EPRP UPDATE

4Q FY2021

4Q FY2021 Changes to EPRP Data Collection Tools

- This presentation will provide an overview of 4Q FY2021 changes to EPRP data collection tools and scoring
- The major changes to each instrument and the scoring specifications will be noted in the following slides however it is very important that you also review the data collection instruments paying close attention to highlighted areas

All Instruments

- You will notice some highlighted text in the "Patient Identifiers" section at the beginning of each data collection instrument
  - **FIN**: This element is in preparation for the Cerner medical record
    - In the future, the FIN (financial encounter number) will be used as a patient identifier on pull lists
    - This has no effect on review for most of you at this time
  - Race and ethnicity: these data elements will be auto-filled in the sample
    - We will continue to do validation in CGPI

SEPSIS

SEPSIS

- We will begin our review of 4Q changes by looking at the Sepsis data collection instrument
- There are some changes for discharges < 07/01/2021 (7/6 and 8/2 pull lists) and other changes that will be effective with discharges >= 07/01/2021 (8/23 pull list)
- Several clarifications and examples were added to the definition/decision rules
- A few questions have been deleted for discharges >=07/01/2021
- There are also some measure updates

Q14 covid

- **At any time during the admission, is there physician/APN/PA documentation coronavirus or COVID-19 is suspected, present or confirmed?**
- There are no changes to this question or the rules, but it seems there are still questions about how to answer correctly
- Per the rules, answer yes to covid (thus excluding the case) **if**
  - there is physician/APN/PA documentation any time during the hospital stay that coronavirus or COVID-19 is suspected or present
    - Only the terms "suspected", "present" or "confirmed" are acceptable to answer "yes"
  - Or you can answer yes If the physician/APN/PA orders a test for **possible or suspected** COVID-19
- Still confused? Check out the examples in the FAQs.

Changes for Discharges <07/01/2021

- The following slides review the changes that will be effective with the 7/6 and 8/2 pull lists (i.e. discharges <07/01/2021)
- These changes are noted in the Sepsis 4Q FY2021_**Pre** instrument

Antibiotics

- We will collect antibiotic administration in the 72 hours prior and **up to 3 hours after severe sepsis presentation** (previously 6 hours) to align with CMS
- This change is reflected in the following questions
  - Q25 antibio
  - Q26 bioname, biodate, biotime
- Scoring remains based on 3 hours

Q31 bioadmindt, bioadmintm

- The earliest date and time of antibiotic administration will be auto-filled in question 31 based on the criteria preceding the question (CMS guidelines)
- **The specified time frame for the administration of a broad spectrum or other antibiotic is 24 hours before or three hours after the Severe Sepsis Presentation Time.**
- If bioadmindt/bioadmintm - sepresdt/seprestm < - 1440 minutes or > 180 minutes, you will go to end of the instrument

Q32 bldcul, q33 bldculdt, bldcultm

- Timing of the blood culture is now based on the auto-filled antibiotic administration date and time (bioadmindt/bioadmintm) in question 31

Q35 lactate

- We will only collect initial lactate drawn 6 hours prior **through 3 hours** after severe sepsis presentation
- Previously we collected those drawn up to 6 hours following severe sepsis presentation for informational purposes only

Changes for discharges >=07/01/2021

- The following slides show changes that will be effective with the 8/23 pull list (i.e. discharges >=07/01/2021)
- These changes are noted in the Sepsis 4Q FY2021 (Post) instrument
- Again, not all of the highlighted changes are noted in this presentation so be sure to read all of the definition/decision rules carefully

Q16 sepinf

- Please note the additional guidance regarding documentation of an initial infection that is *not* acceptable to answer yes
- **Do not use physician/APN/PA documentation of an initial infection if there is additional physician/APN/PA documentation within the following 6 hours indicating that the infection is not present or is due to a viral, fungal, or parasitic source**.

