ACUTE OTITIS EXTERNA (AOE) MEASURES GROUP OVERVIEW

2015 PQRS OPTIONS FOR MEASURES GROUPS:

2015 PQRS MEASURES IN ACUTE OTITIS EXTERNA (AOE) MEASURES GROUP:
#91 Acute Otitis Externa (AOE): Topical Therapy
#93 Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
#130 Documentation of Current Medications in the Medical Record
#131 Pain Assessment and Follow-Up**
#154 Falls: Risk Assessment
#155 Falls: Plan of Care
#226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
#317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

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.

G9465: I intend to report the Acute Otitis Externa (AOE) 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, 2015).

- Patient sample criteria for the AOE Measures Group are patients aged ≥ 2 years with a specific diagnosis of AOE and accompanied by a specific patient encounter.

One of the following diagnosis codes indicating AOE:

Diagnosis for AOE (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 380.10, 380.11, 380.12, 380.13, 380.22
Diagnosis for AOE (ICD-10-CM) [for use 10/01/2015-12/31/2015]: H60.00, H60.01, H60.02, H60.03, H60.10, H60.11, H60.12, H60.13, H60.311, H60.312, H60.313, H60.319, H60.321, H60.322, H60.323, H60.329, H60.331, H60.332, H60.333, H60.339, H60.391, H60.392, H60.393, H60.399, H60.501, H60.502, H60.503, H60.509, H60.511, H60.512, H60.513, H60.519, H60.521, H60.522, H60.523, H60.529, H60.531, H60.532, H60.533, H60.539, H60.541, H60.542, H60.543, H60.549, H60.551, H60.552, H60.553, H60.559, H60.591, H60.592, H60.593, H60.599, H61.90, H61.91, H61.92, H61.93, H62.40, H62.41, H62.42, H62.43, H62.8X1, H62.8X2, H62.8X3, H62.8X9

Accompanied by:

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- Report a numerator option on all applicable measures within the AOE Measures Group for each patient within the eligible professional’s patient sample.
• Instructions for qualifying numerator option reporting for each of the measures within the AOE 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 G9466:** All quality actions for the applicable measures in the AOE Measures Group have been performed for this patient

• To report satisfactorily the AOE Measures Group requires all applicable measures for each patient within the eligible professional’s patient sample to be reported a minimum of once during the reporting period.

• Measures #130, #131, #226, and #317 need only be reported for patients age 18 years and older

• Measures #154 and #155 need only be reported for patients 65 years and older

• Measure #155 only needs to be reported when patients are identified in Measure #154 as having a falls risk assessment which indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year (1100F)

• When reporting measure #317, eligible professionals must perform the blood pressure screening at the time of a qualifying visit and may not obtain measurements from external sources.

• 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 measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 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 or Therapy for Osteoporosis for Women 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 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.

**Please note that PQRS 131 is incorrectly listed under the Communication and Care Coordination domain in the CY 2015 PFS Final Rule. PQRS 131 was finalized in the CY 2013 PFS Final Rule under the Community and Population Health domain and will therefore remain under the Community and Population Health domain for 2015.**
Measure #91 (NQF 0653): Acute Otitis Externa (AOE): Topical Therapy -- National Quality Strategy
Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations

NUMERATOR:
Patients who were prescribed topical preparations

Definition:
Prescribed – May include prescription given to the patient for topical preparations at one or more visits during the episode of AOE OR patient already receiving topical preparations as documented in the current medication list.

