

# Together 2 Goal® Campaign Measurement Specifications

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## 1. Purpose

The purpose of this document is to provide guidance to participating medical groups on data to be submitted for AMGA Foundation’s national diabetes campaign, Together 2 Goal®.

Measurement is essential for improvement. That’s why measurement is a cornerstone of Together 2 Goal, not only to gauge the impact of the campaign but also to serve as a vital tool for AMGA members to use in creating that change.

At the same time, we don’t want measurement to be an obstacle to participating in the campaign, nor an undue burden. So Together 2 Goal offers three data reporting tracks, to fit the capabilities and interests of each AMGA member. This document describes the four individual measures and the bundle measure that make up the “core” measurement track. The “basic” track consists of just the first measure in the core track, HbA<sub>1c</sub> < 8%.

The focus of the campaign is detection and longitudinal management of patients with type 2 diabetes, so the measures are designed to enable participating organizations to track improvement in their performance over the course of the campaign.

These measures were recommended by the Scientific Advisory Committee and the Measurement Committee for Together 2 Goal and were approved by the National Advisory Committee.

The work of these committees was informed by analyses of longitudinal EHR and outbound claims data from AMGA members who are using the Optum One population health analytics platform, through AMGA’s partnership with Optum. We are grateful for these members’ contribution of their data, for their participation in AMGA’s Optum One collaborative, and for Optum’s support.

## 2. Overview of Measures

These specifications describe the measures for the “core” measurement track. Among patients with type 2 diabetes, the core measures describe performance in hemoglobin A<sub>1c</sub> (HbA<sub>1c</sub>) control (< 8%), blood pressure (BP) control (< 140/90 mm Hg), medical attention for nephropathy, and lipid management (statin prescribed).

These measure specs are based on two measure sets from NCQA’s HEDIS 2016 Technical Specifications for Physician Measurement: Comprehensive Diabetes Care (CDC) and Statin Therapy for Patients with Diabetes (SPD).

We have tried to follow these national measures as closely as possible, but some differences are inevitable, mainly in constructing the denominator: Together 2 Goal focuses just on patients with type 2 diabetes, while national measures generally include all patients with diabetes mellitus. HEDIS measures are developed initially for health plans, which have definitive data on member enrollment, but the HEDIS specs for physician measurement construct a denominator based on

patients seen by a practice. We are taking the latter approach for Together 2 Goal. Other differences between these measures and HEDIS 2016 are described throughout the document. Note that although NCQA's HEDIS 2016 Technical Specifications for Physician Measurement are published each year, we will evaluate any changes and make adjustments to the T2G measures if the measurement committee feels they are essential to the campaign. Currently, we have determined that there is no need to update the T2G measure specifications to reflect the minor changes to the 2017 HEDIS CDC and SPD measure specifications with the exception of the accompanying values sets as referenced below. Accordingly, we will reference HEDIS 2017 documents when referring to value sets only, and HEDIS 2016 when referring to the specification documents used to develop the T2G measurement specifications.

None of the measures produced from the AMGA Foundation Together 2 Goal campaign have been validated by NCQA. NCQA specifications provided in the AMGA Foundation Together 2 Goal campaign are for reference only and are not an indication of measure validity.

HEDIS value sets are referenced throughout these specs and are provided in an accompanying Excel workbook (HEDIS Value Sets for T2G Measures v2.0.xlsx). We have evaluated and incorporated HEDIS 2017 changes to the value set to more clearly identify patients with evidence of overt cardiovascular disease and included the new value set for identifying patients with hospice/palliative care. We greatly appreciate NCQA's generosity in granting permission to use these value sets for Together 2 Goal.

These specs are substantially clearer and a little easier to program, thanks to meticulous review of a draft version by several AMGA members and corporate partners. We are deeply grateful for their time and expertise.

Numerical superscripts in the text refer to numbered notes at the end of each section or paragraph (see Section 3.1, for example). These notes are intended to assist in identifying comparable patient populations across organizations.

## 2.1. Measure Definitions

Organizations participating in AMGA Foundation's Together 2 Goal campaign are asked to report seven values for each 12-month measurement period (MP). These values are defined in detail in Sections 3.1 – 3.7:

- (1) Active initial population
  - Patients with two or more encounters in an ambulatory setting, over 18 months
- (2) Active initial population with type 2 diabetes (T2G cohort, the denominator)
  - Patients with evidence of type 2 diabetes (diagnosis on a claim or the problem list)
- (3) T2G cohort (denominator) patients with HbA<sub>1c</sub> in control (measure #1)
  - Patients whose most recent HbA<sub>1c</sub> is < 8%
- (4) T2G cohort (denominator) patients with BP in control (measure #2)
  - Patients whose most recent ambulatory, in-office blood pressure is < 140/90 mm Hg

- (5) T2G cohort (denominator) patients who received medical attention for nephropathy (measure #3)
  - Patients with evidence of a nephropathy screening or monitoring test, a diagnosis of nephropathy, treatment for nephropathy, or evidence of the use of an angiotensin-converting-enzyme inhibitor (ACEi) or angiotensin II receptor blocker (ARB)
- (6) T2G cohort (denominator) patients who received lipid management (measure #4)
  - Patients for whom a statin was prescribed or who had a documented reason not to receive statin therapy
- (7) T2G cohort (denominator) patients who are compliant with all elements of the T2G bundle (measure #5)
  - Patients who are compliant for measures #1, #2, #3, and #4

Using the reported values described above, AMGA Foundation will calculate and track the following measures:

- Prevalence of type 2 diabetes

$$\frac{\textit{Patients with type 2 diabetes (2)}}{\textit{Active initial population (1)}}$$

- HbA<sub>1c</sub> control

$$\frac{\textit{Patients with HbA}_{1c} \textit{ in control (< 8%) (3)}}{\textit{Patients with type 2 diabetes (2)}}$$

- BP control

$$\frac{\textit{Patients with BP in control (< } \frac{140}{90} \textit{) (4)}}{\textit{Patients with type 2 diabetes (2)}}$$

- Medical attention for nephropathy

$$\frac{\textit{Patients with medical attention for nephropathy (5)}}{\textit{Patients with type 2 diabetes (2)}}$$

- Lipid management

$$\frac{\textit{Patients with lipid management (statin prescribed) (6)}}{\textit{Patients with type 2 diabetes (2)}}$$

- T2G bundle

$$\frac{\textit{Patients compliant with all elements of the T2G bundle (7)}}{\textit{Patients with type 2 diabetes (2)}}$$

## 2.2. Using Value Sets

Accompanying this document is an Excel workbook (HEDIS Value Sets for T2G Measures v2.0.xlsx) which contains value sets from the HEDIS 2017 Technical Specifications for Physician Measurement. Value sets are lists of codes used to define diagnoses, procedures, or events. Value sets are referenced in this document as (HEDIS 2017: “Value Set Name” Value Set). Value set names correspond to worksheet tabs in the Excel workbook. For example, (HEDIS 2017: Pregnancy Value Set) refers to the worksheet “Pregnancy.”

