications and lifestyle changes when they are asymptomatic. Symptoms of elevated blood pressure usually do not occur until secondary problems arise such as with vascular diseases (myocardial infarction, stroke, heart failure and renal insufficiency) (Luehr D, et. al., 2012).

Appropriate follow-up after blood pressure measurement is a pivotal component in preventing the progression of hypertension and the development of heart disease. Detection of marginally or fully elevated blood pressure by a specialty clinician warrants referral to a provider familiar with the management of hypertension and prehypertension. The 2010 ACCF/AHA Guideline for the Assessment of Cardiovascular Risk in Asymptomatic Adults continues to support using a global risk score such as the Framingham Risk Score, to assess risk of coronary heart disease (CHD) in all asymptomatic adults (Greenland P, et. al., 2010). Lifestyle modifications have demonstrated effectiveness in lowering blood pressure. (JNC 7, 2003) The synergistic effect of several lifestyle modifications results in greater benefits than a single modification alone. Baseline diagnostic/laboratory testing establishes if a co-existing underlying condition is the etiology of hypertension and evaluates if end organ damage from hypertension has already occurred. Landmark trials such as ALLHAT have repeatedly proven the efficacy of pharmacologic therapy to control blood pressure and reduce the complications of hypertension. Follow-up intervals based on blood pressure control have been established by the JNC 7 and the USPSTF.

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.

2014 GPRO Preventive Care Measure
Narrative Measure Specification for GPRO Web Interface Use ONLY

♣ **GPRO PREV-12 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan**

DESCRIPTION:
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL PATIENT POPULATION:
All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period

DENOMINATOR:
Equals Initial Patient Population

> DENOMINATOR EXCLUSIONS:
> Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder
>
> DENOMINATOR EXCEPTIONS:
> Patient Reason(s): Patient refuses to participate
> OR
> Medical Reason(s): 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
> OR
> Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

NUMERATOR:
Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen

> NUMERATOR EXCLUSIONS:
> Not Applicable

DEFINITIONS:
Screening: Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Clinical Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized.

Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire, Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (SDS), Cornell Scale Screening and PRIME MD-PHQ2

Follow-Up Plan: Follow-up for a positive depression screening *__must__* include one or more of the following:
- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

GUIDANCE:
A clinical depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record**.**

RATIONALE:
The World Health Organization, as seen in Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Persons 40-59 years of age had higher rates of depression than any other age group. Persons 12-17, 18-39 and 60 years of age and older had similar rates of depression. Depression was more common in females than in males. Non-Hispanic black persons had higher rates of depression than non-Hispanic white persons. In the 18-39 and 40-59 age groups, those with income below the federal poverty level had higher rates of depression than those with higher income. Among persons 12-17 and 60 years of age and older, raters of depression did not vary significantly by poverty status. Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms.

15–20 percent of adults older than age 65 in the United States have experienced depression (Geriatric Mental Health Foundation, 2008). 7 million adults aged 65 years and older are affected by depression (Steinman, 2007). Chronically ill Medicare beneficiaries with accompanying depression have significantly higher health care costs than those with chronic diseases alone (Unützer, 2009). People aged 65 years and

older accounted for 16 percent of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages. As reported in Borner (2010), a study conducted by the World Health Organization (WHO) reported that in North America, primary care and family physicians are likely to provide the first line of treatment for depressive disorders. Others consistently report a 10% prevalence rate of depression in primary care patients. But studies have shown that primary care physicians fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments. Coyle et al. (2003) suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated. In 2011, Healthy People 2020 recommended routine screening for mental health problems as a part of primary care for both children and adults. (U.S. Department of Health and Human Services, 2011).

Major depressive disorder (MDD) is a debilitating condition that has been increasingly recognized among youth, particularly adolescents. The prevalence of current or recent depression among children is 3% and among adolescents is 6%. The lifetime prevalence of MDD among adolescents may be as high as 20%. Adolescent-onset MDD is associated with an increased risk of death by suicide, suicide attempts, and recurrence of major depression by young adulthood. MDD is also associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood (Williams et al., 2009). Every fifth adolescent may have a history of depression by age 18. The increase in the onset of depression occurs around puberty. According to Gil Zalsman et al. (2006) as reported in Borner et al. (2010), depression ranks among the most commonly reported mental health problems in adolescent girls.

The economic burden of depression is substantial for individuals as well as society. Costs to an individual may include suffering, possible side effects from treatment, fees for mental health and medical visits and medications, time away from work and lost wages, transportation, and reduced quality of personal relationships. Costs to society may include loss of life, reduced productivity (because of both diminished capacity while at work and absenteeism from work), and increased costs of mental health and medical care. In 2000, the United States spent an estimated $83.1 billion in direct and indirect costs of depression. (USPSTF, 2009).

CLINICAL RECOMMENDATION STATEMENTS:
Adolescent Recommendation (12-18 years)
The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. (AHRQ, 2010, p.141)

Level II Child Preventive Services should be assessed and offered to each patient; as such services have been shown to be effective. Such Level II services include: Screening adolescents ages 12-18 for major depressive disorder when systems are in place for accurate diagnosis, treatment, and follow-up. (ICSI, 2012)

Adult Recommendation (18 years and older)
The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. (AHRQ, 2010, p.136)

Clinicians may need to suspect the diagnosis of major depression or dysthymia based on a profile of risk factors and common presentations. If depression is suspected, it is recommended that the clinicians use a standardized instrument to identify current depression symptoms and track treatment response. Screening tools should be used to enhance but not replace the clinical interview. Patients with a high risk of common comorbid conditions such as substance abuse, diabetes, cardiovascular disease and chronic pain should be screened for depression. Age, culture and other contextual factors which may affect patients require special considerations regarding risk, assessment and treatment of depression (ICSI, 2012).

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