CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

Electronic Health Record Reporting for Patients with Hypertension and Diabetes, and for Identifying At-Risk Patients

Mandated Measure Crosswalk with Value-Based and Reporting Programs

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CDPH California Department of PublicHealth

INTREPID ASCENT

Background: Prevention First and Lifetime of Wellness

The California Department of Public Health (CDPH), in conjunction with ten California counties, has embarked on two Centers for Disease Control and Prevention (CDC) funded programs. These California programs; “Prevention First: Advancing Synergy for Health” (1305) and “Lifetime of Wellness: Communities in Action” (1422); address cardiovascular disease, diabetes, and obesity.

A mutual goal of 1305 and 1422 is to work with community partners to support the prevention and management of chronic conditions with technology methods such as electronic health records (EHR) and health information exchange (HIE), particularly through the identification and management of patients with hypertension and pre-diabetes.

Introduction

The purpose of this document is to provide a crosswalk and offer insight into the alignment of standardized clinical quality measures (CQMs) that may affect metrics associated with 1305 and 1422. Over the last several years, there has been a significant alignment of CQMs across many value-based and other related reporting initiatives, thereby streamlining data extraction, reporting, and quality improvement activities for clinicians and health systems.

In addition to improving management of chronic conditions, 1305 and 1422 seek to promote prevention of chronic conditions, particularly the identification and intervention of undiagnosed hypertension and pre-diabetes, as a means of reducing the overall population with these chronic conditions. Management of such conditions is not enough, as prevention is required to address the overall impact necessary to lower costs and improve population health. To date, there are no standardized measures for detection or intervention regarding undiagnosed hypertension and prediabetes. However, since undiagnosed hypertension and prediabetes are focuses of 1305 and 1422, this crosswalk incorporates measures used by well-respected health care organizations to identify patients with undiagnosed hypertension or pre-diabetes. Through the incorporation of these preventive measures as part of participation in 1305 and 1422, provider organizations can contribute to identification, tracking, and health improvement across the patient population at greatest risk for chronic illness.

Relevant Value-Based Payment and Other Reporting Initiatives

The following value-based care and reporting programs are relevant initiatives that may be coordinated in tandem with 1305 and 1422 to broaden and enhance the CQM approach:

- **Public Hospital Redesign and Incentives in Medi-Cal (PRIME):** Designed to increase access to coordinated primary care achieved through the 2010 "Bridge to Reform: California's Medicaid Section 1115 Waiver." PRIME accelerates efforts of participating entities to change care delivery to maximize health care value and strengthen their ability to successfully perform under risk-based alternative payment models (APMs) in the long term, consistent with the Centers for Medicare & Medicaid Services (CMS) and Medi-Cal 2020 goals.
- **Uniform Data System (UDS):** An integrated reporting system used by all grantees funded for Federally Qualified Health Centers (FQHC), Migrant and Seasonal Farmworkers, Health Care for the Homeless, and Public Housing Primary Care, under the Health Center grant program administered by the United States Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA). The data collected through this report are analyzed to ensure compliance with legislative mandates, report program accomplishments, and justify budget requests to the United States Congress.
- **Merit Based Incentive Payment System (MIPS):** A new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare EHR incentive program into one single program in which Eligible Professionals (EPs) will be measured on quality, resource use, clinical practice improvement, and meaningful use of certified EHR technology.
- **Healthcare Effectiveness Data and Information Set (HEDIS):** A reporting initiative used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.
- **Physician Quality Reporting System (PQRS):** A quality-reporting program that encourages individual EPs and group practices to report information on the quality of care to Medicare. PQRS gives participating EPs and group practices the opportunity to assess the quality of care they provide to their patients, helping to ensure that patients get the right care at the right time.
- **Meaningful Use (MU):** Meaningful use is using certified EHR technology to improve quality, safety, efficiency, and reduce health disparities, engage patients and family, improve care coordination, and population and public health, and maintain privacy and security of patient health information. The goal is that the meaningful use compliance will result in better clinical outcomes, improved population health outcomes, increased transparency and efficiency, empowered individuals, and more robust research data on health systems. The program began in 2011 and will continue through 2019, and beyond.

Identifying Patients with Undiagnosed Hypertension

There is currently no established standardized national preventive criteria or method for identification of undiagnosed hypertension.