Some value sets contain multiple kinds of codes. For example, the ESRD value set contains diagnosis codes (ICD-9-CM, ICD-10-CM), institutional procedure codes (ICD-9-PCS, ICD-10-PCS), professional procedure codes (CPT, HCPCS), CMS place-of-service (POS) codes, UB revenue codes, and UB type-of-bill (TOB) codes. This allows patients to be identified for the ESRD exclusion using any of several data sources. Most organizations have multiple source systems and data repositories, or ways of accessing EHR problem lists. While these specs dictate concepts for inclusion and exclusion criteria, we expect organizations to use their most convenient and reliable data sources to identify patients for these measures and to determine whether each patient is numerator compliant.

## 2.3. Measurement Periods

Participating organizations are asked to report quarterly, using a rolling 12-month measurement period (MP). The first report will be designated 2016 Q1, which corresponds to a 12-month MP of 2015 Q2 – 2016 Q1, or 2015 Apr 1 – 2016 Mar 31. These data will be used as a baseline, to track improvement over the course of the campaign.

After the baseline period, organizations are asked to report quarterly for the duration of the three-year campaign. Each report is due two months after the end of the 12-month MP, so the report for a period ending Q1 (March 31) will be due by June 1.

**Separate instructions will be provided for transmitting data**, but briefly, there will be two options: enter the seven values needed for each quarter into a secure web portal for which participating organizations will be registered by campaign staff; or enter the seven values into an Excel template that will be provided, then either upload the Excel file to the portal or submit it by email, using a special email address that enables automatic parsing and consistency checking for submitted files.

Among patients with type 2 diabetes seen during a typical 12-month period, about two-thirds have their last office visit during the last three months. So a 12-month measure is naturally weighted to reflect recent performance. Reporting quarterly using a rolling 12-month MP maintains consistency with the typical time frame for quality measures and also provides for timely reflection of changes in care process.

	Measurement Periods (Defined by Quarters)	Measurement Periods (Defined by Months and Days)	Reporting Deadline	Blinded, Comparative Reports Sent to Participating Organizations
<b>T2G Baseline:</b>	<b>2016 Q1</b> (2015 Q2 - 2016 Q1)	<b>2016 Q1</b> (2015 Apr 1 - 2016 Mar 31)	June 1, 2016	July 15, 2016
<b>T2G Year 1:</b>	<b>2016 Q2</b> (2015 Q3 - 2016 Q2)	<b>2016 Q2</b> (2015 Jul 1 - 2016 Jun 30)	September 1, 2016	September 23, 2016
	<b>2016 Q3</b> (2015 Q4 - 2016 Q3)	<b>2016 Q3</b> (2015 Oct 1 - 2016 Sep 30)	December 2, 2016	December 22, 2016
	<b>2016 Q4</b> (2016 Q1 - 2016 Q4)	<b>2016 Q4</b> (2016 Jan 1 - 2016 Dec 31)	March 1, 2017	March 24, 2017
	<b>2017 Q1</b> (2016 Q2 - 2017 Q1)	<b>2017 Q1</b> (2016 Apr 1 - 2017 Mar 31)	June 1, 2017	June 23, 2017
<b>T2G Year 2:</b>	<b>2017 Q2</b> (2016 Q3 - 2017 Q2)	<b>2017 Q2</b> (2016 Jul 1 - 2017 Jun 30)	September 1, 2017	September 22, 2017
	<b>2017 Q3</b> (2016 Q4 - 2017 Q3)	<b>2017 Q3</b> (2016 Oct 1 - 2017 Sep 30)	December 1, 2017	December 22, 2017
	<b>2017 Q4</b> (2017 Q1 - 2017 Q4)	<b>2017 Q4</b> (2017 Jan 1 - 2017 Dec 31)	March 1, 2018	March 23, 2018
	<b>2018 Q1</b> (2017 Q2 - 2018 Q1)	<b>2018 Q1</b> (2017 Apr 1 - 2018 Mar 31)	June 1, 2018	June 22, 2018
<b>T2G Year 3:</b>	<b>2018 Q2</b> (2017 Q3 - 2018 Q2)	<b>2018 Q2</b> (2017 Jul 1 - 2018 Jun 30)	September 4, 2018	September 21, 2018
	<b>2018 Q3</b> (2017 Q4 - 2018 Q3)	<b>2017 Q3</b> (2017 Oct 1 - 2018 Sep 30)	December 3, 2018	December 21, 2018
	<b>2018 Q4</b> (2018 Q1 - 2018 Q4)	<b>2018 Q4</b> (2018 Jan 1 - 2018 Dec 31)	March 2, 2019	March 30, 2019
	<b>2019 Q1</b> (2018 Q2 - 2019 Q1)	<b>2019 Q1</b> (2018 Apr 1 - 2019 Mar 31)	June 3, 2019	June 28, 2019

### 3. Patient Counts to be Reported

Sections 3.1 – 3.7 describe the values we are asking participating organizations to report for each 12-month measurement period. Each value is a number of patients. AMGA Foundation will compute the ratios for prevalence and performance rates, as previously specified.

#### 3.1. Active Initial Population<sup>1</sup>

Patients aged 18–75, as of the last day of the 12-month measurement period (MP), with two or more eligible face-to-face encounters (Table 1) in an ambulatory<sup>2</sup> setting during the 12-month MP plus the prior 6 months (18 months total), with an eligible provider specialty (Table 2). The two visits need not be with the same provider or the same specialty.

**Note 1:** An active initial population will allow Together 2 Goal to calculate and track increases in prevalence of type 2 diabetes as additional patients are discovered through practice-based case detection (screening). Patients who are newly diagnosed will count toward the campaign goal of improved care for 1 million patients with type 2 diabetes. Together 2 Goal will report prevalence so groups can track changes over time, not for comparative purposes. For health plans, HEDIS requires continuous enrollment during the measurement year. Since providers don't have enrollment data, the Together 2 Goal visit type, specialty, and time-frame requirements are an attempt to define a cohort of patients for whom the organization is likely to "feel accountable" for providing care for their type 2 diabetes.

**Note 2:** Ambulatory settings include office visits, plus those in urgent care (distinct from ED), and "retail" or "convenience" clinics. To the extent possible, exclude encounters in ambulatory surgery, ED, observation, and inpatient settings. Also exclude telemedicine encounters and visits at the patient's home or in a nursing home.

It is possible that patients whose only encounters occurred in a group's retail or urgent care clinics are not receiving their on-going primary care at the respective group, and thus the group should not be held accountable for their diabetes care. For this reason, groups may optionally exclude patients whose only encounters during the 12-month MP plus the prior 6 months (18 months total) were in retail or urgent care clinics.

