PREVENTIVE CARE MEASURES GROUP OVERVIEW

2016 PQRS OPTIONS FOR MEASURES GROUPS:

2016 PQRS MEASURES IN THE PREVENTIVE CARE MEASURES GROUP:

#39 Screening for Osteoporosis for Women Aged 65 - 85 Years of Age
#48 Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
#110 Preventive Care and Screening: Influenza Immunization
#111 Pneumonia Vaccination Status for Older Adults
#112 Breast Cancer Screening
#113 Colorectal Cancer Screening
#128 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
#134 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
#226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
#431 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

INSTRUCTIONS FOR REPORTING:

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

  G8486: I intend to report the Preventive Care Measures Group

- Report the patient sample method:
  20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2016).

- Patient sample criteria for the Preventive Care Measures Group are for patients aged 50 years and older with a specific patient encounter:

  One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

- To satisfactorily report the Preventive Care Measures Group requires reporting a numerator option on all applicable measures, for each patient within the eligible professional’s patient sample, a minimum of once during the reporting period.

- Applicable measures contain patient demographic criteria specific to the measure. (See the Preventive Care Measures Group Demographic Criteria Table). For example, Screening for Osteoporosis is applicable to women aged 65 -85 years within the sample population, while the Influenza Vaccination measure within this group is applicable to all patients aged 50 years and older. Eligible professionals may find it more efficient to report all measures in the group for each patient within their sample. Reporting measure(s) from the group that are inapplicable to an individual patient will not affect the eligible provider’s reporting or performance rate.
Table 4 - Preventive Care Measures Group Demographic Criteria

<table>
<thead>
<tr>
<th>Age</th>
<th>Measures for Male Patients</th>
<th>Measures for Female Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 50 years</td>
<td>Patient does not qualify for measures group analysis</td>
<td>Patient does not qualify for measures group analysis</td>
</tr>
<tr>
<td>50-64 years</td>
<td>110, 113, 128, 134, 226, 431</td>
<td>110, 112, 113, 128, 134, 226, 431</td>
</tr>
<tr>
<td>75-85 years</td>
<td>110, 111, 128, 134, 226, 431</td>
<td>39, 48, 110, 111, 128, 134, 226, 431</td>
</tr>
<tr>
<td>≥ 86 years</td>
<td>110, 111, 128, 134, 226, 431</td>
<td>48, 110, 111, 128, 134, 226, 431</td>
</tr>
</tbody>
</table>

- Measure #110 only needs to be reported a minimum of once during the reporting period when the patient’s visit included in the patient sample population is between January and March for the 2015-2016 influenza season OR between October and December for the 2016-2017 influenza season. When the patient’s office visit is between April and September, Measure #110 is not applicable and will not affect the eligible provider’s reporting or performance rate.

- Measure #111 assesses whether patients 65 years of age or older have received one or more pneumococcal vaccinations.

- Measure #112 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.

- Measure #128 does not need to be reported (is not applicable) if the patient is considered not eligible for BMI calculation or follow-up plan – A patient is not eligible if one or more of the following reasons are documented:
  - Patient is receiving palliative care
  - Patient is pregnant
  - Patient refuses BMI measurement (refuses height and/or weight)
  - Any other reason documented in the medical record by the provider why BMI measurement was not appropriate
  - 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

- Measure #134 need only be reported on patients without an active diagnosis of Depression or a diagnosed Bipolar Disorder.

- Instructions for qualifying numerator option reporting for each of the measures within the Preventive Care Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when all quality clinical actions for all applicable measures within the group have been performed.
**Composite QDC G8496:** All quality actions for the applicable measures in the Preventive Care Measures Group have been performed for this patient

- **Measure Group Reporting Calculations:**

  Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each applicable measure within the measures group reported by the eligible professional.

  Performance exclusion QDCs are not counted in the performance denominator. If the eligible professional submits all performance exclusion QDCs, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

  If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening for Osteoporosis for Women Aged 65-85 Years of Age would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

- **NOTE:** The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures group option.
Measure #39 (NQF 0046): Screening for Osteoporosis for Women Aged 65-85 Years of Age --
National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis

NUMERATOR:
The number of women who have documentation in their medical record of having received a DXA test of the hip or spine

   Numerator Options:
   Performance Met: Patient with documented results of a central Dual-energy X-Ray Absorptiometry (DXA) ever being performed (G8399)
   OR
   Other Performance Exclusion: Clinician documented that patient was not an eligible candidate for screening (G8401)
   OR
   Performance Not Met: Patient with central Dual-energy X-Ray Absorptiometry (DXA) results not documented, reason not given (G8400)
Measure #48: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older -- National Quality Strategy Domain: Effective Clinical Care

