2016 Group Practice Reporting Option (GPRO) Web Interface

Narrative Measure Specifications

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2016 GPRO Web Interface
Narrative Measure Specifications

Introduction

Group Practice Reporting Option (GPRO) Web Interface is a reporting mechanism that incorporates some characteristics and methods from the Medicare Care Management Performance (MCMP) and Physician Group Practice (PGP) demonstration projects. In order to participate via the 2016 GPRO Web Interface, group practices are required to meet certain technical requirements.

There are a total of 18 individual measures included in the 2016 GPRO Web Interface targeting high-cost chronic conditions, preventive care, and patient safety. The measure specifications are grouped into six disease modules and 10 patient care measures: Care Coordination/Patient Safety (CARE) (two measures); Coronary Artery Disease (CAD) Module (one measure); Diabetes Mellitus (DM) Module (one composite consisting of two measures); Heart Failure (HF) Module (one measure); Hypertension (HTN) Module (one measure); Ischemic Vascular Disease (IVD) Module (one measure); Mental Health (MH) Module (one measure), and Preventive Care (PREV) (nine measures).

NOTE: The Depression Remission at 12 Months measure (MH-1) requires the use of the PHQ-9 screening tool

The GPRO Web Interface, pre-populated with a sample of assigned beneficiaries and certain quality measures data, will serve as the data collection tool for group practices to use in collecting and submitting data to the Centers for Medicare & Medicaid Services (CMS). The data collected will be based on services furnished during the January 1, 2016 through December 31, 2016 measurement period. **For the GPRO Web Interface reporting mechanism, patient age is determined during the sampling process. Patients must meet each measure/module age criteria by January 1 of the measurement period.**

This manual contains specific guidance for reporting 2016 GPRO Web Interface measures. Only those measures defined in this document can be utilized when reporting via the GPRO Web Interface mechanism. This manual describes how to implement 2016 reporting of GPRO Web Interface measures to facilitate satisfactory reporting of quality-data by group practices who wish to participate in the GPRO Web Interface reporting mechanism. Supplementary documents which provide additional guidance and describe how to implement 2016 GPRO Web Interface reporting can be found on the CMS website under GPRO Web Interface Option: GPRO Web Interface at CMS

Narrative Measure Specifications are being provided to allow group practices an opportunity to better understand each of the 18 individual measures included in the 2016 GPRO Web Interface mechanism. Once a group practice registers for the 2016 GPRO Web Interface reporting mechanism, additional detailed information will be provided.

Each Narrative Measure Specification Includes the Following Information:

- Symbol identifying measure developer and measure title
- NQF number (if applicable to measure)
- Description
- Improvement Notation*
- Initial Population
- Denominator
- Denominator Exclusions**
- Denominator Exceptions**
- Numerator
- Numerator Exclusions**
- Definition
- Guidance
- Rationale
- Clinical Recommendation Statements or evidence forming the basis for supporting criteria for the measure

NOTE: Specific definitions of data elements can be found in the Guide for Reading EP and EH eMeasures. This document is posted at CMS Guide for Reading EP Hospital eCQMS

*For the purposes of the 2016 GPRO Narrative Specifications, the Improvement Notation is provided only when there is a corresponding electronic clinical quality measure (eCQM). Conceptually the Improvement Notation is known for all 18 measures within the GPRO Web Interface: A higher score indicates better quality in all measures with the sole exception of DM-2. DM-2 is considered an inverse measure and a lower score indicates better quality.

**The Denominator and Numerator Exclusions/Exceptions data elements will be represented as “None” for measures that have proportion or ratio eCQMs and “Not Applicable” for continuous variable eCQMs, when the measure does not have a corresponding eCQM, or the information is not present or available in the eCQM.

Measures that do not have a corresponding eCQM are identified in the Narrative Specification with “This measure does not have a corresponding eCQM”.

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

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

IMPROVEMENT NOTATION:
A higher score indicates better quality

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

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
None

DENOMINATOR EXCEPTIONS:
Documentation of medical reason(s) for not screening for fall risk (eg, patient is not ambulatory)

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

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITIONS:
Future fall risk: Patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year.
Fall: A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

GUIDANCE:
None

RATIONALE:
As the leading cause of both fatal and nonfatal injuries for older adults, falls are one of the most common and significant health issues facing people aged 65 years or older (Schneider, Shubert and Harmon 2010).

Moreover, the rate of falls increases with age (Dykes et al. 2010). Older adults are five times more likely to be hospitalized for fall-related injuries than any other cause-related injury. It is estimated that one in every three adults over 65 will fall each year (Centers for Disease Control and Prevention 2012). In those over age 80, the rate of falls increases to fifty percent (Doherty et al. 2009). Falls are also associated with substantial cost and resource use, approaching $30,000 per fall hospitalization (Woolcott et al. 2011). Identifying at-risk patients is the most important part of management, as applying preventive measures in this vulnerable population can have a profound effect on public health (al-Aama 2011). Family physicians have a pivotal role in screening older patients for risk of falls, and applying preventive strategies for patients at risk (al-Aama 2011).

CLINICAL RECOMMENDATION STATEMENTS:
All other persons who are under the care of a health professional (or their caregivers) should be asked at least once a year about falls. (AGS/BGS/AAOS)

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

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

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

♠ CARE-3 (NQF 0419): Documentation of Current Medications in the Medical Record

DESCRIPTION:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL POPULATION:
All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
None

DENOMINATOR EXCEPTIONS:
Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR:
Eligible professional attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosages, frequency and route of administration

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITIONS:
Current Medications: Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.
Route: Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical).

GUIDANCE:
This measure is to be reported for every encounter during the measurement period.

Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.

This list must include all prescriptions, over-the-counter (OTC) products, herbals, vitamins, minerals, dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

This measure should also be reported if the eligible professional documented the patient is not currently taking any medications.

By reporting the action described in this measure, the provider attests to having documented a list of current medications utilizing all immediate resources available at the time of the encounter.

