2012 EHR Measure Specifications

- DRAFT FOR PUBLIC COMMENT USE ONLY -

The specifications listed in this document have been updated to reflect clinical practice guidelines and applicable health informatics standards that are the most current available as of May, 2011. These updates have also been carried over to the Electronic Health Record (EHR) Downloadable Resource table.

These specifications may be available for potential use in physician quality initiatives, including but not limited to the EHR submission under the 2012 Physician Quality Reporting System ("Physician Quality Reporting," formerly known as Physician Quality Reporting Initiative or PQRI). A measure's inclusion in this document does not guarantee that measure will be used in any specific CMS (Centers for Medicare & Medicaid Services) program in 2012 or any subsequent year. If a measure is included in the 2012 Physician Quality Reporting System, all measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure accurate performance rates. The EHR Warehouse will calculate the rates based on the data that is submitted in the specified format for this program.

In the case of measures that have been used in prior initiatives – such as the 2011 PQRS EHR program, the 2010 PQRI EHR program, the 2008 and 2009 PQRI EHR testing projects – the specifications detailed in this document supersede any specifications which may have been used in those prior activities.

These specifications are not intended for use in the EHR Incentive Program, at this time. The EHR Incentive Program's American Recovery and Reinvestment Act's (ARRA's) Health Information Technology for Economic and Clinical Health (HITECH) Act's Electronic Specifications and related documents can be found on the CMS website.

To determine which measures are included in any specific CMS program or demonstration, interested parties should refer to the official documentation for that program or demonstration. Please refer to the Medicare Physician Fee Schedule (PFS) 2012 Proposed Rule (to be published in the Federal Register in July, 2011) to identify the measures that may be available for data submission through EHRs under the 2012 Physician Quality Reporting System.

Measure Owner Designation	
*	AMA-NCQA is the measure owner
▲	AMA-PCPI is the measure owner
¥	AMA-PCPI/ASCO/NCCN is the measure owner
☼	CMS is the measure owner
♦	NCQA is the measure owner
♣	QIP/CMS is the measure owner

2012 EHR Measure Specifications

TABLE OF CONTENTS

2012 EHR Measure Specifications
ANALYTIC NARRATIVES

◆ **Measure #1 (NQF 0059):** Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus

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

Denominator: Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Inclusions:

All patients with a documented diagnosis of diabetes at any time in the patient's medical history and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT OR ENCOUNTER OUTPATIENT) with the eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period OR patient was prescribed a medication indicative of diabetes during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

AND

DIABETES

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed medications indicative of diabetes during the measurement period and DRUG_EXCLUSION = N.

Numerator: Patients with most recent hemoglobin A1c level > 9.0%

Numerator Inclusions:

Patients with most recent A1c greater than 9.0% during the measurement period or no test was submitted during the measurement period.
  NOTE: *For performance, a lower rate indicates better performance/control.*

RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HbA1c TEST
WITH
Documentation of HbA1c > 9%

Denominator Exclusions: *(Exclusions only applied if most recent A1c test value not recorded OR most recent A1c value was less than or equal to 9.0%)*

Patients with a diagnosis of polycystic ovaries at any time during the patient's history who were prescribed medications indicative of diabetes.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

AND NOT

Diabetes patients who had a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

OR

Patients with a diagnosis of gestational diabetes or steroid induced diabetes during the measurement period who were prescribed medications indicative of diabetes.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

GESTATIONAL DIABETES
OR
STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

AND NOT

Diabetes patients who had a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

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

Clinical Recommendation Statements:
A glycosylated hemoglobin should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals. (AACE/ACE)

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

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

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

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

◆**Measure #2 (NQF 0064):** Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus

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

Denominator: Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Inclusions:

All patients with a documented diagnosis of diabetes at any time in the patient's medical history and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period OR patient was prescribed a medication indicative of diabetes during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

AND

DIABETES

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed medications indicative of diabetes during the measurement period and DRUG_EXCLUSION = N.

Numerator 1: Patients with LDL-C test result during the measurement period

Numerator Inclusions:

Patients with LDL test result during the measurement period.

RESULTS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL TEST

OR

HIGH DENSITY LIPOPROTEIN (HDL)
AND
TOTAL CHOLESTEROL
AND
TRIGLYCERIDES

AND

Numerator 2: Patients with most recent LDL-C < 100 mg/dL

Numerator Inclusions:

Patients with most recent LDL test result less than 100 mg/dL during the measurement period.

> NOTE: *LDL results are acceptable if directly reported (LDL TEST) from the laboratory, or if the other elements (TRIGLYCERIDES, TOTAL CHOLESTEROL, HIGH DENSITY LIPOPROTEIN (HDL)) listed below are submitted and triglyceride value is ≤ 400 mg/dL. Directly reported values or calculated LDL values must be less than 100 mg/dL for Numerator Inclusion purposes.*

LDL value = [TOTAL CHOLESTEROL value –
HIGH DENSITY LIPOPROTEIN (HDL) value –
(TRIGLYCERIDE value/5)]

RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL TEST
WITH
Documentation of LDL TEST < 100 mg/dL

OR

TRIGLYCERIDES
WITH
*Documentation of Triglycerides ≤ **400 mg/dL***

AND

TOTAL CHOLESTEROL
WITH
Documentation of Total Cholesterol in mg/dL

AND

HIGH DENSITY LIPOPROTEIN (HDL)
WITH
Documentation of HDL in mg/dL

Denominator Exclusions: *(Exclusions only applied if most recent LDL cholesterol test value not recorded OR most recent LDL value was greater than or equal to 100 mg/dL)*

> Patients with a diagnosis of polycystic ovaries at any time during the patient's history who were prescribed medications indicative of diabetes.
>
> PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> POLYCYSTIC OVARIES

AND NOT

> Diabetes patients who had a face-to-face visit with the eligible professional during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> DIABETES
>
> AND
>
> ENCOUNTER ACUTE INPT
> OR
> ENCOUNTER ED
> OR
> ENCOUNTER NON-ACUTE INPATIENT
> OR
> ENCOUNTER OUTPATIENT

OR

> Patients with a diagnosis of gestational diabetes or steroid induced diabetes during the measurement period who were prescribed medications indicative of diabetes.
>
> PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> GESTATIONAL DIABETES
> OR
> STEROID INDUCED DIABETES
>
> AND
>
> MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

AND NOT

Diabetes patients who have a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

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

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

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

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

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

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

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

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

⬥**Measure #3 (NQF 0061):** Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus

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

Denominator: Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Inclusions:

> All patients with a documented diagnosis of diabetes at any time in the patient's medical history and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPATIENT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period OR patient was prescribed a medication indicative of diabetes during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER ACUTE INPT
> OR
> ENCOUNTER ED
> OR
> ENCOUNTER NON-ACUTE INPATIENT
> OR
> ENCOUNTER OUTPATIENT
>
> AND
>
> DIABETES

OR

> MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed medications indicative of diabetes during the measurement period and DRUG_EXCLUSION = N.

Numerator: Patients whose most recent blood pressure < 140/90 mmHg

Numerator Inclusions:

Patients with most recent blood pressure measurement less than 140/90 mmHg during the most recent qualifying visit during the measurement period.

> NOTE: *Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.*

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIASTOLIC BLOOD PRESSURE
WITH
Documentation of Diastolic Blood Pressure < 90 mm[Hg]

AND

SYSTOLIC BLOOD PRESSURE
WITH
Documentation of Systolic Blood Pressure < 140 mm[Hg]

Denominator Exclusions: *(Exclusions only applied if most recent BP value not recorded OR most recent systolic value was greater than or equal to 140 mmHg OR most recent diastolic value was greater than or equal to 90 mmHg)*

Patients with a diagnosis of polycystic ovaries at any time during the patient's history who were prescribed medications indicative of diabetes.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

AND NOT

Diabetes patients who had a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

OR

Patients with a diagnosis of gestational diabetes or steroid induced diabetes during the measurement period who were prescribed medications indicative of diabetes.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

GESTATIONAL DIABETES
OR
STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes medications indicative of diabetes.

AND NOT

Diabetes patients who had a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

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

Clinical Recommendation Statements:
Recommends that a blood pressure determination during the initial evaluation, including orthostatic evaluation, be included in the initial and every interim physical examination. (AACE/ACE)

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

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

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

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

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

Measure #5 (NQF 0081): Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy

Denominator: Heart failure patients aged 18 years and older with LVEF < 40% or with moderately or severely depressed left ventricular systolic function

Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with a documented diagnosis of heart failure at any time before or during their last qualifying visit, and who also have LVSD (defined as ejection fraction less than 40%) or a diagnosis of moderately or severely depressed left ventricular systolic function before their last qualifying visit. A prior ejection fraction study documenting LVSD can be used to identify patients. To be eligible for performance calculations, patients must have at least two face-to-face visits (ENCOUNTER NURSING FACILITY or ENCOUNTER OUTPATIENT) or at least one face-to-face visit (ENCOUNTER INPATIENT DISCHARGE) with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY
OR
ENCOUNTER OUTPATIENT
OR
ENCOUNTER INPATIENT DISCHARGE

AND

HEART FAILURE

AND

RESULTS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EJECTION FRACTION
WITH
Documentation of Ejection Fraction < 40%

OR

LVF ASSMT
WITH
Documentation of LVF ASSMT < 40%

OR

MODERATE OR SEVERE LVSD

OR

LEFT VENTRICULAR SYSTOLIC DYSFUNCTION
AND
Severity: 'Moderate or Severe' Qualifier

Numerator: Patients who were prescribed ACE inhibitor or ARB therapy

Numerator Inclusions:

> MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed ACE inhibitor or ARB during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient did not receive ACE inhibitor or ARB therapy)*

> When drug therapy is not prescribed for a valid medical, patient or system reason the appropriate medication that would have been prescribed should be submitted along with a negation code during the measurement period to indicate the reason the appropriate medication was not ordered or received.
>
> MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for ACE inhibitor or ARB.
>
> AND
>
> MEDICAL REASON
> OR
> PATIENT REASON
> OR
> SYSTEM REASON
> OR
> PATIENT REASON FOR ACE INHIBITOR OR ARB DECLINE

OR

> Patients who had one of the following conditions before or during their last qualifying visit during the measurement period.
>
> PROBLEMS and ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> PREGNANCY
> OR
> DEFICIENCIES OF CIRCULATING ENZYMES
> OR
> DISEASE OF AORTIC AND MITRAL VALVES
> OR
> NONRHEUMATIC MITRAL (VALVE) DISEASE
> OR
> CHRONIC KIDNEY DISEASE WITH AND WITHOUT HYPERTENSION
> OR
> HYPERTENSIVE RENAL DISEASE WITH RENAL FAILURE
> OR
> ARTHEROSCLEROSIS OF RENAL ARTERY
> OR
> RENAL FAILURE AND ESRD
> OR
> ACUTE RENAL FAILURE
> OR
> ATRESIA AND STENOSIS OF AORTA
> OR
> PATIENT REASON FOR ACE INHIBITOR OR ARB DECLINE

OR

When drug therapy was not prescribed due to patient allergy, adverse effects or intolerance identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for ACE inhibitor or ARB.

AND

MEDICATION ALLERGY
OR
MEDICATION ADVERSE EFFECTS
OR
MEDICATION INTOLERANCE

Rationale:

In the absence of contraindications, ACE Inhibitors or ARBs are recommended for all patients with symptoms of heart failure and reduced left ventricular systolic function, as measured by left ventricular ejection fraction (LVEF). Both drugs have been shown to decrease mortality and hospitalizations.

Clinical Recommendation Statements:

Angiotensin converting enzyme inhibitors are recommended for all patients with current or prior symptoms of HF and reduced LVEF, unless contraindicated. (Class I Recommendation, Level of Evidence: A)(ACC/AHA)

Angiotensin II receptor blockers approved for the treatment of HF are recommended in patients with current or prior symptoms of HF and reduced LVEF who are ACEI-intolerant. (Class I Recommendation, Level of Evidence: A) (ACC/AHA)

Angiotensin II receptor blockers are reasonable to use as alternatives to ACEIs as first-line therapy for patients with mild to moderate HF and reduced LVEF, especially for patients already taking ARBs for other indications. (Class IIa Recommendation, Level of Evidence: A) (ACC/AHA)

Measure #6 (NQF 0067): Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy

Denominator: All patients aged 18 years and older with a diagnosis of coronary artery disease

Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with a documented diagnosis of CAD or had a cardiac surgery at any time before or during their last qualifying visit. To be eligible for performance calculations, patients must have at least two face-to-face visits (ENCOUNTER NURSING FACILITY or ENCOUNTER OUTPATIENT) or at least one face-to-face visit (ENCOUNTER INPATIENT DISCHARGE) with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for inclusion in this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY
OR
ENCOUNTER OUTPATIENT
OR
ENCOUNTER INPATIENT DISCHARGE

AND

CORONARY ARTERY DISEASE INCLUDES MI
OR
CARDIAC SURGERY

Numerator: Patients who were prescribed oral antiplatelet therapy

Numerator Inclusions:

> MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed oral antiplatelet therapy during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient did not receive oral antiplatelet therapy)*

> When drug therapy is not prescribed for a valid medical, patient or system reason, the appropriate medication that would have been prescribed should be submitted along with a negation code during the measurement period to indicate the reason the appropriate medication was not ordered or received.
>
> MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for oral antiplatelet therapy.
>
> AND
>
> MEDICAL REASON
> OR
> PATIENT_REASON
> OR
> SYSTEM_REASON

OR

> When drug therapy was not prescribed due to patient allergy, adverse effects or intolerance identified at any time before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.
>
> MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for oral antiplatelet therapy.
>
> AND
>
> MEDICATION ALLERGY
> OR
> MEDICATION ADVERSE EFFECTS
> OR
> MEDICATION INTOLERANCE

OR

> Patients who had one of the following conditions at any time before or during their last qualifying visit during the measurement period.
>
> PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> BLEEDING COAGULATION DISORDERS

Rationale:
Oral antiplatelet therapy, preferably aspirin unless contraindicated, is recommended for all patients with coronary artery disease. By limiting the ability of clots to form in the arteries, antiplatelet agents have proven benefits in reducing the risk of non-fatal myocardial infarction, non-fatal stroke and death.

Clinical Recommendation Statements:
Chronic Stable Angina: Class I – Aspirin 75-325 mg daily should be used routinely in all patients with acute and chronic ischemic heart disease with or without manifest symptoms in the absence of contraindications. Class IIa – Clopidogrel is recommended when aspirin is absolutely contraindicated. Class III – Dipyridamole. Because even the usual oral doses of dipyridamole can enhance exercise-induced myocardial ischemia in patients with stable angina, it should not be used as an antiplatelet agent. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Aspirin 75 to 325 mg/dl in the absence of contraindications. Class I – Clopidogrel 75 qd for patients with a contraindication to ASA. (ACC/AHA)

Acute Myocardial Infarction (AMI): Class I – A dose of aspirin, 160 to 325 mg, should be given on day one of AMI and continued indefinitely on a daily basis thereafter. Trials suggest long-term use of aspirin in the postinfarction patient in a dose as low as 75 mg per day can be effective, with the likelihood that side effects can be reduced. Class IIb – Other antiplatelet agents such as dipyridamole, ticlopidine or clopidogrel may be substituted if true aspirin allergy is present or if the patient is unresponsive to aspirin. (ACC/AHA)

Coronary Artery Bypass Graft Surgery: Aspirin is the drug of choice for prophylaxis against early saphenous graft thrombotic closure and should be considered a standard of care for the first postoperative year. In general, patients are continued on aspirin indefinitely, given its benefit in the secondary prevention of AMI. Ticlopidine is efficacious but offers no advantage over aspirin except as an alternative in the truly aspirin-allergic patient. Clopidogrel offers the potential of fewer side effects compared with ticlopidine as an alternative to aspirin for platelet inhibition. Indobufen appears to be as effective as aspirin for saphenous graft patency over the first postoperative year but with fewer gastrointestinal side effects. Current evidence suggests that dipyridamole adds nothing to the aspirin effect for saphenous graft patency. (ACC/AHA)

Measure #7 (NQF 0070): Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy

Denominator: Patients aged 18 years and older with a diagnosis of coronary artery disease who also have prior myocardial infarction (MI) at any time

Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with a documented diagnosis of CAD or had a cardiac surgery at any time before or during their last qualifying visit who also had prior MI at any time before or during their last qualifying visit. To be eligible for performance calculations, patients must have at least two face-to-face visits (ENCOUNTER NURSING FACILITY or ENCOUNTER OUTPATIENT) or at least one face-to-face visit (ENCOUNTER INPATIENT DISCHARGE) with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY
OR
ENCOUNTER OUTPATIENT
OR
ENCOUNTER INPATIENT DISCHARGE

AND

CORONARY ARTERY DISEASE NO MI
OR
CARDIAC SURGERY

AND

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data elements:

MYOCARDIAL INFARCTION

Numerator: Patients who were prescribed beta-blocker therapy

Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed beta-blocker therapy during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient did not receive beta-blocker therapy)*

When drug therapy is not prescribed for a valid medical, patient or system reason, the appropriate medication that would have been prescribed should be submitted along with a negation code during the measurement period to indicate the reason the appropriate medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for beta-blocker therapy.

AND

MEDICAL REASON
OR
PATIENT REASON
OR
SYSTEM REASON

OR

Patients who had one of the following conditions at any time before or during their last qualifying visit during the measurement period.

PROBLEMS, PROCEDURES, RESULTS, VITAL SIGNS, and MEDICAL EQUIPMENT tab(s) list applicable codes for this measure and are associated with the following data element(s):

ATRIOVENTRICULAR BLOCK
WITHOUT
CARDIAC PACER IN SITU
OR
CARDIAC PACER

OR

ARRHYTHMIA
OR
HYPOTENSION
OR
ASTHMA
OR
BRADYCARDIA
OR
ATRESIA AND STENOSIS OF AORTA
OR
CARDIAC MONITORING

OR

When drug therapy was not prescribed due to patient allergy, adverse effects or intolerance identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for beta-blocker therapy.

AND

MEDICATION ALLERGY
OR
MEDICATION ADVERSE EFFECTS
OR
MEDICATION INTOLERANCE

OR

Patients who had two consecutive heart rate readings less than 50 beats per minute at any time before or during their last qualifying visit.

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data elements(s):

HEART RATE
WITH
Documentation of Heart Rate < 50 /min

Rationale:
In the absence of contraindications, beta-blocker therapy has been shown to reduce the risk of a recurrent MI and decrease mortality for those patients with a prior MI.

Clinical Recommendation Statements:
Chronic Stable Angina: Class I – Beta-blockers as initial therapy in the absence of contraindications in patients with prior MI. Class I – Beta-blockers as initial therapy in the absence of contraindications in patients without prior MI. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Drugs required in the hospital to control ischemia should be continued after hospital discharge in patients who do not undergo coronary revascularization, patients with unsuccessful revascularization, or patients with recurrent symptoms after revascularization. Upward or downward titration of the doses may be required. Class I – Beta-blockers in the absence of contraindications. (ACC/AHA)

Acute Myocardial Infarction: Class I – All but low-risk patients without a clear contraindication to ß-adrenoceptor blocker therapy. Treatment should begin within a few days of the event (if not initiated acutely) and continue indefinitely. Class IIa – Low-risk patients without a clear contraindication to ß-adrenoceptor blocker therapy. Survivors of non-ST-elevation MI. Class IIb – Patients with moderate or severe LV failure or other relative contraindications to ß-adrenoceptor blocker therapy, provided they can be monitored closely. (ACC/AHA)

Although no study has determined if long-term ß-adrenoceptor blocker therapy should be administered to survivors of MI who subsequently have successfully undergone revascularization, there is no reason to believe that these agents act differently in coronary patients who have undergone revascularization. (ACC/AHA)

Measure #8 (NQF 0083): Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy

Denominator: Patients aged 18 years and older with a diagnosis of heart failure with left ventricular ejection fraction (LVEF) < 40% or with moderately or severely depressed left ventricular systolic function

Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with a documented diagnosis of heart failure at any time before or during their last qualifying visit, and who also have LVSD (defined as ejection fraction less than 40%) or a diagnosis of moderately or severely depressed left ventricular systolic function before their last qualifying visit. Any prior ejection fraction study documenting LVSD can be used to identify patients. To be eligible for performance calculations, patients must have at least two face-to-face visits with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY
OR
ENCOUNTER OUTPATIENT

AND

HEART FAILURE

AND

RESULTS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EJECTION FRACTION
WITH
Documentation of Ejection Fraction < 40%

OR

LVF ASSMT
WITH
Documentation of LVF ASSMT < 40%

OR

MODERATE OR SEVERE LVSD

OR

LEFT VENTRICULAR SYSTOLIC DYSFUNCTION
AND
Severity: 'Moderate or Severe' Qualifier

Numerator: Patients who were prescribed beta-blocker therapy

Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed beta-blocker therapy during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient did not receive beta-blocker therapy)*

When drug therapy is not prescribed for a valid medical, patient or system reason, the appropriate medication that would have been prescribed should be submitted along with a negation code during the measurement period to indicate the reason the appropriate medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table lists applicable codes for beta-blocker therapy.

AND

MEDICAL REASON
OR
PATIENT REASON
OR
SYSTEM REASON

OR

Patients who had one of the following conditions before or during their last qualifying visit during the measurement period.

PROCEDURES, PROBLEMS, RESULTS, VITAL SIGNS, and MEDICAL EQUIPMENT tab(s) list applicable codes for this measure and are associated with the following data element(s):

ATRIOVENTRICULAR BLOCK
WITHOUT

CARDIAC PACER IN SITU
OR
CARDIAC PACER

OR

ARRHYTHMIA
OR
HYPOTENSION
OR
ASTHMA
OR
BRADYCARDIA
OR
ATRESIA AND STENOSIS OF AORTA
OR
CARDIAC MONITORING

OR

When drug therapy was not prescribed due to patient allergy, adverse effects or intolerance identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table lists applicable codes for beta-blocker therapy.

AND

MEDICATION ALLERGY
OR
MEDICATION ADVERSE EFFECTS
OR
MEDICATION INTOLERANCE

OR

Patients who had two consecutive heart rate readings less than 50 beats per minute at any time before or during their last qualifying visit.

VITAL SIGNS tab(s) in the Downloadable Resource table lists applicable codes for this measure and are associated with the following data elements(s):

HEART RATE
WITH
Documentation of Heart Rate < 50 /min

Rationale:

Beta-blockers are recommended for all patients with symptoms of heart failure and left ventricular systolic dysfunction, unless contraindicated. Treatment with beta-blockers has been shown to provide multiple benefits to the patient, including reducing the symptoms of heart failure, improving the clinical status of patients, and decreasing the risk of mortality and hospitalizations.

Clinical Recommendation Statements:

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 HF and reduced LVEF, unless contraindicated. (Class I Recommendation, Level of Evidence: A) (ACC/AHA)

* Measure #12 (NQF 0086): Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

Description: Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months

Denominator: All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with a documented diagnosis of primary open-angle glaucoma at any time before or during their last qualifying visit. To be eligible for performance calculations, patients must have at least two face-to-face visits with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OPHTHALMOLOGICAL SERVICES
OR
ENCOUNTER OFFICE & OUTPATIENT CONSULT
OR
ENCOUNTER NURSING FACILITY
OR
ENCOUNTER DOMICILIARY

AND

PRIMARY OPEN ANGLE GLAUCOMA (POAG)

Numerator: Patients who have an optic nerve head evaluation during one or more office visits within 12 months

Numerator Inclusions:

Patients who had an optic nerve head evaluation at least once during a qualifying visit within the 12 month measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

OPTIC NERVE HEAD EVALUATION

Denominator Exclusions: *(Exclusions only applied if the patient has not received an optic nerve head evaluation at least once during the 12 month measurement period)*

When an optic nerve head evaluation was not performed for a valid medical reason, the procedure that would have been performed should be submitted along with a negation code to indicate the reason the appropriate procedure was not performed at least once during a qualifying visit within the 12 month measurement period.