**Table 1: Codes to Identify Visits**

<b>CPT/HCPCS Codes</b>	<b>Description</b>
99201–99205, 99211–99215	Evaluation & Management Office Visit
99241–99245	Evaluation & Management Office Consultation
99381–99387, 99391–99397	Evaluation & Management Preventive Visit
99401–99404	Preventive Medicine: Individual Counseling Visit
99411–99412	Preventive Medicine: Group Counseling Visit
99420, 99429	Other Preventive Medicine Services
G0402	Initial Preventive Physical Examination (“Welcome to Medicare” Visit)
G0438, G0439	Medicare Annual Wellness Visit
G0463	Hospital outpatient clinic visit for assessment and management of a patient
T1015	Clinic visit/encounter, all inclusive

**Table 2: Eligible Provider Specialties**

<b>Provider Specialty*</b>
Primary Care Provider† (e.g., Family Medicine, Internal Medicine, Geriatrics, Pediatrics, General Practice)
Endocrinologist
Cardiologist
Nephrologist
<p>* Eligible providers include: Doctor of Medicine (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Advanced Practice Registered Nurse (APRN, ARNP), and other advanced practice professionals (APPs).</p> <p>† Organizations should use their own definition for classifying a PCP, using this list as a guide.</p>

### 3.1.1. Exclusions<sup>3</sup>

#### Required Exclusions

Exclude patients who:

1. Had a diagnosis for pregnancy (HEDIS 2017: Pregnancy Value Set) on any claim or the problem list, in any setting, during the 12-month measurement period (MP) plus the prior 6 months, **or**
2. Died prior to the end of the 12-month MP.

#### Optional Exclusions

Organizations may choose to exclude patients who had either of the following on a claim or problem list, in any setting, during the 12-month MP plus the prior 6 months:

1. Had a diagnosis of polycystic ovary syndrome (PCOS) (Table 3), **or**
2. Had a diagnosis of gestational or steroid-induced diabetes (HEDIS 2017: Diabetes Exclusions Value Set), **or**
3. Evidence of palliative and/or hospice care (Table 4), or an order to discontinue diabetes treatment.

**Note 3:** Beyond the mandatory exclusion of women who were pregnant, the optional exclusions for PCOS; gestational diabetes; steroid-induced diabetes; and palliative, hospice or discontinuation of care allow each organization to determine whether there are compelling reasons to remove these patients from their cohort. Since PCOS, gestational diabetes, and steroid-induced diabetes are established exclusions (historically, although PCOS was removed in HEDIS 2016), the campaign will retain them as optional exclusions. Thus organizations who have been using these exclusions internally may reflect them in their reporting for Together 2 Goal, if they choose.

**Table 3: Codes to Identify Patients with Polycystic Ovary Syndrome (Optional Exclusion)**

	Diagnosis Codes for PCOS
ICD-9	256.4
ICD-10	E28.2



**Table 4: Codes to Identify Patients with Palliative/Hospice Care (Optional Exclusion)**

	<b>Codes for Palliative/Hospice Care</b>
<b>ICD-9</b>	V66.7
<b>ICD-10</b>	Z51.5
<b>CPT</b>	99377–99378
<b>HCPCS</b>	G0182
<b>HCPCS</b>	Q5001–Q5010
<b>HCPCS</b>	S0255, S0271, S9126
<b>HCPCS</b>	T2042–T2046
	See HEDIS 2017: Hospice Value Set for additional HCPCS, UBREV, and UBTOB codes

## 3.2. T2G Cohort (Denominator for Together 2 Goal Measures)

### 3.2.1. Detailed Description

Number of patients from the active initial population with evidence of type 2 diabetes (Table 5). Evidence of type 2 diabetes is a diagnosis during the 12-month measurement period (MP) plus the prior 6 months, on either:<sup>4, 5, 6</sup>

1. the patient’s problem list,<sup>5</sup> or
2. a claim for a face-to-face visit in an ambulatory setting.<sup>4,5</sup>

**Table 5: Codes to Identify Patients with Type 2 Diabetes**

	Codes
ICD-9	250.*0 or 250.*2, where * is any valid character
ICD-10 <sup>7</sup>	E11.*, where * is any valid character string

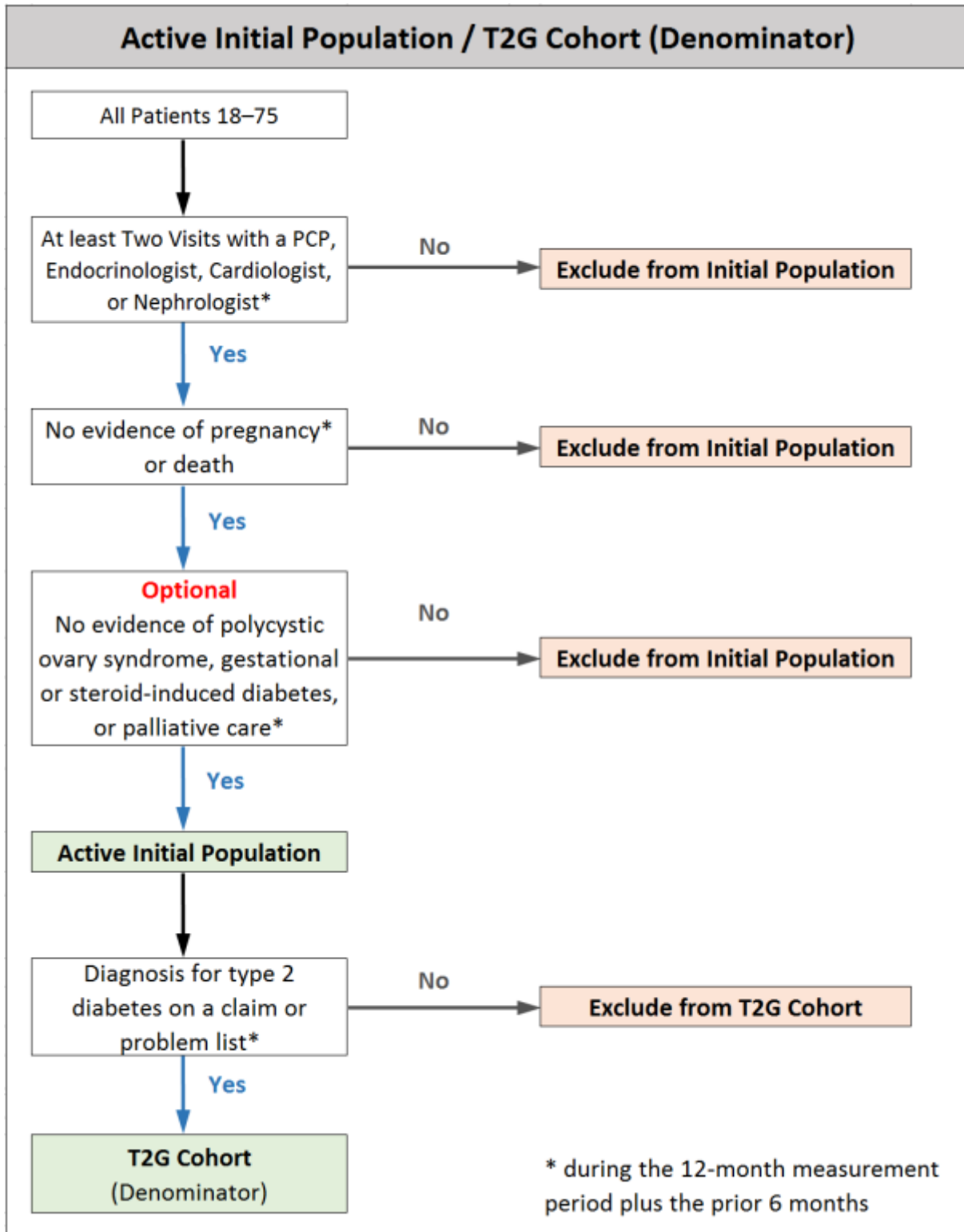
**Note 4:** Please use the CPT/HCPCS codes in Table 1 and the care settings in Note 2 to identify face-to-face encounters in the ambulatory setting. Diabetes diagnoses on other claims, such as for lab tests, should not be considered, because they may have been used in a “rule-out” sense. Include all diagnoses on claims for any of the CPT/HCPCS codes in Table 1, in any of the settings in Note 2, regardless of the specialty of the provider who renders or bills for the service. Although T2G requires two visits with certain specialties within 18 months in order to be in the active initial population, we require a diagnosis code for type 2 diabetes on only one claim for a face-to-face visit in an ambulatory setting, or on the patient’s problem list in the EHR. This differs from HEDIS, which requires a diagnosis code on claims for two ambulatory visits (absent an inpatient admission with type 2 diabetes among the discharge diagnoses). Since Together 2 Goal focuses on longitudinal management, we do not count diagnosis codes on inpatient discharges. In a health system that includes hospitals with open-staff models, not all patients who are discharged from a system hospital would be expected to receive on-going primary care from the system’s medical group.