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

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

**Definition:**  
Urinary Incontinence – Any involuntary leakage of urine.

**Numerator Options:**

**Performance Met:**  
Presence or absence of urinary incontinence assessed (1090F)

**Medical Performance Exclusion:**  
Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence (1090F with 1P)

**Performance Not Met:**  
Presence or absence of urinary incontinence not assessed, reason not otherwise specified (1090F with 8P)
Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization -- National Quality Strategy Domain: Community/Population Health

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

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

Numerator Instructions:
- If reporting this measure between January 1, 2016 and March 31, 2016, quality-data code G8482 should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2015 or January, February, and March of 2016 for the flu season ending March 31, 2016.
- If reporting this measure between October 1, 2016 and December 31, 2016, quality-data code G8482 should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2016 for the flu season ending March 31, 2017.
- Influenza immunizations administered during the month of August or September of a given flu season (either 2015-2016 flu season OR 2016-2017 flu season) can be reported when a visit occurs during the flu season (October 1 - March 31). In these cases, G8482 should be reported.

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).

NUMERATOR NOTE: The numerator for this measure can be met by reporting either administration of an influenza vaccination or that the patient reported previous receipt of the current season’s influenza immunization. If the performance of the numerator is not met, a clinician can report a valid performance exclusion for having not administered an influenza vaccination. For clinicians reporting a performance exclusion for this measure, there should be a clear rationale and documented reason for not administering an influenza immunization if the patient did not indicate previous receipt, which could include a medical reason (e.g., patient allergy), patient reason (e.g., patient declined), or system reason (e.g., vaccination not available). The system reason should be indicated only for cases of disruption or shortage of influenza vaccination supply.

Numerator Options:
Performance Met: Influenza immunization administered or previously received (G8482)

OR

Other Performance Exclusion: Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons) (G8483)

OR

Performance Not Met: Influenza immunization was not administered, reason not given (G8484)
Measure #111 (NQF 0043): Pneumonia Vaccination Status for Older Adults -- National Quality Strategy Domain: Community/Population Health

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

**NUMERATOR:**
Patients who have *ever* received a pneumococcal vaccination

**NUMERATOR NOTE:** While the measure provides credit for adults 65 years of age and older who have ever received either the PCV13 or PPSV23 vaccine (or both), according to ACIP recommendations, patients should receive both vaccines. The order and timing of the vaccinations depends on certain patient characteristics, and are described in more detail in the ACIP recommendations.

**Numerator Options:**

*Performance Met:*

Pneumococcal vaccine administered or previously received (4040F)

*OR*

*Performance Not Met:*

Pneumococcal vaccine was not administered or previously received, reason not otherwise specified (4040F with 8P)
Measure #112 (NQF 2372): Breast Cancer Screening -- National Quality Strategy Domain: Effective Clinical Care

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

NUMERATOR:
Patients 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 Options:
Performance Met: Screening mammography results documented and reviewed (3014F)

OR
Medical Performance Exclusion: Documentation of medical reason(s) for not performing a mammogram (i.e., women who had a bilateral mastectomy or two unilateral mastectomies) (3014F with 1P)

OR
Performance Not Met: Screening mammography results were not documented and reviewed, reason not otherwise specified (3014F with 8P)
**Measure #113 (NQF 0034): Colorectal Cancer Screening -- National Quality Strategy Domain: Effective Clinical Care**

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

**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 Options:**

**Performance Met:**
Colorectal cancer screening results documented and reviewed (3017F)

**OR**

**Medical Performance Exclusion:**
Documentation of medical reason(s) for not performing a colorectal cancer screening (ie, diagnosis of colorectal cancer or total colectomy) (3017F with 1P)

**OR**

**Performance Not Met:**
Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified (3017F with 8P)
Measure #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan -- National Quality Strategy Domain: Community/Population Health

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

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 Instructions:
- 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.
- Follow-Up Plan – 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)
- Performance Met for G8417 & G8418
  - If the provider documents a BMI and a follow-up plan at the current visit OR
  - If the patient has a documented BMI within the previous six months of the current encounter, the provider documents a follow-up plan at the current visit OR
  - If the patient has a documented BMI within the previous six months of the current encounter AND the patient has a documented follow-up plan for a BMI outside normal parameters within the previous six months of the current visit