PROCEDURES and PROCEDURES(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

OPTIC NERVE HEAD EVALUATION
AND
MEDICAL REASON

Rationale:

Changes in the optic nerve are one of two characteristics which currently define progression and thus worsening of glaucoma disease status (the other characteristic is visual field). There is a significant gap in documentation patterns of the optic nerve for both initial and follow-up care (Fremont, 2003), even among specialists (Lee, 2006). Examination of the optic nerve head and retinal nerve fiber layer provides valuable structural information about glaucomatous optic nerve damage. Visible structural alterations of the optic nerve head or retinal nerve fiber layer and development of peripapillary choroidal atrophy frequently occur before visual field defects can be detected. Careful study of the optic disc neural rim for small hemorrhages is important, since these hemorrhages can precede visual field loss and further optic nerve damage.

Clinical Recommendation Statements:

The physical exam focuses on nine elements: visual acuity, pupils, slit-lamp biomicroscopy of the anterior segment, measurement of intraocular pressure (IOP), determination of central corneal thickness, gonioscopy, evaluation of optic nerve head and retinal nerve fiber layer, documentation of optic nerve head appearance, evaluation of fundus (through dilated pupil), and evaluation of the visual field. (Level A: II Recommendation for optic nerve head evaluation) (AAO, 2005)

* **Measure #18 (NQF 0088):** Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months

Denominator: All patients aged 18 years and older with a diagnosis of diabetic retinopathy

Denominator Inclusions:

> All patients greater than or equal to 18 years of age at the beginning of the measurement period with a documented diagnosis of diabetic retinopathy at any time before or during their last qualifying visit. To be eligible for performance calculations, patients must have at least two face-to-face visits with the eligible professional during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER DOMICILIARY
> OR
> ENCOUNTER NURSING FACILITY
> OR
> ENCOUNTER OFFICE & OUTPATIENT CONSULT
> OR
> ENCOUNTER OPHTHALMOLOGICAL SERVICES
>
> AND
>
> DIABETIC RETINOPATHY

Numerator: Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months

Numerator Inclusions:

> Patients who had a dilated macular or fundus exam performed during one or more visits during the measurement period. Documentation of the level of severity of retinopathy AND the presence or absence of macular edema must be done during the qualifying visit during the measurement period.
>
> PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> MACULAR OR FUNDUS EXAM

AND

PROBLEMS and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SEVERITY OF RETINOPATHY AND MACULAR EDEMA FINDINGS

OR

MACULAR EDEMA FINDINGS
AND
Level of Severity of Retinopathy Findings

Denominator Exclusions: *(Exclusions only applied if the patient has not had a dilated macular or fundus exam performed including documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months)*

When a dilated macular or fundus exam was not performed for a valid medical or patient reason, the procedure that would have been performed should be submitted along with a negation code to indicate the reason the appropriate procedure was not performed at least once during a qualifying visit within the 12 month measurement period.

PROCEDURES and PROCEDURES(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MACULAR OR FUNDUS EXAM

AND

MEDICAL REASON
OR
PATIENT REASON

Rationale:

Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study – DRS, Early Treatment Diabetic Retinopathy Study – ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. (McGlynn, 2003). Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.

Clinical Recommendation Statements:

Since treatment is effective in reducing the risk of visual loss, detailed examination is indicated to assess for the following features that often lead to visual impairment: presence of macular edema, optic nerve neovascularization and/or neovascularization elsewhere, signs of severe NPDR and vitreous or preretinal hemorrhage. (Level A:III Recommendation) (AAO, 2003)

* **Measure #19 (NQF 0089):** Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with a documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

Denominator: All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with a documented diagnosis of diabetic retinopathy at any time before or during their last qualifying visit who had a macular or fundus exam during a qualifying visit during the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER DOMICILIARY
OR
ENCOUNTER NURSING FACILITY
OR
ENCOUNTER OFFICE & OUTPATIENT CONSULT
OR
ENCOUNTER OPHTHALMOLOGICAL SERVICES

AND

DIABETIC RETINOPATHY

AND

MACULAR OR FUNDUS EXAM

Numerator: Patients with documentation, at least once within 12 months, of findings of dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Numerator Inclusions:

Patients with documentation of findings of dilated macular or fundus exam that have been 'communicated' after the qualifying visit to the physician who manages the patient's diabetic care at least once during the measurement period.

PROBLEMS Tab(s) lists applicable codes for this measure and are associated with the following data elements:

MACULAR EDEMA FINDINGS
AND
Level of Severity of Retinopathy Findings

OR

SEVERITY OF RETINOPATHY AND MACULAR EDEMA FINDINGS

Denominator Exclusions: *(Exclusions only applied if the patient did not have documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care)*

When documentation of the findings of the dilated macular or fundus exam have been 'communicated' to the physician who manages the patient's diabetic care was not done after the qualifying visit for a valid patient or medical reason, the results and plan of care that would have been performed should be submitted along with a negation code to indicate the reason the appropriate results and plan of care was not performed at least once within the measurement period.

PROBLEMS and PROBLEMS(negation) Tab(s) lists applicable codes for this measure and are associated with the following data elements:

SEVERITY OF RETINOPATHY AND MACULAR EDEMA FINDINGS

AND

PATIENT REASON
OR
MEDICAL REASON

OR

MACULAR EDEMA FINDINGS

AND

PATIENT REASON
OR
MEDICAL REASON

OR

LEVEL OF SEVERITY OF RETINOPATHY FINDINGS

AND

PATIENT REASON
OR
MEDICAL REASON

Rationale:

The physician that manages the on-going care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the on-going diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease. (Diabetes Control and Complications Trial – DCCT, UK Prospective Diabetes Study – UKPDS)

Clinical Recommendation Statements:

While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist's responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient's family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician. (Level A: III Recommendation) (AAO, 2003)

2012 EHR Measure Specifications
ANALYTIC NARRATIVES

* **Measure #39 (NQF 0046):** Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older

Description: Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

Denominator: All female patients aged 65 years and older

Denominator Inclusions:

> All female patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.
>
> ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTERS ALL INPATIENT AND AMBULATORY

Numerator: Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

Numerator Inclusions:

> Female patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed during the measurement period.
>
> PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> DXA (DUAL-ENERGY X-RAY ABSORPTIOMETRY) SCAN

OR

> MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed pharmacologic therapy for osteoporosis during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient has not received a DXA measurement at least once since age 60 or pharmacologic therapy within 12 months)*

> When a central DXA scan was not performed for a valid medical, patient or system reason, the procedure that would have been performed should be submitted along with a negation code to indicate the reason the appropriate procedure was not performed at least once since age 60.
>
> PROCEDURES, PROCEDURES(negation), RESULTS, and RESULTS(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> DXA (DUAL-ENERGY X-RAY ABSORPTIOMETRY) SCAN
>
> AND
>
> MEDICAL REASON
> OR
> PATIENT REASON
> OR
> SYSTEM REASON

OR

> When drug therapy is not prescribed for a valid medical, patient or system reason during the measurement period, the medication that patient would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication treatment was not ordered or received.
>
> MEDICATIONS and MEDICATIONS (negation) tab(s) in the Downloadable Resource table list applicable codes for pharmacologic therapy for osteoporosis.
>
> AND
>
> MEDICAL REASON
> OR
> PATIENT REASON
> OR
> SYSTEM REASON

Rationale:
Patients with elevated risk for osteoporosis should have the diagnosis of osteoporosis excluded or be on treatment of osteoporosis.

Clinical Recommendation Statements:
The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. (B Recommendation) (USPSTF)

The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. Use of risk factors, particularly increasing age, low weight, and non-use of estrogen replacement, to screen younger women may identify high-risk women. (B Recommendation) (USPSTF)

BMD measurement should be performed in all women beyond 65 years of age. Dual x-ray absorptiometry of the lumbar spine and proximal femur provides reproducible values at important sites of osteoporosis-associated fracture. These sites are preferred for baseline and serial measurements. (AACE)

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

BMD testing should be performed on:
- All women aged 65 and older regardless of risk factors
- Younger postmenopausal women with one or more risk factors (other than being white, postmenopausal, and female)
- Postmenopausal women who present with fractures (NQF)

The decision to test for BMD should be based on an individual's risk profile. Testing is never indicated unless the results could influence a treatment decision. (NQF)

Markers of greater osteoporosis and fracture risk include older age, hypogonadism, corticosteroid therapy, and established cirrhosis. (Level B Evidence) (NQF)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (NQF)

Pharmacologic therapy should be initiated to reduce fracture risk in women with:
- BMD T-scores below -2.0 by central dual x-ray absorptiometry (DXA) with no risk factors
- BMD T-scores below -1.5 by central dual x-ray absorptiometry (DXA) with one or more risk factors
- A prior vertebral or hip fracture (NQF)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

* Measure #47 (NQF 0326): Advance Care Plan

Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Denominator: All patients aged 65 years and older

Denominator Inclusions:

All patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

Numerator: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Numerator Inclusions:

Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan during the measurement period.

AdvanceDirectiveStatusCodes on the VOCABS AND VALUESETS tab in the Downloadable Resource table lists applicable codes for this measure:

AdvanceDirectiveStatusCode

Denominator Exclusions:

None

Rationale:

It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

Clinical Recommendation Statements:

Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.
Oral statements

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

Instructional advance directives (DNR orders, living wills)

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy

- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site, which provides resources and information on end-of-life care, including a national repository of state-by-state advance directives.

* Measure #48 (NQF 0098): Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

Description: Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months

Denominator: All female patients aged 65 years and older

Denominator Inclusions:

All female patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

Numerator: Patients who were assessed for the presence or absence of urinary incontinence within 12 months

Numerator Inclusions:

Female patients who were assessed for the presence or absence or urinary incontinence during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

UI CODE
OR
UI ASSESS CODE

Denominator Exclusions: *(Exclusions only applied if patients were not assessed for presence or absence of urinary incontinence)*

Patients who had one of the following conditions during the measurement period.

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MEDICAL REASON
OR
EXCLUSION CODE

Rationale:
Female patients may not volunteer information regarding incontinence so they should be asked by their physician.

Clinical Recommendation Statements:
Strategies to increase recognition and reporting of UI are required and especially the perception that it is an inevitable consequence of aging for which little or nothing can be done. (ICI)

Patients with urinary incontinence should undergo a basic evaluation that includes a history, physical examination, measurement of post-void residual volume, and urinalysis. (ACOG) (Level C)

Health care providers should be able to initiate evaluation and treatment of UI basing their judgment on the results of history, physical examination, post-voiding residual and urinalysis. (ICI) (Grade B for women)

▲Measure #53 (NQF 0047): Asthma: Pharmacologic Therapy

Description: Percentage of patients aged 5 through 50 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment

Denominator: All patients aged 5 through 50 years with a diagnosis of mild, moderate, or severe persistent asthma

Denominator Inclusions:

> All patients aged 5 through 50 years at the beginning of the measurement period with a documented diagnosis of mild, moderate, or severe persistent asthma at any time before or during their last qualifying visit. To be eligible for performance calculations, patient must have at least two face-to-face visits with the eligible professional during the measurement period.
>
> ENCOUNTERS, PROBLEMS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER OFFICE & OUTPATIENT CONSULT
>
> AND
>
> ASTHMA
> AND
> *Severity: 'Persistent'*
>
> OR
>
> ASTHMA PERSISTENT

Numerator: Patients who were prescribed *either* the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta$_2$-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylaxanthines)

Numerator Inclusions:

> MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed corticosteroid, inhaled or alternative asthma medication during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient did not receive either the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta$_2$-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylaxanthines).*

When drug therapy is not prescribed for a valid patient reason, the appropriate medication that would have been prescribed should be submitted along with a negation code during the measurement period to indicate the reason the appropriate medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table lists applicable codes for corticosteroid, inhaled or alternative asthma medication.

AND

PATIENT REASON

OR

When drug therapy was not prescribed due to patient allergy, adverse effects or intolerance identified at any time before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table lists applicable codes for corticosteroid, inhaled or alternative asthma medication.

AND

MEDICATION ALLERGY
OR
MEDICATION ADVERSE EFFECTS
OR
MEDICATION INTOLERANCE

Rationale:
Although current guidelines recommend inhaled corticosteroids as the preferred pharmacological treatment for persistent asthma, other long-term control medications are acceptable alternatives. Long Acting-inhaled Beta$_2$ Agonists (LABA) are recommended in combination with Inhaled Corticosteroids.

Clinical Recommendation Statements:
A stepwise approach to therapy is recommended to maintain long-term control:
Step 1: Mild Intermittent Asthma
- No daily medication needed

Step 2: Mild Persistent Asthma
- *Preferred treatment:* Low-dose inhaled corticosteroids (ICS)
- *Alternative treatment:* Cromolyn, leukotriene modifier, nedocromil, OR sustained-release theophylline

Step 3: Moderate Persistent Asthma
- *Preferred treatment:* Low-medium dose ICS + long-acting inhaled beta$_2$-agonists (LABA)
- *Alternative treatment:* Increase medium-dose ICS OR low-medium dose ICS and either leukotriene modifier or theophylline (If needed, may increase ICS within medium-dose range in either treatment)

Step 4: Severe Persistent Asthma
- *Preferred treatment:* High-dose ICS + LABA AND, if needed, corticosteroid tablets or syrup long-term

Studies comparing ICS to cromolyn, nedocromil, theophylline, or leukotriene receptor antagonists are limited, but available evidence shows that none of these long-term control medications appear to be as effective as ICS in improving asthma outcomes.

For quick relief for all patients, a short-acting bronchodilator is recommended as needed for symptoms. (NAEPP/NHLBI)

▲Measure #64 (NQF 0001): Asthma: Asthma Assessment

Description: Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

Denominator: All patients aged 5 through 50 years with a diagnosis of asthma

Denominator Inclusions:

All patients aged 5 through 50 years at the beginning of the measurement period with a documented diagnosis of asthma at any time before or during their last qualifying visit. To be eligible for performance calculations, patients must have at least two face-to-face visits with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OFFICE & OUTPATIENT CONSULT
AND
ASTHMA

Numerator: Patients who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

Numerator Inclusions:

Patients who were evaluated for the frequency of daytime and nocturnal asthma symptoms at least once at any time before or during a qualifying visit before the end of the measurement period.

PROBLEMS and RESULTS Tab(s) lists applicable codes for inclusion in this measure and are associated with the following data element(s):

ASTHMA DAYTIME SYMPTOMS QUANTIFIED
AND
ASTHMA NIGHTIME SYMPTOMS QUANTIFIED

OR

ASTHMA DAYTIME SYMPTOMS
AND
ASTHMA NIGHTIME SYMPTOMS

OR

ASTHMA SYMPTOM ASSESSMENT TOOL

Denominator Exclusions:

None

Rationale:
Appropriate treatment of asthma patients requires accurate classification of asthma severity. Physician assessment of the frequency of asthma symptoms is the first step in classifying asthma severity.

Clinical Recommendation Statements:
To determine whether the goals of therapy are being met, monitoring is recommended in the 6 areas listed below:
• Signs and symptoms (daytime; nocturnal awakening) of asthma
• Pulmonary function (spirometry; peak flow monitoring)
• Quality of life/functional status
• History of asthma exacerbations
• Pharmacotherapy (as-needed use of inhaled short-acting beta2-agonist, adherence to regimen of long-term-control medications)
• Patient-provider communication and patient satisfaction (NAEPP/NHLBI)

✦ Measure #66 (NQF 0002): Appropriate Testing for Children with Pharyngitis

Description: Percentage of children aged 2 through 18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode

Denominator: All patients aged 2 through 18 years with a diagnosis of pharyngitis

Denominator Inclusions:

> All patients aged 2 through 18 years at the beginning of the measurement period with a documented diagnosis of pharyngitis during a qualifying visit and who were dispensed an antibiotic within three days after the qualifying visit who have not had pharyngitis antibiotics within the thirty days prior to the qualifying visit. To be eligible for performance calculations, patient must have at least one face-to-face visit with the eligible professional during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER ED
> OR
> ENCOUNTER OUTPATIENT
>
> AND
>
> PHARYNGITIS
>
> AND
>
> MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed pharyngitis antibiotics within three days after the qualifying visit who have not had pharyngitis antibiotics at any time during the thirty days prior to the qualifying visit and DRUG_EXCLUSION = N.

Numerator: Patients who were dispensed an antibiotic and who received a group A streptococcus (strep) test for the episode

Numerator Inclusions:

> Patients who received a group A streptococcus (strep) test for the episode within three days prior and three days after the qualifying visit.
>
> PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> GROUP A STREPTOCOCCUS TEST

Denominator Exclusions:

> None

Rationale:
Clinical practice guidelines recommend group A streptococcus pharyngitis be treated with antibiotics (Schwartz et al, 1998).

Clinical Recommendation Statements:
The group A strep test (rapid assay or throat culture) is the definitive test of group A strep pharyngitis. Pharyngitis is the only respiratory tract infection with an objective diagnostic test that can be validated with administrative data, and not medical records. A process measure that requires the performance of a group A strep test for children given antibiotics for pharyngitis is supported by the guidelines. (Ibid)

⚵ **Measure #71 (NQF 0387):** Breast Cancer: Hormonal Therapy for Stage IC–IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer

Description: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period

Denominator: All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

Denominator Inclusions:

All female patients greater than or equal to 18 years of age at the beginning of the measurement period with a documented diagnosis of breast cancer stage IC-IIIC and EP or PR positive at any time before or during their last qualifying visit. History of breast cancer includes patients with a diagnosis date for breast cancer within the five years prior to the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OFFICE VISIT

AND

BREAST CANCER
OR
BREAST CANCER HISTORY

AND

BREAST CANCER STAGE IC-IIIC

AND

BREAST CANCER ER OR PR POSITIVE

Numerator: Patients who were prescribed tamoxifen or aromatase inhibitor (AI) within the 12 months reporting period

Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed Tamoxifen or Aromatase Inhibitor Therapy before or during the last qualifying visit the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient did not receive Tamoxifen or Aromatase Inhibitor Therapy)*

When drug therapy is not prescribed for a valid medical, patient or system reason during the measurement period, the medication that patient would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication treatment was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Tamoxifen or Aromatase Inhibitor Therapy.

AND

MEDICAL REASON
OR
PATIENT_REASON
OR
SYSTEM_REASON

OR

When drug therapy is not prescribed for a valid medical, patient or system reason identified before or during their last qualifying visit, the medication that patient would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication treatment was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table lists applicable codes for Tamoxifen or Aromatase Inhibitor Therapy.

AND

MEDICATION ALLERGY
OR
MEDICATION ADVERSE EFFECTS
OR
MEDICATION INTOLERANCE

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed Gonadotropin-Releasing Hormone Analogue Medication at any time before or during the last qualifying visit and DRUG_EXCLUSION = Y.

OR

Patients who had one of the following conditions before or during their last qualifying visit during the measurement period.

PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

BILATERAL OOPHORECTOMY
OR
METASTATIC SITES COMMON TO BREAST CANCER

OR

Patients who received radiation therapy or chemotherapy after their initial diagnosis of breast cancer and up to their last qualifying visit during the measurement period.

PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

RADIATION THERAPY
OR
CHEMOTHERAPY

Rationale:

Despite evidence suggesting the role of adjuvant endocrine therapy in lowering the risk of tumor recurrence, many female patients who should be receiving this therapy are not. This measure assesses whether patients with a certain stage of breast cancer (IC through IIIC) and ER/PR+ are currently receiving the therapy. There are allowable medical, patient, and system reasons to document instances in which a woman with stage IC through IIIC, ER/PR+ may not be a candidate for the therapy.

> **Note:** The reporting/managing physician does not need to have actually written the prescription; however, the reporting/managing physician must verify that the patient already has been prescribed the hormonal therapy by another physician.

Clinical Recommendation Statements:

Adjuvant therapy for postmenopausal women with hormone receptor–positive breast cancer should include an aromatase inhibitor in order to lower the risk of tumor recurrence. Aromatase inhibitors are appropriate as initial treatment for women with contraindications to tamoxifen. For all other postmenopausal women, treatment options include 5 years of aromatase inhibitors treatment or sequential therapy consisting of tamoxifen (for either 2 to 3 years or 5 years) followed by aromatase inhibitors for 2 to 3, or 5 years (ASCO guidelines include narrative rankings). (ASCO)

Patients intolerant of aromatase inhibitors should receive tamoxifen. Women with hormone receptor–negative tumors should not receive adjuvant endocrine therapy (ASCO guidelines include narrative rankings). (ASCO)

Patients with invasive breast cancers that are estrogen or progesterone receptor positive should be considered for adjuvant endocrine therapy regardless of patient age, lymph node status, or whether or not adjuvant chemotherapy is to be administered (Category 2A). (NCCN)

The most firmly established adjuvant endocrine therapy is tamoxifen for both premenopausal and postmenopausal women. Prospective, randomized trials demonstrate that the optimal duration of tamoxifen appears to be five years. In patients receiving both tamoxifen and chemotherapy, chemotherapy should be given first, followed by sequential tamoxifen. Several studies have evaluated aromatase inhibitors in the treatment of postmenopausal women with early-stage breast cancer (Category 2A). (NCCN)

⌖ Measure #72 (NQF 0385): Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period

Denominator: All patients aged 18 years and older with Stage IIIA through IIIC colon cancer

Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with a documented diagnosis of colon cancer stage III at any time before or during their last qualifying visit. History of colon cancer includes patients with a diagnosis date for colon cancer within the five years prior to the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OFFICE VISIT

AND

COLON CANCER
OR
COLON CANCER HISTORY

AND

COLON CANCER STAGE III

Numerator: Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or who have previously received adjuvant chemotherapy within the 12-month reporting period

Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed Chemotherapy for Colon Cancer before or during the last qualifying visit during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient did not receive Chemotherapy for Colon Cancer)*

When drug therapy is not prescribed for a valid medical, patient or system reason during the measurement period, the medication that patient would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication treatment was not ordered or received.

MEDICATIONS and MEDICATIONS (negation) tab(s) in the Downloadable Resource table lists applicable codes for Chemotherapy for Colon Cancer.

AND

MEDICAL REASON
OR
PATIENT_REASON
OR
SYSTEM_REASON

OR

When drug therapy is not prescribed for a valid medical, patient or system reason identified before or during their last qualifying visit, the medication that patient would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication treatment was not ordered or received.

MEDICATIONS and MEDICATIONS (negation) tab(s) in the Downloadable Resource table lists applicable codes for Chemotherapy for Colon Cancer.

AND

MEDICATION ALLERGY
OR
MEDICATION ADVERSE EFFECTS
OR
MEDICATION INTOLERANCE

OR

Patients who had one of the following conditions before or during their last qualifying visit during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

METASTATIC SITES COMMON TO COLON CANCER
OR
ACUTE RENAL INSUFFICIENCY
OR
NEUTROPENIA
OR
LEUKOPENIA
OR
ECOG PERFORMANCE STATUS-POOR

Rationale:

Patients with Stage IIIA through Stage IIIC colon cancer do not always receive the recommended treatment of adjuvant chemotherapy. This measure is intended to determine whether and how often chemotherapy is administered. The specific chemotherapy drugs specified in this measure reflect the most current guidelines of the National Comprehensive Cancer Network.

Clinical Recommendation Statements:

Following primary surgical treatment, the panel recommends six months of 5-fluorouracil/leucovorin capecitabine, or 5-fluorouracil/leucovorin/oxaliplatin as adjuvant chemotherapy for patients with stage III (T1-4, N1-2, M0) colon cancer (Category 2A). (NCCN)

Measure #102 (NQF 0389): Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients

Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did <u>not</u> have a bone scan performed at any time since diagnosis of prostate cancer

Denominator: All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

Denominator Inclusions:

All male patients, regardless of age, with a documented diagnosis of prostate cancer before or during the measurement period with a low risk for prostate cancer recurrence and a PSA test of ≤10 ng/mL and a Gleason Score of ≤6 before or during the prostate cancer treatment. To be eligible for performance calculations, patients must have at least one prostate cancer treatment with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and RESULTS tab(s) in the Downloadable Resource table lists applicable codes in this measure and are associated with the following data element(s):

PROSTATE CANCER TREATMENT

AND

PROSTATE CANCER

AND

AJCC CANCER STAGE LOW RISK RECURRENCE PROSTATE CANCER

AND

PROSTATE SPECIFIC ANTIGEN TEST
WITH
Documentation of PSA ≤10 ng/mL

AND

GLEASON SCORE <=6
OR
GLEASON SCORE
WITH
Documentation of GLEASON SCORE ≤6

Numerator: Patients who did <u>not</u> have a bone scan performed at any time since diagnosis of prostate cancer

Numerator Inclusions:

> Male patients who did *not* have a bone scan performed at any time since the diagnosis of prostate cancer.
>
> > **NOTE:** *This measure is intended to identify an overuse of bone scans for patients with a diagnosis of prostate cancer. The lack of BONE SCAN codes will indicate that the bone scan was not performed and will meet the quality action for this measure.*
>
> PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> BONE SCAN

Denominator Exclusions: *(Exclusions only applied if the patient has received a bone scan since diagnosis of prostate cancer)*

> Patients who had one of the following conditions at any time since the diagnosis of prostate cancer.
>
> PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> PAIN RELATED TO PROSTATE CANCER
> OR
> SALVAGE THERAPY

Rationale:

A bone scan is generally not required for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. This measure is written as a negative measure so that the performance goal is 100%, consistent with the other measures for this condition.