RATIONALE:

In the American Medical Association's (AMA) Physician's Role in Medication Reconciliation (2007), critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

As identified by The Agency for Healthcare Research and Quality in the National Healthcare Disparities report (2013), "different providers may prescribe medications for the same patient. Patients are responsible for keeping track of all their medications, but medication information can be confusing, especially for patients on multiple medications. When care is not well coordinated and some providers do not know about all of a patient's medications, patients are at greater risk for adverse events related to drug interactions, overdosing, or underdosing."

In addition, providers need to periodically review all of a patient's medications to ensure that they are taking what is needed and only what is needed. Medication reconciliation has been shown to reduce both medication errors and adverse drug events (Whittington & Cohen, 2004).

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADE) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to the first study to utilize nationally-representative data to examine annual rates of ADEs in the ambulatory care setting "Adverse Drug events in U.S. Adult Ambulatory Medical Care," ADE rates increase with age, adults 25-44 years old had a rate of 1.3 per 10,000 person per year, those 45-64 had a rate of 2.2 per 10,000 per year, and those 65 years and older had the highest rate, at 3.8 ADEs per 10,000 persons per year. This study estimates that 13.5 million ADE related visits occurred between 2005-2007, estimating that approximately 4.5 million ambulatory ADE visits occur each year. These 4.5 million visits are associated with approximately 400,000 hospitalizations annually. According to the Institute of Medicine (IOM), in the US, as many as 98,000 deaths per year are attributable to preventable adverse events that occur in the hospitals setting with annual costs of between $17 billion and $29 billion. (Sarkar et al., 2011)

Additionally, findings of The Commonwealth Fund (2010) studies identified 11% to 28% of the 4.3 million visit related ADEs (VADE) in 2001 might have been prevented with improved systems of care and better patient education, yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of $946 million to $2.4 billion.

According to the AMA's published report, The Physician's Role in Medication Reconciliation, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days in 2005. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005, in the United States 701,547 patients were treated for ADEs in emergency departments and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs. (AMA, 2007).

A Systematic Review on "Prevalence of Adverse Drug Events in Ambulatory Care" finds that "In the ambulatory care setting, adverse drug events (ADEs) have been reported to occur at a rate of 25%. Approximately 39% of these ADEs were preventable. Since many ADEs are associated with medication errors, and thus potentially preventable, understanding the nature of medication errors in ambulatory care settings can direct attention toward improvement of medication safety in ambulatory care." Data extracted and synthesized across studies indicated the median preventable ADE rates in ambulatory care-based studies were 16.5%. (Tache et al., 2011).

The Agency for Healthcare Research and Quality's (AHRQ) National's Healthcare Disparities Report (2011) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and sex. The disparities were identified as follows: older Asians were more likely than older Whites to have inappropriate drug use (20.3% compared with 17.3%); Older Hispanics were less likely than

older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); Older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and communication, the Institute of Medicine and others have encouraged the incorporation of IT solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks et al. found there is an opportunity for universal medication lists utilizing health IT.

CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2015 Ambulatory Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section "Use Medicines Safely NPSG.03.06.01" states the following: "Maintain and communicate accurate patient medication information. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected to reconcile current and newly ordered medications and to safely prescribe medications in the future." (Joint Commission, 2015, retrieved at: National Patient Safety Goals 2015.)

The National Quality Forum's 2010 update of the Safe Practices for Better Healthcare, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

The AMA's published report, The Physician's Role in Medication Reconciliation, identified the best practice medication reconciliation team as one that is multidisciplinary and--in all settings of care--will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team's variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.

➧GPRO CAD-7 (NQF 0066): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)

THIS MEASURE DOES NOT HAVE A CORRESPONDING eCQM

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

IMPROVEMENT NOTATION:
No Corresponding eCQM

INITIAL POPULATION:
No Corresponding eCQM

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

DENOMINATOR EXCLUSIONS:
None

DENOMINATOR EXCEPTIONS:
Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, allergy, intolerance, other medical reasons)

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

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

NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy

NUMERATOR EXCLUSIONS:
Not Applicable

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

GUIDANCE:
For the purposes of this measure, a diagnosis of Left Ventricular Systolic Dysfunction (LVSD) is equivalent to a qualitative finding of 'moderately or severely depressed' Left Ventricular Systolic Function as well as a quantitative LVEF result < 40%.

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

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

CLINICAL RECOMMENDATION STATEMENTS:

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

2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease (SIHD)

RENIN-ANGIOTENSIN-ALDOSTERONE BLOCKER THERAPY

ACE inhibitors should be prescribed in all patients with SIHD who also have hypertension, diabetes mellitus, LVEF 40% or less, or CKD, unless contraindicated. (Class I Recommendation, Level of Evidence: A)

ARBs are recommended for patients with SIHD who have hypertension, diabetes mellitus, LV systolic dysfunction, or CKD and have indications for, but are intolerant of, ACE inhibitors. (Class I Recommendation, Level of Evidence: A)

♦GPRO DM-2 (NQF 0059): Composite (All or Nothing Scoring): Diabetes: Hemoglobin A1c Poor Control

DM Composite measure consists of DM-2 and DM-7

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

IMPROVEMENT NOTATION:
Lower score indicates better quality

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

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
None

DENOMINATOR EXCEPTIONS:
None

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

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
None

GUIDANCE:
Patient is numerator compliant if most recent HbA1c level is > 9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement year.

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

RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60 - 70 percent of diabetics suffer from mild or severe nervous system damage (American Diabetes Association 2009).

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

CLINICAL RECOMMENDATION STATEMENTS:

American Geriatrics Society (Brown et al. 2003):

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

American Diabetes Association (2009):

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

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

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

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

♦GPRO DM-7 (NQF 0055): Composite (All or Nothing Scoring): Diabetes: Eye Exam

DM Composite measure consists of DM-2 and DM-7

DESCRIPTION:
Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period

IMPROVEMENT NOTATION:
Higher score indicates better quality

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

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
None

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
None

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

The eye exam must be performed by an ophthalmologist or optometrist.

RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including glaucoma and blindness. Diabetic retinopathy is the most common diabetic eye disease and causes 21,000–24,000 new cases of blindness annually. The consensus among established clinical guidelines is that patients with both types of diabetes should have an initial dilated and comprehensive eye exam soon after diagnosis. Guidelines also recommend consultation with an ophthalmologist for treatment options if a patient has any level of macular edema or diabetic retinopathy (proliferative and nonproliferative) (American Diabetes Association 2009).

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (ADA) (2009):

- Adults and children aged 10 years or older with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (B recommendation)
- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B recommendation)
- Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less frequent exams (every 2–3 years) may be considered following one or more normal eye exams. Examinations will be required more frequently if retinopathy is progressing. (B recommendation)
- Women with preexisting diabetes who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. (B recommendation)
- Eye examination should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum. (B recommendation)
- Promptly refer patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. (A recommendation)
- Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A recommendation)
- The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage. (A recommendation)

American Geriatric Society (AGS) (Brown et al. 2003): The older adult who has new-onset DM should have an initial screening dilated-eye examination performed by an eye-care specialist with funduscopy training. (Level I, Grade B)

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

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

IMPROVEMENT NOTATION:
Higher score indicates better quality

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

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

DENOMINATOR EXCLUSIONS:
None

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

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

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

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

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITIONS:
Prescribed-Outpatient setting: prescription given to the patient for beta-blocker therapy at one or more visits in the measurement period OR patient already taking beta-blocker therapy as documented in current medication list
Prescribed-Inpatient setting: prescription given to the patient for beta-blocker therapy at discharge OR beta-blocker therapy to be continued after discharge as documented in the discharge medication list

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

To satisfy this measure, it must be reported for all heart failure patients at least once during the measurement period if seen in the outpatient setting. If the patient has an eligible inpatient discharge during the measurement period, as defined in the measure logic, it is expected to be reported at each hospital discharge.

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

The requirement of "Count >=2 of Encounter, Performed" is to establish that the eligible professional has an existing relationship with the patient.

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

CLINICAL RECOMMENDATION STATEMENTS:
Use of 1 of the 3 beta blockers proven to reduce mortality (e.g., bisoprolol, carvedilol, and sustained-release metoprolol succinate) is recommended for all patients with current or prior symptoms of HFrEF [heart failure with reduced ejection fraction], unless contraindicated, to reduce morbidity and mortality. (Class I, Level of Evidence: A) (ACCF/AHA, 2013)

Treatment with a beta blocker should be initiated at very low doses [see excerpt from guideline table below] followed by gradual increments in dose if lower doses have been well tolerated. Clinicians should make every effort to achieve the target doses of the beta blockers shown to be effective in major clinical trials. Even if symptoms do not improve, long-term treatment should be maintained to reduce the risk of major clinical events. Abrupt withdrawal of treatment with a beta blocker can lead to clinical deterioration and should be avoided. (ACCF/AHA, 2013)

Table 1 - Drugs Commonly Used for Stage C HFrEF (abbreviated to align with focus of measure to include only Beta-blocker therapy)

Drug	Initial Daily Dose(s)	Maximum Doses(s)	Mean Doses Achieved in Clinical Trials
Beta Blockers			
Bisoprolol	1.25 mg once	10 mg once	8.6 mg/d
Carvedilol	3.125 mg twice	50 mg twice	37 mg/d
Carvedilol CR	10 mg once	80 mg once	N/A
Metoprolol succinate extended release (metoprolol CR/XL)	12.5 to 25 mg once	200 mg once	159 mg/d

For the hospitalized patient:
In patients with HFrEF experiencing a symptomatic exacerbation of HF requiring hospitalization during chronic maintenance treatment with GDMT[guideline-directed medical therapy; GDMT represents optimal medical therapy as defined by ACCF/AHA guideline-recommended therapies (primarily Class I)], it is recommended that GDMT be continued in the absence of hemodynamic instability or contraindications. (Class I, Level of Evidence: B) (ACCF/AHA, 2013)

Initiation of beta-blocker therapy is recommended after optimization of volume status and successful discontinuation of intravenous diuretics, vasodilators, and inotropic agents. Beta-blocker therapy should be initiated at a low dose and only in stable patients. Caution should be used when initiating beta blockers in patients who have required inotropes during their hospital course. (Class I, Level of Evidence: B) (ACCF/AHA, 2013)

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

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

IMPROVEMENT NOTATION:
Higher score indicates better quality

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

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.

DENOMINATOR EXCEPTIONS:
None

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

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
None

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

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

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

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

Better control of blood pressure has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. The relationship between the measure (control of hypertension) and the long-term clinical outcomes listed

is well established. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40 percent), myocardial infarction incidence (20-25 percent) and heart failure incidence (>50 percent) (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).

CLINICAL RECOMMENDATION STATEMENTS:

The United States Preventive Services Task Force (2007) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

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

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

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

IMPROVEMENT NOTATION:
Higher score indicates better quality

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

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
Not Applicable

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Patients who have documentation of use of aspirin or another antithrombotic therapy during the measurement period

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
None

GUIDANCE:
Only patients who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) should be included in the measure

RATIONALE:
Coronary heart disease (CHD) is a major cause of death in the United States – in 2004, it was an underlying or contributing cause of death for 451,300 people (1 of every 5 deaths). Acute myocardial infarction (AMI) was an underlying or contributing cause of death for 156,000 people (American Heart Association 2008). In addition, nearly 16 million people (or 7.3 percent of the American population) had CHD in 2005 (American Heart Association 2008). The cost of cardiovascular diseases and stroke in the United States for 2008 was estimated at $448.5 billion (American Heart Association 2008). This figure includes health expenditures (direct costs such as the cost of physicians and healthcare practitioners, hospital and nursing home services, medications, home health care and other medical durables) and lost productivity resulting from morbidity and mortality (indirect costs). AMI accounts for 18 percent of hospital discharges and 28 percent of deaths due to heart disease (National Heart, Lung, and Blood Institute 2000). Research has shown that costs associated with cardiovascular disease for hospitals are easily $156 billion (American Heart Association 2008).