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 (e.g., a registered dietitian/nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon)
- Pharmacological interventions
- Dietary supplements
- Exercise counseling
• Nutrition counseling

**Not Eligible for BMI Calculation or Follow-Up Plan** – A patient is not eligible if one or more of the following reasons are documented:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement (refuses height and/or weight)
- Any other reason documented in the medical record by the provider why BMI measurement was not appropriate
- 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 Options:**

**Performance Met:** BMI is documented within normal parameters and no follow-up plan is required (G8420)

OR

**Performance Met:** BMI is documented above normal parameters and a follow-up plan is documented (G8417)

OR

**Performance Met:** BMI is documented below normal parameters and a follow-up plan is documented (G8418)

OR

**Performance Not Met:** BMI not documented and no reason is given (G8421)

OR

**Performance Not Met:** BMI documented outside normal parameters, no follow-up plan documented, no reason given (G8419)
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

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 Instructions: 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.

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 Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

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), and PRIME MD-PHQ2

- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Follow-Up Plan – Documented 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

Not Eligible – A patient is not eligible if one or more of the following conditions are documented:

- Patient refuses to participate
- 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
- 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
- Patient has an active diagnosis of Depression
- Patient has a diagnosed Bipolar Disorder

**NUMERATOR NOTE:** The follow-up plan must be related to a positive depression screening, example: “Patient referred for psychiatric evaluation due to positive depression screening.”
Numerator Options:

Performance Met: Screening for clinical depression is documented as being positive AND a follow-up plan is documented (G8431)

OR

Performance Met: Screening for clinical depression is documented as negative, a follow-up plan is not required (G8510)

OR

Other Performance Exclusion: Screening for clinical depression not documented, documentation stating the patient is not eligible (G8433)

OR

Other Performance Exclusion: Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible (G8940)

OR

Performance Not Met: Clinical depression screening not documented, reason not given (G8432)

OR

Performance Not Met: Screening for clinical depression documented as positive, follow-up plan not documented, reason not given (G8511)
**Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention -- National Quality Strategy Domain: Community/Population Health**

**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

**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

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

**NUMERATOR NOTE:** In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation intervention report **4004F with 8P**.

**Numerator Options:**
- **Performance Met:** Patient screened for tobacco use **AND** received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (**4004F**)
- **OR**
  - **Performance Met:** Current tobacco non-user (**1036F**)
  - **Medical Performance Exclusion:** Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons) (**4004F with 1P**)
- **OR**
  - **Performance Not Met:** Tobacco screening **OR** tobacco cessation intervention not performed, reason not otherwise specified (**4004F with 8P**)
Measure #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling -- National Quality Strategy Domain: Community/Population Health

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.

NUMERATOR:
Patients who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.

Definitions:
Systematic screening method - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:

- AUDIT Screening Instrument (score ≥ 8)
- AUDIT-C Screening Instrument (score ≥ 4 for men; score ≥ 3 for women)
- Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥ 2)

Brief counseling - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

NUMERATOR NOTE: In the event that a patient is screened for unhealthy alcohol use and identified as a user but did not receive alcohol cessation counseling report G9624.

Numerator Options:
Performance Met: Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling (G9621)

OR
Performance Met: Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method (G9622)

OR
Medical Performance Exclusion: Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons) (G9623)

OR
Performance Not Met: Patient not screened for unhealthy alcohol screening using a systematic screening method OR patient did not receive brief counseling, reason not given (G9624)
MEASURE #39 - SCREENING OR THERAPY FOR OSTEOPOROSIS FOR WOMEN AGED 65 YEARS AND OLDER
RATIONALE:
This measure assesses the number of women 65-85 who have ever received a dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis. There is convincing evidence that bone mineral density tests predict short-term risk for osteoporotic fractures. There is also evidence osteoporosis treatment reduces the incidence of fracture in women who are identified to be at risk of an osteoporotic fracture. Fractures, especially in the older population, can cause significant health issues, decline in function, and, in some cases lead to mortality.

CLINICAL RECOMMENDATION STATEMENTS:
The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65 year old white women who has no additional risk factors. (B Recommendation) (USPSTF)

“Based on the U.S. FRAX tool, a 65-year-old white woman with no other risk factors has a 9.3% 10-year risk for any osteoporotic fracture. White women between the ages of 50 and 64 years with equivalent or greater 10-year fracture risks based on specific risk factors include but are not limited to the following persons: 1) a 50-year-old current smoker with a BMI less than 21 kg/m2, daily alcohol use, and parental fracture history; 2) a 55-year-old woman with a parental fracture history; 3) a 60-year-old woman with a BMI less than 21 kg/m2and daily alcohol use; and 4) a 60-year-old current smoker with daily alcohol use. The FRAX tool also predicts 10-year fracture risks for black, Asian, and Hispanic women in the United States. In general, estimated fracture risks in nonwhite women are lower than those for white women of the same age.” (USPSTF)

Current diagnostic and treatment criteria for osteoporosis rely on DXA measurements only.

