Quality Reporting System

MEASURE DEFINITIONS

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QRS MEASURE DEFINITIONS

Clinical-Medical

Measure: Use of Appropriate Medications for Asthma[1]

Definition: Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately ordered medication during the measurement period.

Numerator: Patients who were ordered at least one prescription for a preferred therapy during the measurement period.

Denominator: Patients 5-64 years of age with persistent asthma and a visit during the measurement period.

Exclusions: Patients with a diagnosis of emphysema, COPD, obstructive chronic bronchitis, cystic fibrosis or acute respiratory failure that overlaps the measurement period.

Guidance: None

Measure: Childhood Immunizations[2]

Definition: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Numerator: Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday.

Denominator: Children who turn 2 years of age during the measurement period and who have a visit during the measurement period.

Exclusions: Exclude patient who were in hospice care during the measurement year.

Guidance: For the MMR, hepatitis B, VZV and hepatitis A vaccines, numerator inclusion criteria include: evidence of receipt of the recommended vaccine; documented history of the illness; or, a seropositive test result for the antigen. For the DTaP, IPV, HiB, pneumococcal conjugate, rotavirus, and influenza vaccines, numerator inclusion criteria include only evidence of receipt of the recommended vaccine. Patients may be included in the numerator for a particular antigen if they had an anaphylactic reaction to the vaccine. Patients may be included in the numerator for the DTaP vaccine if they have encephalopathy. Patients may be included in the numerator for the IPV vaccine if they have had an anaphylactic reaction to streptomycin, polymyxin B, or neomycin. Patients may be included in the numerator for the influenza, MMR,

[1] *Mirrors CMS 126v5-perPAL-08, Previously referred to as Asthma Pharmacologic Therapy*
[2] *Mirrors CMS117v6-per PAL2017-08*

or VZV vaccines if they have cancer of lymphoreticular or histiocytic tissue, multiple myeloma, leukemia, have had an anaphylactic reaction to neomycin, have Immunodefiency, or have HIV. Patients may be included in the numerator for the hepatitis B vaccine if they have had an anaphylactic reaction to common baker's yeast. The measure allows a grace period by measuring compliance with these recommendations between birth and age two.

Measure: Cervical Cancer Screening[3]

Definition: Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed every 3 years
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Numerator: Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:

- Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test.
- Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test.

Denominator: Women 23-64 years of age with a visit during the measurement period.

Exclusions: Women who had a hysterectomy with no residual cervix. Exclude patients who were in hospice care during the measurement year.

Guidance: To ensure the measure is only looking for a cervical cytology test only after a woman turns 21 years of age, the youngest age in the initial population is 23. Patient self-report for procedures as well as diagnostic studies should be recorded in "Procedure, Performed' template or 'Diagnostic Study, Performed' template in QRDA-1. Patient self-report is not allowed for laboratory tests. Include only cytology and HPV co-testing; in co-testing, both cytology and HPV test are performed (i.e., the samples are collected and both tests are ordered, regardless of the cytology result) on the same date of service. Do not include reflex testing. In addition, if the medical record indicates the HPV test was performed only after determining the cytology result, this is considered reflex testing and does not meet criteria for the measure.

Measure: Colorectal Cancer Screening[4]

Definition: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

Numerator: Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

[3] *Mirrors CMS124v6-per PAL 2017-08*

[4] *Mirrors CMS130-v6-per PAL 2017-08*

- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period.
- FIT-DNA during the measurement period or the two years prior to the measurement period
- CT Colonography during the measurement period or the four years prior to the measurement period

Denominator: Patients 50-75 years of age with a visit during the measurement period.
Exclusions: Patients with a diagnosis or past history of total colectomy or colorectal cancer. Exclude patients who were in hospice care during the measurement year.
Guidance: Patient self-report for procedures as well as diagnostic studies should be recorded in Procedure, Performed template or Diagnostic Study, Performed template in QRDA-1. Patient self-report is not allowed for laboratory tests.