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

reduce the number of strokes by 20 percent, MI by 30 percent, and other vascular events by 30 percent (Weisman and Graham 2002).

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage. U.S. Preventive Services Task Force (2009):

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.

American Diabetes Association (2008):

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).

American Heart Association/American Stroke Association (2008):

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

American College of Clinical Pharmacy (2004):

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.

𝄞 GPRO MH-1 (NQF 0710): Depression Remission at Twelve Months

DESCRIPTION:
Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL POPULATION:
Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter

DENOMINATOR:
Equals the Initial Population

DENOMINATOR EXCLUSIONS:
Patients who died
Patients who received hospice or palliative care services
Patients who were permanent nursing home residents Patients with a diagnosis of bipolar disorder
Patients with a diagnosis of personality disorder

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five

NUMERATOR EXCLUSIONS:
None

DEFINITIONS:
Remission - is defined as a PHQ-9 score of less than five.
Twelve Months - is defined as the point in time from the date in the measurement period that a patient meets the inclusion criteria (diagnosis and elevated PHQ-9 > 9) extending out twelve months and then allowing a grace period of thirty days prior to and thirty days after this date. Any PHQ-9 less than five obtained during this period is deemed as remission at 12 months, values obtained prior to or after this period are not counted as numerator compliant (remission).

GUIDANCE:
None

RATIONALE:
The Centers for Disease Control and Prevention states that nationally 15.7% of people report being told by a health care professional that they had depression at some point in their lifetime. Persons with a current diagnosis of depression and a lifetime diagnosis of depression or anxiety were significantly more likely than persons without these conditions to have cardiovascular disease, diabetes, asthma and obesity and to be a current smoker, to be physically inactive and to drink heavily. According to National Institute of Mental Health (NIMH), 6.7 percent of the U.S. population ages 18 and older (14.8 million people) in any given year have a diagnosis of a major depressive disorder. Major depression is the leading cause of disability in the U.S. for ages 15 - 44. Additionally, dysthymia accounts for an additional 3.3 million Americans.

CLINICAL RECOMMENDATION STATEMENTS:

Improvement in the symptoms of depression and an ongoing assessment of the current treatment plan is crucial to the reduction of symptoms and psychosocial well being of patients with major depression. Most people treated for initial depression need to be on medication at least six to twelve months after adequate response to symptoms, patients with recurrent depression need to be treated for three years or more and response with psychotherapy can take eight to twelve weeks of regular and frequent therapy to show improvement. Remission is defined as a PHQ-9 score of less than five at twelve months. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Developed by Drs. Robert L. Spitzer, Janet

B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This tool was selected for measuring outcomes for this population because it is 1) validated with a sensitivity of .080 and a specificity of 0.92 with substantial heterogeneity I2 = 82%, 2) widely accepted and utilized in Minnesota, 3) available for clinical use, 4) translated into many languages and 5) easy for the patient to complete and the provider to score. Available at www.phqscreeners.com. This nine question tool contains the following questions which are scored on a scale of 0 to 27 based on the scale of Not at All (0), Several Days (1), More Than Half the Days (2), or Nearly Every Day (3) for responses to the questions over the last 2 weeks.

- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless
- Feeling tired or having little energy
- Poor appetite or overeating
- Feeling bad about yourself - or that you are a failure or have let yourself or your family down
- Trouble concentrating on things, such as reading the newspaper or watching television
- Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
- Thoughts that you would be better off dead or of hurting yourself in some way

Source: ICSI Guideline for Major Depression in Adults in Primary Care 16th edition September 2013

♦GPRO PREV-5 (NQF 2372): Breast Cancer Screening

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

IMPROVEMENT NOTATION:
Higher score equals better quality

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

DENOMINATOR:
Equals Initial Population

> ***DENOMINATOR NOTE:*** *The measure's 27-month look back period applies to women ages 52-74 (the numerator looks for a mammogram any time on or between October 1, 27 months prior to the measurement period, and December 31 of the measurement period in order to capture women who have had a mammogram every 24 months per clinical guidelines, with a 3-month grace period). Therefore, women ages 50-52 are included in the measure if they had a visit and a mammogram since age 50, but the 27-month look back period only applies to patients age 52-74. For patients that are 51 years of age during the measurement period, look back only to age 50*
>
> **DENOMINATOR EXCLUSIONS:**
> Women who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies
>
> **DENOMINATOR EXCEPTIONS:**
> None

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

> **NUMERATOR EXCLUSIONS:**
> Not Applicable

DEFINITION:
None

GUIDANCE:
None

RATIONALE:
Breast cancer is one of the most common types of cancers, accounting for a quarter of all new cancer diagnoses for women in the U.S. (BreastCancer.Org, 2011). It ranks as the second leading cause of cancer-related mortality in women, accounting for nearly 40,000 estimated deaths in 2013 (American Cancer Society, 2011).

According to the National Cancer Institute's Surveillance Epidemiology and End Results program, the chance of a woman being diagnosed with breast cancer in a given year increases with age. By age 30, it is one in 2,212. By age 40, the chances increase to one in 235, by age 50, it becomes one in 54, and, by age 60, it is one in 25. From 2004 to 2008, the median age at the time of breast cancer diagnosis was 61 years among adult women (Tangka et al, 2010).

In the U.S., costs associated with a diagnosis of breast cancer range from $451 to $2,520, factoring in continued testing, multiple office visits and varying procedures. The total costs related to breast cancer add up to nearly $7 billion per year in the U.S., including $2 billion spent on late-stage treatment (Lavigne et al, 2008, Boykoff et al, 2009).

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50-74 years (B recommendation). The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms (C recommendation). (USPSTF, 2009) The Task Force concludes the evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years and older (I statement).

U.S. Preventive Services Task Force (2009)

Grade: B recommendation. The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.

Grade: C recommendation. The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.

Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older.

Grade: D recommendation. The USPSTF recommends against teaching breast self-examination (BSE).

Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older.

Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of either digital mammography or magnetic resonance imaging (MRI) instead of film mammography as screening modalities for breast cancer.