Conflicting Documentation

- The guidance for dealing with conflicting information has been revised and is applicable in several questions. Here is the guidance in q18 sepsirs
- **If there is conflicting documentation** within the same physician/APN/PA documentation **or within two or more separate pieces of physician/APN/PA documentation** indicating SIRS criteria is normal for the patient, due to a chronic condition or medication AND due to or possibly due to an infection, **severe sepsis or septic shock, abstract the value based on the documentation closest to and before the Severe Sepsis Presentation Time**

Antibiotics

- As noted in the "pre" instrument we will be collecting antibiotic administration from 72 to hours prior and **up to 3 hours from identification of severe sepsis only** (previously 6 hours) to align with CMS
- **Look for the earliest date/time on which an antibiotic was started within the specified timeframe**
- This change is reflected in the following questions
  - Q25 antibio
  - Q26 bioname, biodate, biotime
- Scoring remains based on 3 hours

Q26 bioname, biodate, biotime

- For each antibiotic administered during the specified timeframe, enter the date and time of antibiotic administration. **If the same antibiotic is administered more than once at different dates and times, enter each date and time it was given**.
- Those receiving IV antibiotics more than 24 hours prior and not **within 3 hours** after the presentation of severe sepsis will be excluded from the Sepsis Bundle measures.

Q27 bioadmindt, bioadmintm

- The earliest date and time of antibiotic administration will be auto-filled in question 27 based on the criteria preceding the question (CMS guidelines)
- **The specified time frame for the administration of a broad spectrum or other antibiotic is 24 hours before or three hours after the Severe Sepsis Presentation Time.**
- **If bioadmindt/bioadmintm - sepresdt/seprestm < - 1440 minutes or > 180 minutes, you will go to end of the instrument**

Questions Removed

- Some antibiotic questions have been removed per CMS guidelines
  - Antibiotic selection
  - Reference to culture results
  - C. diff questions

Q28 bloodcul, q29 bldculdt, bldcultm

- Timing of the blood culture is now based on the auto-filled antibiotic administration date and time (bioadmindt/bioadmintm) in question 27

Q31 lactate, q32 lactdt, lactm

- The lactate questions now reflects the 6 hours before and **3 hours** after severe sepsis presentation time frame that is acceptable

Q46 targvol

- Please review the examples in the definition/decision rules which show acceptable and unacceptable documentation related to target ordered volume of crystalloid fluid infusion

Q46 targvol

- It is now acceptable to choose Value 1 (yes) if less than 30 mL/kg of crystalloid fluids were ordered and given, and if all the following criteria were met:
- The ordering physician/APN/PA must have documented within a single note in the medical record:
  - that administration of 30 mL/kg of crystalloid fluids would be detrimental or harmful for the patient despite having hypotension, a lactate >= 4 mmol/L, or documentation of septic shock;

(continued next slide)

Q46 targvol

- AND that the patient has one of the following conditions, OR that a portion of the crystalloid fluid volume was administered as colloids (if a portion consisted of colloids, there must be an order and documentation that colloids were started or noted as given);
  - advanced or end-stage heart failure (with documentation of NYHA class III or symptoms with minimal exertion, OR NYHA class IV or symptoms at rest or with any activity)
  - advanced or end-stage chronic renal disease (with documentation of stage IV or GFR 15-29 mL/min, OR stage V or GFR < 15 mL/min or ESRD)

(continued next slide)

Q46 targvol

- AND the volume of crystalloid fluids in place of 30 mL/kg the patient was to receive;
- AND an order for the volume of the fluids in place of 30 mL/kg to be administered
- On the next slide is an example that addresses this scenario.

Crystalloid Fluid/Target Volume

- **Example**:
- **Physician documentation: Lactate 5.0, advanced CHF symptomatic with minimal exertion, concerned 30 mL/kg NS may be harmful despite significant lactate elevation, 20 mL/kg NS now, then reevaluate. Orders: NS 0.9% IV, 20 mL/kg over 2 hours. MAR: NS 0.9% IV 20 mL/kg, Start time 1500, Completed time 1700.Select value "1" based on the physician documentation meeting the requirements and identifying 20 mL/kg as the target ordered volume of crystalloid fluids for this patient.**