Clinical Recommendation Statements:

Routine use of a bone scan is not required for staging asymptomatic men with clinically localized prostate cancer when their PSA is equal to or less than 20.0 ng/mL. (AUA)

Patients with a life expectancy > 5 years or symptomatic:

- A bone scan is appropriate for T1 to T2 disease in the presence of a PSA greater than 20 ng/mL, Gleason score of 8 or higher, clinical stage of T3 to T4, or symptomatic disease.
- Patients at higher risk of metastatic disease may undergo pelvic computed tomography (CT) or magnetic resonance imaging (MRI) scanning with possible fine-needle aspiration of enlarged lymph nodes or staging lymph node dissection. Nomograms or risk tables may be used to identify patients with a higher likelihood of having metastatic disease. If the nomogram indicates a probability of lymph node involvement greater than 20% or if the patient is stage T3 or T4, this is recommended as a threshold for doing a staging CT scan or MRI evaluation.

For all other patients, no additional imaging is required for staging. (NCCN) (Category 2A)

Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization for Patients **≥ 50** Years

Description: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February)

Denominator: All patients aged 50 years and older

Denominator Inclusions:

All patients greater than or equal to 50 years of age at the beginning of the measurement period with an encounter during the flu season (September through December of the year prior to the measurement period or January through February during the measurement period). To be eligible for performance calculations, patients must have at least two face-to-face visits (ENCOUNTER OUTPATIENT) or at least one face-to-face visit (ENCOUNTER PREV MED 40 AND OLDER, ENCOUNTER PREV MED GROUP COUNSELING, ENCOUTNER PREV MED – INDIVIDUAL COUNSELING, ENCOUNTER PREV MED OTHER SERVICES, ENCOUNTER NURSING FACILITY, or ENCOUNTER NURSING DISCHARGE) with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT
OR
ENCOUNTER PREV MED 40 AND OLDER
OR
ENCOUNTER PREV MED GROUP COUNSELING
OR
ENCOUNTER PREV MED – INDIVIDUAL COUNSELING
OR
ENCOUNTER PREV MED OTHER SERVICES
OR
ENCOUNTER NURSING FACILITY
OR
ENCOUNTER NURSING DISCHARGE

Numerator: Patients who received an influenza immunization during the flu season (September through February)

Numerator Inclusions:

Patients who received an influenza vaccination in September through December of the year prior to the measurement period or January through February during the measurement period.

IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

INFLUENZA VACCINATION

OR

MEDICATIONS tab(s) in the Downloadable Resource table lists applicable codes for patients who received the influenza vaccine during the flu season and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if influenza vaccination not received)*

When an influenza vaccination is not received for a valid medical, patient or system reason identified before or during their last qualifying visit in the appropriate flu season, the influenza vaccination that would have been received should be submitted along with a negation code to indicate the reason the influenza vaccination was not given.

ALERTS, IMMUNIZATIONS, and IMMUNIZATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

INFLUENZA VACCINATION

AND

INFLUENZA VACCINE DECLINED
OR
MEDICAL REASON
OR
PATIENT REASON
OR
SYSTEM REASON

OR

When the influenza vaccine is not received for a valid medical, patient or system reason identified before or during their last qualifying visit in the appropriate flu season, the influenza vaccine that would have been received should be submitted along with a negation code to indicate the reason the influenza vaccine was not received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for influenza vaccine.

AND

INFLUENZA VACCINE DECLINED
OR
MEDICAL REASON
OR
PATIENT REASON
OR
SYSTEM REASON

OR

When the influenza vaccine is not received due to patient allergy, adverse effects or intolerance identified before or during their last qualifying visit in the appropriate flu season, the influenza vaccine that the patient is allergic to should be submitted along with a negation code to indicate the reason the influenza vaccine was not received.

IMMUNIZATIONS, and IMMUNIZATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

INFLUENZA VACCINATION

AND

PROCEDURE INTOLERANCE
OR
PROCEDURE ADVERSE EVENT

OR

When the influenza vaccine is not received due to patient allergy, adverse effects or intolerance identified before or during their last qualifying visit in the appropriate flu season, the influenza vaccine that the patient is allergic to should be submitted along with a negation code to indicate the reason the influenza vaccine was not received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for influenza vaccine.

AND

MEDICATION INTOLERANCE
OR
MEDICATION ADVERSE EFFECTS
OR
MEDICATION ALLERGY

OR

Patient who has one of the following conditions before or during their last qualifying visit during the flu season.

ALERTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ALLERGY TO EGGS
OR
INFLUENZA VACCINE CONTRAINDICATED
OR
INFLUENZA VACCINE DECLINED

Rationale:

Influenza vaccination has shown to decrease hospitalizations for influenza, especially for those with risk factors, however annual influenza vaccination rates remain low.

Clinical Recommendation Statements:

Annual influenza immunization is recommended for all groups who are at increased risk for complications from influenza including persons aged ≥ 50 years. (CDC, USPSTF)

◆ **Measure #111 (NQF 0043):** Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older

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

Denominator: All patients 65 years and older

Denominator Inclusions:

> All patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.
>
> ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> ENCOUNTER OUTPATIENT

Numerator: Patients who have ever received a pneumococcal vaccination

Numerator Inclusions:

> Patients who received a pneumococcal vaccination at any time before or during the measurement period.
>
> IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> PNEUMOCOCCAL VACCINATION
> OR
> PNEUMOCOCCAL VACCINATION AGES 2 AND OLDER

OR

> MEDICATIONS tab(s) in the Downloadable Resource table lists applicable codes for patients who received the pneumococcal vaccination at any time in the patient's history and DRUG_EXCLUSION = N.

Denominator Exclusions:

> None

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

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

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

One of the *Healthy People 2010* objectives is to increase pneumococcal immunization levels for the non-institutionalized, high-risk populations to at least 90 percent (objective no. 14.29). While the percent of persons 65 years and older receiving the pneumococcal vaccine has increased, it still remains considerably below the *Health People 2010* objective. According to the National Health Interview Survey (NHIS), which is used to track performance on year 2010 objectives, in 1998 only 46 percent of adults age 65 years and older report receiving the vaccine. The figure was 45 percent based on the 1997 Behavioral Risk Factor Surveillance System (BRFSS) survey. (National Center for Health Statistics., 2005; CDC, 1997)
A particular strength of this measure is that it provides an opportunity to compare performance against national, state and/or regional benchmarks, which are collected through nationally organized and administered surveys.

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

2012 EHR Measure Specifications
ANALYTIC NARRATIVES

◆ **Measure #112 (NQF 0031):** Preventive Care and Screening: Screening Mammography

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

Denominator: All female patients aged 40 through 69 years

Denominator Inclusions:

> All female patients between 40 and 69 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.
>
> ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> ENCOUNTER OUTPATIENT

AND NOT

> Female patients who had a bilateral mastectomy before or during the measurement period.
>
> PROCEDURES and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> BILATERAL MASTECTOMY
>
> OR
>
> UNILATERAL MASTECTOMY CPT
> AND
> *-50 modifier associated with CPT code* *(indicates the procedure was performed bilaterally)*

OR

> Female patients who had *two* unilateral mastectomies on two <u>different</u> dates of service before or during the measurement period.
>
> PROCEDURES and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> UNILATERAL MASTECTOMY

Numerator: Patients who had a mammogram at least once within 24 months

Numerator Inclusions:

Female patients who had a mammogram during the measurement period or year prior to the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

BREAST CANCER SCREENING

Denominator Exclusions:

None

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

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

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

The USPSTF concluded that the evidence is also generalizable to women aged 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increases along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminishes from ages 40-70. The balance of benefits and potential harms; therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. (USPSTF, 2002)

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

American College of Preventative Medicine (ACPM):

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

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

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

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

◆**Measure #113 (NQF 0034):** Preventive Care and Screening: Colorectal Cancer Screening

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

Denominator: All patients aged 50 through 75 years

Denominator Inclusions:

> All patients between 50 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.
>
> ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> ENCOUNTER OUTPATIENT

AND NOT

> Patients who had a total colectomy any time before or during the measurement period.
>
> PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> TOTAL COLECTOMY

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

Numerator Inclusions:

> Patients with any of the recommended colorectal cancer screening test(s) performed.
>
> *Current colorectal cancer screening is defined as performing any of the following:*
> - *Fecal occult blood test during the measurement period*
> - *Flexible sigmoidoscopy during the measurement period or four years prior*
> - *Colonoscopy during the measurement period or nine years prior*
>
> PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> FECAL OCCULT BLOOD TEST (FOBT)
> OR
> FLEXIBLE SIGMOIDOSCOPY
> OR
> COLONOSCOPY

Denominator Exclusions: *(Exclusions only applied if screening for colorectal cancer not performed)*

Patients who ever had or currently has a diagnosis of colorectal cancer at any time before or during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

COLORECTAL CANCER

Rationale:

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

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

Clinical Recommendation Statements:

During the past decade, compelling evidence has accumulated that systematic screening of the population can reduce mortality from colorectal cancer. Three randomized, controlled trials demonstrated that fecal occult blood testing (FOBT), followed by complete diagnostic evaluation of the colon for a positive test, reduced colorectal cancer mortality (Hardcastle et al., 1996; Mandel & Oken, 1998; Kronborg; 1996). One of these randomized trials (Mandel et al., 1993) compared annual FOBT screening to biennial FOBT screening, and found that annual screening resulted in greater reduction in colorectal cancer mortality. Two case control studies have provided evidence that sigmoidoscopy reduces colorectal cancer mortality (Selby et al., 1992; Newcomb et al., 1992). Approximately 75% of all colorectal cancers arise sporadically (Stephenson et al., 1991). Part of the effectiveness of colorectal cancer screening is mediated by the removal of the precursor lesion—an adenomatous polyp (Vogtelstein et al., 1988). It has been shown that removal of polyps in a population can reduce the incidence of colorectal cancer (Winawer, 1993). Colorectal screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective (Kavanaugh, 1998).

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

✦**Measure #117 (NQF 0055):** Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient

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

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

Denominator Inclusions:

> All patients with a documented diagnosis of diabetes at any time during the patient's history and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period OR patient was prescribed a medication indicative of diabetes during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> ENCOUNTER ACUTE INPT
> OR
> ENCOUNTER ED
> OR
> ENCOUNTER NON-ACUTE INPATIENT
> OR
> ENCOUNTER OUTPATIENT
>
> AND
>
> DIABETES

OR

> MEDICATIONS tab(s) in the Downloadable Resource table lists applicable codes for patients who were prescribed medications indicative of diabetes during the measurement period and DRUG_EXCLUSION = N.

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

Numerator Inclusions:

> Patients who had a dilated eye exam at least once during the measurement period.
>
> PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> EYE EXAM

OR

Patients who had a dilated eye exam in the year prior to the measurement period without a documented diagnosis of diabetic retinopathy in the year prior to the measurement period.

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

EYE EXAM
AND NOT
DIABETIC RETINOPATHY

Denominator Exclusions: *(Exclusions only applied if the patient has not received a dilated eye exam at least once during the measurement period or a dilated eye exam without diabetic retinopathy in the year prior to the measurement period)*

Patients with a documented diagnosis of polycystic ovaries at any time during the patient's history who were prescribed medications indicative of diabetes during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

AND NOT

Diabetes patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

OR

Patients with a documented diagnosis of gestational diabetes or steroid induced diabetes who were prescribed medications indicative of diabetes during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

GESTATIONAL DIABETES
OR
STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes indicative of diabetes.

AND NOT

Diabetes patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

Rationale:

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

Clinical Recommendation Statements:

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

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

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

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

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

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

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

2012 EHR Measure Specifications
ANALYTIC NARRATIVES

◆**Measure #119 (NQF 0062):** Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months

Denominator: All patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Inclusions:

All patients with a documented diagnosis of diabetes at any time during the patient's history and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period OR patient was prescribed a medication indicative of diabetes during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT
OR
ENCOUNTER OUTPATIENT-OPTHALMOLOGICAL SERVICES

AND

DIABETES

OR

MEDICATIONS tab(s) in the Downloadable Resource table lists applicable codes for patients who were prescribed medications indicative of diabetes during the measurement period and DRUG_EXCLUSION = N.

Numerator: Patients who have a nephropathy screening during at least one office visit within 12 months

Numerator Inclusions:

Patients who had a nephropathy screening at least once during the measurement period.

PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

NEPHROPATHY-RELATED PROCEDURES
OR
NEPHROPATHY
OR
NEPHROPATHY SCREENING
OR
URINE MACROALBUMIN

OR

MEDICATIONS tab(s) in the Downloadable Resource table lists applicable codes for patients who were prescribed ACE Inhibitors/ARBs during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient has not received urine protein screening or medical attention for nephropathy at least within 12 months)*

Patients with a documented diagnosis of polycystic ovaries at any time during the patient's history who were prescribed medications indicative of diabetes during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

AND NOT

Diabetes patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT
OR
ENCOUNTER OUTPATIENT-OPTHALMOLOGICAL SERVICES

OR

Patients with a documented diagnosis of gestational diabetes or steroid induced diabetes who were prescribed medications indicative of diabetes during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

GESTATIONAL DIABETES
OR
STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

AND NOT

Diabetes patients who had at least one face-to-face with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT
OR
ENCOUNTER OUTPATIENT-OPTHALMOLOGICAL SERVICES

Rationale:

Nephropathy is a frequent complication of renal disease for both type 1 and type 2 diabetes and often ends in end-stage renal disease (ESRD) (ADA, 2002). Of all people with diabetes, 10-21% have nephropathy (ADA 2002).

Clinical Recommendation Statements:

American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE): Recommends that the initial assessment should include a urinalysis, test for microalbuminuria and creatinine clearance. The renal complication module should be performed annually and includes a test for microalbuminuria and creatinine clearance (AACE/ACE, 2002).

American Diabetes Association (ADA): A test for the presence of microalbumin should be performed at diagnosis in patients with type 2 diabetes. Microalbuminuria rarely occurs with short duration of type 1 diabetes; therefore, screening in individuals with type 1 diabetes should begin after 5 years' disease duration (Level of Evidence: E). However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be exercised when individualizing these recommendations. Because of the difficulty in precise dating of the onset of type 2 diabetes, such screening should begin at the time of diagnosis. After the initial screening and in the absence of previously demonstrated microalbuminuria, a test for the presence of microalbumin should be performed annually (ADA, 2004).

Screening for microalbuminuria can be performed by three methods:
1) measurement of the albumin-to-creatinine ratio in a random spot collection
2) 24-h collection with creatinine, allowing the simultaneous measurement of creatinine clearance
3) timed (e. g. 4-h or overnight) collection – the analysis of a spot sample for the albumin-to-creatinine ratio is strongly recommended.

The role of annual microalbuminuria assessment is less clear after diagnosis of microalbuminuria and institution of angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy and blood pressure control. Many experts recommend continued surveillance to assess both response to therapy and progression of disease.

National Kidney Foundation (NKF): Individuals at increased risk, but found not to have chronic kidney disease, should be advised to follow a program of risk factor reduction, if appropriate, and undergo repeat periodic evaluation (NKF, 2003).

A comparative analysis of recommendations and evidence in diabetes guidelines from 13 countries (including the American Diabetes Association and Canadian Medical Association) found there was agreement among the guidelines that ACE inhibitors should be recommended to patients with hypertension and renal disease (Burgers, 2002).

The ADA also recommends that for the treatment of both micro- and macroalbuminuria, ARBs should be used except during pregnancy (ADA, 2005).

♠ **Measure #124 (NQF 0488):** Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)

Description: Documents whether provider has adopted and is using health information technology. To report this measure, the eligible professional must have adopted and be using a certified, Physician Quality Reporting System qualified or other acceptable EHR system.

Definitions:

Health Information Technology (HIT) – A system that incorporates both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

Authorized Testing and Certification Bodies (ATCB) – Review bodies that have been authorized to test and certify electronic health record (EHR) systems for compliance with the standards and certification criteria that were issued by the U.S. Department of Health and Human Services.

Certified or Qualified Electronic Health Record – A certified or qualified EHR can be any of the following:
- Certified by an ATCB
- Physician Quality Reporting System qualified* for EHR based reporting

Other Acceptable Systems
- Other systems that are not certified or Physician Quality Reporting System qualified as above must meet all of the following criteria:
    - Ability to manage a medication list
    - Ability to manage a problem list
    - Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
    - Ability to meet basic privacy and security elements

A list of qualified EHR Vendors for the 2012 Physician Quality Reporting System will be available on the Alternative Reporting Mechanisms section from the navigation bar on the left side of the CMS Physician Quality Reporting website at www.cms.gov/pqrs. Please visit this site periodically for updates and contact your EHR vendor to determine if they are planning to become qualified.

Denominator: All patient encounters

Denominator Inclusions:

All patient encounters. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

Numerator: Patient encounter documentation substantiates use of a certified, Physician Quality Reporting System qualified or other acceptable EHR system

Numerator Inclusions:

Patient encounters with documentation substantiating the use of a certified, Physician Quality Reporting System qualified or other acceptable EHR system during the measurement period.

STRUCTURAL CODES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EHR CODE

Denominator Exclusions:

None

Rationale:

The widespread use of electronic health records (EHRs) in the United States is inevitable. EHRs will improve caregivers' decisions and patients' outcomes. Once patients experience the benefits of this technology, they will demand nothing less from their providers. Hundreds of thousands of physicians have already seen these benefits in their clinical practice. (Blumenthal et al, 2010)

Health care experts, policymakers, payers, and consumers consider health information technologies, such as electronic health records and computerized provider order entry, to be critical to transforming the health care industry. Information management is fundamental to health care delivery. Given the fragmented nature of health care, the large volume of transactions in the system, the need to integrate new scientific evidence into practice, and other complex information management activities, the limitations of paper-based information management are intuitively apparent.

Health care is growing increasingly complex, and most clinical research focuses on new approaches to diagnosis and treatment. In contrast, relatively little effort has been targeted at the perfection of operational systems, which are partly responsible for the well-documented problems with medical safety. Safe care now requires a degree of individualization that is becoming unimaginable without computerized decision support. Multiple studies now demonstrate that computer-based decision support can improve physicians' performance and, in some instances, patient outcomes. In the past decade, the risk of harm caused by medical care has received increasing scrutiny. The growing sophistication of computers and software should allow information technology to play a vital part in reducing that risk — by streamlining care, catching and correcting errors, assisting with decisions, and providing feedback on performance. Given the large potential risks and benefits as well as the costs involved, this article includes an analysis of what is known about the role and effect of information technology with respect to safety and considers the implications for medical care, research, and policy. (Bates et al, 2003)

The need for clinical information systems to provide high-quality, safe care is a well recognized fact. This need was well publicized by Dr. Ed Wagner in his "Chronic Care Model" as one of the key elements to provide high-quality care. To quote from the Improving Chronic Care Web site, "Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as populations of patients. A comprehensive clinical information system can enhance the care of individual patients by providing timely reminders about needed services and summarized data to track and plan care. At the practice population level, they identify groups of patients needing additional care, as well as facilitate performance monitoring and quality improvement efforts." To be able to take advantage of many of the more advanced applications of health information technology, the facility must first implement an EMR and use it to document patient encounters.

♠ **Measure #128 (NQF 0421):** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

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

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

Denominator 1: All patients aged 65 years and older

Denominator Inclusions – Population Stratification 1: *(Patients aged 65 and older)*

All patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

> NOTE: *BMI measured and documented in the medical record can be reported if done in the eligible professional's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the eligible professional. The documentation of a follow-up plan should be based on the most recently calculated BMI.*

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

<u>ENCOUNTER OUTPATIENT CPT WITH CLINICIAN</u>
OR
<u>ENCOUNTER OUTPATIENT HCPCS WITH CLINICIAN</u>

Numerator 1: Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters

Numerator Inclusions – Population Stratification 1: *(BMI < 30 kg/m² AND ≥ 23 kg/m²)*

Patients with most recent Body Mass Index (BMI) calculated within the past six months of the current visit or during the current visit with a normal BMI (less than 30 kg/m² AND greater than or equal to 23 kg/m²) during the measurement period.

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

<u>BMI</u>
WITH
Documentation of BMI < 30 kg/m² AND ≥ 23 kg/m²

OR

Patients with most recent BMI calculated within the past six months or during the current visit with a high BMI (greater than or equal to 30 kg/m²) and a follow up plan during the visit documented during the measurement period.

> NOTE: *A follow-up plan may include documentation of a future appointment, education, referral, prescription/administration of medication/dietary supplements, weight loss surgery.*

PROBLEMS, PROCEDURES, VITAL SIGNS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

BMI
WITH
Documentation of BMI ≥ 30 kg/m²

AND

FOLLOW-UP PLAN BMI MANAGEMENT
OR
DIETARY CONSULTATION ORDER

OR

Patients with most recent BMI calculated within the past six months or during the current visit with a low BMI (less than 23 kg/m²) and a follow up plan during the visit documented during the measurement period.

> NOTE: *A follow-up plan may include documentation of a future appointment, education, referral, prescription/administration of medication/dietary supplements, weight loss surgery.*

PROBLEMS, PROCEDURES, VITAL SIGNS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

BMI
WITH
Documentation of BMI < 23 kg/m²

AND

FOLLOW-UP PLAN BMI MANAGEMENT
OR
DIETARY CONSULTATION ORDER

Denominator 2: All patients aged 18 through 64 years and older

Denominator Inclusions – Population Stratification 2: *(Patients aged 18-64)*

All patients between 18 and 64 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

> **NOTE:** *BMI measured and documented in the medical record can be reported if done in the eligible professional's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the eligible professional. The documentation of a follow-up plan should be based on the most recently calculated BMI.*

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT CPT WITH CLINICIAN
OR
ENCOUNTER OUTPATIENT HCPCS WITH CLINICIAN

Numerator 2: Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters

Numerator Inclusions – Population Stratification 2: *(BMI < 25 kg/m² AND ≥ 18.5 kg/m²)*

Patients with most recent Body Mass Index (BMI) calculated within the past six months or during the current visit with a normal BMI (less than 25 kg/m² AND greater than or equal to 18.5 kg/m²) during the measurement period.

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

BMI
WITH
Documentation of BMI < 25 kg/m² AND ≥ 18.5 kg/m²

OR

Patients with most recent BMI calculated within the past six months or during the current visit with a high BMI (greater than or equal to 25 kg/m²) and a follow up plan during the visit documented during the measurement period.

> **NOTE:** *A follow-up plan may include documentation of a future appointment, education, referral, prescription/administration of medication/dietary supplements, weight loss surgery.*

PROBLEMS, PROCEDURES, VITAL SIGNS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

BMI
WITH
Documentation of BMI ≥ 25 kg/m²

AND

FOLLOW-UP PLAN BMI MANAGEMENT
OR
DIETARY CONSULTATION ORDER

OR

Patients with most recent BMI calculated within the past six months or during the current visit with a low BMI (less than 18.5 kg/m²) and a follow up plan during the visit documented during the measurement period.