**Note 5:** A minority of patients included in the T2G cohort (diagnosis code for type 2 diabetes on a claim or problem list) also have a diagnosis code for type 1 diabetes. In the data from AMGA's Optum One collaborative 4.8% of patients (range 1.6 – 11.5%, across provider organizations) included in the T2G cohort also had at least one eligible diagnosis code for type 1 diabetes on a claim or problem list in the 12-month MP plus the prior 6 months. Groups may use whatever logic they believe is appropriate to exclude patients with evidence of both type 1 and type 2 diabetes during the 12-month MP plus the prior 6 months. Options include: (a) excluding patients with any evidence of type 1 diabetes; (b) applying an algorithm (e.g., exclude patients with 1 diagnosis code for type 1 diabetes and fewer than 3 diagnosis codes for type 2 diabetes, 2 codes for type 1 and fewer than 6 codes for type 2, or 3 or more codes for type 1); or (c) not excluding these patients at all. In the Optum One data, patients with diagnosis code evidence of both type 1 and type 2 diabetes have similar rates of performance on BP control, nephropathy, and lipid management, and significantly worse performance on HbA<sub>1c</sub> control, compared to those with just evidence of type 2 diabetes.

**Note 6:** Together 2 Goal does not use pharmacy data (claims, dispensing, e-prescribing, or medication list) to identify patients with diabetes. Only claim/encounter data (diagnosis codes) and EHR data (problem list) are used. Together 2 Goal is focused on patients with type 2 diabetes, and many patients who have only pharmacy evidence of diabetes cannot be definitively classified as having type 2 diabetes and therefore are not included in the T2G cohort. As part of the campaign, organizations are encouraged to identify patients who have evidence of diabetes in the EHR (elevated HbA<sub>1c</sub> or fasting glucose, or medications for glycemic control, except metformin along with evidence of other conditions associated with insulin resistance) and to place a diagnosis on their problem list, as appropriate, and on relevant claims. But these patients do not enter the T2G cohort until the diagnosis of type 2 diabetes is recorded.

**Note 7:** ICD-10 codes O24 (diabetes mellitus in pregnancy, childbirth, and the puerperium) are not included here as exclusions, because we are already excluding patients who were pregnant at any time during the 12-month MP plus the prior 6 months.

### 3.2.2. T2G Cohort Diagram



### 3.3. Measure #1 – HbA<sub>1c</sub> Control

#### 3.3.1. Detailed Description

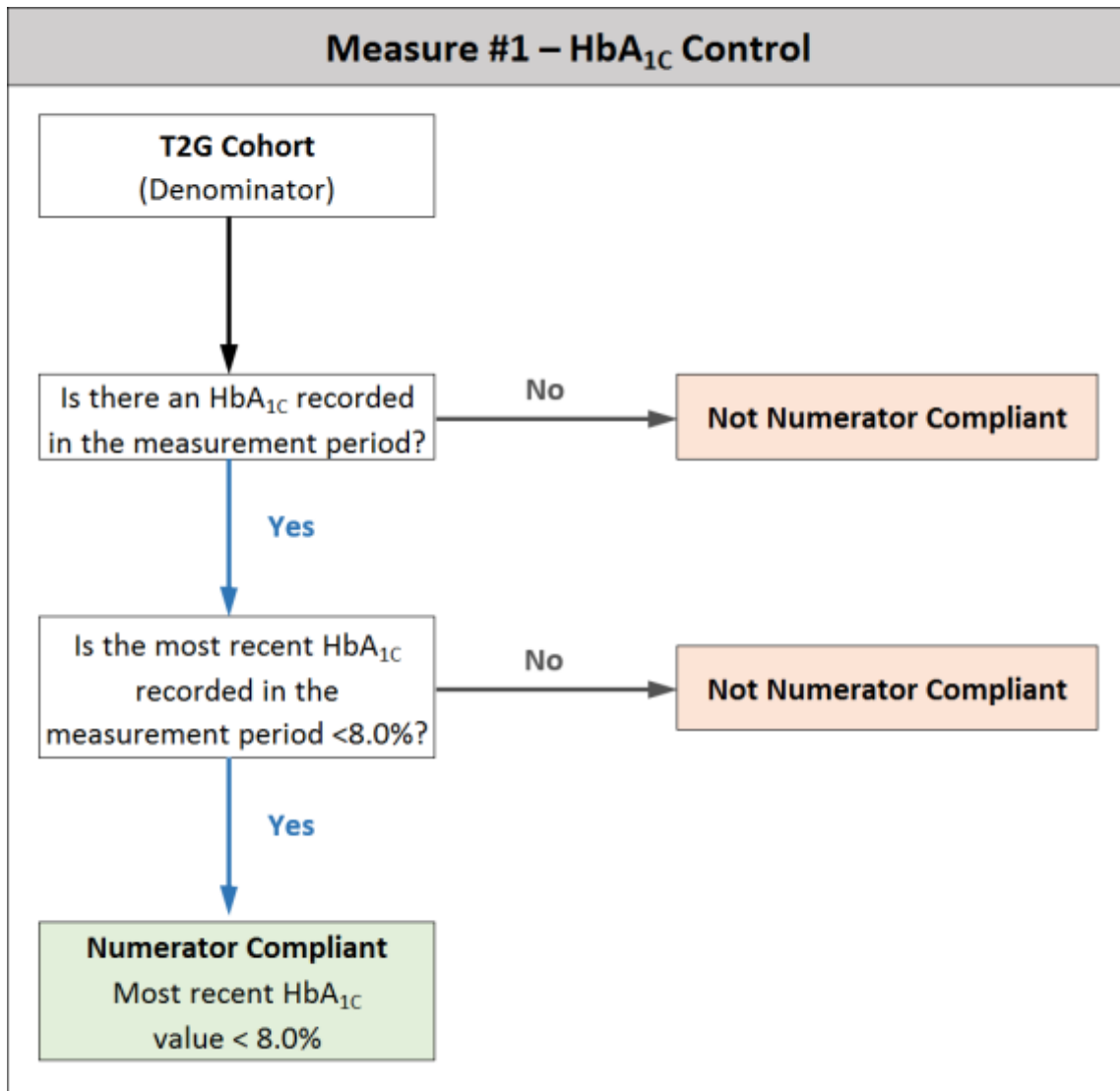
**Numerator** – Number of denominator patients whose most recent HbA<sub>1c</sub> in the 12-month measurement period (MP) is < 8.0%.<sup>8</sup>