Q47 crystlend

- There is an addition to the guidance for determining the earliest documented time the target ordered volume of crystalloid fluids was completed
  - **If using multiple orders toward the target ordered volume, use the start date or time of the crystalloid fluid infusion that completed the target ordered volume**

Q52 rptvolstdt, rptvolsttm

- This question now reads:
  - At what date/time was a repeat volume status and tissue perfusion assessment documented?
  - **The previous question was:**
    - At what date/time was a repeat volume status and tissue perfusion assessment documented by a **physician/APN/PA?**
- **Please note that physician/APN/PA documentation is still required for some of the components in question 51**

Q54 rptvolstdt, rptvolsttm

- Additional suggested data sources for repeat volume status and tissue perfusion assessment documentation have been added to the definition/decision rules for this question
  - **Suggested Data Sources:**
    - Cardiovascular ultrasound or echocardiogram report
    - Consultation notes
    - Critical Care flow sheet
    - ED record
    - History and physical
    - Nurses notes; Physician/APN/PA notes
    - Procedure notes
    - Respiratory Therapy notes or flow sheet
    - Vital signs flow sheet

Sepsis Measures

- **See the 4Q Sepsis Exit Report Guide for details**
  - The requirement for antibiotic selection was removed from sep90 and sep1a
  - Sep90 reflects changes in sub-measures (sep1a, sep1b, sep1c, sep1d)
  - Sub-measures will only score if sep90 criteria is met

TRANSITIONS OF CARE

TOC 4Q FY2021

- We expect the total number of 4Q TOC records per facility to be about the same as in 2Q
  - However, in 4Q the records will be divided into 3 lists, rather than one big list
  - Each of the 3 lists will be due on the same schedule as other instruments
- There are some changes to the data collection instrument that will be discussed in the slides that follow

Q6 ptexpire – New Question

- **Is there documentation that the patient expired during the timeframe from 1/01/2021 to 6/30/2021?**
- If the patient dies during this timeframe, select value "1"and the case will be excluded

Q10 ntfyadm

- There are no changes to this question about documentation of receipt of notification to the PCP or ongoing care provider
- However, one important rule that is often overlooked has been moved for added emphasis
- **The following documentation meets criteria:**
  - **Communication about admission with the patient's PCP or ongoing care provider through a shared electronic medical record (EMR) system.**
  - **When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information (e.g., admission note, admission H&P) was located/accessible in the shared EMR on the day of admission through 2 days after admission (3 total days) meets criteria to select value 1 .**
- **This rule applies when there is documentation of a VA admission in CPRS and the PCP or ongoing care provider is a VA provider**

Q11 dccomp

- **For the discharge on (computer to display, if readm = 2 display dcdt OR if readm = 1 readmdcdt), is there documentation the discharge information includes the following required components?**
  - **The wording of this question was updated to be less confusing and to display the appropriate discharge date**
- Documentation in the outpatient medical record must include evidence or documentation of receipt of discharge information **or that it is accessible to the PCP or ongoing care provider.**
- Please review the examples in the rules that meet criteria for dccomp6 (testing results) and dccomp7 (instructions for care post discharge)

Q12 ntfydc

- **For the discharge on (computer to display, if readm = 2, dcdt to dcdt + 2 days OR if readm = 1, readmdcdt to readmdcdt + 2 days), is there documentation in the medical record of receipt of discharge information?**
  - This question was updated to display the appropriate discharge date and to reduce confusion
- The following rule is not new, but must not be overlooked
  - **When using a shared EMR system, documentation of a "received date" in the EMR is not required to meet criteria.**
  - **Evidence that the information (e.g., discharge summary with all required components) was located/accessible in the shared EMR on the day of discharge through 2 days after the discharge (3 total days) meets criteria to select value "1" or Yes for Receipt of Discharge Information indicator**.