>   NOTE: *A follow-up plan may include documentation of a future appointment, education, referral, prescription/administration of medication/dietary supplements, weight loss surgery.*

PROBLEMS, PROCEDURES, VITAL SIGNS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

BMI
WITH
Documentation of BMI < 18.5 kg/m²

AND

FOLLOW-UP PLAN BMI MANAGEMENT
OR
DIETARY CONSULTATION ORDER

Denominator Exclusions: *(Exclusions only applied if the patient did not have a calculated BMI documented in the medical record as normal OR outside parameters with a follow-up plan documented)*

Patients who have a terminal illness or who are pregnant during the qualifying visit are excluded.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

TERMINAL ILLNESS
OR
PREGNANCY

OR

When a BMI measurement is not performed for a valid medical, patient or system reason, the BMI measurement that would have been performed should be submitted along with a negation code to indicate the reason the BMI measurement was not performed during a qualifying encounter in the measurement period.

VITAL SIGNS and VITAL SIGNS(negation) tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

BMI

AND

MEDICAL REASON
OR
PATIENT REASON
OR
SYSTEM REASON

Rationale:

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

Obesity continues to be a public health concern in the United States and throughout the world (Flegal, et al, 2005; Ogden, et al, 2007)). In the United States, obesity prevalence doubled among adults between 1980 and 2004 (Flegal, et al, 2002; Ogden, et al, 2006). Obesity is associated with increased risk of a number of conditions, including diabetes mellitus, cardiovascular disease, hypertension, and certain cancers, and with increased risk of disability and a modestly elevated risk of all-cause mortality. With obesity on the rise, the medical community anticipates an increase in the complications of obesity, including type 2 diabetes mellitus, hypertension, dyslipidemia, cardiovascular disease, obstructive sleep apnea, degenerative arthritis, non-alcoholic steatohepatitis, gallbladder disease and others.

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

In 2000, obesity was responsible for an estimated 400,000 deaths, compared to 300,000 in 1990 (Flegal, et al, 2005). Obesity places second only to smoking as the leading preventable cause of death in the United States. In addition, obesity is a significant contributor to premature death. In Caucasians ages 20 to30 with a BMI >45 kg/m2, it has been estimated that obesity decreases life expectancy by 13 years in men and 8 years in women (Fontaine, et al, 2003).

Poor nutrition or underlying health conditions can result in underweight. Results from the 2003-2006 National Health and Nutrition Examination Survey (NHANES), using measured heights and weights, indicate that an estimated 1.8% of U.S. adults are underweight. (Source: The National Center for Health Statistics (NCHS) Health E-Stat. Prevalence of Underweight Among Adults: United States, 2003-2006, Accessed September 15, 2010 at http://www.cdc.gov/nchs/data/hestat/underweight/underweight_adults.htm. A tremendous gap still exists between our knowledge of malnutrition and its sequelae and our actions in preventing and treating it. To date professionals in various disciplines have applied their own approaches to solving the problem. Yet the causes of malnutrition are multi-factorial and the solutions demand an integration of knowledge and expertise from the many different disciplines involved in geriatric care. Older people have special nutritional needs due to age and disease processes.

Elderly patients with unintentional weight loss are at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases. Medications that may cause nausea and vomiting, dysphagia, dysgeusia and anorexia have been implicated. Polypharmacy can cause unintended weight loss, as can psychotropic medication reduction (e.g., by unmasking problems such as anxiety). In one study it was found that a BMI of less than 22 kg per m2 in women and less than 23.5 in men is associated with increased mortality. In another study it was found that the optimal BMI in the elderly is 24 to 29 kg per m2. (Huffman, G. B., Evaluation and Treatment of Unintentional Weight Loss in the Elderly, American Family Physician, 2002 Feb, 4:640-650). Ranhoff, et al (2005), identified through an observational study that using a BMI<23, resulted in a positive screen for malnutrition (sensitivity 0.86, specificity 0.71), giving 0.75 correctly classified subjects. Thus leading to the recommendation that a score of BMI<23 should be followed by MNA-SF when the aim is to identify poor nutritional status in elderly.

In 1998 the medical costs of obesity were estimated to be as high as $78.5 billion, with roughly half financed by Medicare and Medicaid (Finkelstein, et al, 2009). This analysis presents updated estimates of the costs of obesity for the United States across payers (Medicare, Medicaid, and private insurers), in separate categories for inpatient, non-inpatient, and prescription drug spending. Finkelstein, et al (2009), found that the increased prevalence of obesity is responsible for almost $40 billion of increased medical spending through 2006, including $7 billion in Medicare prescription drug costs. We estimate that the medical costs of obesity could have risen to $147 billion per year by 2008.

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

A Web search of the National Quality Measures Clearinghouse on the key words of BMI, body mass index, produced four measures, all focused on possible follow-up for overweight and obesity for a broader age range and/or related to a specific disease/condition. There were no measures that focused on underweight or a follow-up plan.

Clinical Recommendation Statements:

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

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

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

- Calculate the body mass index; classify the individual based on the body mass index categories. Educate patients about their body mass index and their associated risks. *(Annotation #1; Aim #1)*

- Weight management requires a team approach. Be aware of clinical and community resources. The patient needs to have an ongoing therapeutic relationship and follow-up with a health care team. Weight control is a lifelong commitment, and the health care team can assist with setting specific goals with the patient. *(Annotations #10, 13; Aim #4)*

There are no current clinical recommendations addressing Underweight or Unintentional Weight Loss in the elderly population that have been developed by professional organizations, societies or associations.

* **Measure #154:** Falls: Risk Assessment

This is a two-part measure which is paired with Measure #155: Falls: Plan of Care. If the falls risk assessment indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year, #155 *should* also be reported.

Description: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months

Denominator: All patients aged 65 years and older who have a history of falls

Denominator Inclusions:

All patients greater than or equal to 65 years of age at the beginning of the measurement period with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year). To be eligible for performance calculations, patients must have at least one face-to-face visit with the clinician during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE
AND
DX CODE

Numerator: Patients who had a risk assessment for falls completed within 12 months

Numerator Inclusion:

Patients with a risk assessment for falls completed during the measurement period.

PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

FALL RISK ASSESS

Denominator Exclusions: *(Exclusions only applied if the patient did not have a risk assessment for falls completed within the measurement period)*

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MEDICAL REASON

Rationale:
Screening for specific medical conditions may direct the therapy. Although the clinical guidelines and supporting evidence calls for an evaluation of many factors, it was felt that for the purposes of measuring performance and facilitating implementation this initial measure must be limited in scope. For this reason, the work group defined an evaluation of balance and gait as a core component that must be completed on all patients with a history of falls as well as four additional evaluations – at least one of which must be completed within the 12 month period. Data elements required for the measure can be captured and the measure is actionable by the physician.

Clinical Recommendation Statements:
Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualized, multifactorial intervention. (NICE) (Grade C)
Multifactorial assessment may include the following:
- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review (NICE) (Grade C)

A falls risk assessment should be performed for older persons who present for medical attention because of a fall, report recurrent falls in the past year, report difficulties in walking or balance or fear of falling, or demonstrate unsteadiness or difficulty performing a gait and balance test.

The falls risk evaluation should be performed by a clinician with appropriate skills and experience. [C]

A falls risk assessment is a clinical evaluation that should include the following, but are not limited to:
- a history of fall circumstances
- review of all medications and doses
- evaluation of gait and balance, mobility levels and lower extremity joint function
- examination of vision
- examination of neurological function, muscle strength, proprioception, reflexes, and tests of cortical, extrapyramidal, and cerebellar function
- cognitive evaluation
- screening for depression
- assessment of postural blood pressure
- assessment of heart rate and rhythm
- assessment of heart rate and rhythm, and blood pressure responses to carotid sinus stimulation if appropriate
- assessment of home environment

The falls risks assessment should be followed by direct intervention on the identified risk. [A] (AGS)

* **Measure #155**: Falls: Plan of Care

This is a two-part measure which is paired with Measure #154: Falls: Risk Assessment.
This measure *should* be reported if "Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year" is submitted for Measure #154.

Description: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

Denominator: All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)

Denominator Inclusions:

> All patients greater than or equal to 65 years of age at the beginning of the measurement period with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year). To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.
>
> ENCOUNTERS and PROBLEMS tabs in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER CODE
> AND
> DX CODE

Numerator: Patients with a plan of care for falls documented within 12 months

Numerator Inclusion:

> Patients with a plan of care for falls documented during the measurement period.
>
> PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> FALLS PLAN OF CARE

Denominator Exclusions: *(Exclusions only applied if the patient did not have a plan of care for falls documented within 12 months)*

> PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> MEDICAL REASON

Rationale:

Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls.

Clinical Recommendation Statements:

Among community-dwelling older persons (i.e., those living in their own homes), multifactorial interventions should include:

- gait training and advice on the appropriate use of assistive devices (Grade B)
- review and modification of medication, especially psychotropic medication (Grade B)
- exercise programs, with balance training as one of the components (Grade B)
- treatment of postural hypotension (Grade B)
- modification of environmental hazards (Grade C)
- treatment for cardiovascular disorders   (Grade D) (AGS/BGS/AAOS)

2012 EHR Measure Specifications
ANALYTIC NARRATIVES

◆ **Measure #163 (NQF 0056):** Diabetes Mellitus: Foot Exam

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

Denominator: Patients aged 18 through 75 years with a diagnosis of diabetes

Denominator Inclusions:

All patients with a documented diagnosis of diabetes at any time during the patient's history and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT, ENCOUNTER OUTPATIENT, or ENCOUNTER OUTPATIENT-OPTHALMOLOGICAL SERVICES) with the eligible professional, one visit may be during the year prior to the measurement period, but at least on visit must be during the measurement period OR patient was prescribed a medication indicative of diabetes during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT
OR
ENCOUNTER OUTPATIENT-OPTHALMOLOGICAL SERVICES

AND

DIABETES

OR

MEDICATIONS tab(s) in the Downloadable Resource table lists applicable codes for patients who were prescribed medications indicative of diabetes during the measurement period and DRUG_EXCLUSION = N.

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

Numerator Inclusions:

Patients who received a foot exam during the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

FOOT EXAM

Denominator Exclusions: *(Exclusions only applied if the patient has not received a foot exam at least once within 12 months)*

Patients with a documented diagnosis of polycystic ovaries at any time during the patient's history who were prescribed medications indicative of diabetes during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

AND NOT

Diabetes patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT
OR
ENCOUNTER OUTPATIENT-OPTHALMOLOGICAL SERVICES

OR

Patients with a documented diagnosis of gestational diabetes or steroid induced diabetes who were prescribed medications indicative of diabetes during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

GESTATIONAL DIABETES
OR
STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

AND NOT

Diabetes patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT
OR
ENCOUNTER OUTPATIENT-OPTHALMOLOGICAL SERVICES

Rationale:

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

Clinical Recommendation Statements:

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

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

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

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

Measure #173: Preventive Care and Screening: Unhealthy Alcohol Use-Screening

Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic method within 24 months

Denominator: All patients aged 18 years and older

Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

Numerator: Patients who were screened for unhealthy alcohol use using a systematic screening method within 24 months

Numerator Inclusions:

Patients who were screened for unhealthy alcohol use using a systematic screening method during the measurement period or the year prior to the measurement period.

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL ABUSE SCRN

Denominator Exclusions: *(Exclusions only applied if patients were not screened for unhealthy alcohol use)*

Patients who had one of the following conditions during the measurement period or year prior to the measurement period.

PROBLEMS tabs in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE
OR
MEDICAL REASON

Rationale:

Screening for unhealthy alcohol use can identify patients whose habits may put them at risk for adverse health outcomes due to their alcohol use. While this measure does not require counseling for those patients to be found at risk, brief counseling interventions for unhealthy alcohol use have shown to be effective in reducing alcohol use. It would be expected that if a provider found their patient to be at risk after screening that intervention would be provided.

A systematic method of assessing for unhealthy alcohol use should be utilized. Please refer to the National Institute on Alcohol Abuse and Alcoholism publication: *Helping Patients Who Drink Too Much: A Clinician's Guide* for additional information regarding systematic screening methods.

Clinical Recommendation Statements:

The USPSTF strongly recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. (B Recommendation) (USPSTF, 2004)

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. (NQF, 2007)

All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive brief motivational counseling intervention by a healthcare worker trained in this technique. (NQF, 2007)

♣**Measure #197 (NQF 0074):** Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).

Denominator: All patients aged 18 years and older with CAD

Denominator Inclusions:

> All patients with a documented diagnosis of coronary artery disease (CAD) OR had a cardiac surgery at any time before or during their last qualifying visit and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the eligible professional during the measurement period.
>
> ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> ENCOUNTER NURSING FACILITY
> OR
> ENCOUNTER OUTPATIENT
>
> AND
>
> CORONARY ARTERY DISEASE INCLUDES MI
> OR
> CARDIAC SURGERY

Numerator: Patients who were prescribed lipid-lowering therapy

Numerator Inclusions:

> MEDICATIONS Tab in the Downloadable Resource table lists applicable codes for patients who were prescribed lipid-lowering therapy during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient has not prescribed lipid-lowering therapy during the measurement period)*

> Most recent LDL test is <130 mg/dL at any time before or during their last qualifying visit.
>
> RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):
>
> LDL LABORATORY TEST
> WITH
> *Documentation of LDL < 130 mg/dL*

OR

When the lipid-lowering therapy is not done for a valid medical, patient or system reason, the appropriate medication that would have been given should be submitted along with a negation code to indicate the reason the lipid-lowering therapy was not received during the measurement period.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for the lipid-lowering therapy.

AND

MEDICAL REASON
OR
PATIENT REASON
OR
SYSTEM REASON

OR

When lipid-lowering therapy was not prescribed due to allergy, adverse effects, or intolerance, the appropriate medication that the patient is not prescribed should be submitted along with negation code to indicate the reason the lipid-lowering therapy was not prescribed at any time before or during a qualifying encounter in the measurement period.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for the lipid-lowering therapy.

AND

MEDICATION ALLERGY
OR
MEDICATION ADVERSE EFFECTS
OR
MEDICATION INTOLERANCE

Rationale:
Studies have demonstrated that active treatment with lipid-lowering therapy is associated with stabilization and regression of coronary atherosclerotic plaques and decreased incidence of clinical events. Recent clinical trials have further documented that LDL-lowering agents can decrease the risk of adverse ischemic events in patients with established CAD.

Clinical Recommendation Statements:
The LDL-C treatment goal is <100 mg/dl. Persons with established coronary heart disease (CHD) who have a baseline LDL-C ³130 mg/dl should be started on a cholesterol-lowering drug simultaneously with therapeutic lifestyle changes and control of nonlipid risk factors (National Cholesterol Education Program [NCEP]).

▲Measure #200 (NQF 0084): Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation

Description: Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy

Denominator: All heart failure patients aged 18 years and older with paroxysmal or chronic atrial fibrillation

Denominator Inclusions:

All patients with a documented diagnosis of heart failure at any time before or during the qualifying visit and a documented diagnosis of atrial fibrillation before or during the measurement period and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY
OR
ENCOUNTER OUTPATIENT

AND

HEART FAILURE

AND

ATRIAL FIBRILLATION

Numerator: Patients who were prescribed warfarin therapy

Numerator Inclusions:

MEDICATIONS Tab in the Downloadable Resource table lists applicable codes for patients who were prescribed warfarin therapy during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient has not been prescribed warfarin therapy at least once during the measurement period)*

When the warfarin therapy is not prescribed for a valid medical, patient or system reason, the appropriate medication that would have been prescribed should be submitted along with a negation code to indicate the reason the lipid-lowering therapy was not prescribed during the measurement period.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for the warfarin therapy.

AND

MEDICAL REASON
OR
PATIENT REASON
OR
SYSTEM REASON

OR

When warfarin therapy is not prescribed due to allergy, adverse effects, or intolerance, the appropriate medication that the patient is not prescribed should be submitted along with a negation code to indicate the reason the warfarin therapy was not prescribed at any time before or during a qualifying encounter in the measurement period.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for the warfarin therapy.

AND

MEDICATION ALLERGY
OR
MEDICATION ADVERSE EFFECTS
OR
MEDICATION INTOLERANCE

OR

Patient who has one of the following conditions any time before or during the qualifying encounter.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ANEMIAS AND BLEEDING DISORDERS
OR
ESOPHAGEAL AND GI BLEED
OR
INTRACRANIAL HEMORRHAGE
OR
LEUKEMIAS/MYELOPROLIFERATIVE DISORDERS
OR
HEMATURIA
OR
HEMOPTYSIS
OR
HEMORRHAGE
OR
LIVER DISORDERS

Rationale:
Adjusted-dose warfarin is highly efficacious in preventing thromboembolism in patients with AF and should be prescribed for all patients with AF and heart failure except those with contraindications to anticoagulation.

Clinical Recommendation Statements:
Physicians should prescribe anticoagulants in patients with HF who have paroxysmal or persistent atrial fibrillation or a previous thromboembolic event. (Class I, Level of Evidence: A)

2012 EHR Measure Specifications
ANALYTIC NARRATIVES

◆ **Measure #201 (NQF 0073):** Ischemic Vascular Disease (IVD): Blood Pressure Management Control

Description: Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who had most recent blood pressure in control (less than 140/90 mmHg)

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

Denominator Inclusions:

All patients with a documented diagnosis of IVD during the qualifying visit OR PTCA performed January 1 through November 1 of the year prior to the measurement period OR a documented diagnosis of AMI during an inpatient encounter January 1 through November 1 of the year prior to the measurement period OR CABG performed during an inpatient encounter January 1 through November 1 of the year prior to the measurement period and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT
OR
ENCOUNTER OUTPATIENT

AND

ISCHEMIC VASCULAR DISEASE

OR

PTCA

OR

ENCOUNTER ACUTE INPT
AND
ACUTE MYOCARDIAL INFARCTION

OR

ENCOUNTER ACUTE INPT
AND
CABG

Numerator: Patients whose most recent blood pressure < 140/90 mmHg

Numerator Inclusions:

Patients who had a most recent blood pressure < 140/90 mmHg during the last qualifying visit during the measurement period.

> NOTE: *Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.*

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIASTOLIC BLOOD PRESSURE
WITH
Documentation of Diastolic BP < 90 mm[Hg]

AND

SYSTOLIC BLOOD PRESSURE
WITH
Documentation of Systolic BP < 140 mm[Hg]

Exclusions:

None

Rationale:

Fifty million or more Americans have high blood pressure that warrants treatment, according to the NHANES survey (JNC-7, 2003). The USPSTF recommends that clinicians screen adults aged 18 and older for high blood pressure (USPSTF, 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 BP, there is a doubling of mortality from both IHD and stroke (JNC-7, 2003).

Better control of BP has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. Thus, 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%), myocardial infarction (20-25%) and heart failure (>50%) (JNC-7, 2003).

Clinical Recommendation Statements:

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

The JNC-7 indicates that treating systolic BP and diastolic BP to targets that are <140/90 mmHg is associated with a decrease in CVD complications.

◆ Measure #202 and #203 (NQF 0075): Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control

Description: Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and who had most recent LDL-C level in control (less than 100 mg/dL)

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

Denominator Inclusions:

All patients with a documented diagnosis of IVD during the qualifying visit OR PTCA performed January 1 through November 1 of the year prior to the measurement period OR a documented diagnosis of AMI during an inpatient encounter January 1 through November 1 of the year prior to the measurement period OR CABG performed during an inpatient encounter January 1 through November 1 of the year prior to the measurement period and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT
OR
ENCOUNTER OUTPATIENT

AND

ISCHEMIC VASCULAR DISEASE

<div align="center">OR</div>

PTCA

<div align="center">OR</div>

ENCOUNTER ACUTE INPT
AND
ACUTE MYOCARDIAL INFARCTION

<div align="center">OR</div>

ENCOUNTER ACUTE INPT
AND
CABG

Numerator 1: Patients who received at least one lipid profile (or ALL component tests)

Numerator Inclusions:

Patients who had at least one lipid profile during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

LDL TEST

OR

HIGH DENSITY LIPOPROTEIN (HDL)
AND
TOTAL CHOLESTEROL
AND
TRIGLYCERIDES

AND

Numerator 2: Patients with most recent LDL-C < 100 mg/dL

Numerator Inclusions:

Patients with most recent LDL-C < 100 mg/dL during the measurement period.
> **NOTE**: *LDL results are acceptable if directly reported (LDL TEST) from the laboratory, or if the other elements (TRIGLYCERIDES, TOTAL CHOLESTEROL, HIGH DENSITY LIPOPROTEIN (HDL)) listed below are submitted and triglyceride value is ≤ 400 mg/dL. Directly reported values or calculated LDL values must be less than 100 mg/dL for Numerator Inclusion purposes.*

> *LDL value = [TOTAL CHOLESTEROL value –*
> *HIGH DENSITY LIPOPROTEIN (HDL) value –*
> *(TRIGLYCERIDE value/5)]*

RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

LDL TEST
WITH
Documentation of LDL Test < 100 mg/dL

OR

TOTAL CHOLESTEROL
WITH
Documentation of Total Cholesterol in mg/dL

AND

HIGH DENSITY LIPOPROTEIN (HDL)
WITH
Documentation of HDL in mg/dL

AND

TRIGLYCERIDES
WITH
Documentation of Triglycerides ≤ 400 mg/dL

Denominator Exclusions:

None

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

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

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

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

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

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

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

◆Measure #204 (NQF 0068): Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

Description: Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or other antithrombotic

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

Denominator Inclusions:

All patients with a documented diagnosis of IVD during the qualifying visit OR PTCA performed January 1 through November 1 of the year prior to the measurement period OR a documented diagnosis of AMI during an inpatient encounter January 1 through November 1 of the year prior to the measurement period OR CABG performed during an inpatient encounter January 1 through November 1 of the year prior to the measurement period and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT
OR
ENCOUNTER OUTPATIENT

AND

ISCHEMIC VASCULAR DISEASE

OR

PTCA

OR

ENCOUNTER ACUTE INPT
AND
ACUTE MYOCARDIAL INFARCTION

OR

ENCOUNTER ACUTE INPT
AND
CABG

Numerator: Patients who are using aspirin or another antithrombotic therapy

Numerator Inclusions:

MEDICATIONS Tab in the Downloadable Resource table lists applicable codes for patients who were prescribed oral anti-platelet therapy during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions:

None

Rationale:

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

Clinical Recommendation Statements:

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

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

USPSTF encourages men age 45 to 79 years to use aspirin when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage. They encourage women age 55 to 79 years to use aspirin when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.

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

AHA/ACC: Start aspirin 75 to 162 mg/d and continue indefinitely in all patients with coronary and other vascular disease unless contraindicated.

ICSI: Aspirin should be prescribed to all patients with stable coronary disease. If a patient is aspirin intolerant, then use clopidogrel.

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

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

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

▲ **Measure #226 (NQF 0028):** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Description: Percentage of patients aged 18 years or older who were screened about tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user

Denominator 1: All patients aged 18 years and older

Denominator Inclusions 1:

All patients greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER PREV MED GROUP COUNSELING, ENCOUNTER PREV MED OTHER SERVICES, ENCOUNTER PREV MED SERVICES 18 AND OLDER, or ENCOUNTER PREV MED – INDIVIDUAL COUNSELING) OR at least two face-to-face visits (ENCOUNTER HEALTH AND BEHAVIOR ASSESSMENT, ENCOUNTER OCCUPATIONAL THERAPY, ENCOUNTER OFFICE VISIT, or ENCOUNTER PSYCHIATRIC & PSYCHOLOGIC) with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER PREV MED GROUP COUNSELING
OR
ENCOUNTER PREV MED OTHER SERVICES
OR
ENCOUNTER PREV MED SERVICES 18 AND OLDER
OR
ENCOUNTER PREV MED 40 & OLDER
OR
ENCOUNTER PREV MED – INDIVIDUAL COUNSELING
OR
ENCOUNTER HEALTH AND BEHAVIOR ASSESSMENT
OR
ENCOUNTER OCCUPATIONAL THERAPY
OR
ENCOUNTER OFFICE VISIT
OR
ENCOUNTER PSYCHIATRIC & PSYCHOLOGIC

Numerator 1: Patients who were screened for tobacco use* at least once within 24 months

Numerator Inclusions 1:

Patients who were screened for tobacco use* before or during a qualifying visit at least once during the measurement period or year prior to the measurement period.
> * Includes use of any type of tobacco

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

TOBACCO USER
OR
TOBACCO NON-USER

AND

Denominator 2: All patients aged 18 years and older who were identified as tobacco users

Denominator Inclusions 2:

All patients who were identified as tobacco users during a qualifying visit in the measurement period and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER PREV MED GROUP COUNSELING, ENCOUNTER PREV MED OTHER SERVICES, ENCOUNTER PREV MED SERVICES 18 AND OLDER, or ENCOUNTER PREV MED – INDIVIDUAL COUNSELING) OR at least two face-to-face visits (ENCOUNTER HEALTH AND BEHAVIOR ASSESSMENT, ENCOUNTER OCCUPATIONAL THERAPY, ENCOUNTER OFFICE VISIT, or ENCOUNTER PSYCHIATRIC & PSYCHOLOGIC) with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER PREV MED GROUP COUNSELING
OR
ENCOUNTER PREV MED OTHER SERVICES
OR
ENCOUNTER PREV MED SERVICES 18 AND OLDER
OR
ENCOUNTER PREV MED 40 & OLDER
OR
ENCOUNTER PREV MED – INDIVIDUAL COUNSELING
OR
ENCOUNTER HEALTH AND BEHAVIOR ASSESSMENT
OR
ENCOUNTER OCCUPATIONAL THERAPY
OR
ENCOUNTER OFFICE VISIT
OR
ENCOUNTER PSYCHIATRIC & PSYCHOLOGIC

AND

TOBACCO USER

Numerator 2: Patients who received tobacco cessation counseling intervention**

Numerator Inclusions 2:

Patients who received tobacco cessation counseling intervention** the year prior to the measurement period or during a qualifying visit in the current measurement period.
    ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy

PROBLEMS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

TOBACCO USE CESSATION COUNSELING

OR

MEDICATIONS Tab in the Downloadable Resource table lists applicable codes for patients who were prescribed smoking cessation agents before or during a qualifying visit during the current year or year prior and DRUG_EXCLUSION = N.