**Additional Notes** –

- Use most recent HbA<sub>1c</sub> test result in the 12-month MP, regardless of setting (ambulatory, urgent care, ER, inpatient, etc.).
- Patients whose most recent HbA<sub>1c</sub> is < 8.0% are numerator compliant.
- Patients whose most recent HbA<sub>1c</sub> is ≥ 8.0% **or** who have no HbA<sub>1c</sub> result recorded during the 12-month MP are **not** numerator compliant.
- For organizations that use LOINC codes, HbA<sub>1c</sub> results may be identified by: 17856-6, 4548-4, or 4549-2.

**Note 8:** For Together 2 Goal, we use only a single threshold, < 8.0%. Other HbA<sub>1c</sub> control measures use a threshold of < 7.0% or > 9.0%. This was a topic of much discussion by the Scientific Advisory Committee, since therapeutic targets should be individualized, and a target lower than 8.0% may be appropriate for many patients. The Committee concluded that since the intent of the campaign is to measure glycemic control across a broad patient population, the < 8% threshold is the best choice, provided that campaign materials emphasize the need to establish an individual target for each patient. Using this population threshold for the campaign avoids the need for exclusions and allows for a consistent denominator across all four elements of the bundled measure.

### 3.3.2. Diagram



## 3.4. Measure #2 – BP Control

### 3.4.1. Detailed Description

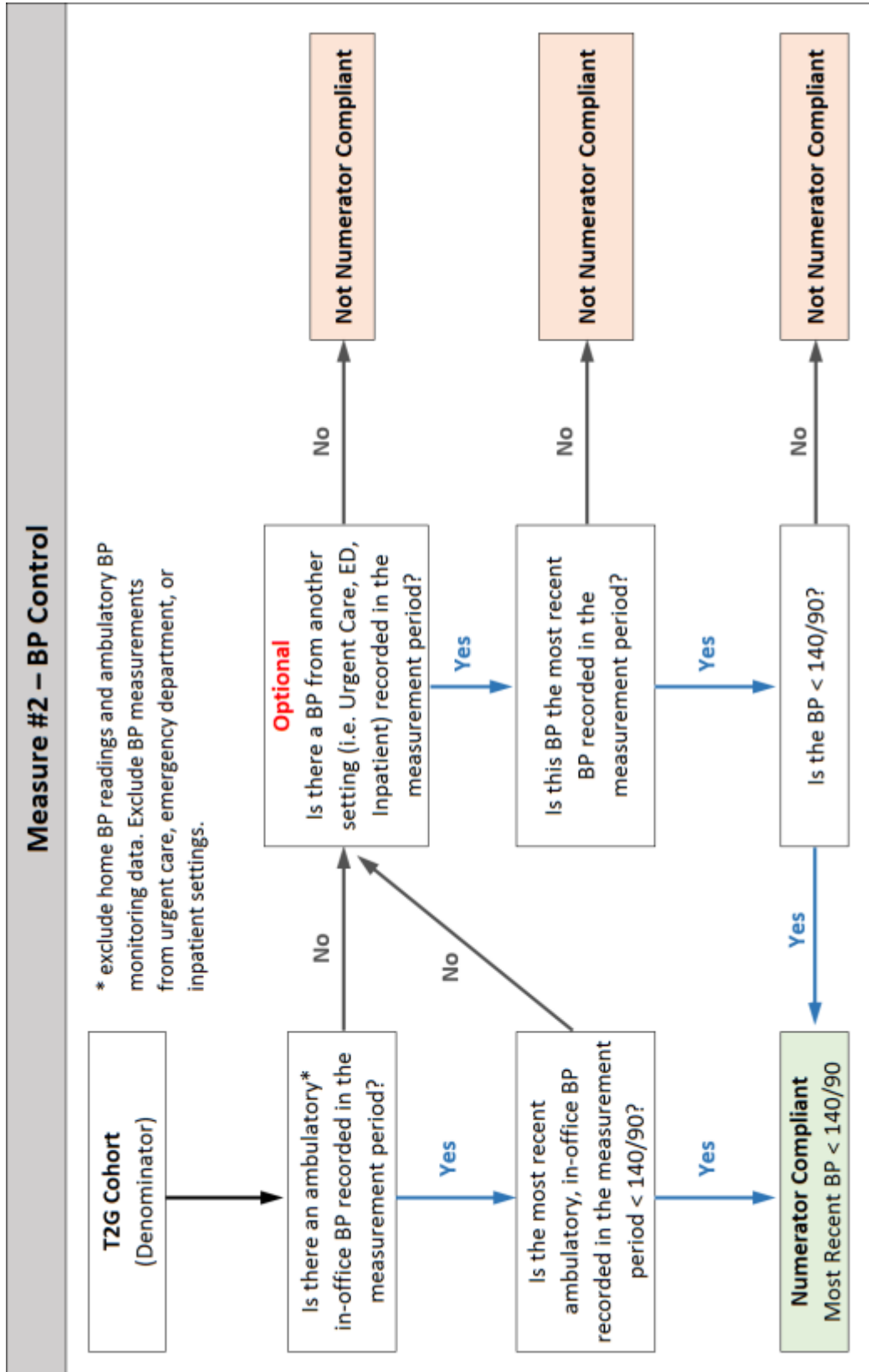
**Numerator** – Number of denominator patients whose most recent ambulatory,<sup>9</sup> in-office blood pressure reading in the 12-month measurement period (MP) is < 140/90 mm Hg.