Numerator Options:
Performance Met: Topical preparations (including OTC) prescribed for acute otitis externa (4130F)
OR
Medical Performance Exclusion: Documentation of medical reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa (eg, coexisting acute otitis media, tympanic membrane perforation) (4130F with 1P)
OR
Patient Performance Exclusion: Documentation of patient reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa (4130F with 2P)
OR
Performance Not Met: Topical preparations (including OTC) for acute otitis externa (AOE) not prescribed, reason not otherwise specified (4130F with 8P)

**DESCRIPTION:**
Percentage of patients aged 2 years and older with a diagnosis of AOE who were **not prescribed** systemic antimicrobial therapy

**NUMERATOR:**
Patients who were **not** prescribed systemic antimicrobial therapy

**Numerator Instructions:** For performance, the measure will be calculated as the number of patients for whom systemic antimicrobial therapy was not prescribed over the number of patients in the denominator (patients aged 2 years and older with acute otitis externa). A higher score indicates appropriate treatment of patients with AOE (e.g., the proportion for whom systemic antimicrobials were not prescribed).

**Numerator Options:**
- **Performance Met:** Systemic antimicrobial therapy **not** prescribed (4132F)
- **Medical Performance Exclusion:** Documentation of medical reason(s) for prescribing systemic antimicrobial therapy (e.g., coexisting diabetes, immune deficiency) (4131F with 1P)
- **Performance Not Met:** Systemic antimicrobial therapy prescribed (4131F)
**Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record -- National Quality Strategy Domain: Patient Safety**

**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.

**NUMERATOR:**
Eligible professional attests to documenting, updating or reviewing a patient’s current medications using all immediate resources available on the date of 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.

**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).
- **Not Eligible** - A patient is not eligible if the following reason is documented:
  - 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 NOTE:** The eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications.

**Numerator Options:**
- **Performance Met:** Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient’s current medications (G8427)
- **Other Performance Exclusion:** Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional (G8430)
- **Performance Not Met:** Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given (G8428)
Measure #131 (NQF 0420): Pain Assessment and Follow-Up -- National Quality Strategy Domain: Community and Population Health**

**Please note that PQRS 131 is incorrectly listed under the Communication and Care Coordination domain in the CY 2015 PFS Final Rule. PQRS 131 was finalized in the CY 2013 PFS Final Rule under the Community and Population Health domain and will therefore remain under the Community and Population Health domain for 2015.

DESCRIPTION:
Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

NUMERATOR:
Patient visits with a documented pain assessment using a standardized tool(s) AND documentation of a follow-up plan when pain is present

Definitions:
Pain Assessment - Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration.

Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS) and Visual Analog Scale (VAS).

Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This must include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions.

Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
- 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

NUMERATOR NOTE: The standardized tool used to assess the patient’s pain must be documented in the medical record (exception: A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity)

Numerator Options:
Performance Met: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented (G8730)
OR
Performance Met: Pain assessment using a standardized tool is documented as negative, no follow-up plan required (G8731)
OR
Other Performance Exclusion: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool (G8442)
OR
Other Performance Exclusion: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible (G8939)
OR

*Performance Not Met:* **No** documentation of pain assessment, reason not given *(G8732)*

OR

*Performance Not Met:* Pain assessment documented as positive using a standardized tool, follow-up plan **not** documented, reason not given *(G8509)*

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

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

- **Numerator Instructions:** All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

- **Definitions:**
  - 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.
  - Risk Assessment – Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months.

- **Numerator Note:** History of falls is defined as 2 or more falls in the past year or any fall with injury in the past year. Documentation of patient reported history of falls is sufficient.

- **Numerator Options:**
  - **Performance Met:** Falls risk assessment documented (3288F)
    AND
    Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year (1100F)
  - **Medical Performance Exclusion:**
    Documentation of medical reason(s) for not completing a risk assessment for falls (ie, patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair) (3288F with 1P)
    AND
    Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year (1100F)
  - **Other Performance Exclusion:**
    Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year (1101F)
    OR
    **Other Performance Exclusion:** No documentation of falls status (1101F with 8P)
  - **Performance Not Met:**
    Falls risk assessment not completed, reason not otherwise specified (3288F with 8P)
    AND
    Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year (1100F)
**Measure #155 (NQF: 0101): Falls: Plan of Care -- National Quality Strategy Domain: Communication and Care Coordination**

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

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

**Numerator Instructions:** All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

**Definitions:**
- **Plan of Care** – Must include: 1) consideration of vitamin D supplementation AND 2) balance, strength, and gait training.
- **Consideration of Vitamin D Supplementation** – Documentation that vitamin D supplementation was advised or considered or documentation that patient was referred to his/her physician for vitamin D supplementation advice.
- **Balance, Strength, and Gait Training** – Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait OR referral to physical therapy.
- **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.