Denominator Exclusions:

None

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 (USPSTF, 2003). Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke (USPSTF, 2003).

Clinical Recommendation Statements:

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

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

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

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

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

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

2012 EHR Measure Specifications
ANALYTIC NARRATIVES

▲ Measure #237 (NQF 0013): Hypertension (HTN): Blood Pressure Measurement

Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension with blood pressure (BP) recorded

Denominator: All visits for patients aged 18 years and older with a diagnosis of HTN

Denominator Inclusions:

> All patient visits with a documented diagnosis of hypertension at any time before or during the measurement period and the patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the eligible professional during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER NURSING FACILITY
> OR
> ENCOUNTER OUTPATIENT
>
> AND
>
> HYPERTENSION

Numerator: Patient visits with blood pressure measurement recorded

Numerator Inclusions:

> Patient visits with a blood pressure measurement recorded during a qualifying visit during the measurement period.
> > **NOTE:** *Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.*
>
> VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> SYSTOLIC BLOOD PRESSURE
> WITH
> *Documentation of Systolic BP mm[Hg]*
>
> AND
>
> DIASTOLIC BLOOD PRESSURE
> WITH
> *Documentation of Diastolic BP mm[Hg]*

Denominator Exclusions:

> None

Rationale:

Data from the National Health and Nutrition Examination Survey (NHANES) have indicated that 50 million or more Americans have high blood pressure (BP) warranting some form of treatment. Worldwide prevalence estimates for hypertension may be as much as 1 billion individuals, and approximately 7.1 million deaths per year may be attributable to hypertension. The World Health Organization reports that suboptimal BP (>115 mm Hg SBP) is responsible for 62% of cerebrovascular disease and 49% of ischemic heart disease, with little variation by sex. In addition, suboptimal blood pressure is the number one attributable risk for death throughout the world. (JNC 7: Complete Report)

Hypertension is an increasingly important medical and public health issue. The prevalence of hypertension increases with advancing age to the point where more than half of people aged 60 to 69 years old and approximately three-fourths of those aged 70 years and older are affected. The age-related rise in SBP is primarily responsible for an increase in both incidence and prevalence of hypertension with increasing age. (JNC 7: Complete Report)

Clinical Recommendation Statements:

Obtaining proper blood pressure (BP) measurements at each health care encounter is recommended for hypertension detection. Repeated BP measurements (≥ 2 per patient visit) will determine if initial elevations persist and require prompt attention (Level 1 Recommendation, Level-C Evidence)

Classification of adult BP (including stages 1-3 of hypertension) is useful for making treatment decisions and is based on the average of ≥ 2 readings taken at each of 2 or more visits after an initial screening.

Hypertension is defined as systolic BP of 140 mm Hg or greater, diastolic BP of 90 mm Hg or greater or taking antihypertensive medication.

✦ Measure #238 (NQF 0022): Drugs to be Avoided in the Elderly

Description: Percentage of patients ages 65 years and older who received at least one drug to be avoided in the elderly and/or two different drugs to be avoided in the elderly in the measurement period

Denominator: All patients ages 65 years and older

Denominator Inclusions:

All patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

Numerator: Patients who received at least one drug to be avoided in the elderly and/or two different drugs to be avoided in the elderly in the measurement period

Numerator Inclusion – Option #1: (*Received one drug to be avoided in the elderly*)

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed drugs to be avoided in the elderly (*Amphetamines; Analgesics; Anti Anxiety; Antiemetics; Antihistamines; Antipsychotic, typical; Barbiturates; Belladonna alkaloids; Calcium channel blockers; Gastrointestinal anti-spasmodics; Long-acting benzodiazepines; Narcotics; Oral estrogens; oral hypoglycemic; Other (Desiccated Thyroid; Methyltestosterone; Nitrofurantoin group); Skeletal muscle relaxants; Vasolidators)* during the measurement period and DRUG_EXCLUSION = N.

OR

Numerator Inclusion – Option #2: (*Received at least two different drugs to be avoided in the elderly*)

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed at least *two* different drugs to be avoided in the elderly (*Amphetamines; Analgesics; Anti Anxiety; Antiemetics; Antihistamines; Antipsychotic, typical; Barbiturates; Belladonna alkaloids; Calcium channel blockers; Gastrointestinal anti-spasmodics; Long-acting benzodiazepines; Narcotics; Oral estrogens; oral hypoglycemic; Other (Desiccated Thyroid; Methyltestosterone; Nitrofurantoin group); Skeletal muscle relaxants; Vasolidators)* during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions:

None

Rationale:
Despite widely-accepted medical consensus that certain drugs increase the risk of harm to the elderly and should generally be avoided, (Fick, 2003) these drugs are still frequently prescribed to the elderly. Studies have found that 21% to almost 37% of elderly patients filled at least one potentially inappropriate prescription and more than 15% filled at least two (Curtis, 2004 and Simon, 2005). A study of elderly managed care patients found that almost 29% receive at least one potentially inappropriate medication (Simon, 2005). While some drugs are generally appropriate to prescribe in the elderly, the side-effects commonly associated with these drugs pose an extra risk to elderly people with certain pre-existing conditions. For example, the unsteadiness (ataxia) frequently associated with antidepressants may be a particular danger for elderly patients with a history of falls. Clinical guidelines identify drugs that are generally inappropriate for the elderly, as well as drugs that are inappropriate for elderly populations with specific diagnoses or conditions (Fick, 2003).

Seniors receiving inappropriate medications are more likely to report poorer health status at follow-up, compared to seniors who receive appropriate medications (Fu, 2004). In 2005, rates of potentially inappropriate medication use in the elderly were as large or larger than in a 1996 national sample, highlighting the need for progress in this area (Simon, 2005). While some adverse drug events are not preventable, studies estimate that between 30% and 80% of adverse drug events in the elderly are preventable (MacKinnon, 2003).

Reducing the number of inappropriate prescriptions can lead to improved patient safety and significant cost savings. Conservative estimates of extra costs due to potentially inappropriate medications in the elderly average $7.2 billion a year (Fu, 2004).

Clinical Recommendation Statements:
The measure is based on the literature and key clinical expert consensus processes by Beers in 1997, Zahn in 2001 and an updated process by Fick in 2003, which identified drugs of concern in the elderly based on various high-risk criteria. NCQA's Medication Management expert panel selected a subset of drugs that should be used with caution in the elderly for inclusion in the proposed measure based upon these two lists. NCQA analyzed the prevalence of drugs prescribed according to their Beers and Zhan's classifications and determined that drugs identified by Zhan that are classified as never or rarely appropriate would form the basis for the list (Fick, 2003). Certain medications (MacKinnon, 2003) are associated with increased risk of harms from drug side-effects and drug toxicity and pose a concern for patient safety. There is clinical consensus that these drugs pose increased risks in the elderly (Kaufman, 2005). Studies link prescription drug use by the elderly with adverse drug events that contribute to hospitalization, increased length of hospital stay, increased duration of illness, nursing home placement and falls and fractures that are further associated with physical, functional and social decline in the elderly (AHRQ, 2009).

◆ **Measure #239 (NQF 0024):** Weight Assessment and Counseling for Children and Adolescents

Description: Percentage of children 2 through 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement period

Denominator: All patients aged 2 through 17 years

Denominator Inclusion – Population Stratification 1: *(Patients aged 2-17)*

> All patients between 2 and 17 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the eligible professional during the measurement period.
>
> ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER OB/GYN
> OR
> ENCOUNTER OUTPATIENT

AND NOT

> Patients who are pregnant during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER PREGNANCY
> OR
> PREGNANCY

Denominator Inclusion – Population Stratification 2: *(Patients aged 2-11)*

> All patients between 2 and 11 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the eligible professional during the measurement period.
>
> ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER OB/GYN
> OR
> ENCOUNTER OUTPATIENT

AND NOT

> Patients who are pregnant during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER PREGNANCY
> OR
> PREGNANCY

Denominator Inclusion – Population Stratification 3: *(Patients aged 12-17)*

> All patients between 12 and 17 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the eligible professional during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER OB/GYN
> OR
> ENCOUNTER OUTPATIENT

AND NOT

> Patients who are pregnant during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER PREGNANCY
> OR
> PREGNANCY

Numerator: Patients who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement period

Numerator Inclusion – Criterion #1: *(BMI percentile recorded)*

> Patients with Body Mass Index (BMI) percentile for age and gender documented during the measurement period.
>
> VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> BMI PERCENTILE
> WITH
> *Documentation of BMI percentile for age and gender (%)*

AND

Numerator Inclusion – Criterion #2: *(Counseling for nutrition performed)*

> Patients who were counseled based on their nutrition during the measurement period.
>
> PROBLEMS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> COUNSELING FOR NUTRITION

AND

Numerator Inclusion – Criterion #3: *(Counseling for physical activity performed)*

> Patients who were counseled based on their physical activity during the measurement period.
>
> PROBLEMS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> COUNSELING FOR PHYSICAL ACTIVITY

Denominator Exclusions:

> None

Rationale:

This measure assesses the percentage of age-appropriate patients who had an outpatient visit with a PCP or OB/GYN and who had evidence of a BMI percentile assessment, counseling for nutrition or counseling for physical activity. The prevalence of overweight and obesity has increased sharply for children over the last 30 years: from 5.0% to 13.9% for those aged 2–5 years; from 6.5% to 18.8% for those aged 6–11 years; and from 5.0% to 17.4% for those aged 12–19 years. This increasing prevalence has had significant economic ramifications, with economic costs correlated to obesity and related comorbidities estimated at over $70 billion, or 7% of the national health care budget. To address this problem and its long-term implications effectively, promotion of routine physical activity and healthy eating and lifestyle changes are essential (CDC 2007). This measure is important in efforts to improve long-term health outcomes and quality of life.

Clinical Recommendation Statements:

U.S. Preventive Services Task Force (USPSTF): "I" Recommendation. Insufficient evidence to recommend for or against screening for overweight in children and adolescents reflects the paucity of strong evidence of the effectiveness of interventions for this problem in the clinical setting.

The American Academy of Pediatrics (AAP): The child's height, weight and percentiles for age should be determined at the start of the physical examination. Because obesity is strongly linked to hypertension, BMI should be calculated from the height and weight, and the BMI percentile should be calculated. Poor growth may indicate an underlying chronic illness.

The American Medical Association (AMA), Health Resources and Services Administration (HRSA), and Centers for Disease Control and Prevention (CDC): The Expert Committee recommends that physicians and allied healthcare providers perform, at a minimum, a yearly assessment of weight status in all children, and that this assessment include calculation of height, weight (measured appropriately), and body mass index (BMI) for age and plotting of those measures on standard growth charts.

The American Academy of Pediatrics and the American College of Clinical Endocrinology (ACCE): The AAP and the ACCE recommend and encourage pediatric providers to screen children for obesity using BMI; examine overweight children for obesity-related diseases; initiate weight management practices to improve diet and physical activity habits; and increase frequency of visits to reinforce behavior changes.

The Centers for Disease Control and Prevention (CDC): The CDC recommends using the percentile BMI for age and gender as the most appropriate and easily available method to screen for childhood overweight or at risk for overweight. BMI is calculated by dividing the weight in kilograms by the height in meters squared. Age and gender norms for BMI are readily accessible. BMI correlates with adiposity and with complications of childhood overweight such as hypercholesterolemia, hypertension and later development of cardiovascular disease. Although more precise measures of lean body mass and body fat such as dual x-ray absorptiometry (DEXA) may be appropriate for clinical studies, BMI norms are particularly helpful for screening in busy office practices and for population assessment.

◆ Measure #240 (NQF 0038): Childhood Immunization Status

Description: The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Denominator: All patients who turn two years of age during the measurement period

Denominator Inclusions:

All patients who turn 2 years of age during the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OB/GYN
OR
ENCOUNTER OUTPATIENT

Numerator: Patients who received four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, rubella (MMR); three H influenza type B (HIB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Numerator Inclusion – Criterion a: *(Patients who received all four doses of DTaP vaccination)*

Patients who received all four doses of the diphtheria, tetanus and acellular pertussis (DTaP) vaccination on <u>different</u> days between the ages of 42 days old and 2 years old for patients who turn 2 years old during the measurement period. *Evidence of the antigen or vaccine must be found.*

IMMUNIZATIONS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>DTAP VACCINATION</u>

AND/OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered *four* doses of DTaP Vaccine with <u>different</u> dates of service between the ages of 42 days and 2 years and DRUG_EXCLUSION = N.

OR Numerator Exclusions (Criterion a):

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete DTaP vaccination series. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

PROBLEMS and ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>ENCEPHALOPATHY</u>
OR
<u>PROGRESSIVE NEUROLOGIC DISORDER</u>
OR
<u>EXCLUSION CODE</u>

OR

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for DTaP Vaccine.
AND
<u>MEDICATION ALLERGY</u>

AND

Numerator Inclusion – Criterion b: (*Patients who received at least three polio vaccinations (IPV)*)

> Patients who received all three doses of the polio (IPV) vaccination on <u>separate</u> days between the ages of 42 days old and 2 years old for patients who turn 2 years old during the measurement period. *Evidence of the antigen or vaccine must be found.*
>
> IMMUNIZATIONS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> IPV VACCINATION

AND/OR

> MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *three* doses of IPV with <u>different</u> dates of service between the ages of 42 days and 2 years and DRUG_EXCLUSION = N.

OR Numerator Exclusions (Criterion b):

> Eligible children with at least one of the medical exclusions listed below may not need to receive the complete polio (IPV) series. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.
>
> ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> EXCLUSION CODE

OR

> When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.
>
> MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for IPV.
> AND
> MEDICATION ALLERGY

AND

Numerator Inclusion – Criterion C: (*Patients who received one measles, mumps and rubella (MMR) vaccination*)

MMR Numerator Inclusions (Criterion c):

Patients who received one dose of the MMR vaccination on or before the child's second birthday for patients who turn 2 years old during the measurement period. *Evidence of the antigen or combination vaccine.*

IMMUNIZATIONS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MMR VACCINATION

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *one* dose of the MMR Vaccine on or before the child's second birthday and DRUG_EXCLUSION = N.

OR MMR Numerator Exclusions (Criterion c):

Eligible children who currently have at least one of the medical exclusions listed below or who has or had CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE at any time before or during the measurement period may not need to receive the MMR vaccination. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

PROBLEMS and ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE
OR
HIV DISEASE
OR
MULTIPLE MYELOMA
OR
LEUKEMIA
OR
IMMUNODEFICIENCY
OR
EXCLUSION CODE

OR

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for the MMR Vaccine.
AND
MEDICATION ALLERGY

OR

Measles Numerator Inclusion (Criterion c1):

Patients who received an equivalent combination of MMR vaccinations on or before the child's second birthday and/or who currently have or had measles, mumps and/or rubella by the child's second birthday for patients who turn 2 years old during the measurement period. *Evidence of the antigen or combination vaccine, or documented history of the illness(es), or seropositive test result(s) must be found.*

IMMUNIZATIONS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MEASLES VACCINATION
OR
MEASLES

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *one* dose of Measles Vaccine on or before the child's second birthday and DRUG_EXCLUSION = N.

OR Measles Numerator Exclusions (Criterion c1):

Eligible children with at least one of the medical exclusions listed below may not need to receive the Measles portion of the vaccination. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

OR

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Measles Vaccine.
AND
MEDICATION ALLERGY

AND

Mumps Numerator Inclusion (Criterion c2):

IMMUNIZATIONS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MUMPS VACCINATION
OR
MUMPS

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *one* dose of Mumps Vaccine on or before the child's second birthday and DRUG_EXCLUSION = N.

OR Mumps Numerator Exclusions (Criterion c2):

Eligible children with at least one of the medical exclusions listed below may not need to receive the MMR vaccination. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

OR

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for mumps Vaccine.
AND
MEDICATION ALLERGY

AND

Rubella Numerator Inclusion (Criterion c3):

IMMUNIZATIONS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

RUBELLA VACCINATION
OR
RUBELLA

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *one* dose of Rubella Vaccine on or before the child's second birthday and DRUG_EXCLUSION = N.

OR Rubella Numerator Exclusions (Criterion c3):

Eligible children with at least one of the medical exclusions listed below may not need to receive the MMR vaccination. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

OR

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Rubella Vaccine.
AND
MEDICATION ALLERGY

AND

Numerator Inclusion – Criterion d: (*Patients who received at least three influenza type B (HiB) vaccinations*)

Patients who received at least three HiB vaccinations on <u>separate</u> days between the ages of 42 days old and 2 years old for patients who turn 2 years old during the measurement period. *Evidence of the antigen or vaccine must be found.*

IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HIB VACCINATION

AND/OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *three* doses of HiB vaccine with <u>different</u> dates of service between the ages of 42 days and 2 years and DRUG_EXCLUSION = N.

OR Numerator Exclusions (Criterion d):

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete HiB vaccination series. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

OR

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for HiB vaccine.
AND
MEDICATION ALLERGY

AND

Numerator Inclusion – Criterion e: (*Patients who received at least three Hepatitis B immunizations*)

Patients who received all three doses of the Hepatitis B vaccinations on <u>separate</u> days and/or who currently have or had Hepatitis B before 2 years of age and the patient turns 2 years old during the measurement period. *Evidence of the antigen or combination vaccine, or documented history of the illness, or a seropositive test result must be found.*

IMMUNIZATIONS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HEPATITIS B VACCINATION
OR
HEPATITIS B DIAGNOSIS

AND/OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who received all *three* does of the Hepatitis B Vaccine on <u>separate</u> days before 2 years of age and DRUG_EXCLUSION = N.

OR Numerator Exclusions (Criterion e):

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete Hepatitis B immunization series. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

OR

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Hepatitis B vaccine, Baker's Yeast or Baker's Yeast Substance.
AND
MEDICATION ALLERGY

AND

Numerator Inclusion – Criterion f: (*Patients who received one chicken pox (VZV) immunization*)

Patients who received one dose of the chicken pox (VZV) vaccination and/or who currently have or had the chicken pox before 2 years of age and the patient turns 2 years old during the measurement period. *Evidence of the antigen or combination vaccine, or documented history of the illness, or a seropositive test result must be found.*

PROBLEMS and IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

VZV VACCINATION
OR
VZV

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least **one** dose of the VZV (chicken pox) Vaccine before 2 years of age and DRUG_EXCLUSION = N.

OR Numerator Exclusions (Criterion f):

Eligible children who currently have at least one of the medical exclusions listed below or who has or had CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE at any time before or during the measurement period may not need to receive the chicken pox (VZV) vaccination. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

PROBLEMS and ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE
OR
HIV DISEASE
OR
MULTIPLE MYELOMA
OR
LEUKEMIA
OR
IMMUNODEFICIENCY
OR
EXCLUSION CODE

OR

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for VZV Vaccine.
AND
MEDICATION ALLERGY

AND

Numerator Inclusion – Criterion g: *(Patients who received all four doses of the pneumococcal conjugate vaccinations)*

Patients who received all four doses of the Pneumococcal conjugate vaccination on separate days before 2 years of age and the patient turns 2 years old during the measurement period. *Evidence of the antigen or vaccine must be found.*

IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PNEUMOCOCCAL VACCINATION

AND/OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered all *four* doses of the Pneumococcal Vaccine on separate days before 2 years of age and DRUG_EXCLUSION = N.

OR Numerator Exclusions (Criterion g):

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete Pneumococcal conjugate vaccination series. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

OR

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Pneumococcal Vaccine.
AND
MEDICATION ALLERGY

AND

Numerator Inclusion – Criterion h: *(Patients who received both doses of the Hepatitis A vaccination)*

Patients who received both doses of the Hepatitis A vaccination on <u>separate</u> days and/or who currently have or had Hepatitis A before 2 years of age and the patient turns 2 years old during the measurement period. *Evidence of the antigen or vaccine, or documented history of the illness, or a seropositive test result must be found.*

PROBLEMS and IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HEPATITIS A VACCINATION
OR
HEPATITIS A DIAGNOSIS

AND/OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered *both* doses of the Hepatitis A Vaccine on <u>separate</u> days before 2 years of age and DRUG_EXCLUSION = N.

OR Numerator Exclusions (Criterion h):

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete Pneumococcal conjugate vaccination series. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

OR

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Hepatitis A Vaccine.
AND
MEDICATION ALLERGY

AND

Numerator Inclusion – Criterion i: (*Patients who received at least two doses of the Rotavirus (RV) vaccination*)

Patients who received at least two doses of the RV immunization on separate days between the ages of 42 days old and 2 years old and the patient turns 2 years old during the measurement period. *Evidence of the antigen or vaccine must be found.*

IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ROTAVIRUS VACCINATION

AND/OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *two* doses of the Rotavirus Vaccine on separate days between the age of 42 days and 2 years old and DRUG_EXCLUSION = N.

OR Numerator Exclusions (Criterion i):

When drug therapy is not prescribed due to patient allergy identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Rotavirus Vaccine.
AND
MEDICATION ALLERGY

AND

Numerator Inclusion – Criterion j: *(Patients who received both doses of the Influenza vaccination)*

Patients who received both doses of the Influenza immunization administered on <u>separate</u> days between the ages of 42 days old and 2 years old and the patient turns 2 years old during the measurement period. *Evidence of the antigen or vaccine must be found.*

IMMUNIZATIONS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

INFLUENZA VACCINATION

AND/OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered **both** doses of the influenza vaccine on <u>separate</u> days between the age of 42 days and 2 years old and DRUG_EXCLUSION = N.

OR Numerator Exclusions (Criterion j):

Eligible children who currently have at least one of the medical exclusions listed below or who has or had CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE at any time before or during the measurement period may not need to receive the influenza vaccination. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

PROBLEMS and ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE
OR
HIV DISEASE
OR
MULTIPLE MYELOMA
OR
LEUKEMIA
OR
IMMUNODEFICIENCY
OR
EXCLUSION CODE

Denominator Exclusion:

None

Rationale:
For the general community, high childhood immunization rates prevent the resurgence of many infectious diseases, such as polio, that have been virtually eradicated from most developed countries (CDC, 1999). The general clinical consensus is that if immunization practices ceased, most infectious and contagious diseases currently prevented by vaccinations would reemerge as lethal health threats. Potential for exposure to infectious disease is even greater with the increase in international travel. By ensuring proper immunization of children by the age of two, health plans can help contain the transmission of these diseases and help protect the general population.

Immunization is a critical aspect of preventive care. Lack of proper immunization lead to an increase in illness, doctor visits and hospitalizations, all of which translate into higher costs. The measles resurgence of 1989-1991, which cost $100 million in direct medical care costs, demonstrates the potential cost to the health care delivery system if the immunization system fails (Battelle, 1994b).