**Additional Notes** –

- Exclude home BP readings and ambulatory BP monitoring data.
- Exclude BP measurements from urgent care, emergency department, or inpatient settings.<sup>9</sup>
- Both the systolic and diastolic readings must occur on the same day. If there are multiple blood pressures on the same date, use the lowest systolic and the lowest diastolic blood pressure, even if they were not measured together.
- Patients where both systolic BP is < 140 and diastolic BP < 90 are numerator compliant.
- Patients where either systolic BP is ≥ 140 or diastolic BP ≥ 90 are **not** numerator compliant.
- Patients with no valid BP recorded during the 12-month MP are **not** numerator compliant.

**Note 9:** A BP measurement from an urgent care, ED, or inpatient setting may optionally be considered, but only if it is the most recent recorded BP and is < 140/90 mm Hg.

### 3.4.2. Diagram





## 3.5. Measure #3 – Medical Attention for Nephropathy

### 3.5.1. Detailed Description

**Numerator** – Number of denominator patients who had evidence of medical attention for nephropathy during the 12-month measurement period (MP). Evidence includes: a nephropathy screening or monitoring test, a diagnosis of nephropathy or treatment for nephropathy, or evidence of use of an angiotensin-converting-enzyme inhibitor (ACEi) or angiotensin II receptor blocker (ARB).

Nephropathy screening or monitoring tests can be identified using:<sup>10</sup>

1. HEDIS 2017: Urine Protein Tests Value Set, **or**
2. A result in the EHR for one of the following urine tests (this list is based on the instructions for medical record review for the “hybrid” method, in the measure specifications of HEDIS 2016 Technical Specifications for Physician Measurement):
  - a. Urine microalbumin.
  - b. 24-hour urine or other timed urine for albumin or protein.
  - c. Spot or random urine for albumin or protein.
  - d. Urine for albumin/creatinine ratio.

Diagnosis of nephropathy or treatment for nephropathy can be identified using:<sup>10</sup>

1. Any of the following value sets:
  - a. HEDIS 2017: Nephropathy Treatment Value Set
  - b. HEDIS 2017: CKD Stage 4 Value Set
  - c. HEDIS 2017: ESRD Value Set
  - d. HEDIS 2017: Kidney Transplant Value Set, **or**
2. At least one visit with a nephrologist, using the CPT/HCPCS codes in Table 1.

ACE inhibitor or ARB use can be identified by:

1. e-Prescribing transaction within the 12-month MP for at least one of the drugs in Table 6 (see table note for discussion of intolerance or contraindications), **or**
2. At least one of the drugs in Table 6 active on the patient’s medication list in the EHR, as of the end of the 12-month MP.

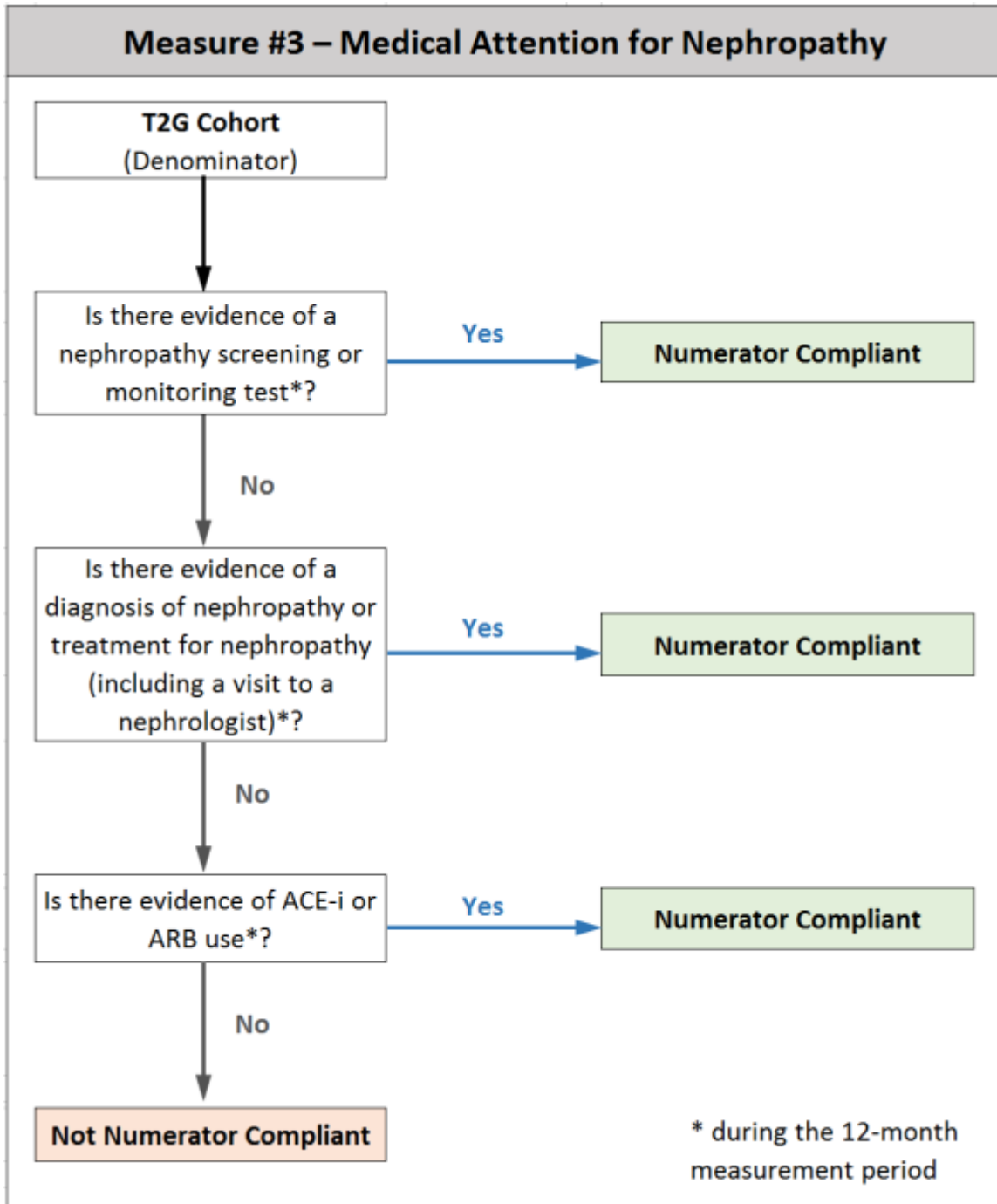
**Note 10:** Diagnosis codes in the value sets for this measure may be identified on a claim or on the patient’s problem list. CPT/HCPCS codes may be identified on a claim.