The USPSTF did not define a specific upper age limit for screening in women, however they noted that clinicians should take into account the patient's remaining lifespan when deciding whether to screen patients with significant illness; the benefit of treatment emerged 18 to 24 months after initiation of treatment.

MEASURE #48 - URINARY INCONTINENCE: ASSESSMENT OF PRESENCE OR ABSENCE OF URINARY INCONTINENCE IN WOMEN AGED 65 YEARS AND OLDER
RATIONALE:
Female patients may not volunteer information regarding incontinence so they should be asked by their physician.

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

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

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

MEASURE #110 - PREVENTIVE CARE AND SCREENING: INFLUENZA IMMUNIZATION
RATIONALE:
Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza vaccine is recommended for all persons aged ≥ 6 months who do not have contraindications to vaccination.
CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Routine annual influenza 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)

MEASURE #111 - PNEUMONIA VACCINATION STATUS FOR OLDER ADULTS
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.

MEASURE #112 - BREAST CANCER SCREENING
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.

MEASURE #113 - COLORECTAL CANCER SCREENING
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).
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).


Tests that Detect Adenomatous Polyps and Cancer:

1) Colonoscopy (every 10 years)
2) Flexible sigmoidoscopy (every 5 years)
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

MEASURE #128 - PREVENTIVE CARE AND SCREENING: BODY MASS INDEX (BMI) SCREENING AND FOLLOW-UP PLAN

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

Padula, Allen and Nair (2014) examined data from a commercial claims and encounters 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 increases in cost for comorbidities ranged from $527 for obesity with 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 for Health Statistics (NCHS) Health E-Stat, Fryer and 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 and 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 interval (CI) = 1.78, 2.90).

Ranhoff, Gjoen and 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 screening 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), 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 25 to 34.9 kg/m², sex risk for patients who have BMI scores indicative of overweight or obesity class I. For adult patients with a BMI of 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 CVD and the current cutpoints for obesity to identify adults who may be at elevated risk of mortality from all causes. They also recommend counseling overweight and obese individuals on their increased risk for CVD, type 2 diabetes, all-cause mortality and need for lifestyle changes.

MEASURE #134 - PREVENTIVE CARE AND SCREENING: SCREENING FOR CLINICAL DEPRESSION AND FOLLOW-UP PLAN

RATIONALE:
The World Health Organization (WHO), 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) concluded 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).

**MEASURE #226 - PREVENTIVE CARE AND SCREENING: TOBACCO USE: SCREENING AND CESSATION 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:**
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

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

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)

MEASURES #431 - PREVENTIVE CARE AND SCREENING: UNHEALTHY ALCOHOL USE: SCREENING & BRIEF COUNSELING

RATIONALE:
This measure is intended to promote unhealthy alcohol use screening and brief counseling which have been shown to be effective in reducing alcohol consumption. About 30% of the U.S. population misuse alcohol, with most engaging in what is considered risky drinking. (SAMHSA, 2012) A recent analysis of data from the National Alcohol Survey shows that approximately one-third of at-risk drinkers (32.4%) and persons with a current alcohol use disorder (31.5%) in the United States had at least 1 primary care visit during the prior year, demonstrating the potential reach of screening and brief counseling for unhealthy alcohol use in the primary care setting. (Mulia et al., 2011) A number of studies, including patient and provider surveys, have documented low rates of alcohol misuse screening and counseling in primary care settings. In the national Healthcare for Communities Survey, only 8.7% of problem drinkers reported having been asked and counseled about their alcohol use in the last 12 months. (D’Amico et al., 2005) A nationally representative sample of 648 primary care physicians were surveyed to determine how such physicians identify--or fail to identify--substance abuse in their patients, what efforts they make to help these patients and what are the barriers to effective diagnosis and treatment. Of physicians who conducted annual health histories, less than half ask about the quantity and frequency of alcohol use (45.3 percent). Only 31.8 percent say they ever administer standard alcohol or drug use screening instruments to patients. (CASA, 2000)

CLINICAL RECOMMENDATION STATEMENTS:
The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. (Grade B recommendation) (USPSTF, 2014)