

AQICC-MU DATA REPORTING AUGUST 2010

PROJECT DESCRIPTION

Clinic consortia in Southern California (Los Angeles, Orange and San Diego) are partnering with the California HealthCare Foundation, the California Primary Care Association and clinics and consortia throughout California to implement a statewide performance improvement project – Aligning Quality Improvement in California Clinics (AQICC): Preparing for Meaningful Use of EHRs.

The purpose of the project is to help community clinics and health centers in California prepare for meaningful use of electronic health records (EHRs) to improve clinical outcomes and operational efficiencies and to ultimately improve the health outcomes of patients and communities throughout the state. Through meaningful use incentives (e.g. Medicare and Medicaid), the project will also result in increased resources to support community clinics and health centers and their providers.

This table outlines the measures and instructions for the upcoming *AQICC-MU* reporting period for the measurement year of 7/01/09 – 6/30/10. These measures are reported for each clinic site.

Measure	Description	Source
Technology Data		
System Progress – systems in use during the measurement year		
Q1 Name of Practice Management System	The name of the Practice Management System used during the measurement year	Clinic
Q2 Name of Electronic Health Record	The name of the Electronic Health Record System used (if applicable) during the measurement year	Clinic
Q3 Name of Chronic Disease Registry System	The name of the Chronic Disease Registry/Management System used (if applicable) during the measurement year.	Clinic
Electronic Lab Data		
Q4 Name of Lab Vendor	Name of Lab Vendor used during the measurement year	Clinic
Q5 Electronic Lab Interface to registry, PMS or EHR?	Are lab results received through an electronic interface to your registry, PMS or EHR (not by fax or pdf)?	Clinic
Clinical Information System(s) Use (e.g. Disease Registry or EMR) <i>Note: if your answer to Q3 was “none” then answer “no” to Q6, Q7, & Q8</i>		
Q6 We use Point of Care prompts to ensure patients get recommended services	Does the clinic site use a system during a patient encounter that recommends evidence-based services due or past due? (i.e. “task lists” or “templates” in electronic system or “visit planner” hard copy documents that are provided prior to patient encounter)	Clinic
Q7 We use population-based reports to recall patients who need recommended services and/or to take	Are reports used to identify patients who need services, to recall patients for chronic care or well-care visits, or to monitor a particular group of patients? Are reports used to show clinic staff areas that patients are	Clinic

Measure	Description	Source
the “pulse” of a specific group of patients	doing well in or areas they could show more improvement?	
Q8 We produce provider, team, or pod reports to give feedback on performance	Are reports from electronic registry or EHR used to give feedback to provider and staff to know how their patients are performing on specific measures compared to patients of other providers or care teams?	Clinic
Process Measures		
Q9 Total number of adults in the PMS and/or EMR	<u>Age:</u> Patients ages 18-75 as of the end of the measurement year AND <u>Utilization:</u> Two or more medical care encounters in the measurement year	Practice Management System
Q10 Total number of adults with diabetes in the PMS and/or EMR	<u>Age:</u> Patients aged 18-75 as of the end of the measurement year AND <u>Utilization:</u> Two or more medical care encounters in the measurement year AND <u>Diagnosis:</u> Diagnosis of diabetes was ever made at the clinic. To confirm the diagnosis of diabetes, one of the following codes must be found in the medical record: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.8, OR Diabetic patients may be identified from pharmacy data (those who were dispensed insulin or oral hypoglycemics/antihyperglycemics). <u>Exclusions:</u> Patients with diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) that do not have 2 face-to-face encounters (in any setting) with the diagnosis of diabetes in the measurement year or the year prior. Also exclude any patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Code 962.0, 251.8) during the measurement year.	Practice Management System or UDS Report
Q11 Total number of adults with diabetes from Chronic Disease Registry	<u>Age:</u> Patients aged 18-75 as of the end of the measurement year AND <u>Utilization:</u> Two or more medical care encounters in the measurement year AND <u>Diagnosis:</u> Diagnosis of diabetes was ever made at the clinic. To confirm the diagnosis of diabetes, one of the following codes must be found in the medical record: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.8, OR Diabetic patients may be identified from pharmacy data (those who were dispensed insulin or oral hypoglycemics/antihyperglycemics). <u>Exclusions:</u> Patients with diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) that do not have 2 face-to-face encounters (in any setting) with the diagnosis of diabetes in the measurement year or the year prior. Also exclude any patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Code 962.0, 251.8) during the measurement year.	Disease Registry, Chronic Disease Management System, or EMR
<p><i>Note for Q10 and Q11: these measures share the same definition. The totals may be equal if all patients with diabetes are being tracked in the registry. The number of patients in the disease registry or EMR, however, should not be greater than the number of patients in your PMS.</i></p>		

