HTN Testing Status

OntarioMD i4C Dashboard Indicator

For more information regarding OntarioMD Indicators or the EMR i4C Dashboard Specification, please refer to:

https://www.ontariomd.ca/emr-certification/emr-specification/ontariomd-indicator-library

1. VERSION HISTORY

INDICATOR VERSION	PUBLICATION DATE	REMARKS
1.0	2019-02-18	• Initial release
2.0	2019-07-09	• Added Indicator ID, Indicator Segment ID and Display Indicator Segment properties • Changed format and content of Indicator User Help • Changed format of Source property • Indicator Segment IDs re-sequenced to provide consistency across indicators • Indicator Segment Query Criteria clarifies that query result from a segment should produce a count of patients

2. INDICATOR DEFINITION

2.1 Indicator Properties

PROPERTY	VALUE
Indicator ID	CDM-HTN-002
Indicator Name	HTN Testing Status
Indicator Version	2.0
Date Published	2019-07-09
Description	**Purpose:** This indicator is used to identify patients with one more completed elements of care commonly associated with hypertension. **Base Population:** All patients age 18 and over with an Active demographic status recorded in the EMR who have a confirmed HTN diagnosis through entry of an appropriate diagnosis code. **Indicator Segments:** Indicator segments provide counts of patients with one or more elements of care complete (documented Blood Pressure measurement in last 12 months, documented blood glucose or HbA1c screening in last 12 months, documented obesity/overweight screening in last 12 months), and counts of patients who are missing all three elements of care. **Suggested Indicator Use:** Physician or Practice use of this indicator is to recall patients where all elements of care are overdue, indicating they may not have been seen in over 12 months.

PROPERTY	VALUE
	Measurements of Interest: Percentage of patients with one or elements of care complete out of all patients in the base population.
Source	CIHI
Source Description	Based on the CIHI indicator framework version published in 2012.
Status	Active
Category	CDM
Subcategory	Hypertension
Indicator Order	2
Indicator Graphic Type	Pie Chart, Bar Chart
Indicator Graphic Notes	
Indicator User Help	**Hypertensive Pts 18+: Testing Status** **Purpose:** This indicator is used to identify patients with one more completed elements of care commonly associated with hypertension. **Base Population:** All patients age 18 and over with an Active demographic status recorded in the EMR who have a confirmed HTN diagnosis through the entry of an appropriate diagnosis code. **Indicator Segments:**

PROPERTY	VALUE
	Indicator segments provide counts of patients with one or more elements of care complete (documented Blood Pressure measurement in last 12 months, documented blood glucose or HbA1c screening in last 12 months, documented obesity/overweight screening in last 12 months), and counts of patients who are missing all three elements of care. **Suggested Indicator Use:** Physician or Practice use of this indicator is to recall patients where all elements of care are overdue, indicating they may not have been seen in over 12 months. **Measurements of Interest:** Percentage of patients with one or elements of care complete out of all patients in the base population. **Metric Criteria:** *1+ test up to date*[1]*:* WITH one or more of the following: • BP in the past 12 months • BMI OR height and weight OR height and waist circumference, documented in the last 12 months • Fasting Blood sugar OR Random Blood sugar OR HbA1C, documented in the last 12 months *All tests overdue*[2]*:* WITHOUT any of the following:

[1] Optional: Implementer may include EMR-specific information on the workflow for documenting BP, Obesity/overweight screening, and Blood Sugar/HbA1C screening.

[2] Optional: Implementer may include EMR-specific information on the workflow for documenting BP, Obesity/overweight screening, and Blood Sugar/HbA1C screening.

PROPERTY	VALUE
	• BP in the past 12 months • BMI OR height and weight OR height and waist circumference, documented in the last 12 months • Fasting Blood sugar OR Random Blood sugar OR HbA1C, documented in the last 12 months

