AAOS Orthopaedic Quality Resource Center

This registry has been approved by CMS as a 2021 Qualified Clinical Data Registry (QCDR) for eligible clinicians and group practices for Quality Payment Program (QPP). All AAOS registries are eligible through the AAOS Orthopaedic Quality Resource Center.

QCDR MEASURES	MEASURE ID

Hip Arthroplasty: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy — AJRR3

Percentage of patients undergoing a hip arthroplasty with documented shared decision-making including discussion of conservative (non-surgical) therapy (e.g. NSAIDs, analgesics, weight loss, exercise, injections) prior to the procedure.

Numerator: Patients with documented shared decision-making including discussion of conservative (non-surgical) therapy (e.g. NSAIDs, analgesics, weight loss, exercise, injections) prior to the procedure.

Denominator: Patients with a diagnosis of a hip fracture at the time of the total hip arthroplasty procedure.

National Quality Strategy Domain: Communication and Care Coordination
Meaningful Measurement Area: Care is Personalize and Aligned with Patient's Goals
Care Settings: Hospital
Type: Proportional Process Measure
High-Priority: Yes
Number of Performance Rates: 1
Data Submission Method(s): Registry Measure

Denominator Exclusions: Patients with a diagnosis of a hip fracture at the time of the total hip arthroplasty procedure.
Denominator Exceptions: None
Numerator Exclusions: None

Hip Arthroplasty: Venous Thromboembolic and Cardiovascular Risk Evaluation — AJRR4

Percentage of patients undergoing a hip arthroplasty who are evaluated for the presence or absence of cardiovascular risk factors within 30 days prior to the procedure (e.g. history of deep venous thrombosis (DVT), pulmonary embolism (PE), myocardial infarction (MI), arrhythmia, and stroke).

Numerator: Patients who were evaluated for the presence or absence of cardiovascular risk factors within 30 days prior to the procedure (e.g. history of DVT, PE, MI, arrhythmia, and stroke).

Denominator: All patients undergoing an elective primary total hip arthroplasty.

National Quality Strategy Domain: Patient Safety
Meaningful Measurement Area: Management of Chronic Conditions
Care Settings: Hospital
Type: Proportional Process Measure
High-Priority: Yes
Number of Performance Rates: 1
Data Submission Method(s): Registry Measure

Denominator Exclusions: Patients with a diagnosis of a hip fracture at the time of the total hip arthroplasty procedure.
Denominator Exceptions: None
Numerator Exclusions: None

Hip/Knee Arthroplasty: Unplanned Readmission within 90 Days Following the Primary Procedure — AJRR6

Percentage of patients 18+ who underwent a primary Total Hip Arthrolplasty or Total Knee Arthroplasty and who had an unplanned 90-day readmission.

Numerator: Denominator patients who had an unplanned 90-day readmission.

Denominator: Patients 18+ who underwent a total hip or total knee arthroplasty, during the measurement period.

National Quality Strategy Domain: Efficiency and Cost Reduction
Meaningful Measurement Area: Admission and Readmission to Hospitals
Care Settings: Hospital
Type: Inverse Proportional Outcome Measure
High-Priority: Yes
Number of Performance Rates: 1
Data Submission Method(s): Registry Measure

Denominator Exclusions: Remove reporting entities with less than 100 total cases during the performance period.
Denominator Exceptions: None
Numerator Exclusions: None

*CMS Quality Measure Specifications are available at https://qpp.cms.gov/about/resource-library.

QCDR MEASURES	MEASURE ID

Hip/Knee Replacement: Postoperative Ambulation — AJRR7

Adult patients 18+ undergoing a total hip or total knee replacement who ambulated postoperatively.

Numerator	Number of denominator patients with documented same-day ambulation postoperatively.
Denominator	Patients 18+ who underwent a total hip or total knee arthroplasty, during the measurement period.

National Quality Strategy Domain: Effective Clinical Care
Meaningful Measurement Area: Functional Outcomes
Care Settings: Hospital Inpatient
Type: Proportional Process Measure
High-Priority: Yes
Number of Performance Rates: 1
Data Submission Method(s): Registry Measure

Denominator Exclusions: None
Denominator Exceptions: None
Numerator Exclusions: None

Quality of Life - Physical Health Outcomes — OBERD32

Percentage of patients 18 years of age and older who completed a baseline and, within the CY(calendar year) reporting period of Jan. 1, 20xx - Dec.31, 20xx, a follow-up quality of life (QoL) patient-reported outcomes assessment (VR-12, SF-12, SF-36, PROMIS Global 10 or equivalent Computer Adaptive Test (CAT) assessment if available) which yielded a physical component score that showed a statistically significant improvement in comparison to initial assessment or who had already reported a score in which there is no room for statistical improvement. The use of Patient Reported Outcomes (PROs) in clinical research is well documented. In addition, the AAOS Quality Outcomes Work Group recommends that QoL PROs in the clinical setting can lead to improved care.

Numerator	Number of patients whose follow-up QoL Physical Component Score has a clinical improvement (improvement meets or exceeds the Minimally Clinically Important Difference (MCID) of the questionnaire in use) during the CY(calendar year) reporting period of Jan. 1, 20xx - Dec.31, 20xx in comparison to baseline.
Denominator	Number of patients 18 years and older who have a baseline and, within the CY(calendar year) reporting period of Jan. 1, 20xx - Dec.31, 20xx, at least one follow-up QoL assessment completed.