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

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

IMPROVEMENT NOTATION:
Higher score indicates better quality

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

DENOMINATOR:
Equals Initial Population

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

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria below:

- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
None

GUIDANCE:
None

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

Screening for colorectal cancer is extremely important as there are no signs or symptoms of the cancer in the early stages. If the disease is caught in its earliest stages, it has a five-year survival rate of 91%; however, the disease is often not caught this early. While screening is extremely effective in detecting colorectal cancer, it remains underutilized (American Cancer Society 2010).

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

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

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

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

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

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

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

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

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

DESCRIPTION:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL POPULATION:
All patients aged 6 months and older seen for at least two visits or at least one preventive visit during the measurement period

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

DENOMINATOR EXCLUSIONS:
None

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

Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons)

Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)

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

NUMERATOR EXCLUSIONS:
Not Applicable

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

GUIDANCE:
To enable reporting of this measure at the close of the reporting period, this measure will only assess the influenza season that ends in March of the reporting period. The subsequent influenza season (ending March of the following year) will be measured and reported in the following year.

To account for the majority of reporting years' appropriate flu season duration, the measure logic will look at the first 89 days of the measurement period for the appropriate criteria and actions to be present/performed (January 1 through March 31). The measure developer believes it is best to keep the logic as static as possible from one reporting year to the next. Therefore, during leap years, only encounters that occur through March 30 will be counted in the denominator.

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

CLINICAL RECOMMENDATION STATEMENTS:

Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months who do not have contraindications. Vaccination optimally should occur before onset of influenza activity in the community. Health care providers should offer vaccination soon after vaccine becomes available (by October, if possible). Vaccination should be offered as long as influenza viruses are circulating. (CDC/ACIP, 2014)

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

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

IMPROVEMENT NOTATION:
Higher score indicates better quality

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

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
None

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Patients who have ever received a pneumococcal vaccination

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
None

GUIDANCE:
It is recommended that patients 65 years of age or older receive one pneumococcal vaccination in their lifetime

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

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

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

CLINICAL RECOMMENDATION STATEMENTS:
The Advisory Committee on Immunization Practices' (ACIP) released recommendations in September, 2014, describing the use of 13-valent pneumococcal conjugate vaccine (PCV13) and 23-valent pneumococcal polysaccharide vaccine (PPSV23) among adults aged ≥65 Years. According to the ACIP, both the PCV13 and PPSV23 should be administered routinely in series to all adults aged ≥65 years. Adults aged ≥65 years with no previous history or an unknown history of pneumococcal vaccination should receive PCV13 before PPSV23. Adults aged ≥65 years with a history of PPSV23 should receive PCV13, after which a second dose of PPSV23 may be administered for those adults with an indication for two doses of PPSV23.

♠ GPRO PREV-9 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

DESCRIPTION:
Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 kg/m2

Age 18 – 64 years BMI ≥ 18.5 and < 25 kg/m2

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL POPULATION:
All patients 18 years and older on the date of the encounter with at least one eligible encounter during the measurement period

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
Patients who are pregnant or encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.

DENOMINATOR EXCEPTIONS:
None

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

NUMERATOR EXCLUSIONS:
Not Applicable

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

Metric Units: BMI = Weight (kg) / (Height (m) x Height (m))

OR

English Units: BMI = Weight (lbs.) / (Height (in) x Height (in)) x 703

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

GUIDANCE:

- There is no diagnosis associated with this measure.
- This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period.
- This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding.

BMI Measurement Guidance:

- Height and Weight - An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within six months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.
- The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider.
- If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous six months of the current encounter.
- The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters". (See Definitions for examples of a follow-up plan treatments).
- If more than one BMI is reported during the measurement period, the most recent BMI will be used to determine if the performance has been met.

RATIONALE:

Normal Parameters for Age 65 Years and Older

Winter et al. (2014) performed a meta-analysis looking at the relationship between BMI and all-cause mortality among adults 65 and older. They identified a higher risk of mortality among those with a BMI <23 kg/m2 and recommended monitoring weight status in this group to address any modifiable causes of weight loss promptly with due consideration of individual comorbidities. Dahl et al. (2013) reported that old persons (70-79) who were overweight had a lower mortality risk than old persons who were of normal weight, even after controlling for weight change and multimorbidity. The study also shows that persons who increased or decreased in BMI had a greater mortality risk than those who had a stable BMI, particularly those aged 70 to 79. Their results provide support to the belief that the World Health Organization guidelines for BMI are overly restrictive in old age.

BMI Above Upper Parameters

Obesity continues to be a costly public health concern in the United States. The Centers for Disease Control and Prevention (CDC, 2010) reported in 2009, no state met the Healthy People 2010 obesity target of 15 percent and the self-reported overall prevalence of obesity among adults had increased 1.1 percentage points in 2007 to 26.7 percent (2010). Ogden, Carroll, Kit and Flegel (2013) reported the prevalence of BMI-defined obesity in adults is high and continues to exceed 30% in most sex-age groups (34.9% overall). They also stated the overall prevalence of obesity did not differ between men and women in 2011-2012; however, among non-Hispanic Black adults, 56.6% of women were obese compared with 37.1% of men. In addition to the continued high prevalence rate for adults in general, Flegel, Carroll, Kit & Ogden (2012) report a significant increase for men and for non-Hispanic Black and Mexican American women over the 12-year period from 1999 through 2010 (2012). Moyer (2012) reported: Obesity is associated with such health problems as an increased risk for coronary artery disease, type 2 diabetes, various types of cancer, gallstones and disability. These comorbid medical conditions are associated with a higher use of health care services and costs among obese patients (p. 373).

Obesity is also associated with an increased risk of death, particularly in adults younger than age 65 years and has been shown to reduce life expectancy by 6 to 20 years depending on age and race (LeBlanc et al., 2011). Masters et al. (2013) also showed mortality due to obesity varied by race and gender. They estimated adult deaths between 1986 and 2006 associated with overweight and obesity was 5.0% and 15.6% for Black and White men, and 26.8% and 21.7% for Black and White women, respectively. They also found a stronger association than previous research demonstrated between obesity and mortality risk at older ages.

