

## Measure Dictionary

### Adolescent Preventative Care

*Medical Record Hybrid Specification:* Compliance with this measure will include notation of assessment, counseling, or education on:

- Risk behaviors and preventive actions associated with sexual activity
- Depression
- Tobacco usage
- Substance Use

Notation that a specific tool was used without noting which areas were assessed, counseled, or discussed does not count as a positive numerator finding. If a checklist is used and included in the medical record or if there is reference to the areas covered, the notations will be counted as positive numerator findings for the respective areas. If the notation states the tool was used and sexual activity, depression, tobacco, and substance use were reviewed, these will be considered positive numerator findings for the four topic areas.

*Key Elements:*

- Notations of assessments, counseling, referral, prescription, discussions
- Distribution of educational materials
- Use of checklists or questionnaires

*Time Frame:*

- Measurement year (January – December)

### Adult BMI Assessment

*Medical Record Hybrid Specification:* If 20+ years of age, medical record documentation must include weight and BMI value from the same data source. For members younger than 20 on the date of service, the medical record must include height, weight and BMI percentile, again from the same source. All documentation must be dated during the measurement year or year prior to the measurement year. BMI percentile must be documented as a value (e.g. 85<sup>th</sup> percentile) or plotted on an age-growth chart in order to meet criteria.

*Key Elements (same source required):*

- Weight
- BMI Value
- Height (if under 20 years old)

*Time Frame:*

- Measurement year (January – December) or year prior

## **Antidepressant Medication Management**

*Administrative Specification Only:* This measure reports on two rates (see sample medication list in Appendix 1):

- Members who had at least 84 days (12 weeks) of treatment with antidepressant medication
- Members who remained on an antidepressant medication for at least 180 days (6 months)

*Key Elements:*

- Medication documentation
- Notation of review/reconciliation

*Time Frame:*

- The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year (intake period)

## **Asthma Medication Ratio**

*Administrative Specification Only:* This measure will evaluate members who have consistent asthma and their ratio of controller medications to total asthma medications. Both types are listed below in Appendix 1.

*Key Elements:*

- Admin-only – Asthma and controller medication coding

*Time Frame:*

- Measurement Year (January – December)

## **Breast Cancer Screening**

*Administrative Specification Only:* Numerator-compliant patients will have had one or more mammograms.

*Key Elements:*

- Admin-only – Mammogram coding

*Time Frame:*

- For Measurement Year 2020: 10/1/18-12/31/2020

## **Care for Older Adults - Advance Care Planning**

*Medical Record Hybrid Specification:* Evidence of advance care planning must include either:

*Key Elements:*

- An advance care plan in the medical record

- Documentation of an advance care planning discussion with the provider, including the date
- Notation of a previously executed advance care plan by the member

*Time Frame:*

- Measurement Year (January – December)

**Care for Older Adults - Functional Status Assessment**

*Medical Record Hybrid Specification:* Medical record documentation must include evidence of a complete functional status assessment and the assessment date. Note that a functional status assessment will not be deemed comprehensive if it is limited to an acute or single condition, event, or body system.

*Key Elements (non-comprehensive):*

- Functional status assessment
  - Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring, using toilet, walking
  - Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances

*Time Frame:*

- Measurement Year (January – December)

**Care for Older Adults - Medication Review**

*Medical Record Hybrid Specification:* Documentation must include one of the following, from the same medical record. A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Do not include medication lists or medication reviews performed in an acute inpatient setting.

*Key Elements (same medical record):*

- Medication list
- Evidence of a medication review by a prescribing practitioner or clinical pharmacist
- Review date
- Notation that the member is not taking any medication
- Notation date

*Time Frame:*

- Measurement Year (January – December)

## Care for Older Adults - Pain Assessment

*Medical Record Hybrid Specification:* Medical record documentation must include evidence of a pain assessment and assessment date. Do not include pain assessments performed in an acute inpatient setting, and please note that notation of a pain management or pain treatment plan alone will not meet criteria. Pain assessment notation must include one of the following:

*Key elements (non-comprehensive):*

- Documentation that the patient was assessed for pain (positive or negative findings)
- Assessment result, using a standardized pain assessment tool including, but not limited to:
  - Numeric rating scales (verbal or written)
  - Face, Legs, Activity, Cry Consolability (FLACC) scale
  - Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory)
  - Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale)

*Time Frame:*

- Measurement Year (January – December)