2.2 Indicator Segment Properties

PROPERTY	VALUE	VALUE
Indicator Segment ID	1	2
Indicator Segment Label	1+ test up to date	All tests overdue
Display Indicator Segment	Yes	Yes
Indicator Segment Query Criteria	**COUNT OF:** Active patients age 18 and over **WITH** a coded diagnosis of Hypertension **AND** (WITH a documented Blood Pressure (BP) measurement in the last 12 months **OR** WITH a documented Blood Glucose or HbA1c screening in the last 12 months **OR** WITH a documented Obesity/Overweight Screening in the last 12 months)	**COUNT OF:** Active patients age 18 and over **WITH** a coded diagnosis of Hypertension **AND** WITHOUT a documented Blood Pressure (BP) measurement in the last 12 months **AND** WITHOUT a documented Blood Glucose or HbA1c screening in the last 12 months **AND** WITHOUT a documented Obesity/Overweight Screening in the last 12 months
Indicator Segment Query Notes	**Active Patients** are patients identified as 'Active' in the *Patient Status* data element *(DE01.016)* within *Patient Demographics.* **Patient Age** can be calculated based on the difference between the current date and the patient's date of birth captured in the *Date of Birth* data element *(DE01.007)* within *Patient Demographics.* **Hypertension Coded Diagnosis** is any of the following codes captured in the *Diagnosis/Problem* data element *(DE06.004)* within *Ongoing Health:* • 401, 402, 403, 404, 405 *(ICD-9 Coding System)* • I10 *(ICD-10 Coding System)*	

PROPERTY	VALUE	VALUE
	• D3-02120, D3-02010, D3-02100, D3-020000 *(SNOMED-RT Coding System)* • 1201005, 10725009, 59621000, 38341003 *(SNOMEDCT Coding System)* **Documented Blood Pressure Measurement** is a value captured in the *Blood Pressure* data element *(DE16.001)* within *Generic Care Elements.* **Documented Blood Glucose or HbA1c Screening** is a value captured within *Laboratory Test Results (DE10)* for a Fasting Blood Sugar Test, Random Blood Sugar Test, or HbA1c test. Test names may be identified using EMR's proprietary test names, laboratory proprietary test codes or test names, or LOINC codes which cross-reference test names across different EMR and laboratory test names. **Documented Obesity/Overweight Screening** may be represented by: • A documented BMI value captured in *BMI* data element *(DE16.009* within *Generic Care Elements*, **OR** • A documented Height value captured in *Height* data element *(DE16.005)* within *Generic Care Elements* with either a documented Weight value captured in *Weight* data element *(DE16.007)* **or** a documented Waist Circumference data element *(DE16.011)* recorded within *Generic Care Elements.*	
Patient List Criteria	**Mandatory** Patient Name Unique Patient Identifier **Optional** Patient Date of Birth Patient Age Patient Phone Number Latest Blood Pressure Measurement	**Mandatory** Patient Name Unique Patient Identifier **Optional** Patient Date of Birth Patient Age Patient Phone Number Latest Blood Pressure Measurement

PROPERTY	VALUE	VALUE
	Latest Blood Glucose/HbA1c Screening Latest Obesity/Overweight Screening Last Seen Date Next Appointment Date	Latest Blood Glucose/HbA1c Screening Latest Obesity/Overweight Screening Last Seen Date Next Appointment Date
Patient List Notes	**Patient Name** is a combination of First Name *(DE01.003)* and Last Name *(DE01.002)* data items from *Patient Demographics*. Names may be displayed either as separate columns or concatenated into one column. **Unique Patient Identifier** is any data item from *Patient Demographics* that can be used by a physician or clinic to uniquely identify a patient when displayed. Examples include Health Card Number *(DE01.008*) or Chart Number *(DE01.012).* **Patient Date of Birth** is captured into *Patient Demographics* as Date of Birth *(DE01.007).* **Patient Age** is a calculated data item representing the difference between the current date and Date of Birth *(DE01.007)* from *Patient Demographics*. Age should be displayed in years. **Patient Phone Number** is the preferred phone number for contacting a patient and may include Residence Phone *(DE02.007),* Cell Phone *(DE02.008)* or Work Phone *(DE02.009)* from *Patient Address*. **Latest Blood Pressure Measurement** represents the results and/or date from the latest documented blood pressure measurement. **Latest Blood Glucose/HbA1c Screening** represents the results and/or dates from the latest documented screening for Fasting Blood Sugar and/or Random Blood Sugar and/or HbA1c tests. **Latest Obesity/Overweight Screening** represents the results and/or dates from the latest documented obesity measurement(s): BMI, Height, Weight, and Waist Circumference.	

PROPERTY	VALUE	VALUE
	Last Seen Date is a date representing the last time a patient was seen by the physician or another clinician within the clinic. This may be based on *Appointment Date/Time (DE15.001)*, where appointments with status of 'No Show', 'Cancelled', or 'Deleted' are excluded, or this may be based on any additional documentation supported by the EMR to track when a patient has last been seen (e.g., encounter notes). **Next Appointment Date** is a date representing the next time a patient is scheduled to be seen by the physician or another clinician within the clinic. This may be based on *Appointment Date/Time (DE15.001*).	