

## Crystal PM and Clinical Quality Measures

Crystal Practice Management has received the federal government's "meaningful use" stamp of approval by earning Complete EHR Ambulatory certification. The designation officially deems the electronic health record (EHR) software capable of enabling providers to qualify for funding under the American Recovery and Reinvestment Act (ARRA). Tested and certified under the Drummond Group's Electronic Health Records Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) program, the EHR software is 2011/2012 compliant in accordance with the criteria adopted by the Secretary of Health and Human Services.

For additional information and to register for incentives visit: [www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms).  
[CMS Government Page](#)

CMS EHR Certification ID is: **30000001TA4YEAC**

Certifying ATCB: Drummond Group Inc. | CHPL Product Number: 01192011-9207-1  
Classification: Complete EHR | Practice Setting: Ambulatory  
Additional Software Required\*: Allscripts eRx, Email software

**\*The 2 additional requirements for Complete EHR Ambulatory certification are the use of All Scripts Platinum Account e-prescribing and any email software. If you do not already have a Platinum account with All Scripts please contact them at 1.800.347.3473.**

### What are the requirements for recording Clinical Quality Measures?

Eligible professionals must report from the table of 44 clinical quality measures which includes, 3 Core, 3 Alternate Core, and 38 additional CQMs.

- Core CQMs - EPs must report on 3 required core CQMs, and if the denominator of 1 or more of the required core measures is 0, then EPs are required to report results for up to 3 alternate core measures.
- EPs also must also select 3 additional CQMs from a set of 38 CQMs (excluding the core/alternate core measures). It is acceptable to have a '0' denominator provided the EP does not have an applicable population.

In sum, EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures. A maximum of 9 measures would be reported if the EP needed to attest to the 3 required core, the three alternate core, and the 3 additional measures.

**Reporting Period:** The reporting period for the EHR Incentive program using a certified EHR is any continuous 90 day period during the first payment year. Please note that although the measure

specifications assume a full calendar year you should only calculate the denominator and numerator from the first day of the 90 day reporting period to the last day of the 90 day reporting period.

This document details the measures that are supported in the Crystal PM software.

## **Core Measures:**

- Hypertension: Blood Pressure Measurement (NQF 0013)
- Weight Assessment and Counseling for Children and Adolescents (NQF 0024)
- Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment (NQF 0028a)
- Preventive Care and Screening Measure Pair: b. Tobacco Cessation Intervention (NQF 0028b)
- Preventive Care and Screening: Influenza Immunization for Patients > 50 Years Old (NQF 0041)
- Adult Weight Screening and Follow-Up (NQF 0421)

## **Additional Measures:**

- Diabetes: Eye Exam (NQF 0055)
- Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation (NQF 0086)
- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy (NQF 0088)
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (NQF 0089)

## Hypertension: Blood Pressure Measurement (NQF 0013)

<b>EMeasure Name</b>	Hypertension: Blood Pressure Measurement	<b>EMeasure Id</b>	Pending
<b>Version Number</b>	1	<b>Set Id</b>	Pending
<b>Available Date</b>	No information	<b>Measurement Period</b>	January 1, 20xx through December 31, 20xx
<b>Measure Steward</b>	American Medical Association – Physician Consortium for Performance Improvement		
<b>Endorsed by</b>	National Quality Forum		
<b>Description</b>	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.		
<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Rationale</b>	Effective management of blood pressure in patients with hypertension can help prevent cardiovascular events, including myocardial infarction, stroke, and the development of heart failure.		
<b>Clinical Recommendation Statement</b>	Treating SBP and DBP to targets that are <140/90 mm Hg is associated with a decrease in CVD risk complications. In patients with hypertension and diabetes or renal disease, the BP goal is <130/80 mm Hg. (JNC VII, 2004).		
<b>Improvement notation</b>	Higher score indicates better quality		
<b>Measurement duration</b>	12 months		

### Crystal Directions:

In the ARRA tab of the Medical Records page, there are two fields labeled “Blood Pressure” to record the patient’s blood pressure. Any value counts toward this measure.

There is a field labeled “Hypertension?” to indicate whether the provider diagnoses the patient with hypertension. A value of “Yes” counts toward this measure.

Patient must have blood pressure recorded, hypertension marked “Yes”, and have 2 or more medical records corresponding to 2 or more office visits to count toward the measure.