## Cervical Cancer Screening

*Medical Record Hybrid Specification:* Appropriate screenings will be in the medical records of:

- Women between the ages of 24-64 (in the measurement year), who had cervical cytology during that year or the two years prior. Medical record documentation must include both the result/finding and the date. Cervical cancer screening methods including collection and microscopic analysis of cervical cells count towards the measure
- Women between the ages of 30-64 (in the measurement year) with high-risk human papillomavirus (hrHPV) testing that year or the four years prior (if over 30 at time of the test). Medical record documentation must include both the result/findings and the date

*Note: Do not count biopsies for both screening types.*

*Key Elements:*

- Testing performed
- Results
- Date

*Time Frame:*

- 3 years – Cervical Cytology
- 5 years – HrHPV (high-risk human papillomavirus)

## Colorectal Screening

*Medical Record Hybrid Specification:* Medical record documentation must include the date of the colorectal cancer screening; a result is required if the documentation not is clearly part of the member's "medical history".

Pathology reports that indicate the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the screening date meet criteria. If the report does not indicate the type of screening, or for incomplete procedures, criteria can be met either by evidence that the scope advanced beyond the splenic flexure or evidence that the scope advanced into the sigmoid colon.

Do not count digital rectal exams (DRE), FOBT tests performed in an office setting, or FOBT tests performed on a sample collected via DRE.

*Key Elements:*

- Date of screening
- Result (as necessary)

*Time Frame:*

- 1 Year: Fecal Occult Blood Test
- 3 Years: Stool DNA Test
- 5 Years: Flexible Sigmoidoscopy
- 5 Years: Computed Tomography Colonography
- 10 Years: Colonoscopy

**Comprehensive Diabetes Care Eye Exam**

*Medical Record Hybrid Specification:* The following items meet medical record documentation requirements, though are not an exhaustive list:

- Indication (note, letter, etc.) from a health care provider that an ophthalmoscopic exam was completed by an optometrist or ophthalmologist (eye care professional), the date the procedure was performed, and the results
- A chart or photograph indicating the date the fundus photography was performed and evidence of review by an eye care professional
- Evidence of bilateral eye enucleation or acquired absence of both eyes

*Key Elements (non-comprehensive):*

- Indication of ophthalmoscopic exam/fundus photography/bilateral eye enucleation/etc.
- Date
- Evidence of review by eye care professional
- Results

*Time Frame:*

- 1 year – retinal or dilated eye exam
- 2 years – negative retinal or dilated exam (negative for retinopathy)
- Any time during the member’s history: bilateral eye enucleation

### **Comprehensive Diabetes Care: Results (Including control and poor control)**

*Medical Record Hybrid Specification:* To satisfy the measure, medical record documentation must include the date of the HbA1c test and the result. Ranges and thresholds will not meet criteria. Control is established if the member’s most recent HbA1c level during the measurement year is <8.0%. Poor control is established if the most recent HbA1c level is >9.0%.

*Key Elements:*

- Testing performed
- Results
- Date

*Time Frame:*

- Measurement Year (January – December)

### **Comprehensive Diabetes Care: HbA1c Test**

*Medical Record Hybrid Specification:* To satisfy the measure, medical record documentation must include the date of the HbA1c test and the result. Ranges and thresholds will not meet criteria. Medical record notation of the following will count:

A1c	Glycohemoglobin A1c
HbA1c	Glycohemoglobin
HgbA1c	Glycated hemoglobin
Hemoglobin A1c	Glycosylated hemoglobin

*Key Elements:*

- Testing performed
- Results
- Date

*Time Frame:*

- Measurement Year (January – December)

### **Comprehensive Diabetes Care Nephropathy Screening**

*Medical Record Hybrid Specification:* The following items meet nephropathy measure requirements, though are not an exhaustive list:

*Key Elements (non-comprehensive):*

- Documentation of a nephrologist visit
- Renal transplant documentation
- Medical attention for the following: Diabetic nephropathy; ESRD; Chronic renal failure (CRF); Chronic kidney disease (CKD); Renal insufficiency; Acute renal failure (ARF); Dialysis, hemodialysis

- Evidence of ACE inhibitor/ARB therapy

*Time Frame:*

- Measurement year (January – December)

### **Controlling High Blood Pressure < 140/90**

*Medical Record Hybrid Specification:* For the measurement year, the most recent noted blood pressure (BP) reading must occur after the second diagnosis of hypertension. BP readings from remote monitoring devices are allowed if they are digitally stored and both transmitted to and interpreted by the provider. Documentation must reflect that the reading is from an electronic device.