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

Padula, Allen & Nair (2014) examined data from a commercial claims and encounter database to estimate the cost for obesity and associated comorbidities among working-age adults who had a claim with a primary or secondary diagnosis of obesity in 2006-2007. The mean net expenditure for inpatient and outpatient claims was $1,907 per patient per visit. The increase in cost for comorbidities ranged from $527 for obesity with congestive heart failure (CHF) to $15,733 for the combination of obesity, diabetes mellitus, hypertension and depression. In addition to a high prevalence rate of obesity, less than 50% of obese adults in 2010 received advice to exercise or perform physical activity (Barnes & Schoenborn, 2012).

BMI Below Normal Parameters

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

In a cohort study conducted by Borrell & Lalitha (2014), data from NHANES III (1988-1994) was linked to the National Death Index mortality file with follow-up to 2006, and showed that when compared to their normal weight counterparts (BMI 18.5-25 kg/m2), underweight (BMI <18.5 kg/m2) had significantly higher death rates (Hazard Ratio=2.27; 95% confidence intervals (CI) = 1.78, 2.90).

Ranoff, Gjoon& Mowe (2005) recommended using BMI < 23 kg/m2 for the elderly to identify positive results with malnutrition screens and poor nutritional status.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

As cited in Wilkinson et al. (2013), the Institute for Clinical Systems Improvement (ICSI) Preventive Services for Adults, Obesity Screening (Level II) Recommendation provides the following guidance:

- Record height, weight and calculate body mass index at least annually
    - Clinicians should consider waist circumference measurement to estimate disease risk for patients who have BMI scores indicative of overweight or obesity class I. For adult patients with a BMI of 25 to 34.9 kg/m2, sex-specific waist circumference cutoffs should be used in conjunction with BMI to identify increased disease risk.
    - A BMI greater or equal to 30 is defined as obese
    - A BMI of 25-29 is defined as overweight
    - Intensive intervention for obese individuals, based on BMI, is recommended by the U.S. Preventive Services to help control weight

Similarly, the 2013 joint report/guideline from the American Heart Association, American College of Cardiology and the Obesity Society also recommend measuring height and weight and calculating BMI at annual visits or more frequently, using the current cutpoints for overweight (BMI >25.0-29.9 kg/m2) and obesity (BMI ≥ 30 kg/m2) to identify adults who may be at elevated risk of mortality from all causes. They also recommended counseling overweight and obese individuals on their increased risk for CVD, type 2 diabetes, and all-cause mortality, and need for lifestyle changes.

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

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

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL POPULATION:
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
None

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

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

NUMERATOR EXCLUSIONS:
Not Applicable

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

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

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

Exceptions only apply to the screening data element of the measure; once a patient has been screened, there are no allowable exceptions for not providing the intervention.

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

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

♠ GPRO PREV-11: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

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

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL POPULATION:
All patients aged 18 years and older before the start of the measurement period with at least one eligible encounter during the measurement period

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
Patient has an active diagnosis of hypertension

DENOMINATOR EXCEPTIONS:
Patient Reason(s): Patient refuses to participate (either BP measurement or follow-up)
OR
Medical Reason(s): Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated.

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

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITIONS:
Blood Pressure (BP) Classification: BP is defined by four (4) BP reading classifications: Normal, Pre- Hypertensive, First Hypertensive, and Second Hypertensive Readings.
Recommended BP Follow-Up: The Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) recommends BP screening intervals, lifestyle modifications and interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow-Up Interventions" listed below.
Recommended Lifestyle Modifications: The JNC 7 report outlines lifestyle modifications which must include one or more of the following as indicated:

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

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

Second Hypertensive BP Reading Interventions: The JNC 7 report outlines BP follow-up interventions for a second hypertensive BP reading and must include one or more of the following as indicated:

- Anti-Hypertensive Pharmacologic Therapy
- Laboratory Tests
- Electrocardiogram (ECG)

Recommended Blood Pressure Follow-Up Interventions:

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

GUIDANCE:

Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple blood pressures on the same date of service, use the most recent as the representative blood pressure.

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

The intent of this measure is to screen patients for high blood pressure and provide recommended follow-up as indicated. The documented follow up plan must be related to the current BP reading as indicated, example: "Patient referred to primary care provider for BP management."

RATIONALE:

Hypertension is a prevalent condition that affects approximately 66.9 million people in the United States. It is estimated that about 20-40% of the adult population has hypertension; the majority of people over age 65 have a hypertension diagnosis (Appleton SL, et. al., 2012 and Luehr D, et. al., 2012). Winter (2013) noted that 1 in 3 American adults have hypertension and the lifetime risk of developing hypertension is 90% (Winter KH, et. al., 2013). The African American population or non-Hispanic Blacks, the elderly, diabetics and those with chronic kidney disease are at increased risk of stroke, myocardial infarction and renal disease. Non-Hispanic Blacks have the highest prevalence at 38.6% (Winter KH, et. al., 2013). Hypertension is a major risk factor for ischemic heart disease, left ventricular hypertrophy, renal failure, stroke and dementia (Luehr D, et. al., 2012).