Q15 medrec

- Please remember that medication reconciliation in TOC is vastly different than the data elements we look for in CGPI or Inpatient Medication Reconciliation
- **Medication reconciliation must be documented in the medical record by a physician/APN/PA, clinical pharmacist or registered nurse, on the date of discharge to 30 days after discharge (31 days total) and documentation must indicate current medications are reconciled with the discharge medications**
- Documentation should include a comparison between the outpatient medication list and the inpatient discharge medications or must include notation that outpatient medications were reconciled with the inpatient discharge medication list

TOC Measures

- There is one change to the TRC measures
- If ptexpire=1, the case will be excluded from all measures

GLOBAL MEASURES

Global Measures

- There are no changes to the Global Measures data collection instrument
- Be sure to check FAQs for some new additions
- The only change to scoring is to update the discharge date parameter

Common Modules

- There are no changes to Inpatient Medication Reconciliation or Delirium Risk

HOSPITAL OUTPATIENT

HOP

- There are no changes to the HOP data collection instrument
  - A rule in the question edctm has been highlighted for emphasis:
  - The actual departure time must be documented: **Note that signature time is NOT acceptable**.
- There are no changes to HOP scoring

HBPC

Q5 admisdt

- For some records, the date of admission to HBPC may be prefilled
  - If so, please verify the date in the medical record
  - If the prefilled date is incorrect, enter the correct date
- If the admission date is not prefilled, enter the correct date, paying close attention to the rules for determining the date of admission

Q23 assesmal2

- There are some updates to the definition and decision rules for emphasis and clarification
- **Malnutrition assessment by telephone is NOT acceptable.**
- **Review the required elements of the malnutrition assessment and be sure the documentation in the medical record includes all of them in order to answer yes**
- **For assessments completed on or after 4/01/2021, <u>the numeric results</u> of hand grip strength must be documented**

Q37 permci

- Permci is a new question for 4Q FY2021 related to cognitive impairment
- **During the past year, did a physician/APN/PA or psychologist document that the patient has probable permanent cognitive impairment using a Clinical Reminder?**
- You will get this question if you answer yes to dementdx2

Probable Permanent Cognitive Impairment

- A VHA Clinical Reminder for capture of probable permanent cognitive impairment is scheduled for release in June 2021.
- **In order to answer "1" to permci, there must be physician/APN/PA or psychologist documentation of the Clinical Reminder in the progress note that the veteran has probable permanent cognitive impairment and should be excluded from future mental health screening or other applicable clinical reminders.**
- **Acceptable Source**: Clinical Reminder taxonomy which may be present in a Mental Health Screening note or other applicable templates or Clinical Reminders

Q38 permcidt

- If you find documentation in the past year that the patient has probable permanent cognitive impairment, enter the date of the documentation in q38

Q46 scrnaudc, q47 dtalscrn

- The AUDIT-C questions have been revised to ask about screening done in the past year
- Previously the time frame was 03/01/2021 to study end

Q81 vacssrs

- **Clinical Pharmacy Specialist** has been added to the list of acceptable providers who can complete the Columbia Suicide Severity Rating Scale (C-SSRS) Screener

Q94 vacsredt

- A new question was added to capture the date of the CSRE
- **Enter the most recent date the CSRE was completed during the past year**.
- If the CSRE was completed the same date as the Columbia screener, the date will be auto-filled with that date

HBPC Scoring Changes

- **The exclusion for probable permanent cognitive impairment (permci=1) has been added to the following measures**
  - Hc38
  - Hc41
  - Hc59
  - Hc60
  - Hc61
  - Hc62
- **Hc61, hc62**
  - The parameter check for the date of the AUDIT-C has changed to "the past year"

COMMUNICATION OF TEST RESULTS

CTR

- There are no changes to the CTR data collection instrument or scoring for 4Q FY2021

Colonoscopy Follow Up

- Examples have been added to q9, reasless of acceptable and unacceptable documentation of a follow up interval less than 10 years
- There are no other changes to this instrument and there are no changes to the scoring (HOP29)

COLONOSCOPY FOLLOW UP INTERVAL

CATARACT SURGERY

Cataract Surgery

- There are no changes to the Cataract Surgery data collection instrument or to the scoring for 4Q FY2021

CGPI

CGPI VALIDATION MODULE

- As previously noted, race and ethnicity will be received on the pull list
- In 4Q we are going to validate the pull list information
- As a result, new questions have been added to the Validation module

Q1 raceval, q2 racerec2

- **Is the prefilled race, (computer display race), the same race documented in demographics in the medical record?**
- **Note that Demographics is the only acceptable source for this information**
- If the race documented in Demographics matches the prefilled information, answer yes and go to the ethnicity validation question
- If the information in demographics does not match the prefilled information, go to question 2 racerec2, which is the same question as in 3Q
  - Please note that demographics may indicate more than one race, e.g. Alaska Native and White. Select 6, multi-race.