Clinical Measures – Reporting period is 7/01/2009 – 6/30/2010		
Measure # 1 Percent of Patients with Diabetes with Annual HbA1c Test		
Q12 Denominator: Total number of adults with diabetes from Clinical Information System (e.g. Disease Registry or EMR)	<p><u>Age:</u> Patients aged 18-75 as of the end of the measurement year AND</p> <p><u>Utilization:</u> Two or more medical care encounters in the measurement year AND</p> <p><u>Diagnosis:</u> Diagnosis of diabetes was ever made at the clinic. To confirm the diagnosis of diabetes, one of the following codes must be found in the medical record: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.8, OR Diabetic patients may be identified from pharmacy data (those who were dispensed insulin or oral hypoglycemics/antihyperglycemics.</p> <p><u>Exclusions:</u> Patients with diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) that do not have 2 face-to-face encounters (in any setting) with the diagnosis of diabetes in the measurement year or the year prior. Also exclude any patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Code 962.0, 251.8) during the measurement year.</p>	Disease Registry, Chronic Disease Management System, or EMR
Q13 Numerator: Most recent laboratory test in the measurement year (7/01/09 – 6/30/10)	Total number of HbA1c tests in the measurement year for patients with a diagnosis of diabetes aged 18-75 with two or more medical care encounters in the measurement year	Disease Registry, Chronic Disease Management System, or EMR
Measure # 2 Glycemic Control in Patients with Diabetes		
Q14 < 7.0	Number of patients with HbA1c lab result less than 7.0	Disease Registry, Chronic Disease Management System, or EMR
Q15 >= 7 and <= 9.0	Number of patients with HbA1c lab results greater or equal to 7.0 and less than or equal to 9.0	Disease Registry, Chronic Disease Management System, or EMR
Q16 > 9.0	Number of patients with HbA1c lab results greater than 9.0	Disease Registry, Chronic Disease Management System, or EMR
Q17 Data not measured or reported	This is a calculated field identifying the difference between the total number of adults with diabetes (Q12) and the total number of patients with an HbA1c test (Q13). This result shows the number of patients with a lab result reported.	Disease Registry, Chronic Disease Management System, or EMR
Measure # 3 Percent of Patients with Diabetes with LDL-Cholesterol Screening		
Q18 Numerator: Most recent laboratory test in the	Total number of LDL tests in the measurement year for patients with a diagnosis of diabetes aged 18-75 with two or more medical care	Disease Registry, Chronic Disease Management

measurement year (7/01/09 – 6/30/10)	encounters in the measurement year	System, or EMR
Measure # 4 LDL-Cholesterol Control in Patients with Diabetes		
Q19 < 100	Number of patients with LDL lab results less than 100	Disease Registry, Chronic Disease Management System, or EMR
Q20 ≥ 100 and ≤ 130	Number of patients with LDL lab results greater than or equal to 100 and less than or equal to 130	Disease Registry, Chronic Disease Management System, or EMR
Q21 > 130	Number of patients with LDL lab results greater than 130	Disease Registry, Chronic Disease Management System, or EMR
Q22 Data not measured or reported	This is a calculated field identifying the difference between the total number of adults with diabetes (Q12) and the total number of patients with a LDL test (Q18). This result shows the number of patients with a lab result reported.	Disease Registry, Chronic Disease Management System, or EMR
Operational Measures – Reporting period is 5/01/2010 – 8/31/2010 – One measure for each month		
Clinics are required to report on at least one of the following two measures		
Q23 Cycle Time	Average of all patients' cycle time collected during the selected shift. This number is calculated in minutes. The amount of time (in minutes) a patient spends at a primary care visit from check-in to check-out.	Practice Management system, EMR, or manual collection
Q24 Third Next Available Appointment	Average number of days until 3 rd next available appointment for all providers collected during the selected day. The length of time (in days) between the day a patient makes a request for an appointment with a provider and the third next available appointment for a primary care visit with that provider.	Practice Management system, EMR, or manual collection