Measure: Coronary Artery Disease: LDL Management[5]

Definition: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy**.**
Numerator: Patients who received a prescription for or were provided or were taking lipid lowering medications during the measurement period.
Denominator: Universe (Denominator): Patients 18 years of age and older who had an active diagnosis of CAD or diagnosed as having had a myocardial infarction (MI) or had cardiac surgery in the past, with at least one medical visit during the measurement period and had at least two medical visits ever (Columns A and B) Enter the number of patients who:

- Were born on or before December 31, 1997, ***and***
- Have an active diagnosis of CAD or were diagnosed as having had a myocardial infarction (MI) or had cardiac surgery, ***and***
- Were last seen by health center after their 18th birthday, ***and***
- Had at least one medical visit during the measurement year, ***and***
- Had at least two medical visits ever.

Exclusion:

- Individuals whose last low-density lipoprotein(LDL) lab test during the measurement year was less than 130 mg/dL
- Individuals with an allergy to or a history of adverse outcomes from or intolerance to LDL lowering medications

Note: Patients who have no record of an LDL lab test must be included in the universe and evaluated for this measure. Do not count as compliant patients who are receiving a form of treatment other than pharmacologic treatment. Persons involved in therapeutic lifestyle

[5] *Mirrors 2016 UDS Manual, Previously, referred to as Ischemic Vascular Disease: Complete Lipid Panel*

changes and/or control of non-lipid risk factors without concomitant pharmaceutical treatment have not met the measurement standard.

Measure: Depression Screening and Follow Up[6]

Definition: Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Numerator: Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Denominator: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.
Exclusions: Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder.
Exceptions: Patient Reason(s): Patient refuses to participate **OR** Medical Reason(s): Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status **OR** situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.
Guidance: A depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the positive screen.

Screening Tools:

- The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record
- The depression screening must be reviewed and addressed in the office of the provider, filing the code, on the date of the encounter
- The screening should occur during a qualified encounter
- Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record.

Follow-Up Plan:

- The follow-up plan must be related to a positive depression screening, example: Patient referred for psychiatric evaluation due to positive depression screening.
- Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is

[6] *Mirrors CMS2v7-per PAL 2017-08*

advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Measure: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)[8]

Definition: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.

Numerator: Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%.

Denominator: Patients 18-75 years of age with diabetes with a visit during the measurement period.

Exclusions: Exclude patients who were in hospice care during the measurement year.

Guidance: 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.

Measure: Fluoride Treatment[9]

Definition: Prophylaxis and Fluoride Varnish

99188: Application of topical fluoride varnish by a physician or other qualified health care professional.

- This code was approved to begin January 1, 2015. It only includes varnish application, not risk assessment, education, or referral to a dentist.

Numerator: Number of visits during reporting period with applicable HCPC 99188 code.

Denominator: Total number of dental visits in reporting year.

Exclusions: None

Measure: HIV Linkage to Care[10]

Definition: Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 90 days of diagnosis.

Numerator: Newly diagnosed HIV patients that received treatment within 90 days of diagnosis

Include patients who:

• Were newly diagnosed by your health center providers, ***and***

[8] *Mirrors CMS122-per PAL2017-08*

[9] *Mirrors Current Procedural Terminology 2015 American Medical Association, Oral Health Coding Fact Sheet for Primary Care Physicians*

[10] *Mirrors 2016 UDS Manual*

• Had a medical visit with your health center provider who initiates treatment for HIV, ***or***

• Had a visit with a referral resource who initiates treatment for HIV.

Note: The numerator criteria are only fulfilled when the patient attended the medical visit for HIV care within 90 days of the HIV diagnosis. If the treatment is by referral to another clinician/organization (such as a Ryan White provider), the medical treatment at the referral source must begin and the referral loop must be closed during the 90-day period. That is, the referring provider receives confirmation from the provider to whom the patient was referred that the visit was completed.

Also note: Actual treatment must be initiated within 90 days of the HIV diagnosis, not just a referral made or education provided or retesting at the referral site.