**Weight Assessment and Counseling for Children and Adolescents  
(NQF 0024)**

<b>EMeasure Name</b>	Weight Assessment and Counseling for Children and Adolescents	<b>EMeasure Id</b>	Pending
<b>Version Number</b>	1	<b>Set Id</b>	Pending
<b>Available Date</b>	No information	<b>Measurement Period</b>	January 1, 20xx through December 31, 20xx
<b>Measure Steward</b>	National Committee for Quality Assurance		
<b>Endorsed by</b>	National Quality Forum		
<b>Description</b>	The percentage of patients 2-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.		
<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Rationale</b>	This measure assesses the percentage of age-appropriate patients who had an outpatient visit with a PCP or OB/GYN and who had evidence of a BMI percentile assessment, counseling for nutrition or counseling for physical activity. The prevalence of overweight and obesity has increased sharply for children over the last 30 years: from 5.0% to 13.9% for those aged 2–5 years; from 6.5% to 18.8% for those aged 6–11 years; and from 5.0% to 17.4% for those aged 12–19 years. This increasing prevalence has had significant economic ramifications, with economic costs correlated to obesity and related comorbidities estimated at over \$70 billion, or 7% of the national health care budget. To address this problem and its long-term implications effectively, promotion of routine physical activity and healthy eating and lifestyle changes are essential (CDC 2007). This measure is important in efforts to improve long-term health outcomes and quality of life.		

<p><b>Clinical Recommendation Statement</b></p>	<p>U.S. Preventive Services Task Force (USPSTF): “I” Recommendation. Insufficient evidence to recommend for or against screening for overweight in children and adolescents reflects the paucity of strong evidence of the effectiveness of interventions for this problem in the clinical setting. The American Academy of Pediatrics (AAP): The child’s height, weight and percentiles for age should be determined at the start of the physical examination. Because obesity is strongly linked to hypertension, BMI should be calculated from the height and weight, and the BMI percentile should be calculated. Poor growth may indicate an underlying chronic illness. The American Medical Association (AMA), Health Resources and Services Administration (HRSA), and Centers for Disease Control and Prevention (CDC): The Expert Committee recommends that physicians and allied healthcare providers perform, at a minimum, a yearly assessment of weight status in all children, and that this assessment include calculation of height, weight (measured appropriately), and body mass index (BMI) for age and plotting of those measures on standard growth charts.</p> <p>The American Academy of Pediatrics and the American College of Clinical Endocrinology (ACCE): The AAP and the ACCE recommend and encourage pediatric providers to screen children for obesity using BMI; examine overweight children for obesity-related diseases; initiate weight management practices to improve diet and physical activity habits; and increase frequency of visits to reinforce behavior changes.</p> <p>The Centers for Disease Control and Prevention (CDC): The CDC recommends using the percentile BMI for age and gender as the most appropriate and easily available method to screen for childhood overweight or at risk for overweight. BMI is calculated by dividing the weight in kilograms by the height in meters squared. Age and gender norms for BMI are readily accessible. BMI correlates with adiposity and with complications of childhood overweight such as hypercholesterolemia, hypertension and later development of cardiovascular disease. Although more precise measures of lean body mass and body fat such as dual x-ray absorptiometry (DEXA) may be appropriate for clinical studies, BMI norms are particularly helpful for screening in busy office practices and for population assessment.</p>
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**Crystal Directions:**

There are four fields used to calculate this measure. All are located in the ARRA tab of the Medical Records.

Is Primary Care Provider – this measure only applies to doctors that are the primary care provider for the child in question, so the doctor is required to mark this field “Yes” in order to count toward the measure

BMI – a value must be recorded to count toward the measure. The physician may enter height and weight and click the Calc BMI button to fill this field automatically.

Counseled for Nutrition – mark “Yes” if nutrition was discussed with child

Counseled for Activity – mark “Yes” if exercise was discussed with child

All fields must be marked as noted above to count toward this measure.

**Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment (NQF 0028a)**

<b>EMeasure Name</b>	Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment	<b>EMeasure Id</b>	Pending
<b>Version Number</b>	1	<b>Set Id</b>	Pending
<b>Available Date</b>	No information	<b>Measurement Period</b>	January 1, 20xx through December 31, 20xx
<b>Measure Steward</b>	American Medical Association – Physician Consortium for Performance Improvement		
<b>Endorsed By</b>	National Quality Forum		
<b>Description</b>	Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.		
<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Rationale</b>	Tobacco use is one of the leading causes of many preventable diseases, however, not all individuals are screened for tobacco use.		
<b>Clinical Recommendation Statement</b>	The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (USPSTF, 2003).		