*Note - BP readings will not count if: taken during an acute inpatient stay or an ED visit; member self-reported; or taken on the same day, or the day before, as a medical event requiring a change in diet/medication.*

*Key Elements:*

- Testing performed
- Results
- Date

*Time Frame:*

- Measurement year (January – December)

### **Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication**

*Administrative Specification Only:* This measure seeks to evaluate those taking antipsychotic medication who received a glucose test or an HbA1c test during the measurement year. See list of diabetes medications and SSD antipsychotic medications below in Appendix 1.

*Key Elements:*

- Admin-only – medication coding

*Time Frame:*

- Measurement year (January – December)

### **HIV Viral Load Suppression**

*Administrative Specification Only:* The Viral Load Suppression measure will be calculated by the AIDS Institute and the Office of Quality and Patient Safety using the NYSDOH HIV Surveillance System.

Upon close of the measurement year NYSDOH staff will apply an algorithm to identify Medicaid recipients who are potentially HIV-positive using claims and encounters from January 1, 2012 through December 31, 2018. DOH staff will then employ a multistage matching algorithm to link information on potentially HIV-positive members to the HIV Surveillance System. The HIV

Surveillance System provides information on the Viral load suppression levels for all matched cases. NYS Public Health law requires electronic reporting to the NYSDOH any laboratory test, tests, or series of tests approved for the diagnosis or periodic monitoring of HIV infection.

*Key Elements:*

- Admin-only – utilize NYS DOH reporting

*Time Frame:*

- Measurement year (January – December)

**Medication Reconciliation Post-Discharge**

*Medical Record Hybrid Specification:* Outpatient medical record documentation must include evidence of medication reconciliation and the reconciliation. The following, non-exhaustive, list exhibits some of the documentation types meeting criteria:

- Documentation of current medications, with a note that the provider reconciled the current and discharge medications
- Documentation of current medications with a note referencing the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, etc.)
- Documentation of the member's current medications with notation of discharge medication review
- Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service

*Key Elements:*

- Medication documentation
- Notation of review/reconciliation

*Time Frame:*

- January 1 through December 1 of the measurement year

**Sexually Transmitted Infections: Screening for Chlamydia**

*Medical Record Hybrid Specification:* The measure evaluates the percentage of patients with a diagnosis of HIV who received a Chlamydia screening during the measurement year (any site).

*Key Elements:*

- Testing performed
- Date
- Results (as applicable)

*Time Frame:*

- Measurement year (January – December)

### **Sexually Transmitted Infections: Screening for Gonorrhea**

*Medical Record Hybrid Specification:* The measure evaluates the percentage of patients with a diagnosis of HIV who received a Gonorrhea screening during the measurement year (any site).

*Key Elements:*

- Testing performed
- Date
- Results (as applicable)

*Time Frame:*

- Measurement year (January – December)

### **Sexually Transmitted Infections: Screening for Syphilis**

*Medical Record Hybrid Specification:* The measure evaluates the percentage of patients with a diagnosis of HIV who received a Gonorrhea screening during the measurement year (any site).

*Key Elements:*

- Testing performed
- Date
- Results (as applicable)

*Time Frame:*

- Measurement year (January – December)

### **Use of Spirometry Testing in the Assessment and Diagnosis of COPD**

*Administrative Specification Only:* This measure will evaluate members with a spirometry claim or encounter during the two years prior to the IESD (730 days) through six months (180 days) after the IESD.

*Key Elements:*

- Admin-only – Spirometry coding

*Time Frame:*

- Intake period: 12-month window (July 1 of the year prior to the measurement year through June 30 of the measurement year). The Intake Period captures the first COPD diagnosis.
- Two years prior to index episode start date through six months afterward

### **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**

*Medical Record Hybrid Specification:*

- BMI percentile during the measurement year as identified by medical record review.

- Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by medical record review
- Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by medical record review

*Key Elements:*

- BMI: Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source
- Nutrition and Physical Activity: Documentation must include a note indicating the date and at least one of the following:
  - Discussion of current behaviors
  - Checklist used
- Counseling or referral for education
- Member received educational materials
- Anticipatory guidance

*Time Frame:*

- Measurement year (January – December)