Ohio's Diabetes & Hypertension Quality Improvement Project Measure Definitions

	Measure	Definition	Reference	Specifications	Notes
Hypertension	Number of hypertensive patients	Number of adult patients (aged 18-85) seen during the measurement period with a diagnosis of essential Hypertension (HTN)	NQF 0018/CMS 165v7 Denominator UDS ICD-10-CM I10 (Essential (primary) Hypertension)	Patients 18-85 years of age who had a diagnosis of essential HTN: -Age ≥19-85 at the end of the period -Active diagnosis of essential HTN prior to or within the first 6 months of the measurement period -Qualifying visit in the last 12 months **Exclusions:** -Active pregnancy during the measurement period -End Stage Renal Disease -Chronic Kidney Disease -Dialysis -Hospice care	
	Number of hypertensive patients in control	Number of adult patients (aged 18-85) seen during the measurement period with a diagnosis of essential HTN whose blood pressure at the most recent visit is adequately controlled (<140/90 mmHg)	NQF 0018/CMS 165v7 Numerator UDS ICD-10-CM I10 (Essential (primary) HTN)	Adequately controlled: -Systolic blood pressure <140 mmHg in the last 12 months -Diastolic blood pressure <90 mmHg in the last 12 months **Exclusions:** -Active pregnancy during the measurement period -End Stage Renal Disease -Chronic Kidney Disease -Dialysis -Hospice care	
	Number of hypertensive patients referred to community programs	Number of adult patients (aged 18-85) seen during the measurement period with a diagnosis of HTN who received a referral to an evidence-based lifestyle program from their health care provider within the last 12 months	ICD-10-CM I10 (Essential (primary) HTN)	**Exclusions:** -Active pregnancy during the measurement period -End Stage Renal Disease -Chronic Kidney Disease -Dialysis -Hospice care	People with high blood pressure should be referred to evidence-based lifestyle programs that can increase blood pressure control. These programs should promote the following elements: reduce weight, adopt DASH (Dietary Approaches to Stop Hypertension) eating plan principles including lower sodium intake, and engaging in regular physical activity. Programs may include any that have been approved by ODH.
Undiagnosed Hypertension	Number of patients meeting the criteria for having undiagnosed HTN	Number of adult patients (aged 18-85) seen during the measurement period who do not have a diagnosis of HTN but are identified as potentially having HTN in the last 12 months	Undiagnosed HTN- Million Hearts (CDC)	Patients who do not have a diagnosis of HTN and had at least one stage 2 blood pressure reading or at least two stage 1 blood pressure readings in the last year Two stage 1 HTN BP measurements (BP at last visit and one other visit during the last 12 months) -Systolic >=140 and < 160 mm Hg OR -Diastolic >=90 and < 100 mm Hg OR One stage 2 HTN BP measurement at any visit during the past 12 months -Systolic >=160 mm Hg OR -Diastolic >= 100 mm Hg **Exclusions:** -Active pregnancy during the measurement period -End Stage Renal Disease -Chronic Kidney Disease -Hospice care	Criteria can be varied amongst health centers (example: algorithm via EHR query to identify patients)