**Crystal Directions:**

In the ARRA tab of the Medical Records page, there is a field labeled “Smoking Status” to indicate patient’s current and past tobacco use.

This field must be filled out, and the patient must have at least 2 medical records representing two or more office visits to count toward this measure.

**Preventive Care and Screening Measure Pair: b. Tobacco Cessation Intervention (NQF 0028b)**

<b>EMeasure Name</b>	Preventive Care and Screening Measure Pair: b. Tobacco Cessation Intervention	<b>EMeasure Id</b>	Pending
<b>Version Number</b>	1	<b>Set Id</b>	Pending
<b>Available Date</b>	No information	<b>Measurement Period</b>	January 1, 20xx through December 31, 20xx
<b>Measure Steward</b>	American Medical Association – Physician Consortium for Performance Improvement		
<b>Endorsed By</b>	National Quality Forum		
<b>Description</b>	Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.		
<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Rationale</b>	The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products.		
<b>Clinical Recommendation Statement</b>	The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (USPSTF, 2003).		

**Crystal Directions:**

In the ARRA tab of the Medical Records page, there is a field labeled “Discussed Cessation” to mark whether the physician discussed smoking cessation options with the patient.

This field must be marked “Yes” for patients whose smoking status indicates they are tobacco users in order to count toward this measure.

**Preventive Care and Screening: Influenza Immunization for Patients  $\geq$  50 Years Old (NQF 0041)**

<b>EMeasure Name</b>	Preventive Care and Screening: Influenza Immunization for Patients > 50 Years Old	<b>EMeasure Id</b>	Pending
<b>Version Number</b>	1	<b>Set Id</b>	Pending
<b>Available Date</b>	No information	<b>Measurement Period</b>	January 1, 20xx through December 31, 20xx
<b>Measure Steward</b>	American Medical Association – Physician Consortium for Performance Improvement		
<b>Endorser</b>	National Quality Forum		
<b>Description</b>	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).		
<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Rationale</b>	Influenza vaccination has shown to decrease hospitalizations for influenza, especially for those with risk factors, however annual influenza vaccination rates remain low.		
<b>Clinical Recommendation Statement</b>	Annual influenza immunization is recommended for all groups who are at increased risk for complications from influenza including persons aged $\geq$ 50 years. (CDC, USPSTF)		

**Crystal Directions:**

In the ARRA tab of the Medical Records page, there is a field labeled “Recvd Influenza Immun” that indicates whether the patient received an influenza immunization.

Any patients aged 50 years and older that have this field marked “Yes” will be counted toward this measure.

**Diabetes: Eye Exam (NQF 0055)**

<b>EMeasure Name</b>	Diabetes: Eye Exam	<b>EMeasure Id</b>	Pending
<b>Version Number</b>	1	<b>Set Id</b>	Pending
<b>Available Date</b>	No information	<b>Measurement Period</b>	January 1, 20xx through December 31, 20xx
<b>Measure Steward</b>	National Committee for Quality Assurance		
<b>Endorsed by</b>	National Quality Forum		
<b>Description</b>	The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional .		
<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Rationale</b>	<p>This measure evaluates the percentage of patients in a specific age demographic who were diagnosed with type 1 or type 2 diabetes and who had an eye (retinal) exam performed. Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body’s inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including glaucoma and blindness. Diabetic retinopathy is the most common diabetic eye disease and causes 21,000–4,000 new cases of blindness annually. The consensus among established clinical guidelines is that patients with both types of diabetes should have an initial dilate and comprehensive eye exam soon after diagnosis (ADA 2009). Guidelines also recommend consultation with an ophthalmologist for treatment options if a patient has any level of macular edema or diabetic retinopathy (proliferative and nonproliferative). This measure facilitates the prevention and long-term management of retinal-based complications for patients diagnosed with diabetes.</p>		

<p><b>Clinical Recommendation Statement</b></p>	<p>American Diabetes Association (ADA) – 2009:</p> <ul style="list-style-type: none"> <li>•Adults and children aged 10 years or older with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (B)</li> <li>•Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B)</li> <li>•Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less frequent exams (every 2–3 years) may be considered following one or more normal eye exams. Examinations will be required more frequently if retinopathy is progressing. (B)</li> <li>•Women with preexisting diabetes who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. (B)</li> <li>•Eye examination should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum. (B)</li> <li>•Promptly refer patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. (A)</li> <li>•Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A)</li> <li>•The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage. (A)</li> </ul> <p>American Geriatric Society (AGS) - 2003: The older adult who has new-onset DM should have an initial screening dilated-eye examination performed by an eye-care specialist with funduscopy training. (Level I, Grade B)</p>
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**Crystal Directions:**

In the ARRA tab of the Medical Records page, there is a field labeled “Retinal/Dilated Eye Exam” that indicates whether the patient received a retinal or dilated eye exam.