Denominator: Patients first diagnosed with HIV by the health center between October 1 of the prior year through September 30 of the current measurement year and who had at least one medical visit during the measurement period or prior year (Columns A and B) Enter the number of patients who:

• Were diagnosed with HIV for the first time ever by the health center between October 1, 2015, and September 30, 2016, ***and***

• Had at least one medical visit during 2016 or 2015.

Note that the identification of patients for this measure crosses years and may include prior year patients.

Exclusions: None

Measure: Controlling High Blood Pressure[11]

Definition: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

Numerator: Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

Denominator: Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.

Exclusions: Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. Exclude patients who were in hospice care during the measurement year.

Guidance: In reference to the numerator element, only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient's home (including readings directly from monitoring

[11] *Mirrors CMS165v6-per PAL2017-08*

devices) are not acceptable. If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed not controlled. If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

Measure: Ischemic Vascular Disease(IVD): Use of Aspirin or Another Antiplatelet[12]

Definition: Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.

Numerator: Patients who had an active medication of aspirin or another antiplatelet during the measurement year.

Denominator: Patients 18 years of age and older with a visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement year or who had a diagnosis of IVD overlapping the measurement year.

Exclusions: Patients who had documentation of use of anticoagulant medications overlapping the measurement year. Exclude patients who were in hospice care during the measurement year.

Measure: Tobacco Use Screening and Cessation Intervention[13]

Definition: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

Three rates are reported:

a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months

b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention

c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

Numerator: Population 1:

Patients who were screened for tobacco use at least once within 24 months

Population 2:

[12] *Mirrors CM164v6-per PAL 2017-08*

[13] *Mirrors CMS138v6-per PAL 2017-08*

Patients who received tobacco cessation intervention

Population 3:

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

Denominator: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.

Denominator Statement: Population 1:
Equals Initial Population

Population 2:

Equals Initial Population who were screened for tobacco use and identified as a tobacco user

Population 3:

Equals Initial Population

Exceptions: Population 1:
Documentation of medical reason(s) for not screening for tobacco use (eg. limited life expectancy, other medical reason)

Population 2:

Documentation of medical reason(s) for not providing tobacco cessation intervention (eg. limited life expectancy, other medical reason)

Population 3:

Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason) **Guidance:** If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.

If a patient has multiple tobacco use screenings during the 24 month period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.

If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and should be considered a measure failure. Instances where tobacco use status of unknown is recorded include: 1) the patient was not screened; or 2) the patient was screened and the patient (or caregiver) was unable to provide a definitive answer. If the patient does not meet the screening component of the numerator but has an allowable medical exception, then the patient should be removed from the denominator of the measure and reported as a valid exception.

The medical reason exception may be applied to either the screening data element OR to any of the applicable tobacco cessation intervention data elements (counseling and/or pharmacotherapy) included in the measure.

If a patient has a diagnosis of limited life expectancy, that patient has a valid denominator exception for not being screened for tobacco use or for not receiving tobacco use cessation intervention (counseling and/or pharmacotherapy) if identified as a tobacco user.

As noted above in a recommendation statement from the USPSTF, the current evidence is insufficient to recommend electronic nicotine delivery systems (ENDS) including electronic cigarettes for tobacco cessation. Additionally, ENDS are not currently classified as tobacco in the recent evidence review to support the update of the USPSTF recommendation given that the devices do not burn or use tobacco leaves. In light of the current lack of evidence, the measure does not currently capture e-cigarette usage as either tobacco use or a cessation aid.

The requirement of Count >=2 Encounter, Performed is to establish that the eligible professional or eligible clinician has an existing relationship with the patient for certain types of encounters.

This measure contains three reporting rates which aim to identify patients who were screened for tobacco use (rate/population 1), patients who were identified as tobacco users and who received tobacco cessation intervention (rate/population 2), and a comprehensive look at the overall performance on tobacco screening and cessation intervention (rate/population 3). By separating this measure into various reporting rates, the eligible professional or eligible clinician will be able to better ascertain where gaps in performance exist, and identify opportunities for improvement. The overall rate (rate/population 3) can be utilized to compare performance to prior published versions of this measure.

Measure: Body Mass Index (BMI) Screening and Follow-Up Plan[14]

Definition: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.

Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2

Numerator: Patients with a documented BMI during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelvemonths of the current encounter.

Denominator: All patients 18 and older on the date of the encounter with at least one eligible encounter during the measurement period.

Denominator Exceptions:

[14] *Mirrors CMS69v6-per PAL 2017-08*

- Patients with a documented Medical Reason:
- Elderly Patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:
- Illness or physical disability
- Mental illness, dementia, confusion
- Nutritional deficiency, such as Vitamin/mineral deficiency
- Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Exclusions: Patients who are pregnant, receiving palliative care or who refuse measurement of height and/or weight or refuse follow-up.
Exceptions: Patients with a documented Medical Reason: Elderly Patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples: Illness or physical disability; Mental illness, dementia, confusion; Nutritional deficiency, such as Vitamin/mineral deficiency.
Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
Guidance: There is no diagnosis associated with this measure. This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding.

BMI Measurement Guidance:

-Height and Weight - An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within twelve months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.
-The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider.
-If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous six months of the current encounter.
-If more than one BMI is reported during the measurement period, the most recent BMI will be used to determine if the performance has been met.
-Review the exclusions criteria to determine those patients that BMI measurement may not be appropriate or necessary. Follow-Up Plan Guidance:
1. * The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters, example: Patient referred to nutrition counseling for BMI above or below normal parameters.

(See Definitions for examples of follow-up plan treatments).

Variation has been noted in studies exploring optimal BMI ranges for the elderly (see Donini et al., (2012); Holme and Tonstad (2015); and Diehr et al. (2008). Notably however, all these

studies have arrived at ranges that differ from the standard range for ages 18 and older, which is >=18.5 and < 25 kg/m2. For instance, both Donini et al. (2012) and Holme and Tonstad (2015) reported findings that suggest that higher BMI (higher than the upper end of 25kg/m2) in the elderly may be beneficial. Similarly, worse outcomes have been associated with being underweight (at a threshold higher than 18.5 kg/m2) at age 65 (Diehr et al. 2008). Because of optimal BMI range variation recommendations from these studies, no specific optimal BMI range for the elderly is used. However, It may be appropriate to exempt certain patients from a follow-up plan by applying the exception criteria. Review the following to apply the Medical Reason exception criteria:

The Medical Reason exception could include, but is not limited to, the following patients as deemed appropriate by the health care provider:

* Elderly Patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:

*Illness or physical disability

*Mental illness, dementia, confusion

Nutritional deficiency such as Vitamin/mineral deficiency

* Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Measure: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents [15]

Definition: Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.

- Percentage of patients with height, weight, and body mass index (BMI) percentile documentation.
- Percentage of patients with counseling for nutrition.
- Percentage of patients with counseling for physical activity.

Numerator:

1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period.

2: Patients who had counseling for nutrition during a visit that occurs during the measurement period.

3. Patients who had counseling for physical activity during a visit that occurs during the measurement period.

Denominator: Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period

[15] *Mirrors CMS155v6-per PAL 2017-08*

Exclusions: Patients who have a diagnosis of pregnancy during the measurement period. Exclude patients who were in hospice care during the measurement year.
Guidance: The visit must be performed by a PCP or OB/GYN. Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Clinical-Dental

Measure: Treatment Plan Completion[16]

Definition: Percentage of dental patients completing Phase I treatment plan within 6 months.
Numerator: Number of Phase I Treatment Plans Completed w/in 6 months after initial or recall exams.
Denominator: Number of initial and recall exams performed 6 months ago.

Measure: Caries at Recall[17]

Definition: Percentage of patients who complete a periodic oral evaluation and have a caries diagnosis.
Numerator: Number of Patients with a Periodic Exam who also have a diagnosis code indicating caries.
Denominator: Number of Patients with a completed Periodic Exam.

Measure: Risk Assessment of all Dental Patients[18]

Definition: Identifies how many dental patients have been evaluated for caries risk.
Numerator: Number of Dental Patients with Completed Risk Assessments.
Denominator: Number of All Unique Dental Patients with a Periodic or Comprehensive Exam.