**Table 6: ACE Inhibitors/ARBs\***

Description	Prescription			
<b>Angiotensin converting enzyme inhibitors (ACE-i)</b>	<ul style="list-style-type: none"> <li>● Benazepril</li> <li>● Captopril</li> <li>● Enalapril</li> </ul>	<ul style="list-style-type: none"> <li>● Fosinopril</li> <li>● Lisinopril</li> <li>● Moexipril</li> </ul>	<ul style="list-style-type: none"> <li>● Perindopril</li> <li>● Quinapril</li> <li>● Ramipril</li> </ul>	<ul style="list-style-type: none"> <li>● Trandolapril</li> </ul>
<b>Angiotensin II inhibitors (ARB)</b>	<ul style="list-style-type: none"> <li>● Azilsartan</li> <li>● Candesartan</li> </ul>	<ul style="list-style-type: none"> <li>● Eprosartan</li> <li>● Irbesartan</li> </ul>	<ul style="list-style-type: none"> <li>● Losartan</li> <li>● Olmesartan</li> </ul>	<ul style="list-style-type: none"> <li>● Telmisartan</li> <li>● Valsartan</li> </ul>
<b>Antihypertensive combinations</b>	<ul style="list-style-type: none"> <li>● Azilsartan-chlorthalidone</li> <li>● Benazepril-amlodipine</li> <li>● Benazepril-hydrochlorothiazide</li> <li>● Candesartan-hydrochlorothiazide</li> <li>● Captopril-hydrochlorothiazide</li> <li>● Enalapril-hydrochlorothiazide</li> <li>● Eprosartan-hydrochlorothiazide</li> <li>● Fosinopril-hydrochlorothiazide</li> <li>● Irbesartan-hydrochlorothiazide</li> <li>● Lisinopril-hydrochlorothiazide</li> <li>● Losartan-hydrochlorothiazide</li> <li>● Moexipril-hydrochlorothiazide</li> <li>● Olmesartan-amlodipine</li> <li>● Olmesartan-amlodipine-hydrochlorothiazide</li> <li>● Olmesartan-hydrochlorothiazide</li> <li>● Quinapril-hydrochlorothiazide</li> <li>● Telmisartan-amlodipine</li> <li>● Telmisartan-hydrochlorothiazide</li> <li>● Trandolapril-verapamil</li> <li>● Valsartan-aliskiren</li> <li>● Valsartan-amlodipine</li> <li>● Valsartan-amlodipine-hydrochlorothiazide</li> <li>● Valsartan-hydrochlorothiazide</li> </ul>			

\*Medication list based on Table CDC-L: ACE Inhibitors/ARBs. HEDIS 2016 Technical Specifications for Physician Measurement, p. 138. In version 1.0 of these specs, we allowed patients with documented intolerance or contraindications to ACE inhibitors or ARBs to be considered numerator compliant. This was in error. While an intolerance or contraindication is a reason not to receive an ACEi/ARB, it does not eliminate the requirement for other nephropathy treatment, as described in the measure above (to include screening/monitoring tests, a visit with a nephrologist, or a diagnosis indicating nephropathy treatment has been considered and/or performed).

### 3.5.2. Diagram



## 3.6. Measure #4 – Lipid Management

### 3.6.1. Detailed Description

**Numerator** – Number of denominator patients who had a statin prescribed or had documentation of a reason not to receive a statin.

Statin use can be identified by:<sup>11</sup>

1. e-Prescribing transaction within the 12-month measurement period (MP) for at least one of the drugs in Table 7, **or**
2. At least one of the drugs in Table 7 active on the patient’s medication list in the EHR, as of the end of the 12-month MP.

**Note 11:** Although the ACC/AHA guidelines for lipid management specify that patients should be on a moderate or high statin dose, the Measurement Committee recognized that it may be difficult to determine the prescribed dose, so we do not require organizations to assess the dose. For Together 2 Goal, we accept evidence of any statin use. This is consistent with the approach used in HEDIS.

Documented reasons for not receiving a statin include:<sup>12,13</sup>

1. Any of the following during the 12-month MP plus the prior 6 months:
  - a. In vitro fertilization (HEDIS 2017: IVF Value Set or supplemental codes<sup>14</sup>)
  - b. Prescription for clomiphene (Clomid):
    - i. e-Prescribing transaction, **or**
    - ii. Clomiphene on the active medication list in the EHR at any time during the 12-month MP plus the prior 6 months
  - c. End-stage renal disease (HEDIS 2017: ESRD Value Set)
  - d. Cirrhosis (HEDIS 2017: Cirrhosis Value Set)
2. Documented statin intolerance (such as myalgia or transient elevation in liver enzymes associated with statins) **within the 12-month measurement period:**<sup>15</sup>
3. Most recent low-density lipoprotein (LDL) during the 12-month MP plus the prior 6 months < 70 mg/dL<sup>16</sup> (Optional)
4. Active liver disease (e.g., hepatitis) during the 12-month MP plus the prior 6 months<sup>16</sup> (Optional)

5. Age < 40 (as of the end of the MP) and **none** of the following<sup>17</sup> (Optional):
  - a. A cardiovascular event or diagnosis of overt cardiovascular disease (CVD) during the 12-month MP plus the prior 6 months:
    - i. Myocardial infarction (HEDIS 2017: MI Value Set)
    - ii. Coronary artery bypass graft (HEDIS 2017: CABG Value Set)
    - iii. Percutaneous coronary intervention (HEDIS 2017: PCI Value Set)
    - iv. Other revascularization procedure (HEDIS 2017: Other Revascularization Value Set)
    - v. Ischemic vascular disease (HEDIS 2017: IVD Value Set)
  - b. CVD risk factors any time during the 12-month MP plus the prior 6 months:
    - i. Most recent LDL cholesterol  $\geq$  100 mg/dL, **or**
    - ii. Diagnosis of hypertension (Table 8), **or**
    - iii. Current smoker, **or**
    - iv. Most recent BMI  $\geq$  25 kg/m<sup>2</sup>

**Note 12:** Patients with a documented reason not to receive a statin are considered numerator compliant. Although it would be logical to exclude them from the denominator for the statin measure, we want to maintain the same denominator as for the other three measures, so we can include lipid management in the bundle measure.

**Note 13:** Diagnosis codes in the value sets for the lipid management measure may be identified either on a claim or on the patient’s problem list. CPT/HCPCS codes may be identified on a claim. LDL, BMI, and smoking status may be used if these values are available in the EHR.

**Note 14:** The HEDIS value set for in vitro fertilization (IVF) includes only HCPCS codes. Groups may choose to use CPT codes to define IVF and may use the following, in addition to others they believe are appropriate.

**CPT:** 58970, 58974, 58976

**Note 15:** Groups may use whatever codes they believe are appropriate for identifying patients with statin intolerance (for example, ICD-9 E942.2 or ICD-10 T46.6X5, Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs; HEDIS 2017: Muscular Pain and Disease Value Set which can be used to identify myalgia, myositis, myopathy, or rhabdomyolysis). This value set includes only those muscular pain and disease diagnosis codes that we would expect to be associated specifically with statin intolerance, rather than general muscle pain. **Note** that while we use an 18-month period for all other reasons for not receiving a statin, we use a **12-month period for this exclusion**. The T2G Scientific Advisory Committee stressed the importance of statin therapy for patients with diabetes and discussed the need to re-try patients on statins, after complaints of myalgia or transient elevation in liver enzymes. They felt it might be reasonable not to expect re-trying statins within 12 months of muscle complaints, so the patient is considered numerator-compliant if these symptoms occurred during the 12-month MP. But if these symptoms were last reported in the 6 months prior to the 12-month MP, the Committee believed **statins should be re-tried within the MP**. This is consistent with the approach used in HEDIS.