**Numerator Note:** History of falls is defined as 2 or more falls in the past year or any fall with injury in the past year. Documentation of patient reported history of falls is sufficient.

**Numerator Options:**
- **Performance Met:** Falls plan of care documented (0518F)
- **Medical Performance Exclusion:** Documentation of medical reason(s) for no plan of care for falls (ie, patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair) (0518F with 1P)
- **Performance Not Met:** Plan of care not documented, reason not otherwise specified (0518F with 8P)
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 counseling intervention if identified as a tobacco user.

Definitions:
- **Tobacco Use**: Includes use of any type of tobacco.
- **Cessation Counseling 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 counseling 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)
- **OR**
- **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 #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented -- National Quality Strategy Domain: Community/Population Health

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

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 NOTE: Although the recommended screening interval for a normal BP reading is every 2 years, to meet the intent of this measure, BP screening and follow-up must be performed once per measurement period. The intent of this measure is to screen patients for high blood pressure and provide recommended follow-up as indicated. Normal blood pressure follow-up is not recommended for patients with clinical or symptomatic hypotension.

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 current Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC) recommends BP screening intervals, lifestyle modifications and interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow-Up Interventions" listed below.

Recommended Lifestyle Modifications:
The current JNC report outlines lifestyle modifications which must include one or more of the following as indicated:
• Weight Reduction
• 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 current JNC report outlines BP follow-up interventions for a second hypertensive BP reading and must include one or more of the following as indicated:
• Anti-Hypertensive Pharmacologic Therapy
• Laboratory Tests
• Electrocardiogram (ECG)
Recommended Blood Pressure Follow-up Interventions:
- Normal BP: No follow-up required for Systolic BP <120 mmHg AND Diastolic BP < 80 mmHg
- Pre-Hypertensive BP: Follow-up with rescreen every year with systolic BP of 120 – 139 mmHg OR diastolic BP of 80 – 89 mmHg AND recommended lifestyle modifications OR referral to Alternate/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

Recommended Blood Pressure Follow-Up Table

<table>
<thead>
<tr>
<th>BP Classification</th>
<th>Systolic BP mmHg</th>
<th>Diastolic BP mmHg</th>
<th>Recommended Follow-Up (must include all indicated actions for each BP Classification)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal BP Reading</td>
<td>&lt; 120</td>
<td>AND &lt; 80</td>
<td>• No Follow-Up required</td>
</tr>
<tr>
<td>Pre-Hypertensive BP Reading</td>
<td>≥ 120 AND ≤ 139</td>
<td>OR ≥ 80 AND ≤ 89</td>
<td>• Rescreen BP within a minimum of 1 year AND Recommend Lifestyle Modifications OR • Referral to Alternative/Primary Care Provider</td>
</tr>
<tr>
<td>First Hypertensive BP Reading</td>
<td>≥ 140</td>
<td>OR ≥ 90</td>
<td>• Rescreen BP within a minimum of ≥ 1 day and ≤ 4 weeks AND Recommend Lifestyle Modifications OR • Referral to Alternative/Primary Care Provider</td>
</tr>
<tr>
<td>Second Hypertensive BP Reading</td>
<td>≥ 140</td>
<td>OR ≥ 90</td>
<td>• Recommend Lifestyle Modifications AND 1 or more of the Second Hypertensive Reading Interventions (see definitions) OR • Referral to Alternative/Primary Care Provider</td>
</tr>
</tbody>
</table>

Not Eligible – A patient is **not** eligible if one or more of the following reason(s) are documented:
- Patient has an active diagnosis of hypertension
- Patient refuses to participate (either BP measurement or follow-up)
- 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. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated

Numerator Options:
- **Performance Met:** Normal blood pressure reading documented, follow-up not required \((G8783)\)
- OR
- **Performance Met:** Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented \((G8950)\)
Other Performance Exclusion: Blood pressure reading not documented, documentation the patient is not eligible (G8784)

OR

Other Performance Exclusion: Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, documentation the patient is not eligible (G8951)

OR

Performance Not Met: Blood pressure reading not documented, reason not given (G8785)

OR

Performance Not Met: Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given (G8952)
AOE MEASURES GROUP RATIONALE AND CLINICAL RECOMMENDATION STATEMENTS

Measure #91 - Acute Otitis Externa (AOE): Topical Therapy

RATIONALE:
Topical preparations should be used to treat AOE as they are active against the most common bacterial pathogens in AOE, Pseudomonas aeruginosa and Staphylococcus aureus. Topical preparations have demonstrated efficacy in the treatment of AOE with resolution in about 65-90% of patients.

CLINICAL RECOMMENDATION STATEMENTS:
Clinicians should prescribe topical preparations for initial therapy of diffuse, uncomplicated AOE. (Recommendation based on randomized trials with some heterogeneity and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF, 2014)

Measure #93 - Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use

RATIONALE:
Despite their limited utility, many patients with AOE receive systemic antimicrobial therapy, often in addition to topical therapy. "There are no data on the efficacy of systemic therapy with the use of appropriate antibacterials and stratified by severity of the infection. Moreover, orally administered antibiotics have significant adverse effects that include rashes, vomiting, diarrhea, allergic reactions, altered nasopharyngeal flora, and development of bacterial resistance." The use of systemic antimicrobial therapy to treat AOE should be limited only to those clinical situations in which it is indicated.

CLINICAL RECOMMENDATION STATEMENTS:
Clinicians should not prescribe systemic antimicrobials as initial therapy for diffuse, uncomplicated AOE unless there is extension outside the ear canal or the presence of specific host factors that would indicate a need for systemic therapy. (Strong recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF, 2014)

Measure #130 – Documentation of Current Medications in the Medical Record

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.

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 (ADEs) 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 Commonwealth Fund report (2010) about 11 to 15 of every 1,000 Americans visit a health care provider because of ADEs in a given year, representing about three to four of every 1,000 patient visits during 1995 to 2001. The total number of visits to treat ADEs increased from 2.9 million in 1995 to 4.3 million visits in 2001.

ADEs in the ambulatory setting substantially increased the healthcare costs of elderly persons and estimated costs were $1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million visit related ADEs (VADEs) 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.

In the Institute for Safe Medication Practices, *The White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists* (2007), the American Pharmaceutical Association identified that Americans spend more than $75 billion per year on prescription and nonprescription drugs. Unnecessary costs include: improper use of prescription medicines due to lack of knowledge costs the economy an estimated $20-100 billion per year; American businesses lose an estimated 20 million workdays per year due to incorrect use of medicines prescribed for heart and circulatory diseases alone; failure to have prescriptions dispensed and/or renewed has resulted in an estimated cost of $8.5 billion for increased hospital admissions and physician visits, nearly one percent of the country's total health care expenditures.

In 2005, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days. 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 “The median ADE prevalence rate for retrospective studies was 3.3% (interquartile range [IQR] 2.3–7.1%) vs 9.65% (IQR 3.3–17.35%) for prospective studies. Median preventable ADE rates in ambulatory care-based studies were 16.5%, and 52.9% for hospital-based studies. Median prevalence rates by age group ranged from 2.45% for children to 5.27% for adults, 16.1% for elderly patients, and 3.45% for studies including all ages (Tache et al., 2011).”

The Agency for Healthcare Research and Quality’s (AHRQ) The National Healthcare Disparities Report (2011) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings as 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 gender. 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 that 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 2014 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” includes the following: “Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.”
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.