In 1998, the U.S. Centers for Disease Control estimated that without any vaccines there would have been over 500,000 measles related deaths in comparison to the 89 actual American cases. Furthermore, all of these cases were associated with international importations (CDC, 1999). This trend has been seen over the years as more of the population is vaccinated. However, the viruses and bacteria that cause vaccine-preventable diseases and deaths still exist and can be passed on to people who are not protected by vaccines. Immunizations are very important because they can protect people who are not immunized. The importance of vaccines is shown by the reappearance of diseases when immunization coverage drops (Kane, 2002). Vaccine-preventable diseases have a costly impact, resulting in doctor's visits, hospitalizations, and premature deaths. Sick children can also cause parents to lose time from work. Therefore, there is continued interest in strategies to increase immunization levels.

Clinical Recommendation Statements:
Concern over poor immunization rates has fostered a number of initiatives including, but not limited to, policy goals in Health People 2010. One of Healthy People 2010's objectives is to increase the proportion of providers who have measured the vaccination coverage levels among children in their practice population within the past two years (USDHHS, 2000).

Variations in immunization coverage exist among some populations. Children of lower socioeconomic status are slightly less likely to be fully immunized. According to data from the Center for Disease Control and Prevention's National Immunization Survey, white, non-Hispanic children are more likely to be fully immunized by 35 months of age than children of other race categories are. This difference in immunization rates, however, is small (0-9%) and the gap is narrowing (CDC, 2005).

Data show that in 2005 children living below the poverty level have lower immunization coverage rates as well (CDC, 2005). Although great progress has been made in improving childhood immunization rates, some disparities in overall immunization coverage rates among racial and ethnic groups still exist (NIP, 2003). This disparity is of great concern in large urban areas with underserved populations because of the potential for outbreaks of vaccine-preventable diseases. In the 2004 National Immunization Survey showed that first dose coverage for children 23 – 35 months was 54 percent for states for which the vaccination is recommended, while there is 27 percent coverage in states for which the vaccination is considered and 2 percent coverage for the rest of the United States (CDC MMWR Hepatitis A, 2006). In the United States, four of five children will have rotavirus gastroenteritis, one in seven will require a clinic or emergency department visit, one in 70 will be hospitalized, and one in 200,000 will die from the disease (CDC MMWR Rotavirus, 2006). A 2007 CDC study found across six demonstration states that less than 30 percent of children aged 6 – 23 months were fully vaccinated, with vaccination coverage for children 6 – 23 months ranging from 13.9 percent to 46.6 percent for children who received at least one dose and 3.0 percent to 26.9 percent for children who were fully vaccinated (CDC, 2007).

◆ **Measure NQF 0004:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:
(a) Initiation, (b) Engagement

Description: Percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment AND who had two or more additional services with an AOD diagnosis within 30 days of the initial visit

Denominator: Patients aged 13 years and older with a new episode of alcohol and other drug (AOD) dependence

Denominator Inclusion – Population Stratification 1: *(Patients aged 13-17)*

All patients between 13 and 17 years old at the beginning of the measurement period with a documented diagnosis of their first episode of alcohol or other drug (AOD) dependence during an encounter with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol or other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED
OR
ENCOUNTER OUTPATIENT BH
OR
ENCOUNTER ACUTE INPT
OR
ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPT BH REQ POS
WITH
Encounter Point of Service Modifier

AND

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for inclusion in this measure and are associated with the following data element(s):

ALCOHOL OR DRUG DEPENDENCE

OR

All patients between 13 and 17 years old at the beginning of the measurement period who had their <u>first</u> AOD *intervention* during an inpatient AOD admission (ENCOUNTER ACUTE INPT or ENCOUNTER NON-ACUTE INPATIENT) with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol or other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>ENCOUNTER ACUTE INPT</u>
OR
<u>ENCOUNTER NON-ACUTE INPATIENT</u>

AND

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS</u>

OR

All patients between 13 and 17 years old at the beginning of the measurement period who have their <u>first</u> AOD (DETOXIFICATION INTERVENTIONS) intervention during the first ten and a half months of the year. Patients presenting with a subsequent episode of alcohol or other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have an intervention within the first ten and a half months of the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>DETOXIFICATION INTERVENTIONS</u>

Denominator Inclusion – Population Stratification 2: *(Patients aged greater than or equal to 18)*

All patients greater than or equal to 18 years old at the beginning of the measurement period with a documented diagnosis of their <u>first</u> episode of alcohol or other drug (AOD) dependence during an encounter with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol or other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>ENCOUNTER ED</u>
OR
<u>ENCOUNTER OUTPATIENT BH</u>
OR
<u>ENCOUNTER ACUTE INPT</u>
OR
<u>ENCOUNTER NON-ACUTE INPATIENT</u>

OR

<u>ENCOUNTER OUTPT BH REQ POS</u>
WITH
Encounter Point of Service Modifier

AND

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>ALCOHOL OR DRUG DEPENDENCE</u>

OR

All patients greater than or equal to 18 years old at the beginning of the measurement period who had their <u>first</u> AOD *intervention* during an inpatient AOD admission (ENCOUNTER ACUTE INPT or ENCOUNTER NON-ACUTE INPATIENT) with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol or other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>ENCOUNTER ACUTE INPT</u>
OR
<u>ENCOUNTER NON-ACUTE INPATIENT</u>

AND

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS</u>

OR

All patients greater than or equal to 18 years old at the beginning of the measurement period who have their first AOD (DETOXIFICATION INTERVENTIONS) intervention during the first ten and a half months of the year. Patients presenting with a subsequent episode of alcohol or other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have an intervention within the first ten and a half months of the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DETOXIFICATION INTERVENTIONS

Denominator Inclusion – Population Stratification 3: *(Patients aged greater than or equal to 13)*

All patients greater than or equal to 13 years old at the beginning of the measurement period with a documented diagnosis of their first episode of alcohol or other drug (AOD) dependence during an encounter with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol or other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED
OR
ENCOUNTER OUTPATIENT BH
OR
ENCOUNTER ACUTE INPT
OR
ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPT BH REQ POS
WITH
Encounter Point of Service Modifier

AND

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL OR DRUG DEPENDENCE

OR

All patients greater than or equal to 13 years old at the beginning of the measurement period who had their first AOD *intervention* during an inpatient AOD admission (ENCOUNTER ACUTE INPT or ENCOUNTER NON-ACUTE INPATIENT) with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol or other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT
OR
ENCOUNTER NON-ACUTE INPATIENT

AND

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS

OR

All patients greater than or equal to 13 years old at the beginning of the measurement period who have their first AOD (DETOXIFICATION INTERVENTIONS) intervention during the first ten and a half months of the year. Patients presenting with a subsequent episode of alcohol or other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have an intervention within the first ten and a half months of the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DETOXIFICATION INTERVENTIONS

Numerator: Patients who initiated treatment within 14 days of the initial diagnosis of AOD or intervention for AOD <u>AND</u> had two or more additional services with an AOD diagnosis within 30 days of the initial visit

Numerator Inclusion – Criterion 1: *(<u>Initiation of Treatment</u> - Patients who initiated treatment within 14 days of the initial diagnosis of AOD or intervention for AOD)*

Patients who an AOD detoxification intervention and an inpatient admission (ENCOUNTER ACUTE INPT or ENCOUNTER NON-ACUTE INPATIENT) within 14 days after their <u>first</u> diagnosis of AOD or <u>first</u> intervention for AOD.

ENCOUNTERS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS</u>

AND

<u>ENCOUNTER ACUTE INPT</u>
OR
<u>ENCOUNTER NON-ACUTE INPATIENT</u>

OR

Patients who had an outpatient or inpatient visit (ENCOUNTER OUTPATIENT BH, ENCOUNTER ACUTE INPT, ENCOUNTER NON-ACUTE INPATIENT, or ENCOUNTER OUTPATIENT BH REQ POS with ENCOUNTER POINT OF SERVICE MODIFIER) within 14 days after their <u>first</u> diagnosis of AOD or <u>first</u> intervention for AOD.

ENCOUNTERS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

<u>ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS</u>

AND

<u>ENCOUNTER OUTPATIENT BH</u>
OR
<u>ENCOUNTER ACUTE INPT</u>
OR
<u>ENCOUNTER NON-ACUTE INPATIENT</u>

OR

<u>ENCOUNTER OUTPT BH REQ POS</u>
WITH
Encounter Point of Service Modifier

AND

Numerator Inclusion – Criterion 2: *(Engagement of Treatment - Patients who had two or more additional services with an AOD diagnosis within 30 days of the initial visit)*

> Patients with a diagnosis of AOD who had at least *two* of the following services and/or procedures (ENCOUNTER NON-ACUTE INPATIENT, ENCOUNTER ACUTE INPT, ENCOUNTER OUTPATIENT BH, ENCOUNTER OUTPT BH REQ POS with qualifying ENCOUNTER POINT OF SERVICE MODIFIER, or ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS) within 30 days of the Initiation of Treatment.
>
> ENCOUNTERS, PROBLEMS, PROCEDURES, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ALCOHOL OR DRUG DEPENDENCE
>
> AND
>
> ENCOUNTER OUTPATIENT BH
>
> OR
>
> ENCOUNTER ACUTE INPT
>
> OR
>
> ENCOUNTER NON-ACUTE INPATIENT
>
> OR
>
> ENCOUNTER OUTPT BH REQ POS
> WITH
> *Encounter Point of Service Modifier*
>
> OR
>
> ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS

Denominator Exclusions:

> None

Rationale:

There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance use and abuse places a huge burden on the health care system. According to a report from the 2001 National Household Survey on Drug Abuse (NHSDA), an estimated 16.6 million Americans aged 12 or older in 2001 were classified with dependence on or abuse of either alcohol or illicit drugs (7.3 percent of the total population). Of these, 2.4 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.2 million were dependent on or abused illicit drugs but not alcohol, and 11.0 million were dependent on or abused alcohol but not illicit drugs.(SAMHSA, 2002).

Clinical Recommendation Statements:

The identification of individuals with AOD (Alcohol and Other Drug) disorders is an important first step in the process of care. However, the identification of AOD disorders often does not routinely lead to the initiation of care. Reasons that an individual may not initiate treatment include the social stigma associated with AOD disorder, denial that there is an AOD problem, non-compliance to AOD treatment offered, or the lack of immediately available treatment services. This measure is designed to ensure that treatment is initiated once the need has been identified, and will permit comparison of effectiveness in initiating care.

Treatment engagement is defined as an intermediate step between initially accessing care (in the first visit) and completing a full course of treatment. Numerous studies have indicated that individuals who remain in treatment longer have improved outcomes. However, a 1990 Drug Service Research Survey has suggested that many clients (52%) with AOD disorders leave treatment prematurely. This measure is seen as an important intermediate indicator that is closely related to outcomes. In fact, studies have tied the frequency and intensity of engagement as important in treatment outcomes and reducing drug-related illnesses.

AOD problems left untreated, cause a significant burden that extends beyond individuals to their communities and to society. Empirical evidence links better outcomes to the identification and treatment of people with AOD disorders. This measure may influence performance by increasing screening for AOD problems in primary care settings and increasing communication between primary care and specialty providers. Moving forward, performance measures are needed to establish clear standards of accountability that, in turn, will lead to efforts to improve the quality of care for people with AOD disorders.

♣Measure NQF 0012: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)

Description: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal visit

Denominator: All patients, regardless of age, who gave birth during a 12-month period, seen for continuing prenatal care

Denominator Inclusions:

> All patients, regardless of age, who gave birth during the measurement period and were seen for prenatal care. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.
>> **NOTE:** *The prenatal visit must have occurred within 10 months prior to the date of delivery and after the estimated date of conception.*
>
> ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ESTIMATED DATE OF CONCEPTION
> AND
> PRENATAL VISIT
> AND
> DELIVERY LIVE BIRTHS-DIAGNOSIS
> AND
> DELIVERY LIVE BIRTHS-PROCEDURE

Numerator: Patients who were screened for HIV infection during the first or second prenatal visit

Numerator Inclusions:

> Patients who were screened for HIV infection during their first or second prenatal visit (PRENATAL VISIT) during the measurement period.
>
> PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> HIV SCREENING

Denominator Exclusions: *(Exclusions only applied if patient was not screened for HIV infection during the first or second prenatal visit)*

When HIV therapy is not prescribed during the first or second prenatal visit for a valid medical or patient reason, the appropriate screening that would have been done should be submitted along with a negation code (within 30 days of either the first or second PRENATAL VISIT) to indicate the reason the appropriate treatment was not done prior to delivery.

PROBLEMS, PROBLEMS(negation), PROCEDURES, PROCEDURES(negation), RESULTS, and RESULTS(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HIV SCREENING

AND

MEDICAL REASON
OR
PATIENT REASON

OR

Patients who currently has or has had a diagnosis of HIV before or during their second prenatal visit (PRENATAL VISIT).

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HIV

Rationale:

While the number of perinatally transmitted cases of HIV has decreased, perinatal transmission still accounts for the majority of new cases of HIV in children.

Benefits of knowing a woman's HIV status early on in pregnancy have been well documented and allow the health care provider to initiate treatment early on in the pregnancy, thereby decreasing the risk of transmission of HIV to the child.

Clinical Recommendation Statements:

Universal HIV testing with patient notification should be a routine component of prenatal care; however, this must be in accordance with current state laws (ACOG/AAP). PHS recommends that all pregnant women in the United States be tested for HIV infection. All health-care providers should recommend HIV testing to all of their pregnant patients, pointing out the substantial benefit of knowledge of HIV status for the health of women and their infants. HIV screening should be a routine part of prenatal care for all women (CDC). Clinicians should screen all pregnant women for HIV. There is good evidence that both standard and FDA-approved rapid screening tests accurately detect HIV infection in pregnant women and fair evidence that introduction of universal prenatal counseling and voluntary testing increases the proportion of HIV-infected women who are diagnosed and are treated before delivery (USPSTF) (A Recommendation).

♠Measure NQF 0014: Prenatal Care: Anti-D Immune Globulin

Description: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation

Denominator: All patients, regardless of age, who are D (Rh) negative and unsensitized who gave birth during a 12-month period, seen for continuing prenatal care

Denominator Inclusions:

All female patients, regardless of age, who are D (Rh) negative and unsensitized who gave birth to their first child (primgravida) during the measurement period and were seen for continuing prenatal care. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

> NOTE: *A prenatal visit must have occurred within 10 months prior to the date of delivery and after the estimated date of conception where the patient's pregnancy status (__primigravida__ or multigravida) was identified along with the* **patient's** *(RH STATUS MOTHER) D (Rh) status.*

ENCOUNTERS, PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ESTIMATED DATE OF CONCEPTION
AND
PRENATAL VISIT
AND
DELIVERY LIVE BIRTHS-DIAGNOSIS
AND
DELIVERY LIVE BIRTHS-PROCEDURE
AND
D(RH) NEGATIVE

OR

PRIMIGRAVIDA
AND

RH STATUS MOTHER
WITH
Negative

OR

All female patients, regardless of age, who are D (Rh) negative and unsensitized with another child who was already identified as being D (Rh) negative prior to giving birth to a child succeeding their first child (multigravida) during the measurement period and were seen for continuing prenatal care. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

> NOTE: *A prenatal visit must have occurred within 10 months prior to the date of delivery and after the estimated date of conception where the patient's pregnancy status (primigravida or* **multigravida***) was identified along with the* **patient's** *(RH STATUS MOTHER)* **and** **prior child's** *(RH STATUS BABY) D (Rh) status.*

ENCOUNTERS, PROBLEMS, PROCEDURES, FAMILY HISTORY, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ESTIMATED DATE OF CONCEPTION
AND
PRENATAL VISIT
AND
DELIVERY LIVE BIRTHS-DIAGNOSIS
AND
DELIVERY LIVE BIRTHS-PROCEDURE
AND
D(RH) NEGATIVE

OR

MULTIGRAVIDA
AND

RH STATUS MOTHER
WITH
Negative

AND

RH STATUS BABY
WITH
Negative

Numerator: Patients who received anti-D immune globulin at 26-30 weeks gestation

Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered Anti-D Immune Globulin during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if patient did not receive anti-D immune globulin at 26-30 weeks gestation)*

Patient who had one of the following conditions during the measurement period.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ANTI-D IMMUNE GLOBULIN DECLINED

OR

When Anti-D Immune Globulin therapy is not prescribed between the 26th and 30th week of pregnancy (based on the estimated date of conception) for a valid medical, patient or system reason, the appropriate therapy that would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate treatment was not prescribed prior to delivery.

MEDICATIONS, MEDICATIONS(negation), and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for Anti-D Immune Globulin medication.

AND

MEDICAL REASON
OR
PATIENT REASON
OR
SYSTEM REASON
OR
ANTI-D IMMUNE GLOBULIN DECLINED

AND

ESTIMATED DATE OF CONCEPTION

Rationale:

Rh sensitization is a serious complication of pregnancy that places the lives of both mother and child at risk. This complication can be avoided through the prophylactic administration of anti-D immune globulin.

Clinical Recommendation Statements:

Antibody tests can be repeated in an unsensitized, D-negative patient at 26-28 weeks gestation. She should also receive anti-D immune globulin prophylactically at that time. In addition, any unsensitzed, D-negative patient should receive anti-D immune globulin if she has one of the following conditions or procedures:

• Ectopic gestation
• Abortion (either threatened, spontaneous, or induced)
• Procedure associated with possible fetal-to-maternal bleeding, such as chorionic villus sampling (CVS) or amniocentesis
• Condition associated with fetal-maternal hemorrhage (eg, abdominal trauma, abruptio placentae)
• Delivery of a D-positive newborn(AAP/ACOG)(LevelA)

The USPSTF recommends the repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D)-negative (USPSTF) (B Recommendation).

◆ **Measure NQF 0018**: Controlling High Blood Pressure

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

Denominator: Patients aged 18 through 85 years with the diagnosis of hypertension

Denominator Inclusions:

All patients with a documented diagnosis of hypertension within the *first six months* of the measurement period and patient is between18 and 85 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT
AND
HYPERTENSION

AND NOT

Patients with a documented diagnosis of end stage renal disease (ESRD), who had a procedure indicative of ESRD or who are pregnant during the measurement period.

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ESRD
OR
PROCEDURES INDICATIVE OF ESRD
OR
PREGNANCY

Numerator: Patients whose most recent blood pressure < 140/90 mmHg

Numerator Inclusions:

Patients who had their blood pressure taken at the most recent visit during the measurement period and blood pressure measurement was less than 140/90 mmHg during the measurement period.

> NOTE: *Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.*

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SYSTOLIC BLOOD PRESSURE
WITH
Documentation of Systolic BP < 140 mm[Hg]

AND

DIASTOLIC BLOOD PRESSURE
WITH
Documentation of Diastolic BP < 90 mm[Hg]

Denominator Exclusions:

None

Rationale:

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

Clinical Recommendation Statements:

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

◆ **Measure NQF 0027:** Smoking and Tobacco Use Cessation, Medical Assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies

Description: Percentage of patients aged 18 years and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies

Denominator: All patients aged 18 years and older

Denominator Inclusions:

> All patients 18 years or older at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.
>
> ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER OUTPATIENT

Numerator: Patients who were identified as a current smoker or tobacco user AND received cessation, medical assistance

Numerator Inclusion:

> Patients identified as a current smoker or tobacco user during the measurement period.
>
> PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> TOBACCO USER

AND

> Smokers and tobacco users who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies received during the current measurement period.
>
> PROBLEMS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> TOBACCO USE CESSATION COUNSELING

Denominator Exclusions: *(Exclusions only applied if patient is not a current smoker or tobacco user)*

Patients identified as a current *non-tobacco user during the measurement period.
* Patients must be identified as BOTH a non-chewer and non-smoker

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list
applicable codes for this measure and are associated with the following data element(s):

NON CHEWER CODE
AND
NON SMOKER CODE

Rationale:

This measure assesses different facets of providing medical assistance with smoking cessation or tobacco use. Smoking is the leading preventable cause of premature death in the United States and is identified as a causal factor in more than 25 diseases and health problems (USDHHS 2004). In 2003, based on evidence that cessation strategies are effective in improving health outcomes, the USPSTF recommended that clinicians screen adults for tobacco use and provide tobacco cessation interventions. Interventions to control smoking are also strategically important because of the financial burden: approximately $167 billion in annual health related economic losses, when considered with other tobacco use causes. This measure facilitates efforts to implement recommended clinical practices and guidelines and subsequently reduce mortality rates and health problems related to smoking and tobacco use.

Clinical Recommendation Statements:

United States Preventative Services Task Force (USPSTF): The USPSTF guideline strongly recommends that clinicians screen all adult for tobacco use and provide tobacco cessation interventions for those who use tobacco products. The USPSTF found good evidence that brief smoking cessation interventions, including screening, brief behavioral counseling (less than 3 minutes), and pharmacotherapy delivered in primary care settings, are effective in increasing the proportion of smokers who successfully quit smoking and remain abstinent after 1 year.

Veterans' Affairs/Department of Defense: The VA/DoD's Clinical Practice Guideline for the Management of Tobacco Use recommends that any person (age greater than 12 years) who is eligible for care in the Veterans Health Administration (VHA) or the Department of Defense (DoD) health care delivery system should be screened for tobacco use and should be asked about tobacco use at most visits. Tobacco users should be advised to quit and assessed for willingness to quit at every visit. All tobacco users who are willing to quit should be offered an effective tobacco cessation intervention, including: pharmacotherapy, counseling, and follow-up. Tobacco users attempting to quit should be prescribed one or more effective first-line pharmacotherapies for tobacco use cessation. The guideline also cites strong evidence that minimal counseling (lasting less than three minutes) increases overall tobacco abstinence rates.

Public Health Service: The Public Health Service Clinical Practice Guideline recommends that clinicians engage in a number of activities to aid tobacco users in quitting, which include:

[1]Implement an officewide system that ensures that, for EVERY patient at EVERY clinic visit, tobacco-use status is queried and documented (repeated assessment is not necessary in the case of the adult who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record).
[2]In a clear, strong, and personalized manner, urge every tobacco user to quit.
[3]As every tobacco user if he or she is willing to make a quit attempt at this time (e.g., within the next 30 days).
[4]Provide practical counseling (problem solving/training).
[5]Recommend the use of approved pharmacotherapy, except in special circumstances.
[6]Provide supplementary materials.

Measure NQF 0032: Cervical Cancer Screening

Description: Percentage of women aged 21 through 63 years who received one or more Pap tests to screen for cervical cancer

Denominator: All female patients aged 21 through 63 years

Denominator Inclusions:

All female patients between 21 and 63 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OB/GYN
OR
ENCOUNTER OUTPATIENT

AND NOT

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HYSTERECTOMY

Numerator: Patients who had one or more Pap tests during the measurement year or within two years prior

Numerator Inclusions:

Female patients who had one or more Pap tests during the measurement period or within two years prior to the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PAP TEST

Denominator Exclusions:

None

Rationale:

American Cancer Society (ACS, Nov 2002): Test approximately 3 years after onset of vaginal intercourse, but no later than age 21; intervals annually, every 2-3 years for women >=30 with 3 negative cytology tests.

U. S. Preventive Services Task Force (USPSTF, Jan 2003): Test within 3 years of onset of sexual activity or age 21, whichever comes first; intervals of at least every 3 years.

American College of Obstetricians and Gynecologists (ACOG, Aug 2003): Approximately 3 years after onset of sexual intercourse, but no later than age 21; annually, every 2-3 years for women >=30 with 3 negative cytology tests.

Clinical Recommendation Statements:

This measure assesses the percentage of women in a specific age demographic who receive appropriate screening for cervical cancer. The American Cancer Society predicted that in 2009, nearly 11,270 women would be newly diagnosed with cervical cancer and 4,070 women would die of cervical cancer. The financial burden is also noteworthy: treatment for cervical cancer cost about $2 billion in 2004 (CDC). The American Cancer Society reported that screening can save lives, stating that the overall five-year survival rate for cervical cancer is nearly 71%, with a survival rate of 92% for detection in the earliest stage (2010). This evidence is corroborated by the fact that from 1955–1992, the mortality rate from cervical cancer declined by 74% because of screening. This measure facilitates efforts toward early detection of cervical cancer and acceleration of treatment upon diagnosis.