The Hiding in Plain Sight[1] (HIPS) criteria for screening patients for risk of undiagnosed hypertension is outlined below. The following clinical criteria may help organizations build an algorithm. To identify adults with undiagnosed hypertension the HIPS criteria recommend one Stage 2 blood pressure reading OR two Stage 1 blood pressure readings in the past 12 months, with no diagnosis of hypertension documented in the EHR.

- **Stage 1:** Patients ages 18 to 85 years without a diagnosis of hypertension (HTN) who have Blood Pressure (BP) readings ≥120mmHg Systolic Blood Pressure (SBP) or ≥90mmHg Diastolic Blood Pressure (DSP) at two separate medical visits, including the most recent visit, during the past 12 months.
- **Stage 2:** Patients ages 18 to 85 years without a diagnosis of HTN who have a BP reading ≥160mmHg SBP or ≥100mmHg DSP at any one medical visit during the past 12 months.

Crosswalk of Standardized Measures to Screen for and Manage Hypertension

Measure Definitions

Hypertension—Good Control: **National Quality Forum (NQF) Measure 0018; Physician Quality Reporting System (PQRS) 236;** Group Practice Reporting Option HTN-2—Percentage of patients who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

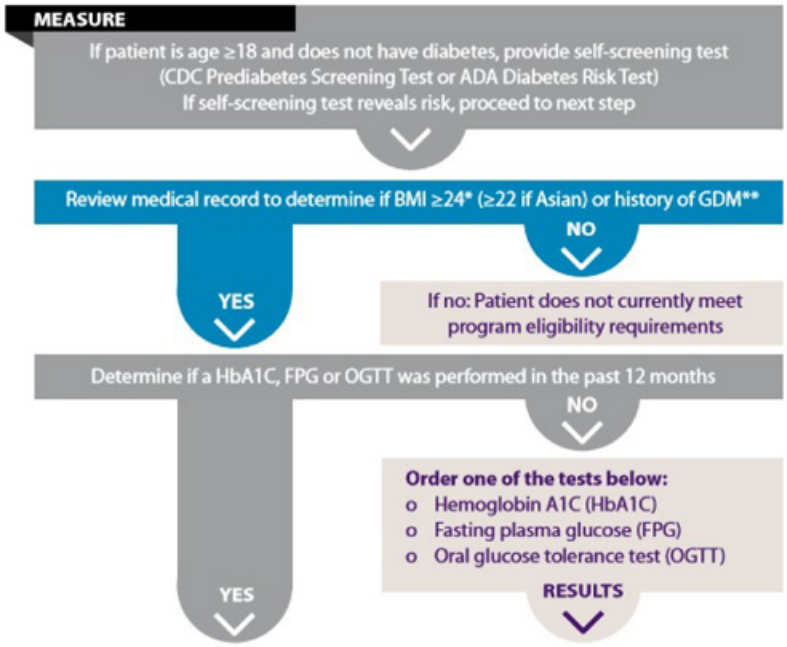
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented; **PQRS 317; GPRO PREV 11**—Percentage of patients aged >18 years seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the BP reading.

1. National Association of Community Health Centers. "Million Hearts: Leveraging Health Information Technology (HIT), Quality Improvement (QI), and Primary Care Teams to Identify Hypertensive Patients Hiding in Plain Sight (HIPS)." 30 June 2015. http://mylearning.nachc.com/diweb/fs/file/id/229350

Measure	1305/ 1422	Prime	UDS 2016	MIPS	HEDIS	PQRS 2016-17	MU
Hypertension —Good Control	NQF 18 PQRS 236 GPRO HTN-2 UDS Table 7 Section B			NQF 18 PQRS 236	% of patient panel 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement period based on the following criteria: • 18–59 years of age with BP <140/90mmHg. • 60–85 years of age with a diagnosis of diabetes with BP <140/90mmHg. • 60–85 years of age without a diagnosis of diabetes with BP <150/90mmHg.	NQF 18 PQRS 236 GPRO HTN-2	
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	No other HTN metrics	PQRS 317 GPRO PREV–11	No other HTN metrics	PQRS 317	N/A	PQRS 317 GPRO PREV–11	

Identifying Patients with Prediabetes

While there is not an established standardized national preventive criteria or method for identification of pre-diabetes, there are promising practices. Professional organizations and disease-based initiatives, including the American Association of Clinical Endocrinologists[2] and the Diabetes Coalition of California,[3] provide algorithms for extracting lists of patients from the EHR who may have pre-diabetes. Listed below is a recommended workflow for identifying patients at the point of care from the CDC's Point-of-Care prediabetes identification algorithm.[4]



Diagnostic test	Normal	Prediabetes	Diabetes
HbA1C(%)	< 5.7	5.7–6.4	≥ 6.5
Fasting plasma glucose (mg/dL)	< 100	100–125	≥ 126
Oral glucose tolerance test (mg/dL)	<140	140–199	≥ 200

ACT

Encourage patient to maintain a healthy lifestyle. Continue with exam/ consult. Retest within three years of last negative test.	Refer to diabetes prevention program, provide brochure. Consider retesting annually to check for diabetes onset.	Confirm diagnosis; retest if necessary. Counsel patient re: diagnosis. Initiate therapy.