	Number of patients newly diagnosed with essential Hypertension	Number of adult patients (aged 18-85) newly diagnosed with essential Hypertension (HTN) during the measurement period	NQF 0018/CMS 165v7 Denominator UDS ICD-10-CM I10 (Essential (primary) Hypertension)	Patients 18-85 years of age who had a new diagnosis of essential HTN: -Age ≥19-85 at the end of the period -New active diagnosis of essential HTN during the measurement period **Exclusions:** -Active pregnancy during the measurement period -End Stage Renal Disease -Chronic Kidney Disease -Dialysis -Hospice care	
High Blood Cholesterol Measures	Number of adults at risk for a cardiovascular event	Patients aged ≥21 years meeting on or more criteria (considered at "high risk" for cardiovascular events, under ACC/AHA guidelines)	CMS 347v2 Denominator UDS	Patients who have a qualifying encounter AND meet any of the following criteria groupings: -Age ≥21 years at the end of the measurement period AND -ASCVD at any time prior to the measurement period end date (acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or arterial revascularization, stroke or transient ischemic attack or peripheral arterial disease) OR -Age ≥21 years at the end of the measurement period AND -Have ever had a fasting or direct laboratory LDL-C result of ≥ 190 mg/dL in the measurement year OR an active diagnosis of familial or pure hypercholesterolemia at any time prior to the end of the measurement period OR -Age ≥40 and ≤75 years at the end of the measurement period AND -Active diabetes AND -LDL result of 70-189 mg/dL in the measurement year or the two years prior to the measurement period **Exclusions:** -Pregnancy and/or breastfeeding during the measurement period -Active diagnosis of Rhabdomyolysis	
	Number of at risk patients on a Statin	Patients who are actively using or who receive an order (prescription) for Statin Therapy at any point during the measurement period	CMS 347v2 Numerator UDS	**Exclusions:** -Pregnancy and/or breastfeeding during the measurement period -Active diagnosis of Rhabdomyolysis	
Prediabetes	Number of patients with prediabetes	Prediabetes prevalence: patients age 18-75 seen during the measurement period that have a diagnosis of Prediabetes	ICD-10-CM R73.03 (Prediabetes)	Patients with a diagnosis of Prediabetes that are not diagnosed with type 1 or type 2 Diabetes: -Active Prediabetes diagnosis -No active Diabetes diagnosis **Exclusions:** -End Stage Renal Disease -Pregnancy	
	Number of patients screened for prediabetes	Number of adults (aged 18-75) seen during the measurement period who were screened using the American Diabetes Association (ADA)/Centers for Disease Control and Prevention (CDC) Prediabetes Risk Assessment			

	Number of screened patients newly diagnosed with Prediabetes	Number of adults (aged 18-75) seen during the measurement period who were screened using the ADA/CDC Prediabetes Risk Assessment and diagnosed with Prediabetes	ICD-10-CM R73.03 (Prediabetes)		
	Number of Prediabetes patients referred to a Diabetes Prevention Program (DPP) within the last 12 months	Number of adults (aged 18-75) seen during the measurement period with a diagnosis of Prediabetes who receive a referral to a CDC recognized/accredited DPP from their health care provider			An organization that offers the National DPP lifestyle change program and has received pending, preliminary, or full recognition from the Diabetes Prevention Recognition Program (DPRP).
Diabetes	Number of patients with Diabetes	Number of adults (aged 18-75) with diagnosed Diabetes with a medical visit during the measurement period	NQF 0059/CMS 122v7 Denominator UDS	**Exclusions:** -End Stage Renal Disease -Hospice care	
	Number of patients with Diabetes with an A1c >9% or no A1c test performed	Number of adults (aged 18-75) seen during the measurement period with a diagnosis of Diabetes whose most recent A1c level is > 9% or no A1c test performed	NQF 0059/CMS 122v7 Numerator UDS	-No A1c in the last 12 months OR -Most recent A1c in >9% **Exclusions:** -Hospice care	Patient is numerator compliant if most recent HbA1c level >9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance Only patients with a diagnosis of Type 1 or Type 2 Diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary Diabetes due to another condition should not be included
	Number of diabetic patients referred to Diabetes Self-Management Education (DSME) programs within the last 12 months	Number of adults (aged 18-75) with a diagnosis of Diabetes who receive a referral to a recognized/accredited DSMES program from their health care provider within the past 12 months			Program offering diabetes self-management education and support with ADA recognition or American Association of Diabetes Educators (AADE) accreditation. A DSME program includes satellite sites established by those programs.
MTM	Number of Diabetes, HTN, or HBC Patients referred to clinical pharmacy services within the last 12 months	Number of adult Diabetes (aged 18-75), adult HTN (aged 18-75), and adult HBC (aged 18-85) patients seen during the measurement period who were referred to Clinical Pharmacy Services within the last 12 months			
	Number of adult patients seen during measurement period	Number of adult patients (aged 18+) seen for a medical visit during the reporting period	UDS		
	Number of adult patients screened for Social Determinants of Health (SDOH) within the last 12 months	Number of adult patients (aged 18+) SDOH of health using a standard screening tool			Examples: -AAFP Social Needs Screening Tool (https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/physician-long.pdf) -PRAPARE

Social Determinants/ Community Linkages	Number of adult patients screened for SDOH who were referred to community/social services	Number of adult patients (aged 18+) screened for SDOH given information or connected to community resources to help address their social needs			Patients referred to community and social services; including housing, food, transportation, utilities, child care, financial assistance, job services, education needs, etc. Referral, linking, and tracking patients to support