**Measure #131 – Pain Assessment and Follow-Up**

**RATIONALE:**

Several provisions from the National Pain Care Policy Act (H.R. 756/S. 660) have been included in the Affordable Care Act (ACA) of 2010 to improve pain care. The legislation includes:

- Mandating an Institute of Medicine (IOM) conference on pain to address key medical and policy issues affecting the delivery of quality pain care.
- Establishing a training program to improve the skills of health care professionals to assess and treat pain.
- Enhancing the pain research agenda for the National Institute of Health (NIH).

The American Pain Foundation (2009) identified pertinent facts related to the impact of pain as follows:

- Approximately 76.5 million Americans suffer from pain.
- Pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care.
- Uncontrolled pain is a leading cause of disability and diminishes quality of life for patients, survivors, and their loved ones. It interferes with all aspects of daily activity, including sleep, work, social and sexual relations.
- Under-treated pain drives up costs – estimated at $100 billion annually in healthcare expenses, lost income, and lost productivity—extending length of hospital stays, as well as increasing emergency room trips and unplanned clinic visits.
- Medically underserved populations endure a disproportionate pain burden in all health care settings. Disparities exist among racial and ethnic minorities in pain perception, assessment, and treatment for all types of pain, whether chronic or acute.

The Institute Of Medicine’s (IOM) *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011) report suggests that chronic pain rates will continue to increase as a result of:

- More Americans will experience a disease in which chronic pain is associated (diabetes, cardiovascular disease, etc.).
- Increase in obesity which is associated with chronic conditions that have painful symptoms.
- Progress in lifesaving techniques for catastrophic injuries for people who would have previously died leads to a group of young people at risk for lifelong chronic pain.
- Surgical patients are at risk for acute and chronic pain.
- The public has a better understanding of chronic pain syndromes and new treatments and therefore may seek help when they may not have sought help in the past.
Persistent chronic pain costs $560 to $635 billion in the USA. Additional healthcare costs due to pain range from $261 to $300 billion. Lost productive time amounts to $299 to $334 billion. Productivity is affected by number of days missed, number of annual hours worked and hourly wages (Gaskin, 2012). Stewart et al. (2003) identified almost thirteen percent of the total workforce experienced a loss in productive time during a two-week period due to a common pain condition: 5.4% for headache; 3.2% for back pain; 2.0% for arthritis pain; 2.0% for other musculoskeletal pain.

There are no current estimates of the total cost of poorly controlled pain in today’s dollars. Viewed from the perspective of health care inflation at levels of more than 40% during the past decade (President’s Council of Economic Advisors, 2009), the cost of health care due to pain is estimated to be between $261 to $300 billion. The value of lost productivity based on estimates of days of work missed is $11.6 to 12.7 billion, hours of work lost is $95.2 to $96.5 billion and lower wages is $190.6 to $226.3 billion. Total financial cost of pain to society, combining healthcare cost estimates and productivity estimates, ranges from $560 to $635 billion in 2010 dollars (Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research, Appendix C, 2011).

“Medical care, specifically specialty care, rather than primary care, chiropractic care, or physical therapy is responsible for the rising costs of ambulatory care for spine conditions” (Davis, 2012).

Medical Expenditures Panel (MEP) data from 2000-2007 show that prevalence of back pain has increased by 29% and chronic back pain has increased 64%. Inflation adjusted ($2010) biennial expenditures on ambulatory services for chronic back pain increased by 129% from $15.6 billion in 2000-2001 to $35.7 billion in 2006-2007 (Smith, 2013).

Chronic pain is defined as pain without biological values that has persisted beyond the normal time and despite the usual customary efforts to diagnose and treat the original condition and injury. If a patient’s pain has persisted for six weeks (or longer than the anticipated healing time), a thorough evaluation for the course of the chronic pain is warranted (ICSI, 2013).