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

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

therapy to control blood pressure and reduce the complications of hypertension. Follow-up intervals based on blood pressure control have been established by the JNC 7 and the USPSTF.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

IMPROVEMENT NOTATION:
Higher score indicates better quality

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

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder

DENOMINATOR EXCEPTIONS:
Patient Reason(s): Patient refuses to participate
OR
Medical Reason(s): Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
OR
Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

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

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITIONS:
Screening: Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Clinical Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized.
Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**
  - Patient Health Questionnaire for Adolescents (PHQ-A)
  - Beck Depression Inventory-Primary Care Version (BDI-PC)
  - Mood Feeling Questionnaire (MFQ)
  - Center for Epidemiologic Studies Depression Scale (CES-D)
  - PRIME MD-PHQ-2

- **Adult Screening Tools (18 years and older)**
  - Patient Health Questionnaire (PHQ-9)
  - Beck Depression Inventory (BDI or BDI-II)
  - Center for Epidemiologic Studies Depression Scale (CES-D)
  - Depression Scale (DEPS)
  - Duke Anxiety-Depression Scale (DADS)
  - Geriatric Depression Scale (GDS)
  - Cornell Scale Screening
  - PRIME MD-PHQ-2

Follow-Up Plan: Follow-up for a positive depression screening ***must*** include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

GUIDANCE:

A clinical depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Screening Tools:

- The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record
- The depression screening must be reviewed and addressed in the office of the provider filing the code, on the date of the encounter
- The screening and encounter must occur on the same date
- Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record

Follow-Up Plan:

- The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

RATIONALE:

The World Health Organization, as seen in Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Persons 40-59 years of age had higher rates of depression than any other age group. Persons 12-17, 18-39 and 60 years of age and older had similar rates of depression. Depression was more common in females than in males. Non-Hispanic Black persons had higher rates of depression than non-Hispanic White persons. In the 18-39 and 40-59 age groups, those with income below the federal poverty level had higher rates of depression than those with higher income. Among persons 12-17 and 60 years of age and older, raters of depression did not vary significantly by poverty status.

Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms.

15–20 percent of adults older than age 65 in the United States have experienced depression (Geriatric Mental Health Foundation, 2008). 7 million adults aged 65 years and older are affected by depression (Steinman, 2007). Chronically ill Medicare beneficiaries with accompanying depression have significantly higher health care costs than those with chronic diseases alone (Unützer, 2009). People aged 65 years and older accounted for 16 percent of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages. As reported in Borner (2010), a study conducted by the World Health Organization (WHO. reported that in North America, primary care and family physicians are likely to provide the first line of treatment for depressive disorders. Others consistently report a 10% prevalence rate of depression in primary care patients. But studies have shown that primary care physicians fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments. Coyle et al. (2003) suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated. Healthy People 2020 recommends routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014).

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

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

CLINICAL RECOMMENDATION STATEMENTS:
Adolescent Recommendation (12-18 years)

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

Clinicians and health care systems should try to consistently screen adolescents, ages 12-18, for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up (ICSI, 2013, p. 16).

Adult Recommendation (18 years and older)

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

A system that has embedded the elements of best practice and has capacity to effectively manage the volume, should consider routine screening of all patients based on the recommendations of the U.S. Preventive Services Task Force (ICSI, 2013, p. 7). Clinicians should use a standardized instrument to screen for depression if it is suspected, based on risk factors or presentation. Clinicians should assess and treat for depression in patients with some comorbidities. Clinicians should acknowledge the impact of culture and cultural differences on physician and mental health. Clinicians should screen and monitor depression in pregnant and post-partum women (ICSI, 2013, p. 4).

♠ GPRO PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

THIS MEASURE DOES NOT HAVE A CORRESPONDING eCQM

DESCRIPTION:
Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period:

- Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR
- Adults aged >=21 years with a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL; OR
- Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL

IMPROVEMENT NOTATION:
No Corresponding eCQM

INITIAL POPULATION:
No Corresponding eCQM

DENOMINATOR: (PATIENT MUST BE IN AT LEAST ONE OF THE THREE DENOMINATORS BELOW)
There are three reporting criteria for this measure*:

1) Patients aged ≥21 years at the beginning of the measurement period with clinical ASCVD diagnosis
   OR
2) Patients aged ≥ 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C ≥ 190 mg/dL
   OR
3) Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70–189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period

*All patients who meet one or more of the criteria indicated above would be considered at "high risk" for cardiovascular events under ATP IV guidelines.

DENOMINATOR EXCLUSIONS:
None

DENOMINATOR EXCEPTIONS:

- Patients with adverse effect, allergy, or intolerance to statin medication
- Patients who have an active diagnosis of pregnancy or who are breastfeeding
- Patients who are receiving palliative care
- Patients with active liver disease or hepatic disease or insufficiency
- Patients with end-stage renal disease (ESRD)
- Patients with diabetes who have a fasting or direct LDL-C laboratory test result < 70 mg/dL and are not taking statin therapy

NUMERATOR:
Patients who are statin therapy users during the measurement period or who receive an order (prescription) to receive statin therapy at any point during the measurement period

NUMERATOR NOTE: *In order to meet the measure, a current statin medication therapy use must be documented in the current medication list. Statin therapy use is considered active for the measurement period if it is active during any denominator-eligible encounter. Only statin therapy meets measure Numerator criteria (NOT other cholesterol lowering medications). Prescription or order does not need to be linked to an encounter or visit; may be called to the pharmacy. Statin medication "samples" provided to patients can be documented as "current statin therapy" if documented/specified in the medication list in health/medical record. Patients who meet the denominator criteria for inclusion but are not using statin therapy will not meet performance for this measure. Adherence is not calculated in this measure.*

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITIONS:
Clinical atherosclerotic cardiovascular disease (ASCVD) includes:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke or transient ischemic attack (TIA)
- Peripheral arterial disease of atherosclerotic origin

Lipoprotein Density Cholesterol (LDL-C) - A fasting or direct LDL-C laboratory test performed and test result documented in the medical record.
Statin therapy - Administration of one or more of a group of medications that are used to lower plasma lipoprotein levels in the treatment of hyperlipoproteinemia; the group includes all statin-containing medication (HMG-CoA [3-hydroxy-3-methylglutaryl coenzyme A] Reductase Inhibitors).

Sample list of statin medications (list is NOT inclusive of all agents) is included in the clinical recommendations

GUIDANCE:
Denominator Guidance: The denominator covers three distinct populations. Use this process to prevent counting patients more than once.