Q3 ethnicval, q4 ethnicrec2

- **Is the prefilled ethnicity, (computer display ethnicity), the same ethnicity documented in demographics in the medical record?**
- **The only acceptable source is demographics**
- If the ethnicity in demographics is NOT the same as the prefilled ethnicity, enter value 2. For example, the prefilled ethnicity indicates patient is of Hispanic, Latino, or Spanish ethnicity and the information found in demographics indicates the patient is NOT Hispanic, Latino, or Spanish; select value 2.
- If you select 2 to ethnicval, go to ethnicrec2, which is the same question as in 3Q

Q11 valnexus

- See the added rules in question 11 valnexus related to telephone encounters and CPT codes
- Telephone encounters: **Primary care telephone encounters** must have a CPT code of 99443 (21-30-min. encounter). **Mental health telephone encounters** must be matched with one of the following CPT codes: 99443, 99442, 98968, 98967, 90838, 90833, 90836, 98966, 99441, 99211, 99212
- The same guidance is in seenyr2

Core Module

- Q1 vhabps/vhabpd
- There are no changes to this question or rules in 4Q
- We do need to provide a clarification about one of the acceptable sources of blood pressure readings
  - Self-reported BP readings by the patient/caregiver that are documented in the medical record
  - **If you find a self-reported blood pressure without a date in a progress note, it is acceptable to use the date the note was signed**

ADLs and iADLs

- **Q14 asesadl and q16 asesiadl**
- **The Vulnerable Elders Survey Tool (VES) is an acceptable tool for assessment of the patient's ADLs and IADLs.**
- The VES is a 13 item, simple, function-based questionnaire that considers four factors: age, self-rated health, limitations in physical function and functional disability.
  - The total score ranges from 0-10; the likelihood of future functional decline or death increases linearly as the score increases.
  - A score of 3 or higher is often used to identify individuals as vulnerable to functional decline, but providers can elect to use higher scores if they want to narrow selection and identify persons at even greater risk.

Diabetes Module

- The previous question about diabetic nephropathy has been divided into two questions in order to capture the exclusions for the new kidney health evaluation measure (ked1h) and dmg34 separately
- Q6 renaldis
  - **At any time prior to or on (computer to display stdyend) is there documentation in the medical record of any one of the following**:
    - End stage renal disease (ESRD) may include but is not limited to:
      - Chronic kidney disease, stage 5 (stage V)
      - End stage renal failure
    - Dialysis:
      - Hemodialysis
      - Peritoneal dialysis
  - Refer to Table 8 for other specific terminology for ESRD and dialysis

Q7 dmnephdx

- **Within the past year, did the patient have an active diagnosis of diabetic nephropathy?**
- This question is the same as the kidisdx question in previous quarters but does not include ESRD and Dialysis
- Please review the terms that indicate a diagnosis of diabetic nephropathy

CGPI Mental Health Module

- The questions about documentation of probable permanent cognitive impairment as discussed in the HBPC slides are also in the CGPI Mental Health module
- The other Mental Health module changes also mirror those in the HBPC mental health questions
  - Addition of Clinical Pharmacy Specialist to the acceptable providers who can complete the CSSR-S
  - Addition of the question to capture the date of the most recent CSRE

CGPI OP Medication Reconciliation

- **Q4 opmedlst2**
  - The definition/decision rules have been revised to include additional guidance related to providing a copy of the reconciled medication list to the patient
  - Face to Face encounter:
    - There must be documentation that a copy of the list of reconciled medications was given to, **sent by secure message, or mailed to the patient/caregiver on the same day as the visit is acceptable.**
    - The medication list should reflect any changes made **and the list must be provided (or sent) to the patient/caregiver on the same day as the visit.**
- If the visit is conducted by Clinical Video Telehealth (CVT) **or telephone encounter**, documentation MUST indicate the medication list was sent by secure messaging or traditional mail on the day of the visit.
  - Documentation the list was only "given" to the patient/caregiver is **NOT** acceptable.
  - **Documentation that the list was "given" via My HealtheVet is NOT acceptable. It does not currently include a full list of medications.**