Measure: Oral Evaluation and/or Risk Assessment[19]

Definition: Percentage of patients who receive an oral health evaluation and/or risk assessment in a primary care setting.
Numerator: Number of primary care clinic patients that receive an Oral Health Evaluation and/or Risk Assessment by a medical provider.
Denominator: Number of unique primary care patients with an office visit in a medical setting.

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[16] *NNOHA Dental Dashboard*
[17] *NNOHA Dental Dashboard*
[18] *NNOHA Dental Dashboard*
[19] *NNOHA Dental Dashboard*

Measure: Topical Fluoride[20]

Definition: Percentage of pediatric patients in both medical and dental clinics who receive a topical fluoride application.
Numerator: Number of pediatric patients (0-5 years) who receive topical fluoride application.
Denominator: Number of all unique pediatric patients.

Measure: Sealants (6-9 year olds)[21]

Definition: Percentage of children, age 6-9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period.
Numerator: Children who received a sealant on a permanent first molar tooth during the measurement period**.**
Denominator: Children 6 through 9 years of age who had a dental visit in the measurement period who had an oral assessment or comprehensive or periodic oral evaluation visit and are at moderate to high risk for caries in the measurement period**.** Enter the number of patients who:

- Were born between January 1,2007, and December 31, 2009, ***and***
- Had a dental visit with the health center or with another dental provider through a paid referral, ***and***
- Had at least one oral assessment or comprehensive or periodic oral evaluation visit during the measurement period, ***and***
- Were at moderate to high risk for caries.

Exclusions: Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/ missing).

Measure: Sealants (10-14 year olds)[22]

Definition: percentage of 10-14 year old age range who are at "elevated" risk, ("moderate" or "high" in risk assessments) who have received sealants on at least one or more permanent molar tooth.
Numerator: Number of 10-14 year old pediatric patients at moderate to high risk for caries who received a sealant on one or more permanent molar teeth.
Denominator: Number of unique 10-14 year old pediatric patients with an oral assessment or comprehensive periodic oral evaluation who are at moderate to high risk for caries and have sealable molars.

[20] *NNOHA Dental Dashboard*
[21] *MirrorsUniform Data System 9/2017, Table 6B*
[22] *NNOHA Dental Dashboard*

Measure: Self-Management Goal Setting[23]

Definition: Percentage of dental patients who have at least one oral health self-management goal set by their care team.

Numerator: Number of Dental Patients who have an oral health self-management goal set with their care team.

Denominator: Percentage of Unique Dental Patients who had a comprehensive or periodic exam within the measurement period.

Measure: Self-Management Goal Review[24]

Definition: Percentage of health center patients who have established oral health self-management goals and reviewed them with their care team.

Numerator: Number of all Health center patients who have oral health self-management goals reviewed with their care team.

Denominator: Number of all unique dental patients with established self-management goals.

Measure: Recommendations to Family and Friends[25]

Definition: Percentage of patients who have completed a satisfaction survey and would recommend the health center's services to their family and friends.

Numerator: Number of patients that indicate they would recommend the health center services to family and friends.

Denominator: Number of patients who complete a satisfaction survey.

Measure: Dental Services Visits

A visit between a **dentist** or **dental hygienist** and a patient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. NOTE: A dental hygienist is credited with a visit only when s/he provides a service independently, not jointly with a dentist. Two visits may **not** be generated during a patient's visit to the dental clinic in one day, regardless of the number of clinicians who provide independent services or the volume of service (number of procedures) provided. The application of dental varnishes, and dental screenings, especially in a group setting, or absent other comprehensive dental services, does not qualify as a visit. (Note: x in the code denotes any number including the absence of a number in that place.)

Emergency Services:

Definition: ADA Code: D9110

[23] *NNOHA Dental Dashboard*
[24] *NNOHA Dental Dashboard*
[25] *NNOHA Dental Dashboard. Satisfaction survey in denominator, is not a specific type of survey. Any patient satisfaction survey is acceptable.*

Numerator: Number of visits during reporting period with applicable ADA code.
Denominator: Total number of dental visits in reporting year.