Patients who have a diagnosis of diabetes in their medical records and have this field marked “Yes” will be counted toward this measure.

**Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation (NQF 0086)**

<b>EMeasure Name</b>	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	<b>EMeasure Id</b>	Pending
<b>Version Number</b>	1	<b>Set Id</b>	Pending
<b>Available Date</b>	No information	<b>Measurement Period</b>	January 1, 20xx through December 31, 20xx
<b>Measure Steward</b>	American Medical Association – Physician Consortium for Performance Improvement		
<b>Endorsed by</b>	National Quality Forum		
<b>Description</b>	Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least 2 office visits, who have an optic nerve head evaluation during one or more office visits within 12 months.		
<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Rationale</b>	Changes in the optic nerve are one of two characteristics which currently define progression and thus worsening of glaucoma disease status (the other characteristic is visual field). There is a significant gap in documentation patterns of the optic nerve for both initial and follow-up care (Fremont, 2003), even among specialists (Lee, 2006). Examination of the optic nerve head and retinal nerve fiber layer provides valuable structural information about glaucomatous optic nerve damage. Visible structural alterations of the optic nerve head or retinal nerve fiber layer and development of peripapillary choroidal atrophy frequently occur before visual field defects can be detected. Careful study of the optic disc neural rim for small hemorrhages is important, since these hemorrhages can precede visual field loss and further optic nerve damage.		
<b>Clinical Recommendations</b>	The physical exam focuses on nine elements: visual acuity, pupils, slit-lamp biomicroscopy of the anterior segment, measurement of intraocular pressure (IOP), determination of central corneal thickness, gonioscopy, evaluation of optic nerve head and retinal nerve fiber layer, documentation of optic nerve head appearance, evaluation of fundus (through dilated pupil), and evaluation of the visual field (Level A: II Recommendation for optic nerve head evaluation) (AAO, 2005).		

**Crystal Directions:**

In the ARRA tab of the Medical Records page, there is a field labeled “Optic Nerve Evaluation” that indicates whether the physician performed an optic nerve head evaluation.

Patients who have a diagnosis of Primary Open Angle Glaucoma in their medical records and have this field marked “Yes” will count toward this measure.

**Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy (NQF 0088)**

<b>EMeasure Name</b>	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	<b>EMeasure Id</b>	Pending
<b>Version Number</b>	1	<b>Set Id</b>	Pending
<b>Available Date</b>	No information	<b>Measurement Period</b>	January 1, 20xx through December 31, 20xx
<b>Measure Steward</b>	American Medical Association – Physician Consortium for Performance Improvement		
<b>Endorsed by</b>	National Quality Forum		
<b>Description</b>	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.		
<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Rationale</b>	Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study – DRS, Early Treatment Diabetic Retinopathy Study – ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. (McGlynn, 2003). Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.		
<b>Clinical Recommendation Statement</b>	Since treatment is effective in reducing the risk of visual loss, detailed examination is indicated to assess for the following features that often lead to visual impairment: presence of macular edema, optic nerve neovascularization and/or neovascularization elsewhere, signs of severe NPDR and vitreous or preretinal hemorrhage (Level A:III Recommendation) (AAO, 2003)		

**Crystal Directions:**

In the ARRA tab of the Medical Records page, there are three fields related to this measure.

The field labeled “Dilated Macular/Fundus Exam” indicates whether the patient received a dilated macular or fundus exam. This field must be marked “Yes” to count toward the measure.

The field labeled “Retinopathy Severity Level” indicates severity of the retinopathy noted by the physician. Any value in this field will count toward the measure.

The field labeled “Macular Edema” indicates the presence or absence of macular edema. Any value in this field will count toward the measure.

A patient with a diagnosis of diabetic retinopathy in their medical records, a value of “Yes” in the Dilated Macular/Fundus Exam field, and values present in both the Retinopathy Severity Level and Macular Edema fields will count toward this measure.

**Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (NQF 0089)**

<b>EMeasure Name</b>	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	<b>EMeasure Id</b>	Pending
<b>Version Number</b>	1	<b>Set Id</b>	Pending
<b>Available Date</b>	No information	<b>Measurement Period</b>	January 1, 20xx through December 31, 20xx
<b>Measure Steward</b>	American Medical Association – Physician Consortium for Performance Improvement		
<b>Endorsed by</b>	National Quality Forum		
<b>Description</b>	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.		
<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Rationale</b>	The physician that manages the on-going care of the patient with diabetes should be aware of the patient’s dilated eye examination and severity of retinopathy to manage the on-going diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease (Diabetes Control and Complications Trial – DCCT, UK Prospective Diabetes Study – UKPDS).		
<b>Clinical Recommendation Statement</b>	While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist’s responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient’s family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician (Level A: III Recommendation) (AAO, 2003).		

**Crystal Directions:**

In the ARRA tab of the Medical Records page, there are three fields related to this measure.

The field labeled “Dilated Macular/Fundus Exam” indicates whether the patient received a dilated macular or fundus exam. This field must be marked “Yes” to count toward the measure.

The other two fields are located under the heading “Communicated to Diabetes Care Provider”. The field labeled “Exam Findings” indicates the physician has communicated the exam results to the

patient's diabetes care provider. This field must be marked "Yes" to count toward the measure. The field labeled "Severity of Retinopathy" indicates the physician has communicated the severity level of the retinopathy to the patient's diabetes care provider. This field must be marked "Yes" to count toward the measure.

A patient with a diagnosis of diabetic retinopathy in their medical records, and values of "Yes" in the Dilated Macular/Fundus Exam field, Exam Findings field and Severity of Retinopathy field will count toward this measure.

**Adult Weight Screening and Follow-Up (NQF 0421)**

<b>EMeasure Name</b>	Adult Weight Screening and Follow-Up	<b>EMeasure Id</b>	Pending
<b>Version Number</b>	1	<b>Set Id</b>	Pending
<b>Available Date</b>	No information	<b>Measurement Period</b>	January 1, 20xx through December 31, 20xx
<b>Measure Steward</b>	Quality Insights of Pennsylvania		
<b>Endorsed by</b>	National Quality Forum		
<b>Description</b>	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.		
<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Rationale</b>	<p>Of the Medicare population, 37 percent are overweight, and 18 percent are obese. Between 1991 and 1998, the prevalence of obesity among persons age 60-69 increased by 45 percent (American Obesity Association). According to a 1998 survey, only 52 percent of adults age 50 or older reported being asked during routine medical check-ups about physical activity or exercise. The likelihood of being asked about exercise during a routine check-up declined with age (Center for the Advancement of Health, 2004). Elderly patients with unintentional weight loss are at higher risk for infection, depression and death. In one study it was found that a BMI of less than 22 kg per m2 in women and less than 23.5 in men is associated with increased mortality. In another study it was found that the optimal BMI in the elderly is 24 to 29 kg per m2. (Huffman, G. B., Evaluation and Treatment of Unintentional Weight Loss in the Elderly, American Family Physician, 2002 Feb, 4:640-650.)</p>		
<b>Clinical Recommendation Statement</b>	<p>The USPSTF (2009) recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. (Level of Evidence = B, USPSTF) The clinical guideline for obesity recommends assessment of BMI at each encounter (National Heart, Lung and Blood Institute). Management of Obesity indicates that the body mass index should be calculated at least annually for screening and as needed for management (The Institute for Clinical Systems Improvement's 2009 Guideline for Prevention and Management of Obesity). Validated measure of nutrition status serves as an indicator of over-nourishment and under-nourishment. Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.). The NSI-suggested BMI range is 22-27 (values outside this range indicate overweight or underweight for elderly) Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-</p>		

	sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).
<b>Improvement Notation</b>	Higher score indicates better quality
<b>Measurement Duration</b>	12 months

**Crystal Directions:**

In the ARRA tab of the Medical Records page, there is a field labeled BMI to indicate the BMI of the patient. The physician may calculate this value by entering the height and weight of the patient and pressing the Calc BMI button.

The “BMI Followup?” field indicates whether the physician has discussed and implemented a follow-up plan based on the patient’s BMI number.

To count toward this measure, BMI must be recorded, and if the BMI is out of the normal range the BMI Followup field must be marked “Yes”.