Prevention Indicators Module

- q15 tobscrn18
- Patients with cognitive impairment will be excluded from the tobacco screening questions [(dementdx2 = 1) AND (permci = 1) OR (cogscor2=5) OR (incsevci = 1) OR (modsevci=1)]
- There are some additions to the acceptable providers who may complete the National Clinical Reminder for Tobacco Use
  - **Addictions Therapists**
  - **Licensed Professional Mental Health Counselors (LPMHC)**
  - **Marriage and Family Therapists**

Colorectal Cancer Screening

- Patients age >45 will get the colorectal cancer screening questions
  - Previously the age was >50
- Otherwise, there are no changes to the colorectal series of questions.

Pap Tests

- You will note some skip changes in the field format column for several of the Pap test questions. These changes are to account for the path to the new question hpvtest2
- Hpvtest2 looks for documentation of a cervical high-risk human papillomavirus (hrHPV/HPV) test **within the past 5 years** and replaces the previous question hpvtest
  - The new question accounts for women ages 30- 64 who had cervical high risk HPV testing performed within the last 5 years.

Q57 hpvtest2

- **Within the past 5 years, was a cervical hrHPV/HPV test performed?**
  - **1. hrHPV/HPV test was performed by the VHA**
  - **3. hrHPV/HPV test was performed by the private sector**
  - **99. No documentation hrHPV/HPV test performed**
- A hrHPV/HPV test may be performed in conjunction with a pap test or as a stand-alone test
- Other than the change in the timeframe, the rules for this question are essentially the same as the previous HPV question

hrHPV/HPV

- If an hrHPV/HPV was done **in the past 5 years** you will enter the date the test was **performed** in q58 and the date the test result was **reported** will be entered in q59
- The **date of the report** must be:
  - >=hpvtstdt2 and <=45 days after hpvtestdt2 and
  - <= the study end or
  - <= the pull list date if the study end date is > the pull list date (i.e. the last pull of the quarter)

CGPI Shared Module

- New questions have been added and changes to existing questions have been made to capture the data needed to score the new Kidney Health Evaluation measure as well as to score dmg34h

New DM lab questions

- Cases flagged for diabetes will get the new questions about kidney health evaluation tests UNLESS the patient is >= age 66 and
  - frailflag = 1 or frailty = 1 and
  - illflag = 1 or advillns = 1 or demeds = 1
  - OR inltcset = 1

Q20 ualb

- During the past year is there documentation in the medical record of a **urine albumin or microalbumin** test?
  - 1. Yes
  - 2. No
  - 98. Patient refused urine albumin or microalbumin test
- Note that the question asks for a *urine* albumin (not serum albumin) or microalbumin
- The quantitative urine albumin or microalbumin test detects and measures the amount of albumin or microalbumin in the urine to screen for kidney disease.
  - Quantitative refers to a numerical value. There must be a result present to select value "1" or yes.
  - Urine microalbumin or albumin measurement is acceptable
- **Urine protein alone is not acceptable and does not meet criteria for Kidney Health Evaluation**

Q21 ualbdt

- If a urine albumin or microalbumin test was done in the past year, you will enter the date of the most recent urine albumin or microalbumin in question 21

Q22 protinyr2

- Question 22, protinyr2, has no changes from the previous question protinyr
  - During the past year, was a urinalysis for protein done?
    - 1. Yes
    - 2. No
    - 98. Patient refused urinalysis test
- If a urine albumin or microalbumin was done in the past year (ualb=1), protinyr2 will be skipped and you will go to q23 **unless**
  - The patient is age >= 81 and (frailty = 1 or frailflag = 1)