**Note 16:** In an effort to reduce the burden of reporting for Together 2 Goal and to accommodate potential objections from providers, we have included optional exclusions for patients with *LDL < 70 mg/dL* and patients with *active liver disease*. This is consistent with the approach used by Minnesota Community Measurement.

**Note 17:** The ADA guidelines specify that patients < 40 years of age with CVD risk factors or overt CVD should be on a statin, while patients < 40 with neither are exempt. In the data from AMGA's Optum One collaborative, 5.1% of patients included in the T2G cohort are < 40 years of age, and 93% of these patients have at least one CVD risk factor. Considering the small proportion of patients who meet this criterion and its complexity, it is optional for Together 2 Goal reporting. **If organizations choose not to look for CVD risk factors or overt CVD**, patients < 40 years of age need evidence of statin use or another reason for not receiving a statin to be considered numerator compliant.

**Table 7: Statin Prescriptions\***

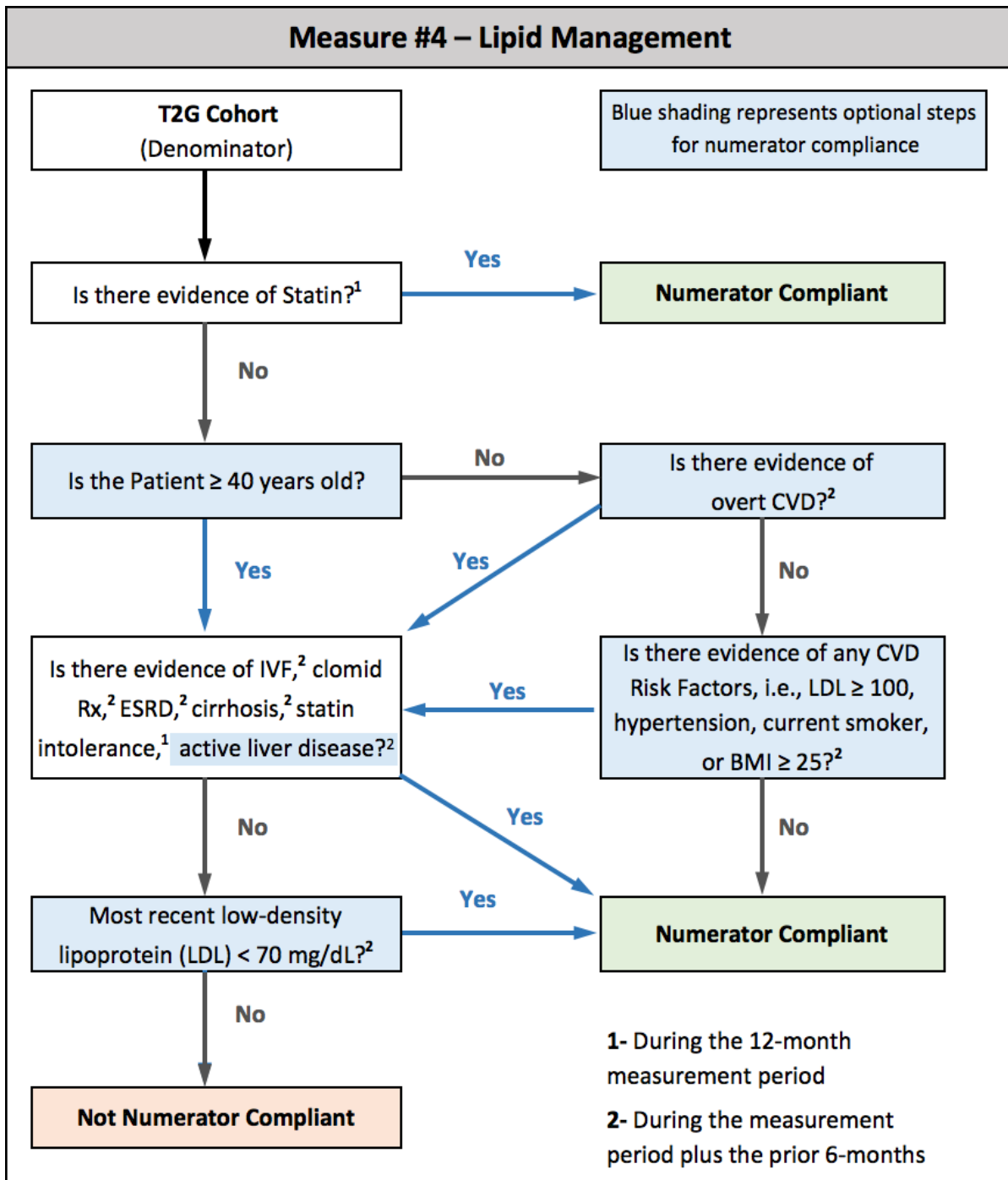
Prescription	
• Atorvastatin	• Atorvastatin-amlodipine
• Fluvastatin	• Atorvastatin-ezetimibe
• Fluvastatin XL	• Lovastatin-niacin
• Lovastatin	• Pravastatin-aspirin
• Pitavastatin	• Simvastatin-ezetimibe
• Pravastatin	• Simvastatin-niacin
• Rosuvastatin	• Simvastatin-sitagliptin
• Simvastatin	

\*Medication list is based on Table CDC-L: SPD-A: High, Moderate, and Low-Intensity Statin Prescriptions. HEDIS 2016 Technical Specifications for Physician Measurement, p. 149.

**Table 8: Codes to Identify Patients with Hypertension**

	<b>Codes</b>
<b>ICD-9</b>	401.*, 402.*, 403.*, 404.*, or 405.*, where * is any valid character string
<b>ICD-10</b>	I10.*, I11.*, I12.*, I13.*, I15.*, where * is any valid character string

3.6.2. Diagram





## 3.7. Measure #5 – T2G Bundle Measure<sup>18</sup>

### 3.7.1. Detailed Description

**Numerator** – Number of patients who were numerator-compliant for all four measures above. Patients are considered numerator compliant if they met each of the following:

1. Most recent HbA<sub>1c</sub> < 8% (measure #1), **and**
2. Most recent BP < 140/90 (measure #2), **and**
3. Received medical attention for nephropathy (measure #3), **and**
4. Statin prescribed or documented reason not to prescribe a statin (measure #4).

Patients who are not numerator compliant in any of the four measures are **not** numerator compliant for the bundle measure.

**Note 18:** An all-or-none, or “bundle,” measure best reflects the patient’s perspective, and it encourages provider organizations to think of each patient as a whole and to take a system-oriented approach to improvement. We owe each patient attention to all of his or her needs. It is sobering to learn how difficult it can be to achieve high performance rates on a bundle measure, even with what feels like good performance on the individual components.

3.7.2. Diagram