◆ **Measure NQF 0033:** Chlamydia Screening for Women

Description: Percentage of women aged 15 through 24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement year

Denominator: Female patients aged 15 through 24 years who were identified as sexually active

Denominator Inclusion – Population Stratification 1: *(Patients aged 15-24)*

> All female patients who were identified as sexually active and patient is between15 and 24 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.
>
> ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER OUTPATIENT

AND

> Female patients who ever had a procedure indicative of a sexually active woman, an IUD applied, an allergy to an IUD, contraceptive use education, laboratory tests indicative of sexually active women, or a diagnosis of being sexually active.
>
> PROBLEMS, PROCEDURES, RESULTS, PLAN OF CARE, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> PROCEDURES INDICATIVE OF SEXUALLY ACTIVE WOMEN
> OR
> IUD USE
> OR
> CONTRACEPTIVE USE EDUCATION
> OR
> LABORATORY TESTS INDICATIVE OF SEXUALLY ACTIVE WOMEN
> OR
> SEXUALLY ACTIVE WOMAN

OR

> When device was not used due to a patient allergy, the device that the patient is allergic to should be submitted along with a negation code to indicate the reason the treatment was not given during the measurement period.
>
> PROBLEMS, PROBLEMS(negation), PROCEDURES, and PROCEDURES(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> IUD USE
> AND
> DEVICE ALLERGY

OR

Female patients who had a pregnancy test performed, a pregnancy encounter, or contraceptives ordered during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY TEST
OR
ENCOUNTER PREGNANCY

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed contraceptives during the measurement period and DRUG_EXCLUSION = N.

Denominator Inclusion – Population Stratification 2: *(Patients aged 15-20)*

All female patients who were identified as sexually active and patient is between15 and 20 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

Female patients who ever had a procedure indicative of a sexually active woman, an IUD applied, an allergy to an IUD, contraceptive use education, laboratory tests indicative of sexually active women, or a diagnosis of being sexually active.

PROBLEMS, PROCEDURES, RESULTS, PLAN OF CARE, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PROCEDURES INDICATIVE OF SEXUALLY ACTIVE WOMEN
OR
IUD USE
OR
CONTRACEPTIVE USE EDUCATION
OR
LABORATORY TESTS INDICATIVE OF SEXUALLY ACTIVE WOMEN
OR
SEXUALLY ACTIVE WOMAN

OR

When device was not used due to a patient allergy, the device that the patient is allergic to should be submitted along with a negation code to indicate the reason the treatment was not given during the measurement period.

PROBLEMS, PROBLEMS(negation), PROCEDURES, and PROCEDURES(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

IUD USE
AND
DEVICE ALLERGY

OR

Female patients who had a pregnancy test performed, a pregnancy encounter, or contraceptives ordered during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY TEST
OR
ENCOUNTER PREGNANCY

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed contraceptives during the measurement period and DRUG_EXCLUSION = N.

Denominator Inclusion – Population Stratification 3: *(Patients aged 21-24)*

All female patients who were identified as sexually active and patient is between 21 and 24 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

Female patients who ever had a procedure indicative of a sexually active woman, an IUD applied, an allergy to an IUD, contraceptive use education, laboratory tests indicative of sexually active women, or a diagnosis of being sexually active.

PROBLEMS, PROCEDURES, RESULTS, PLAN OF CARE, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PROCEDURES INDICATIVE OF SEXUALLY ACTIVE WOMEN
OR
IUD USE
OR
CONTRACEPTIVE USE EDUCATION
OR
LABORATORY TESTS INDICATIVE OF SEXUALLY ACTIVE WOMEN
OR
SEXUALLY ACTIVE WOMAN

OR

When device was not used due to a patient allergy, the device that the patient is allergic to should be submitted along with a negation code to indicate the reason the treatment was not given during the measurement period.

PROBLEMS, PROBLEMS(negation), PROCEDURES, and PROCEDURES(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

IUD USE
AND
DEVICE ALLERGY

OR

Female patients who had a pregnancy test performed, a pregnancy encounter, or contraceptives ordered during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) n the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY TEST
OR
ENCOUNTER PREGNANCY

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed contraceptives during the measurement period and DRUG_EXCLUSION = N.

Numerator: Patients who had at least one chlamydia test during the measurement period

Numerator Inclusions:

Female patients who had at least one chlamydia test during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CHLAMYDIA SCREENING

Denominator Exclusions: *(Exclusions only applied if at least one chlamydia test was not performed during the reporting year)*

Female patients who received an x-ray study or a retinoid prescription within one week (seven days) after a pregnancy test is taken during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

X-RAY STUDY

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for female patients who were prescribed retinoid within in one week (seven days) after a pregnancy test is taken during the measurement period and DRUG_EXCLUSION = Y.

OR

Female patients who had a pregnancy test performed during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY TEST

Rationale:

This measure assesses appropriate screening for chlamydia among women in a specific age demographic. Chlamydia is one of the most frequently occurring sexually-transmitted diseases in the United States, resulting in over 2.8 million new cases each year. Women 14–30 are particularly susceptible and account for over 80% of new cases, according to the U.S. National Health and Nutrition Examination Survey. Additionally, heath care costs attributable to chlamydia and its complications exceed $3.5 billion per year in the U.S.. Early detection and treatment have proven to be effective in preventing and managing chlamydia. Several studies have shown that screening reduces overall disease prevalence by 4.2% and is strongly correlated with a reduced incidence of pelvic inflammatory disease (PID). This measure facilitates efforts toward early screening and treatment to improve health outcomes for infected women and prevent the spread of disease.

Clinical Recommendation Statements:

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians routinely screen all sexually active women aged 25 years and younger, and other asymptomatic women at increased risk for infection, for chlamydial infection. Rating: A recommendation (http://www.ahrq.gov/clinic/uspstf/uspschlm.htm).

The American Academy of Family Physicians (AAFP, 2005) strongly recommends screening all sexually active females age 25 years or younger and other women at increased risk for chlamydia.

American College of Preventive Medicine: Sexually active women with risk factors should be screened annually by any well-validated, laboratory-based amplification or antigen method, using cervical or urine specimens. Risk factors include age <=25 years, a new male sex partner or two or more partners during the preceding year, inconsistent use of barrier contraception, history of a prior sexually transmitted disease (STD), African-American race, and cervical ectopy. All partners of women with positive tests should be tested for Chlamydia trachomatis. Women with mucopurulent discharge, suggestive of cervicitis, should be tested immediately.

The American College of Obstetricians and Gynecologists recommends routine screening for chlamydial infection for all sexually active adolescents and other asymptomatic women at high risk for infection.

◆Measure NQF 0036: Use of Appropriate Medications for Asthma

Description: Percentage of patients aged 5 through 50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year

Denominator: Patients aged 5 through 50 years with a diagnosis of persistent asthma

Denominator Inclusions – Population Stratification 1: *(Patients aged 5-11)*

> Patients with a documented diagnosis of persistent asthma during the measurement period and patient is between 5 and 11 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face (ENCOUNTER ED or ENCOUNTER ACUTE INPT) visit with the eligible professional during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER ED
> OR
> ENCOUNTER ACUTE INPT
>
> AND
>
> ASTHMA

OR

> Patients between 5 and 11 years of age at the beginning of the measurement period with a documented diagnosis of persistent asthma who had at least four face-to-face (ENCOUNTER OUTPATIENT) visits during the measurement period and were prescribed a qualifying medication (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist) at least *two* times at any time in the patient's history.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER OUTPATIENT
>
> AND
>
> ASTHMA
>
> AND
>
> MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist at any time in the patient's history and DRUG_EXCLUSION = N.

OR

Patients between 5 and 11 years of age at the beginning of the measurement period who were prescribed a qualifying medication (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist) at least *four* times at any time in the patient's history.

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist at least *four* times at any time in the patient's history and DRUG_EXCLUSION = N.

OR

Patients with a documented diagnosis of persistent asthma during the measurement period and patient is between 5 and 11 years of age at the beginning of the measurement period and were prescribed the qualifying medication (leukotriene inhibitors) at least *four* times at any time in the patient's history.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ASTHMA

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed leukotriene inhibitors at least *four* times at any time in the patient's history and DRUG_EXCLUSION = N.

Denominator Inclusions – Population Stratification 2: *(Patients aged 12-50)*

Patients with a documented diagnosis of persistent asthma during the measurement period and patient is between 12 and 50 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face (ENCOUNTER ED or ENCOUNTER ACUTE INPT) visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED
OR
ENCOUNTER ACUTE INPT

AND

ASTHMA

OR

Patients between 12 and 50 years of age at the beginning of the measurement period with a documented diagnosis of persistent asthma who had at least *four* face-to-face (ENCOUNTER OUTPATIENT) visits during the measurement period and were prescribed a qualifying medication (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist) at least *two* times at any time in the patient's history.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

ASTHMA

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist at least *two* times at any time in the patient's history and DRUG_EXCLUSION = N.

OR

Patients between 12 and 50 years of age at the beginning of the measurement period who were prescribed a qualifying medication (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist) at least *four* times at any time in the patient's history.

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist at least *four* times at any time in the patient's history and DRUG_EXCLUSION = N.

OR

Patients with a documented diagnosis of persistent asthma during the measurement period and patient is between 12 and 50 years of age at the beginning of the measurement period and were prescribed the qualifying medication (leukotriene inhibitors) at least *four* times at any time in the patient's history.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ASTHMA

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed leukotriene inhibitors at least *four* times at any time in the patient's history and DRUG_EXCLUSION = N.

Denominator Inclusions – Population Stratification 3: *(Patients aged 5-50)*

Patients with a documented diagnosis of persistent asthma during the measurement period and patient is between 5 and 50 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face (ENCOUNTER ED or ENCOUNTER ACUTE INPT) visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED
OR
ENCOUNTER ACUTE INPT

AND

ASTHMA

OR

Patients between 5 and 50 years of age at the beginning of the measurement period with a documented diagnosis of persistent asthma who had at least four face-to-face (ENCOUNTER OUTPATIENT) visits during the measurement period and were prescribed a qualifying medication (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist) at least *two* times at any time in the patient's history.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

ASTHMA

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist at least *two* times at any time in the patient's history and DRUG_EXCLUSION = N.

OR

Patients between 5 and 50 years of age at the beginning of the measurement period who were prescribed a qualifying medication (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist) at least *four* times at any time in the patient's history.

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer, methylxanthines or short acting beta 2 agonist at least *four* times at any time in the patient's history and DRUG_EXCLUSION = N.

OR

Patients with a documented diagnosis of persistent asthma during the measurement period and patient is between 5 and 50 years of age at the beginning of the measurement period and were prescribed the qualifying medication (leukotriene inhibitors) at least *four* times at any time in the patient's history.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ASTHMA

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed leukotriene inhibitors at least *four* times at any time in the patient's history and DRUG_EXCLUSION = N.

Numerator: Patients who were appropriately prescribed asthma medication

Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, mast cell stabilizer or methylxanthines during the measurement period and DRUG_EXCLUSION = N.
> NOTE: *Long acting inhaled beta 2 agonist and short acting beta 2 agonist do not meet numerator compliance.*

Denominator Exclusions: *(Exclusions only applied if patients were not appropriately prescribed asthma medication)*

Patient who had one of the following conditions during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

COPD
OR
CYSTIC FIBROSIS
OR
EMPHYSEMA
OR
ACUTE RESPIRATORY FAILURE

Rationale:

This measure assesses the appropriate and timely use of medications for long-term control of asthma symptoms and offers meaningful and actionable information to health care providers and consumers. Asthma is the most common chronic childhood disease, affecting an estimated 6.2 million children and resulting in more than 6.5 million office visits, 500,000 hospitalizations, 1.51 million nonemergency outpatient department visits and 1.81 million ER visits for children and adults. In 1998, over $10 billion was spent on related medical expenditures in the United States. The financial and disease burden can be alleviated if patients have appropriate medications and medical management. This measure facilitates efforts toward effective disease management and prevention of traumatic outcomes.

Clinical Recommendation Statements:

The US DHHS National Asthma Education Program Expert Panel Report-2 recommends inhaled corticosteroids over other long-term control medications in improving asthma outcomes, with the acknowledgement of a potential but small risk of adverse events with use of inhaled corticosteroids. Bronchodilators (e.g., beta2-adrenergic agonists, methylxanthines) act to relieve the symptoms of the disease during acute events, but do not lead to long-term improvement. Studies cited by the Expert Panel Report 2002 Update demonstrate inhaled corticosteroids improve asthma control compared to as-needed beta2-agonists without any other long-term control medication. Therefore, disease management relies on the use of combination therapy including anti-inflammatory medications to ensure clinical improvement of patient care.

◆ **Measure NQF 0052:** Low Back Pain: Use of Imaging Studies

Description: Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis

Denominator: Patients aged 18 through 50 years with a diagnosis of low back pain

Denominator Inclusions:

All patients with the *first* documented diagnosis of low back pain during the measurement period and patient is between18 and 50 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED
OR
ENCOUNTER OUTPATIENT
OR
ENCOUNTER OUTPATIENT INCLUDING ORTHOPEDICS AND CHIRPORACTICS

AND

LOW BACK PAIN

AND NOT

Patients who had one of the following conditions during the current measurement period or year prior to the measurement period.

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CANCER
OR
TRAUMA
OR
IV DRUG ABUSE
OR
NEUROLOGIC IMPAIRMENT

OR

Patients who had a prior diagnosis of low back pain at any time in the patient's history.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LOW BACK PAIN

Numerator: Patients who did <u>not</u> have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis

Numerator Inclusions:

Patients who did not have an imaging study (plain X-ray, MRI, CT scan) performed within 28 days of the first diagnosis during the measurement period.

> **NOTE:** *This measure is intended to identify an overuse of imaging studies for patients with the first diagnosis of low back pain during the measurement period. The lack of IMAGING STUDY-SPINAL codes will indicate that the imaging study was not performed and will meet the quality action for this measure.*

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

IMAGING STUDY-SPINAL

Denominator Exclusions:

None

Rationale:

This measure assesses the percentage of patients in a specific age demographic who did not receive an imaging study (i.e., x-ray, MRI, CT scan) in the 28 days following a new episode of low back pain. Low back pain is the second most frequently listed reason for physician office visits. It is a common cause of lost productivity and absenteeism from work in the United States. The general consensus from literature reviews indicates that nearly half of American adults will experience low back pain in a year, and about two-thirds will suffer from it in their lifetime. Low back pain is particularly prevalent among men and women between 30 and 50 years of age, and most likely results from aging and an inactive lifestyle. Low back pain has a significant financial impact, costing an average of $8,000 per claim (Atlas, Devo 2001). This measure facilitates efforts toward improved musculoskeletal condition and individual quality of life.

Clinical Recommendation Statements:

Agency for Healthcare Policy and Research (AHCPR): Plain x-rays are not recommended for routine evaluation of patients with acute low back problems within the first month of symptoms unless a "red flag" [indicator of potentially serious spinal pathology or other nonspinal pathology] is noted on clinical examination. (Strength of evidence: B) Plain x-rays of the lumbar spine are recommended for ruling out fractures in patients with acute low back problems when any of the following red flags are present: recent significant trauma (any age), recent mild trauma (patient over age 50), history of prolonged steroid use, osteoporosis, patient over age 70. (Strength of evidence: C) Plain x-rays in combination with CBC and ESR may be useful for ruling out tumor or infection in patients with acute low back problems when any of the following red flags are present: prior cancer or recent infection, fever over 100 degrees F, IV drug abuse, prolonged steroid use, low back pain worse with rest, unexplained weight loss. (Strength of evidence: C). AHCPR recommendations reaffirmed by Jarvik and Deyo, 2002.

American Academy of Orthopaedic Surgeons/ North American Spine Society: When critical exclusionary diagnoses (eg, cauda equina syndrome, fracture, neoplasm, etc.) NOT suspected, plain lumbar spine x-rays recommended if non-specific lower back pain without radicular symptoms or lower back pain with radicular symptoms remains unresolved after 4-6 weeks of activity modification (e.g., medications, self-applied thermal modalities, etc.). (Evidence not rated)

American College of Radiology: Uncomplicated low back pain is a benign, self-limited condition that does not warrant any imaging studies. The vast majority of these patients are back to their usual activities in 30 days. The challenge for the clinician, therefore, is to distinguish that small segment within this large patient population that should be evaluated further because of suspicion of a more serious problem.

◆**Measure NQF 0105:** Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment

Description: The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.

Denominator: Patients 18 years and older diagnosed with a new episode of major depression and treated with antidepressant medication

Denominator Inclusions:

> All patients greater than or equal to 18 years of age as of May 1st of the year prior to the measurement period with a documented diagnosis of a new episode of major depression between May 1st of the previous year and April 30th of the measurement period AND who had an antidepressant prescribed within the thirty days prior and fourteen days after the new episode of major depression.
>
> PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> MAJOR DEPRESSION
>
> AND
>
> MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications within the thirty days prior and fourteen days after the new episode of major depression and DRUG_EXCLUSION = N.

OR

All patients greater than or equal to 18 years of age as of May 1st of the year prior to the measurement period with a documented diagnosis of a _new_ episode of major depression between May 1st of the previous year and April 30th of the measurement period during a face-to-face visit (ENCOUNTER ED or ENCOUNTER OUTPATIENT BH) or (ENCOUNTER POINT OF SERVICE MODIFIER with ENCOUNTER OUTPT BH REQ POS) with the eligible professional AND who had an antidepressant prescribed within the thirty days prior and fourteen days after the _new_ episode of major depression. To be eligible for performance calculations, patients must have at least two face-to-face visits (ENCOUNTER ED or ENCOUNTER OUTPATIENT BH) or (ENCOUNTER POINT OF SERVICE MODIFIER with ENCOUNTER OUTPT BH REQ POS) with the eligible professional between May 1st of the previous year and April 30th of the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MAJOR DEPRESSION

AND

ENCOUNTER ED
OR
ENCOUNTER OUTPATIENT BH
OR
ENCOUNTER OUTPT BH REQ POS
WITH
Encounter Point of Service Modifier

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications within the thirty days prior and fourteen days after the _new_ episode of major depression and DRUG_EXCLUSION = N.

OR

All patients greater than or equal to 18 years of age as of May 1st of the year prior to the measurement period with a documented diagnosis of a new episode of major depression between May 1st of the previous year and April 30th of the measurement period during a face-to-face visit (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER ACUTE INPT) with the eligible professional AND who had an antidepressant prescribed within the thirty days prior and fourteen days after the new episode of major depression. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER ACUTE INPT) with the eligible professional between May 1st of the previous year and April 30th of the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MAJOR DEPRESSION

AND

ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER ACUTE INPT

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications within the thirty days prior and fourteen days after the new episode of major depression and DRUG_EXCLUSION = N.

AND NOT

All patients greater than or equal to 18 years of age as of May 1st of the year prior to the measurement period with a diagnosis of major depression or depression any time prior to May 1st of the previous year OR who had an antidepressant prescribed during the ninety days prior to a first antidepressant prescription for a new episode of major depression.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MAJOR DEPRESSION

OR

DEPRESSION

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications during the ninety days prior to a first antidepressant prescription for a new episode of major depression and DRUG_EXCLUSION = N.

Numerator 1: Patients with an 84-day (12-week) acute treatment of antidepressant medication

Numerator Inclusions:

Patients who were prescribed or who were at the completion of an 84-day (12-week) acute treatment of antidepressant medication within the four months following a <u>new</u> episode of major depression.

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications for an 84-day acute treatment and DRUG_EXCLUSION = N.

AND

Numerator 2: Patients with a 180-day (6-month) continuation phase treatment of antidepressant medication

Numerator Inclusions:

Patients who were prescribed or who were at the completion of a 180-day (6-month) continuation phase treatment of antidepressant medication within the eight months following a <u>new</u> episode of major depression.

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications for a 180-day continuation phase treatment and DRUG_EXCLUSION = N.

Denominator Exclusions:

None

Rationale:

This multi-component measure assesses different facets of the successful pharmacological management of depression. Depression has a significant impact on patients' quality of life which includes: interference with completing work responsibilities, lack of motivation, and difficulty in concentrating, discomfort, and dealing with coworkers. Depression contributes significantly to poor disease outcomes and premature death. Studies have shown that increasing the intensity of depression treatment may be an important key to improvements in outcomes and cost-effectiveness and that appropriate therapy improves the daily functioning and overall health of patients with depression.

Clinical guidelines for depression stress the importance of effective clinical management in: increasing patients' medication compliance; monitoring treatment effectiveness by providers, and identifying and managing side effects. If pharmacological treatment is initiated, appropriate dosing and continuation of therapy through the acute and continuation phases decreases recurrence of depression. Thus, evaluation of length of treatment serves as an important indicator of success in promoting patient compliance with the establishment and maintenance of an effective medication regimen.

Clinical Recommendation Statements:

American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Major Depressive Disorder, 2000 revised, 2005 reviewed

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans. Treatment consists of an acute phase, during which remission is induced; a continuation phase, during which remission is preserved; and a maintenance phase, during which the susceptible patient is protected against the recurrence of a subsequent major depressive episode.

When pharmacotherapy is part of the treatment plan, it must be integrated with psychiatric management and any other treatments that are being provided. Patients who have started taking an antidepressant medication should be carefully monitored to assess their response to pharmacotherapy as well as the emergence of side effects, clinical condition and safety. (APA "I" Recommendation: Recommended with substantial clinical confidence)

Factors to consider when determining the frequency of patient monitoring include the severity of illness, the patient's cooperation with treatment, the availability of social supports, and the presence of co-morbid general medical problems. Visits should be frequent enough to monitor and address suicidality and to promote treatment adherence. In practice, the frequency of monitoring during the acute phase of pharmacotherapy can vary from once a week in routine cases to multiple times per week in more complex cases. Patients who have been treated with antidepressant medications in the acute phase should be maintained on these agents to prevent relapse. (APA "I" Recommendation: Recommended with substantial clinical confidence)

Reference: American Psychiatric Association practice guideline for the treatment of patients with major depressive disorder. Am J Psychiatry 2000 Apr;157(4 Suppl):1-45.

◆**Measure NQF 0575:** Diabetes Mellitus: Hemoglobin A1c Control (<8%)

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

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

Denominator Inclusions:

All patients with a documented diagnosis of diabetes at any time during the patient's history and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPATIENT or ENCOUNTER ED) with the eligible professional during the measurement period or at least two face-to-face visits (ENCOUTNER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period OR patient was prescribed a medication indicative of diabetes during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

AND

DIABETES

OR

MEDICATIONS tab(s) in the Downloadable Resource table lists applicable codes for patients who were prescribed medications indicative of diabetes during the measurement period and DRUG_EXCLUSION = N.

Numerator: Patients with a most recent HbA1c test < 8%

Numerator Inclusions:

Patients with a most recent HbA1c test < 8% during the measurement period.

RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

HbA1c TEST
WITH
Documentation of HbA1c < 8%

Denominator Exclusions: *(Exclusions only applied if the patient's most recent HbA1c test is not < 8%)*

Patients with a documented diagnosis of polycystic ovaries at any time during the patient's history who were prescribed medications indicative of diabetes during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

AND NOT

Diabetes patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

OR

Patients with a documented diagnosis of gestational diabetes or steroid induced diabetes who were prescribed medications indicative of diabetes during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

GESTATIONAL DIABETES
OR
STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

AND NOT

Diabetes patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT
OR
ENCOUNTER ED
OR
ENCOUNTER NON-ACUTE INPATIENT
OR
ENCOUNTER OUTPATIENT

Rationale:

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

Clinical Recommendation Statements:

American Geriatric Society:

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

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

American Diabetes Association:

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

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

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

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

☼**Measure #M119a:** Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed

This is a two-part measure which is paired with Measure #M119b: Preventive Care and Screening: Cholesterol – Risk-Stratified Fasting LDL. If the fasting LDL test is performed, #M119b *should* also be reported.