Oral Exams:
Definition: ADA Code: D0120, D0140, D0145, D0150, D0160, D0170, D0180
Numerator: Number of visits during reporting period with applicable ADA code.
Denominator: Total number of dental visits in reporting year.

Prophylaxis:
Definition: ADA Code: D1110, D1120
Numerator: Number of visits during reporting period with applicable ADA code.
Denominator: Total number of dental visits in reporting year.

Sealants:
Definition: ADA Code: D1351
Numerator: Number of visits during reporting period with applicable ADA code.
Denominator: Total number of dental visits in reporting year.

Fluoride Treatment:
Definition: Preventative procedures ADA Code: D1206, D1208
Numerator: Number of visits during reporting period with applicable ADA code.
Denominator: Total number of dental visits in reporting year.

Restorative Services:
Definition: ADA Code: D21xx - D29xx
Numerator: Number of visits during reporting period with applicable ADA code.
Denominator: Total number of dental visits in reporting year.

Oral Surgery: (extractions and other surgical procedures)[26]
Definition: ADA Code: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250,D7260, D7261, D7270, D7272, D7280
Numerator: Number of visits during reporting period with applicable ADA code.
Denominator: Total number of dental visits in reporting year.

Rehabilitative Services:
Definition: ADA Code: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx
Numerator: Number of visits during reporting period with applicable ADA code.
Denominator: Total number of dental visits in reporting year.

[26] *UDS definition also includes D7251, D7290-D7294*

Financial-Medical

Measure: Cost per Medical Patient[27]

Definition: Annual cost per medical patient.
Numerator: Total medical staff (includes benefits) plus medical/other direct (direct costs for medical care including, but not limited to, supplies, equipment depreciation, related travel, CME registration and travel, subscriptions, EHR system) and after allocation of overhead. Excludes: Lab and x-ray costs and donations.
Denominator: Total number of medical patients.

Measure: Cost per Medical Visit[28]

Definition: Annual cost per medical visit.
Numerator: Total medical staff (includes benefits) plus medical/other direct (direct costs for medical care including, but not limited to, supplies, equipment depreciation, related travel, CME registration and travel, subscriptions, EHR system) and after allocation of overhead. Excludes: Lab and x-ray costs and donations.
Denominator: Total number of medical visits (excludes nursing (RN & LPN).

Financial-Dental

Measure: Encounters Per Hour[29]

Definition: Average number of patients each provider sees per hour.
Numerator: Number of patients seen by each provider.
Denominator: Number of scheduled hours for each provider.

Measure: No Shows[30]

Definition: Percentage of patients who either don't show up or call to cancel an appointment.
Numerator: Number of patients who do not show up for scheduled dental visits.
Denominator: Number of patients scheduled for a dental visit.

[27] *Mirrors 2016 UDS Manual*
[28] *Mirrors 2016 UDS Manual*
[29] *Mirrors NNOHA Dental Dashboard*
[30] *Mirrors NNOHA Dental Dashboard*

Measure: Recall Rates[31]

Definition: Percentage of patients who have returned for a recommended recall visit established during a previous dental appointment.
Numerator: Number of patients up to date with recall visits.
Denominator: Number of patients with recalls.

Measure: Cost per Dental Patient[32]

Definition: Annual cost per dental patient.
Numerator: Total accrued dental staff and dental other cost (including but not limited to staff, fringe benefits, supplies, equipment depreciations, related travel, dental lab services and dental x-ray) after allocations of overhead.
Denominator: Total number of dental patients.

Measure: Cost per Dental Visit[33]

Definition: Annual cost per dental visit.
Numerator: Total accrued dental staff and dental other cost (including but not limited to staff, fringe benefits, supplies, equipment depreciation, related travel, dental lab services and dental x-ray) after allocation of overhead.
Denominator: Total number of dental visits.

[31] *Mirrors NNOHA Dental Dashboard*
[32] *Mirrors 2016 UDS Manual*
[33] *Mirrors 2016 UDS Manual*