2. Diabetes Coalition of California. "Algorithm for Pre-Diabetes Identification & Intervention in Adults." November 2011. http://diabetescoalitionofcalifornia.org/wp-content/uploads/2013/11/Algorithm_for_Prediabetes_Identification_and_Inter.pdf
3. Garber A, Abrahamson M, Barzilay J, Blonde L, Bloomgarden Z, Bush M, Dagogo-Jack S, Davison M, Einhorn D, Garber J, Garvey WT, Grunberger G, Handelsman Y, Hirsch I, Jellinger P, McGill J, Mechanick J, Rosenblit P, Umpierrez G, Davidson M. (2015) "AACE/ACE Comprehensive Diabetes Management Algorithm." Endocrine Practice, 21(4): 438-447. https://www.aace.com/files/aace_algorithm.pdf
4. Prevent Diabetes STAT. "Point-of-care prediabetes identification." The American Medical Association and the Centers for Disease Control and Prevention. http://www.cdc.gov/diabetes/prevention/pdf/point-of-care-prediabetes-identification-algorithm_tag508.pdf

Crosswalk of Standardized Measures to Manage Diabetes

Definitions for Measures Used for More than One Program

Diabetes—Poor Control: NQF 59; PQRS 01; GPRO DM2—Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c > 9.0 percent during the measurement period.

Diabetes Eye Exam: NQF 0055; PQRS 117 GPRO DM-7—Percentage of patients 18–75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during a given measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the identified measurement period.

Diabetes Foot Exam: PQRS 163; NQF 0056; GPRO DM-8—Percentage of patients aged 18–75 years of age with diabetes who had a foot exam during a given measurement period.

Measure	1305/ 1422	Prime	UDS 2016	MIPS	HEDIS	PQRS 2016-17	MU
Diabetes— Poor Control	NQF 59 PQRS 01 GPRO DM2 UDS Table 7 Section C				Comprehensive Diabetes Care: The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: • HemoglobinA1c (HbA1c) testing. (NCQA 0034) • HbA1c control (<8.0%) (NCQA 0055) • Eye exam (retinal) performed (NCQA 0057) • Medical attention for nephropathy (NCQA 0062)[5]	NQF 59 PQRS 01 GPRO DM2	

5. See detailed measurement specifications on pp. 119-127 in https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2016-QRS-Measure-Technical-Specifications.pdf

Measure	1305/ 1422	Prime	UDS 2016	MIPS	HEDIS	PQRS 2016-17	MU
Diabetes: Eye Exam	No additional DM metrics			No additional DM metrics Retinopathy and the presence or absence of macular edema during one or more office visits within 12 months. (NQF 89, PQRS 19)		PQRS 117 GPRO DM-7 NQF 0055 —1 of 2 measures for Diabetes Composite score (all or nothing, along w/ diabetes poor control measure)	PQRS 117 GPRO DM-7 NQF 0055
Diabetes: Foot Exam	No additional metrics				No additional metrics	PQRS 163 NQF 0056 GPRO DM-8	PQRS 163 NQF 0056 GPRO DM-8
Diabetes: Urine Protein Screening	No additional metrics			No additional DM metrics	No additional metrics	No additional DM metrics	CMS134v4 The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.
Diabetes: Low Density Lipoprotein (LDL) Management	No additional DM metrics					No additional DM metrics	CMS163v4 Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/ dL) during the measurement period.

Conclusion

Organizations may have already implemented channels to track and report clinical quality measures that support Prevention First and Lifetime of Wellness objectives. However, preventive measures for undiagnosed HTN and/or prediabetes may not be in place with active reporting conducted on a regular basis. By incorporating algorithms for undiagnosed hypertension and pre-diabetes screening within the EHR or HIE reporting tools, organizations can take action to prevent and reduce the volume of new cases of diabetes and hypertension from occurring while managing existing patients with hypertension and diabetes to minimize disability and premature death.

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