Description: Percentage of patients aged 20 through 79 years whose risk factors* have been assessed and a fasting LDL test has been performed
* Based on risk factors defined below

There are three criteria for this measure based on the patient's risk category.
1. Highest Level of Risk: Coronary Heart Disease (CHD) or CHD Risk Equivalent
2. Moderate Level of Risk: Multiple (2+) Risk Factors
3. Lowest Level of Risk: 0 or 1 Risk Factor

This measure will be calculated for each of the criteria as well as a composite performance rate for all patients aged 20 through 79 years who were seen by the eligible professional during the measurement period.

Denominator 1: All patients aged 20 through 79 years who have CHD or CHD Risk Equivalent

> **Denominator Inclusions 1 – Criteria #1 (*High Risk*):**

> All patients 20 through 79 years of age at the beginning of the measurement period who have CHD or CHD Risk Equivalent. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.
>
> ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> ENCOUNTER CODE
> AND
> CHD OR CHD RISK EQUIVALENT

Numerator 1: Patients who had a fasting LDL test performed during the measurement period

Numerator Inclusions 1 – (Fasting LDL test):

Patients who had a fasting LDL test performed during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE

OR

TOTAL CHOLESTEROL
AND
HIGH DENSITY LIPOPROTEIN (HDL)
AND
TRIGLYCERIDES

Denominator Exclusions 1: *(Exclusions only applied if the fasting LDL test is not performed during the measurement period)*

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY CODE
OR
TERMINAL ILLNESS
OR
PATIENT REASON

Denominator 2: All patients aged 20 through 79 years who have Multiple Risk Factors (2+) of the following: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL), Family History of Premature CHD, or Age (men ≥ 55; women ≥ 65)

Denominator Inclusions 2 – Criteria #2 (*Moderate Risk*):

All patients 20 through 79 years of age at the beginning of the measurement period with Multiple Risk Factors (≥2). To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

AND

All patients with two or more of the applicable risk factors including smoking, hypertension (diagnosis, blood pressure ≥ 140/90 mmHg, or antihypertension medications prescribed), HDL (<40 mg/dL)**, family history of CHD (Male first degree relative < 55 years old; Female first degree relative < 65 years), and age (men ≥ 45 years: women ≥ 55 years) during the measurement period.

**HDL-C ≥ or equal to 60 mg/dL subtracts 1 risk from the above (it is a negative risk factor)

PROBLEMS, SOCIAL HISTORY, FAMILY HISTORY, VITAL SIGNS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SMKG

OR

HYPERTENSION

OR

SYSTOLIC BLOOD PRESSURE
WITH
Documentation of Systolic Blood Pressure ≥ 140mm[Hg]

OR

DIASTOLIC BLOOD PRESSURE
WITH
Documentation of Diastolic Blood Pressure ≥ 90mm[Hg]

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antihypertensive medications during the measurement period and DRUG_EXCLUSION = N.

OR

HDL
WITH
Documentation of HDL <40 mg/dL

OR

FAMILY HISTORY CHD

Numerator 2: Patients who had a fasting LDL test performed during the measurement period

Numerator Inclusions 2:

Patients who had a fasting LDL test performed during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE

OR

TOTAL CHOLESTEROL
AND
HIGH DENSITY LIPOPROTEIN (HDL)
AND
TRIGLYCERIDES

Denominator Exclusions 2: *(Exclusions only applied if the fasting LDL test is not performed during the measurement period)*

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY CODE
OR
TERMINAL ILLNESS
OR
PATIENT REASON

Denominator 3: All patients aged 20 through 79 years who have 0 or 1 risk factors

Denominator Inclusions 3 – Criteria #3 (*Low Risk*):

All patients 20 through 79 years of age at the beginning of the measurement period with 0 or exactly 1 risk factor. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

AND

All patients with zero or exactly one of the applicable risk factors including smoking, hypertension (diagnosis, blood pressure ≥ 140/90 mmHg, or antihypertension medications prescribed), HDL (<40 mg/dL)**, family history of CHD (Male first degree relative < 55 years old; Female first degree relative < 65 years), and age (men ≥ 45 years: women ≥ 55 years) during the measurement period.

**HDL-C ≥ or equal to 60 mg/dL subtracts 1 risk from the above (it is a negative risk factor)

PROBLEMS, SOCIAL HISTORY, FAMILY HISTORY, VITAL SIGNS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SMKG

OR

HYPERTENSION

OR

SYSTOLIC BLOOD PRESSURE
WITH
Documentation of Systolic Blood Pressure ≥ 140mm[Hg]

OR

DIASTOLIC BLOOD PRESSURE
WITH
Documentation of Diastolic Blood Pressure ≥ 90mm[Hg]

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antihypertensive medications during the measurement period and DRUG_EXCLUSION = N.

OR

HDL
WITH
Documentation of HDL <40 mg/dL

OR

FAMILY HISTORY CHD

Numerator 3: Patients who had a fasting LDL test performed during the measurement period or four years prior to the measurement period

Numerator Inclusions 3:

> Patients who had a fasting LDL test performed during the measurement period or four years prior to the measurement period.
>
> PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> LDL CODE
>
> OR
>
> TOTAL CHOLESTEROL
> AND
> HIGH DENSITY LIPOPROTEIN (HDL)
> AND
> TRIGLYCERIDES

Denominator Exclusions 3: *(Exclusions only applied if the fasting LDL test is not performed during the measurement period)*

> PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):
>
> PREGNANCY CODE
> OR
> TERMINAL ILLNESS
> OR
> PATIENT REASON

☼Measure #M119b: Preventive Care and Screening: Cholesterol – Risk-Stratified Fasting LDL

This is a two-part measure which is paired with Measure #M119a: Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed. If the fasting LDL results are documented, #M119a should also be reported.

Description: Percentage of patients aged 20 through 79 years who had a fasting LDL test performed and whose risk-stratified* fasting LDL is at or below the recommended LDL goal
Based on risk factors defined below and on the calculation of the Framingham Risk Score

There are three criteria for this measure based on the patient's risk category.
1. Highest Level of Risk: Coronary Heart Disease (CHD) or CHD Risk Equivalent OR Multiple Risk Factors (2+) and 10-year Framingham risk >20%
2. Moderate Level of Risk: Multiple (2+) Risk Factors and 10-year Framingham risk ≤20%
3. Lowest Level of Risk: 0 or 1 Risk Factor

This measure will be calculated for each of the criteria as well as a composite performance rate for all patients aged 20 through 79 years who were seen by the eligible professional during the measurement period.

Denominator 1: All patients aged 20 through 79 years who had a fasting LDL test performed and have CHD or CHD Risk Equivalent OR Multiple Risk Factors (2+) and 10-year Framingham risk >20%

Denominator Inclusions 1 – Criteria #1 (*High Risk*):

All patients 20 through 79 years of age at the beginning of the measurement period who had a fasting LDL test performed and have either CHD (or CHD Risk Equivalent) OR Multiple Risk Factors (2+) and 10-year Framingham risk >20%. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE
AND

LDL CODE

OR

TOTAL CHOLESTEROL

AND

HIGH DENSITY LIPOPROTEIN (HDL)

AND

TRIGLYCERIDES

AND

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CHD OR CHD RISK EQUIVALENT

OR

All patients with two or more of the applicable risk factors including smoking, hypertension (diagnosis, blood pressure ≥ 140/90 mmHg, or antihypertension medications prescribed), HDL (<40 mg/dL)**, family history of CHD (Male first degree relative < 55 years old; Female first degree relative < 65 years), and age (men ≥ 45 years: women ≥ 55 years) during the measurement period.

**HDL-C ≥ or equal to 60 mg/dL subtracts 1 risk from the above (it is a negative risk factor)

PROBLEMS, SOCIAL HISTORY, FAMILY HISTORY, VITAL SIGNS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SMKG

OR

HYPERTENSION

OR

SYSTOLIC BLOOD PRESSURE
WITH
Documentation of Systolic Blood Pressure ≥ 140mm[Hg]

OR

DIASTOLIC BLOOD PRESSURE
WITH
Documentation of Diastolic Blood Pressure ≥ 90mm[Hg]

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antihypertensive medications during the measurement period and DRUG_EXCLUSION = N.

OR

HDL
WITH
Documentation of HDL <40 mg/dL

OR

FAMILY HISTORY CHD

AND

Patients with a 10-year Framingham Risk Score >20%. The Framingham Risk Score will be calculated based on the following patient data received (along with age and gender) and will follow the Adult Treatment Panel (ATP) III Guidelines.

PROBLEMS, RESULTS, VITAL SIGNS, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

TOTAL CHOLESTEROL
WITH
Documentation of Total Cholesterol in mg/dL

AND

SMKG STATUS

AND

HIGH DENSITY LIPOPROTEIN (HDL)
WITH
Documentation of HDL in mg/dL

AND

SYSTOLIC BLOOD PRESSURE
WITH
Documentation of Systolic BP in mm[Hg]

Numerator 1: Patients whose most recent fasting LDL test is <100 mg/dL

Numerator Inclusions 1:

Patients whose most recent fasting LDL test is <100 mg/dL during the measurement period.

> **NOTE:** *LDL results are acceptable if directly reported (LDL CODE) from the laboratory, or if the other elements (TRIGLYCERIDES, TOTAL CHOLESTEROL, and HIGH DENSITY LIPOPROTEIN (HDL)) listed below are submitted and triglyceride value is ≤ 400 mg/dL. Directly reported values or calculated LDL values must be less than 100 mg/dL for Numerator Inclusion purposes.*
>
> > *LDL value = [TOTAL CHOLESTEROL value –*
> > *HIGH DENSITY LIPOPROTEIN (HDL) value –*
> > *(TRIGLYCERIDE value/5)]*

RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE
WITH
Documentation of LDL <100 mg/dL

OR

TOTAL CHOLESTEROL
WITH
Documentation of Total Cholesterol in mg/dL

AND

HIGH DENSITY LIPOPROTEIN (HDL)
WITH
Documentation of HDL in mg/dL

AND

TRIGLYCERIDES
WITH
Documentation of Triglycerides ≤ 400 mg/dL

Denominator Exclusions 1: *(Exclusions only applied if the fasting LDL test is not performed during the measurement period)*

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY CODE
OR
TERMINAL ILLNESS
OR
PATIENT REASON

Denominator 2: All patients aged 20 through 79 years who had a fasting LDL test performed and have Multiple Risk Factors (2+) and 10-year Framingham risk ≤20%

Denominator Inclusions 2 – Criteria #2 (*Moderate Risk*):

All patients 20 through 79 years of age at the beginning of the measurement period who had a fasting LDL test performed and Multiple Risk Factors (2+) and 10-year Framingham risk ≤20%. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

AND

LDL CODE

OR

TOTAL CHOLESTEROL
AND
HIGH DENSITY LIPOPROTEIN (HDL)
AND
TRIGLYCERIDES

AND

All patients with two or more of the applicable risk factors including smoking, hypertension (diagnosis, blood pressure ≥ 140/90 mmHg, or antihypertension medications prescribed), HDL (<40 mg/dL)**, family history of CHD (Male first degree relative < 55 years old; Female first degree relative < 65 years), and age (men ≥ 45 years: women ≥ 55 years) during the measurement period.

**HDL-C ≥ or equal to 60 mg/dL subtracts 1 risk from the above (it is a negative risk factor)

PROBLEMS, SOCIAL HISTORY, FAMILY HISTORY, VITAL SIGNS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SMKG

OR

HYPERTENSION

OR

SYSTOLIC BLOOD PRESSURE
WITH
Documentation of Systolic Blood Pressure ≥ 140mm[Hg]

OR

DIASTOLIC BLOOD PRESSURE
WITH
Documentation of Diastolic Blood Pressure ≥ 90mm[Hg]

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antihypertensive medications during the measurement period and DRUG_EXCLUSION = N.

OR

HDL
WITH
Documentation of HDL <40 mg/dL

OR

FAMILY HISTORY CHD

AND

Patients with a 10-year Framingham Risk Score ≤20%. The Framingham Risk Score will be calculated based on the following patient data received (along with age and gender) and will follow the Adult Treatment Panel (ATP) III Guidelines.

PROBLEMS, RESULTS, VITAL SIGNS, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

TOTAL CHOLESTEROL
WITH
Documentation of Total Cholesterol in mg/dL

AND

SMKG STATUS

AND

HIGH DENSITY LIPOPROTEIN (HDL)
WITH
Documentation of HDL in mg/dL

AND

SYSTOLIC BLOOD PRESSURE
WITH
Documentation of Systolic BP in mm[Hg]

Numerator 2: Patients whose most recent fasting LDL test is <130 mg/dL

Numerator Inclusions 2:

Patients whose most recent fasting LDL test is <130 mg/dL during the measurement period.

> **NOTE:** *LDL results are acceptable if directly reported (LDL CODE) from the laboratory, or if the other elements (TRIGLYCERIDES, TOTAL CHOLESTEROL, and HIGH DENSITY LIPOPROTEIN (HDL)) listed below are submitted and triglyceride value is ≤ 400 mg/dL. Directly reported values or calculated LDL values must be less than 100 mg/dL for Numerator Inclusion purposes.*
>
> **LDL value = [TOTAL CHOLESTEROL value –**
> **HIGH DENSITY LIPOPROTEIN (HDL) value –**
> **(TRIGLYCERIDE value/5)]**

RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE
WITH
Documentation of LDL <130 mg/dL

OR

TOTAL CHOLESTEROL
WITH
Documentation of Total Cholesterol in mg/dL

AND

HIGH DENSITY LIPOPROTEIN (HDL)
WITH
Documentation of HDL in mg/dL

AND

TRIGLYCERIDES
WITH
Documentation of Triglycerides ≤ 400 mg/dL

Denominator Exclusions 2: *(Exclusions only applied if the fasting LDL test is not performed during the measurement period)*

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY CODE
OR
TERMINAL ILLNESS
OR
PATIENT REASON

Denominator 3: All patients aged 20 through 79 years who have 0 or 1 risk factors

Denominator Inclusions 3 – Criteria #3 (*Low Risk*):

All patients 20 through 79 years of age at the beginning of the measurement period with 0 or exactly 1 risk factor. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

AND

LDL CODE

OR

TOTAL CHOLESTEROL
AND
HIGH DENSITY LIPOPROTEIN (HDL)
AND
TRIGLYCERIDES

AND

All patients with zero or exactly one of the applicable risk factors including smoking, hypertension (diagnosis, blood pressure ≥ 140/90 mmHg, or antihypertension medications prescribed), HDL (<40 mg/dL)**, family history of CHD (Male first degree relative < 55 years old; Female first degree relative < 65 years), and age (men ≥ 45 years: women ≥ 55 years) during the measurement period.

**HDL-C ≥ or equal to 60 mg/dL subtracts 1 risk from the above (it is a negative risk factor)

PROBLEMS, SOCIAL HISTORY, FAMILY HISTORY, VITAL SIGNS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SMKG

OR

HYPERTENSION

OR

SYSTOLIC BLOOD PRESSURE
WITH
Documentation of Systolic Blood Pressure ≥ 140mm[Hg]

OR

DIASTOLIC BLOOD PRESSURE
WITH
Documentation of Diastolic Blood Pressure ≥ 90mm[Hg]

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antihypertensive medications during the measurement period and DRUG_EXCLUSION = N.

OR

HDL
WITH
Documentation of HDL <40 mg/dL

OR

FAMILY HISTORY CHD

Numerator 3: Patients whose most recent fasting LDL test is <160 mg/dL

Numerator Inclusions 3:

Patients whose most recent fasting LDL test is <160 mg/dL during the measurement period or four years prior to the measurement period.

> **NOTE**: *LDL results are acceptable if directly reported (LDL CODE) from the laboratory, or if the other elements (TRIGLYCERIDES, TOTAL CHOLESTEROL, and HIGH DENSITY LIPOPROTEIN (HDL)) listed below are submitted and triglyceride value is ≤ 400 mg/dL. Directly reported values or calculated LDL values must be less than 100 mg/dL for Numerator Inclusion purposes.*

> *LDL value = [TOTAL CHOLESTEROL value –*
> *HIGH DENSITY LIPOPROTEIN (HDL) value –*
> *(TRIGLYCERIDE value/5)]*

RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE
WITH
Documentation of LDL <160 mg/dL

OR

TOTAL CHOLESTEROL
WITH
Documentation of Total Cholesterol in mg/dL

AND

HIGH DENSITY LIPOPROTEIN (HDL)
WITH
Documentation of HDL in mg/dL

AND

TRIGLYCERIDES
WITH
Documentation of Triglycerides ≤ 400 mg/dL

Denominator Exclusions 3: *(Exclusions only applied if the fasting LDL test is not performed during the measurement period)*

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY CODE
OR
TERMINAL ILLNESS
OR
PATIENT REASON

Rationale:

The Agency for Healthcare Research and Quality (AHRQ) conducts systematic evidence reviews prior to recommendations issued by the U.S. Preventive Services Task Force (USPSTF). In the systematic evidence review, *Screening for Lipid Disorders*, (Pignone MP, Phillips CJ, Lannon CM, et al. Screening for Lipid Disorders, Systematic Evidence Review No.4 (Prepared by the Research Triangle Institute. University of North Carolina Evidence-based Practice Center, under contract No. 290-98-0011. AHRQ Publication No. AHRQ 01-S004. Rockville, MD: Agency for Healthcare Research and Quality. April 2001.), "Coronary Heart Disease (CHD) was identified as the leading cause of morbidity and mortality in the United States, causing nearly 500,000 deaths each year and requiring nearly 12 million hospital days of care per year. It is the leading cause of disabled life-years and is second only to injuries as a cause of life-years lost. The age-adjusted annual death rate for CHD is 100 per 100,000 persons overall and 140 per 100,000 persons among African Americans. The lifetime risk of having a CHD event, calculated at age 40, is estimated to be 49% for men and 32% for women in the United States. CHD accounted for $78 billion in health care costs in 1995."

The risk of CHD is independently related to several potentially modifiable risk factors besides abnormal lipids, including smoking, diabetes, hypertension, and physical inactivity. Recent epidemiologic studies and basic science research expanded knowledge about several new potential CHD risk factors. Use of a Framingham risk-based algorithm that directly incorporates age, the presence and magnitude of other risk factors, and measures of total cholesterol and HDL is the most accurate approach. "Screening for lipid disorders by measuring cholesterol levels in adult patients is quite feasible for physicians because it involves ordering only a blood test. Providers appear to have achieved high levels of lipid screening based on population-based patient survey data." (AHRQ, 2001) This systematic review recommends using a supplemental table to improve the feasibility of a risk-based strategy.

The primary recommendation of several advisory bodies state adults should undergo an office-based assessment as the first step to identify patients at a higher CHD risk. The National Cholesterol Education Program Panel III (NCEP-III) has adopted using an adaptation of the risk prediction algorithm originating from the Framingham Heart Study estimating a patient's 10-year risk for developing CHD and has recommended its' use as the primary goal of preventive treatment. Stratifying CHD risk includes determining if CHD is present as well as CHD risk equivalents and major CHD risk factors. A history of CHD includes myocardial infarction, myocardial ischemia, angina (stable, unstable), percutaneous transluminal coronary angioplasty & coronary artery bypass surgery. CHD risk equivalents include peripheral artery disease, abdominal aortic aneurysm, thrombotic stroke, transient ischemic attacks, diabetes & Framingham 10-yr CHD risk > 20%. Major CHD risk factors include age, yr (men ≥ 45; women ≥ 55), cigarette smoking, hypertension (BP ≥140/90 mm Hg) or anti hypertensive medication, Low HDL-C (<40 mg/dL) & negative risk factor: high HDL-C (>60 mg/dL). The Framingham risk categories include gender, age, systolic blood pressure, smoking status, total cholesterol, and HDL-C levels.
A potential limitation of the NCEP-III guidelines is the underestimation of risk in young individuals and women, as highlighted in previous reports. While the NCEP Panel III guidelines are generally valuable in predicting CVD, etc., they may under-predict the risk for relatively young persons (men under age 55 and women under age 65) and women in general. This is further supported by Akosah et al. (2003) that "75% of 222 asymptomatic young adults presenting with their first and unheralded myocardial infarction would not have been considered candidates for statin therapy in the days preceding the event, and the finding by Hecht et al. (2001) "that only 59% of 304 asymptomatic women submitted to EBT screening were correctly identified by NCEP guidelines as either high or low risk."

In multiple clinical trials, greater LDL-C reduction in both primary and secondary prevention populations can achieve greater reductions in relative risk of CHD. The Adult Treatment Panel (ATP)-II and ATP-III goals were adjusted downward to the current recommendations (Grundy, 2008).

Clinical Recommendation Statements:

Routine cholesterol testing should begin in young adulthood (≥20 years of age). When LDL cholesterol concentrations range from 100–129 mg/dL, young adults should be encouraged to modify life habits to minimize long-term risk. In those with borderline high LDL cholesterol (130–159 mg/dL), clinical attention through therapeutic lifestyle changes is needed both to lower LDL cholesterol and to minimize other risk factors. If LDL cholesterol is high (160–189 mg/dL), more intensive clinical intervention should be initiated, with emphasis on therapeutic lifestyle changes.

However, if LDL cholesterol remains elevated despite therapeutic lifestyle changes, particularly when LDL cholesterol is ≥190 mg/dL, consideration should be given to long-term management with LDL-lowering drugs.

ATP III recognizes that detection of cholesterol disorders and other coronary heart disease (CHD) risk factors occurs primarily through clinical case finding. Risk factors can be detected and evaluated as part of a person's work-up for any medical problem. Alternatively, public screening programs can identify risk factors, provided that affected individuals are appropriately referred for physician attention. The identification of cholesterol disorders in the setting of a medical examination has the advantage that other cardiovascular risk factors—including prior CHD, PVD, stroke, age, gender, family history, cigarette smoking, high blood pressure, diabetes mellitus, obesity, physical inactivity—co-morbidities, and other factors can be assessed and considered prior to treatment.
National Cholesterol Education Program
National Heart, Lung, and Blood Institute
National Institutes of Health
NIH Publication No. 02-5215
September 2002

The U.S. Preventive Services Task Force (USPSTF), 2008 strongly recommends screening men aged 35 and older for lipid disorders.

> The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.
> The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
> The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.
> The USPSTF makes no recommendation for or against routine screening for lipid disorders in men aged 20 to 35, or in women aged 20 and older who are not at increased risk for coronary heart disease.

The National Strategy for Quality Improvement in Health Care for 2011 has identified the promotion of the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease as one of its' national priorities. These priorities are based on the most recent research as well as stakeholder input. Opportunities for success include increase blood pressure control in adults, reduced high cholesterol levels in adults, and decrease smoking among adults and adolescents. Illustrative measures include:

- Percentage of patients ages 18 years and older with ischemic vascular disease whose most recent blood pressure during the measurement year is <140/90 mm Hg
- Percentage of patients with ischemic vascular disease whose most recent low-density cholesterol is <100
- Percentage of patients who received evidence-based smoking cessation services (e.g., medications)

The U.S. Department of Health and Human Service's Healthy People 2020 has set a target of 82.1% for HDS-6 : Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years (a 10% improvement over the next decade).

2012 EHR Measure Specifications
COPYRIGHTS

The following notice applies to each of the measures that contain a diamond (◆) before the title:

NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged and the measure developers have agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care providers in connection with their own practices is not commercial use. Commercial use of a measure does require the prior written consent of the measure developer. As used herein, a "commercial use" refers to any sale, license, or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed, or distributed for commercial gain, (even if there is no actual charge for inclusion of the measure.)

These performance measure were developed and are owned by the National Committee for Quality Assurance ("NCQA"). These performance measures are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures. NCQA holds a copyright in this measure and can rescind or alter this measure at any time. Users of the measure shall not have the right to alter, enhance, or otherwise modify the measure and shall not disassemble, recompile, or reverse engineer the source code or object code relating to the measure. Anyone desiring to use or reproduce the measure without modification for a noncommercial purpose may do so without obtaining any approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA. ©2004 National Committee for Quality Assurance, all rights reserved.

Performance measures developed by NCQA for CMS may look different from the measures solely created and owned by NCQA.

The following notice applies to each of the measures that contain a triangle (▲) before the title:

Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND

© 2008 American Medical Association. All Rights Reserved

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

THE SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

CPT® contained in the Measures specifications is copyright 2011 American Medical Association.