Chronic pain affects approximately 100 million adults in the USA. (Gaskin, 2012). It is clear the enormous pain-related costs represent both a great challenge and an opportunity in terms of improving the quality and cost-effectiveness of care (Mayday Fund, 2009).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women’s pain complaints tend to be poorly assessed and undertreated (Green, 2003; Chronic Pain Research Alliance 2011, Weimer 2013). Although women may have higher baseline pain, differences in pain levels may not persist at one month (Peterson, 2012).

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Burgess, 2013; Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (e.g., acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007). Black race is associated with neighborhood socio-economic status (SES) and race plays a role in pain outcomes beyond SES (Green, 2012).

**CLINICAL RECOMMENDATION STATEMENTS:**
Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.
A patient-centered, multifactorial, comprehensive care plan is necessary; one that includes biopsychosocial factors, as well as spiritual and cultural issues. It is important to have an interdisciplinary team approach which includes the primary care physician and specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2013) Assessment and Management of Chronic Pain Guideline, Sixth Edition is based on a very broad foundation of evidence addressing a wide range of clinical conditions. It was chosen because it addresses the key factors of the comprehensive plan of care which incorporates self-management and active input from the patient and primary care clinician, pain assessment outcomes and referral to a pain medicine specialist or pain medicine specialty clinic.

The Institute for Clinical Systems Improvement (ICSI, 2012) Adult Acute and Sub-acute Low Back Pain guideline provides guidelines for physical therapists for low back pain assessment criteria, reducing or eliminating imaging for diagnosis of non-specific low back pain in patients 18 years and older, first-line treatment which emphasizes patient education and a core treatment plan that includes encouraging activity, use of heat, no imaging, cautious and responsible use of opioids, anti-inflammatory and analgesic over-the-counter medications and return to work assessment, advising patients with acute or subacute low back pain to stay active and the use of opioids.

Low Back Pain: Clinical Guidelines Linked to the International Classification of Functioning, Disability, and Health from the Orthopedic Section of the American Physical Therapy Association (Delitto, 2012) provides evidence to classify musculoskeletal conditions, specify interventions and identify appropriate outcome measures.

"Initial physical therapy management was not associated with increased health care costs or utilization of specific services following a new primary care LBP consultation" (Fritz, 2013, p. 1).

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

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

**CLINICAL RECOMMENDATION STATEMENTS:**
Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualized, multifactorial intervention. (NICE) (Grade C)

Multifactorial assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person’s perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review (NICE) (Grade C)
A falls risk assessment should be performed for older persons who present for medical attention because of a fall, report recurrent falls in the past year, report difficulties in walking or balance or fear of falling, or demonstrate unsteadiness or difficulty performing a gait and balance test.

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

Measure #155 – Falls: Plan of Care

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

CLINICAL RECOMMENDATION STATEMENTS:
The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.
Grade: B Recommendation.

The AGS 2010 Clinical Practice Guidelines Recommend:

Multifactorial/Multicomponent Interventions to Address Identified Risk(s) and Prevent Falls

1. A strategy to reduce the risk of falls should include multifactorial assessment of known fall risk factors and management of the risk factors identified. [A]
2. The components most commonly included in efficacious interventions were:
   a. Adaptation or modification of home environment [A]
   b. Withdrawal or minimization of psychoactive medications [B]
   c. Withdrawal or minimization of other medications [C]
   d. Management of postural hypotension [C]
   e. Management of foot problems and footwear [C]
   f. Exercise, particularly balance, strength, and gait training [A]
3. All older adults who are at risk of falling should be offered an exercise program incorporating balance, gait, and strength training. Flexibility and endurance training should also be offered, but not as sole components of the program. [A]
4. Multifactorial/multicomponent intervention should include an education component complementing and addressing issues specific to the intervention being provided, tailored to individual cognitive function and language. [C]
5. The health professional or team conducting the fall risk assessment should directly implement the interventions or should assure that the interventions are carried out by other qualified healthcare professionals. [A]

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 (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

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

Measure #317 - Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up

**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.