Denominator Population 1: Patients aged >= 21 years and older at the beginning of the measurement period with clinical ASCVD
If YES, patient meets Denominator Population 1 risk category
If NO, screen for next risk category

Denominator Population 2: Patients aged >= 21 years and older at the beginning of the measurement period who have ever had a fasting or direct laboratory test result of LDL-C ≥ 190 mg/dL
If YES, patient meets Denominator Population 2 risk category
If NO, screen for next risk category

Denominator Population 3: Patients aged 40 through 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70–189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period
If YES, patient meets Denominator Population 3 risk category
If NO, patient does NOT meet denominator criteria and is NOT eligible for measure inclusion

Denominator Guidance for Encounter:
In order for the patient to be included in the denominator, the patient must have at least ONE denominator- eligible visit, defined as follows:

- Outpatient encounter visit type:
- Encounter, performed: initial or established office visit, face-to-face interaction, preventive care services, or annual wellness visit
- Exclude inpatient encounter and observation status encounters

LDL-C Laboratory test result options:
The measure can be reported for all patients with a documented fasting or direct LDL-C level recorded as follows:

To meet Denominator Population 1:
There is no required LDL-C result

To meet Denominator Population 2:
If a patient has ANY previous fasting or direct laboratory result of LDL-C >= 190 mg/dL, report the highest value >= 190 mg/dL.

To meet Denominator Population 3:
If a patient has more than one LDL-C result during the measurement period or during the two years before the start of the measurement period, report the highest level recorded during either time.

Intensity of statin therapy in primary and secondary prevention:
The expert panel of the 2013 ACC/AHA Guidelines (Stone et al. 2013) defines recommended intensity of statin therapy on the basis of the average expected LDL-C response to specific statin and dose. Although intensity of statin therapy is important in managing cholesterol, this measure assesses prescription of ANY statin therapy, irrespective of intensity. Assessment of appropriate intensity and dosage documentation added too much complexity to allow inclusion of statin therapy intensity in the measure at this time.

Lifestyle modification coaching:
A healthy lifestyle is important for the prevention of cardiovascular disease, and coaching may help patients achieve improved outcomes. However, lifestyle modification monitoring and documentation added too much complexity to allow its inclusion in the measure at this time.

RATIONALE:
This measure specification is based on the following clinical guideline: "2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology [ACC]/American Heart Association [AHA] Task Force on Practice Guidelines" (Stone et al. 2013). This document is also referred to as Adult Treatment Panel IV or ATP IV. It is an update to the National Cholesterol Education Program (NCEP), National Heart, Lung, and Blood Institute (NHLBI), and National Institutes of Health (NIH) guideline called ATP III, published in 2002.

To produce ATP IV, an expert panel synthesized evidence from randomized controlled trials to identify people most likely to benefit from cholesterol-lowering therapy. The ATP IV recommendations are intended to provide a strong evidence-based foundation for the treatment of blood cholesterol for the primary and secondary prevention and treatment of ASCVD in adult men and women (>= 21 years of age). The evidence demonstrated that cholesterol management recommendations should be based on a treatment strategy to incorporate optimal doses of statin therapy rather than on achievement of a target LDL-C level; however, it is important to monitor LDL cholesterol levels

ATP IV identifies four major statin benefit categories:

1. Secondary prevention in individuals with clinical ASCVD
2. Primary prevention in individuals with primary elevations (i.e., initial readings) of LDL-C >=190 mg/dL
3. Primary prevention in individuals with diabetes ages 40 to 75 years who have LDL-C 70 to 189 mg/dL
4. Primary prevention in individuals ages 40 to 75 years without diabetes but with estimated 10-year ASCVD risk >=7.5%, and LDL-C 70 to 189 mg/dL

The first three of these four categories were deemed "high risk" in ATP IV, so this measure of statin therapy focuses on patients in those high-risk categories. Stone et al. (2013) state as follows:

> The Expert Panel found extensive and consistent evidence supporting the use of statins for the prevention of ASCVD in many higher-risk primary- and all secondary-prevention individuals without New York Heart Association class II–IV heart failure who were not receiving hemodialysis.
>
> In addition, the relative reduction in ASCVD risk is consistent for primary and secondary prevention and for various patient subgroups. Therefore, statin therapy is recommended for individuals at increased ASCVD risk who are most likely to experience a net benefit in terms of the potential for ASCVD risk reduction and the potential for adverse effects.

CLINICAL RECOMMENDATION STATEMENTS:

The addition of statin therapy reduces the risk of cardiovascular events (such as stroke and myocardial infarction) among high-risk individuals, defined as follows: individuals with clinical ASCVD, with LDL-C >= 190 mg/dL, or with diabetes and LDL-C 70–189 mg/dL (Stone et al. 2013).

This electronic clinical quality measure aligns with the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol (Stone et al. 2013), which indicates the use of statins as the first line of cholesterol-lowering medication therapy to reduce the risk of ASCVD among those who currently do not have an ASCVD diagnosis and to lower the risk of cardiovascular events (such as stroke and myocardial infarction) among at-risk populations.

Intensity of statin therapy in primary and secondary prevention:

The expert panel of the 2013 ACC/AHA Guidelines (Stone et al. 2013) defines recommended intensity of statin therapy on the basis of the average expected LDL-C response to specific statin and dose. Although intensity of statin therapy is important in managing cholesterol, this measure assesses prescription of ANY statin therapy, irrespective of intensity. Assessment of appropriate intensity and dosage documentation added too much complexity to allow inclusion of statin therapy intensity in the measure at this time.

Table 2 - Sample (List is NOT inclusive of all agents) Statin Medication Therapy List:

Generic Name	Brand or Trade Name	Medication Type, If Applicable
Atorvastatin	Lipitor	Statin
Fluvastatin	Lescol XL or Lescol	Statin
Lovastatin (Mevinolin)	Mevacor or Altoprev	Statin
Pitavastatin	Livalo	N/A
Pravastatin Sodium	Pravachol	Statin
Rosuvastatin Calcium	Crestor	Statin
Simvastatin	Zocor	Statin
Amlodipine Besylate/Atorvastatin Calcium	Caduet	Combination
Ezetimibe/Simvastatin	Vytorin	Combination
Niacin/Lovastatin	Advicor	Combination
Niacin/Simvastatin	Simcor	Combination
Sitagliptin/Simvastatin	Juvisync	Diabetes Combination
Sitagliptin Phosphate/Simvastatin	Juntadueto	Diabetes Combination

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