Q23 ucreat

- During the time frame from (computer display ualbdt – 4 days to ualbdt + 4 days) is there documentation in the medical record of a **urine creatinine** test.
  - The urine creatinine test measures the amount of creatinine in the urine to evaluate kidney function.
  - Look for a urine creatinine test done within 4 days prior to or after the urine albumin test.
  - Creatinine must be taken from a urine test or urinalysis

Urine Creatinine

- There must be a result present in the record to select value 1 (yes) to ucreat
- If you select value 1, you will get a warning asking if you are sure the test is a urine creatinine test
- You will enter the date of the most recent urine creatinine test done within 4 days prior to or after the urine albumin test in q24 ucreatdt

Q25 uacrratio

- During the past year, was a urine albumin-creatinine ratio (uACR) documented in the medical record?
- **Select value "1" (yes) if there is:**
  - uALB/CR or MALB/CR result found in the **laboratory report**; often reported in mg/G with reference range 0 – 30 mg/G.
  - Provider documentation in a **progress note** (e.g., urine albumin-creatinine ratio calculated as 42 mg/G from urine albumin and urine creatinine results).
- **Select value "2" or no if there is:**
  - No documentation or documentation of a urine albumin-creatinine ratio in a laboratory report or a progress note
  - Documentation that the ratio could not be calculated
- Enter the date of the most recent urine albumin- creatinine ratio in question 26

Q27 egfr

- **During the past year is there documentation in the medical record of an estimated glomerular filtration rate (eGFR)?**
- The estimated glomerular filtration rate (eGFR) provides an assessment of the filtering capacity of the kidney.
- The eGFR is calculated based on a blood (plasma or serum) test for creatinine.
- The eGFR may be taken from the laboratory report or from results documented in a progress note.
- **There must be a result present to select value "1" or yes.**
  - The eGFR may be reported as a numerical value or with cut points.
  - The eGFR is usually reported with a reference range.
  - See the definition/decision rules for an example
- Enter the date of the most recent eGFR in question 28

CGPI Scoring Changes

- Two CGPI pilot measures were added
  - P44h: Cervical Screen age 21-64 (includes hrHPV test age 30)
  - P45h: Cervical Screen age 30-64 (includes hrHPV test)
  - Please see the CGPI Exit Report Guide for details
- The other cervical screening measures, p41h, p42, and p43h remain unchanged

Another New Measure

- KED1h: Kidney Health Evaluation for patients with diabetes
  - Includes cases flagged for DM
  - Age >=18 and <=85
  - Cases pass that have
    - a urine albumin or microalbumin in the past year and
    - a urine creatinine within 4 days of the urine albumin/microalbumin or if no urine albumin/microalbumin and urine creatinine, a urine albumin-creatinine ratio was documented in the past year

    and
    - an eGFR in the past year
- See the CGPI Exit Report Guide for complete details

Other measure changes

- A check for the cognitive impairment exclusions (DEMENTDX2, PERMCI, DEMSEV, COGSCOR2, INCSEVCI, MODSEVCI) has been added to the tobacco measures
  - P7, p7s
  - Smg19n, smg19mn, smg19sn
  - Smg8, smg8s
  - Smg9, smg9s
  - Smg10, smg10s

More measure changes

- An exclusion for othrcare=1 was added to
  - Smg8, smg8s
  - Smg9, smg9s
  - Smg10, smg10s
  - Smg19mn, smg19sn
- An exclusion for probable permanent cognitive impairment (permci=1) was added to
  - Csre1
  - Cssrs1
  - Mdd40
  - Ptsd51,
  - Sa7,
  - Sa17

Dmg34h: Renal testing

- Checks for deleted questions were removed (kidisdx, protinyr, micoralbn) and checks for new questions were added (renaldis, dmnephdx, protinyr2, ualb
- See exit report guide for details

Changes

- Thank you for reviewing the 4Q changes to the data collection tools and scoring
- The facility liaison has access to this presentation as well as the instruments and scoring specifications on the Quality Insights website
  - You should be prepared to discuss them with facility staff at the exit conference for the 7/6 pull list
- As always it is important to review rules carefully as you abstract, especially those that have changed