National Quality Strategy Domain: Effective Clinical Care
Meaningful Measurement Area: Functional Outcomes
Care Settings: Ambulatory Care: Clinician Office/Clinic
Type: Proportional Outcome Measure (Patient Reported)
High-Priority: Yes
Number of Performance Rates: 1
Data Submission Method(s): Registry Measure

Denominator Exclusions: Patient who has a max score at baseline.
Denominator Exceptions: None
Numerator Exclusions: None

Percent of Patients Meeting SCB Thresholds for Back or Neck Pain — SPINETRACK4

Calculation of the percent of patients who meet the substantial clinical benefit (SCB) thresholds for improvement in back or neck pain following a spine surgical intervention (cervical or lumbar)

Numerator	Number of patients who have a final value of 3.5 or less, have at least a 2.5 point improvement, or a at least a 41.4% improvement in back or at least a 3.5 point improvement in neck pain on NRS measures at least 6 months after the intervention.
Denominator	Any patient ≥18 years of age (at the time of surgery) who have a baseline and, who underwent a spinal fusion procedure using any method. Spinal fusion and 6-month follow-up time point window must occur during reporting period of Jan. 1, 20xx - Dec. 31, 20xx.

National Quality Strategy Domain: Effective Clinical Care
Meaningful Measurement Area: Functional Outcomes
Care Settings: Ambulatory Care: Clinician Office/Clinic
Type: Proportional Outcome Measure (Patient Reported)
High-Priority: Yes
Number of Performance Rates: 1
Data Submission Method(s): Registry Measure

Denominator Exclusions: Those patients who underwent a spinal fusion procedure without back or neck pain, measured as ≤3 on a numeric rating scale (e.g., patients being treated primarily for myelopathy). Those patients who had not yet reached the minimum 6-month follow-up time point window. The follow-up time point window is defined by the SpineTRACK Guidelines. Those patients missing baseline patient-reported outcome measures, including those who are seen in hospital for intake as acute or trauma case.
Denominator Exceptions: None
Numerator Exclusions: None

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QCDR MEASURES	MEASURE ID

Percent of Patients Meeting SCB Thresholds for Leg or Arm Pain — SPINETRACK5

Calculation of the percent of patients who meet the substantial clinical benefit (SCB) thresholds for improvement in leg or arm pain following a spine surgical intervention (cervical or lumbar)

Numerator: Number of patients who have a final value of 3.5 or less, have at least a 2.5 point improvement, or at least a 38.8% improvement in leg or at least a 3.5 point improvement in arm pain on NRS measures at least 6 months after the intervention.

Denominator: Any patient ≥18 years of age (at the time of surgery) who have a baseline and, who underwent a spinal fusion procedure using any method. Spinal fusion and 6-month follow-up time point window must occur during reporting period of Jan. 1, 20xx - Dec. 31, 20xx.

National Quality Strategy Domain: Effective Clinical Care
Meaningful Measurement Area: Functional Outcomes
Care Settings: Ambulatory Care: Clinician Office/Clinic
Type: Proportional Outcome Measure (Patient Reported)
High-Priority: Yes
Number of Performance Rates: 1
Data Submission Method(s): Registry Measure

Denominator Exclusions: Those patients who underwent a spinal fusion procedure without leg or arm pain, measured as ≤3 on a numeric rating scale (e.g., patients being treated primarily for myelopathy). Those patients who had not yet reached the minimum 6-month follow-up time point window. The follow-up time point window is defined by the SpineTRACK Guidelines. Those patients missing baseline patient-reported outcome measures, including those who are seen in hospital for intake as acute or trauma case.
Denominator Exceptions: None
Numerator Exclusions: None

Percent of Patients Meeting SCB Thresholds for Pain-Related Disability (ODI/NDI) — SPINETRACK6

Calculation of the percent of patients who meet the substantial clinical benefit (SCB) thresholds for improvement in pain-related disability following a spine surgical intervention (cervical or lumbar)

Numerator: Number of patients who have at least an 18.8 point improvement, at least a 36.8% improvement, or final disability value below 31.3 measured by ODI or at least a 9.5 point improvement on NDI questionnaires at least 6 months after the intervention.

Denominator: Any patient ≥18 years of age (at the time of surgery) who have a baseline and, who underwent a spinal fusion procedure using any method. Spinal fusion and 6-month follow-up time point window must occur during reporting period of Jan. 1, 20xx - Dec. 31, 20xx.

National Quality Strategy Domain: Effective Clinical Care
Meaningful Measurement Area: Functional Outcomes
Care Settings: Ambulatory Care: Clinician Office/Clinic
Type: Proportional Outcome Measure (Patient Reported)
High-Priority: Yes
Number of Performance Rates: 1
Data Submission Method(s): Registry Measure

Denominator Exclusions: Those patients who underwent a spinal fusion procedure without market disability, measured as ≤30 on Oswestry or neck disability questionnaires (e.g., patients being treated primarily for myelopathy). Those patients who had not yet reached the minimum 6-month follow-up time point window. The follow-up time point window is defined by the SpineTRACK Guidelines. Those patients missing baseline patient-reported outcome measures, including those who are seen in hospital for intake as acute or trauma case
Denominator Exceptions: None
Numerator Exclusions: None

Patient Satisfaction Following Spinal Fusion Surgery — SPINETRACK8

Calculation of the percent of patients who are 'Very satisfied' or 'Somewhat satisfied' with their surgical outcome following a spine surgical intervention (cervical or lumbar).

Numerator: Number of patients who are 'Very satisfied' or 'Somewhat satisfied' with their surgical outcome at least 6 months after the intervention.

Denominator: Any patient ≥18 years of age (at the time of surgery) who underwent a spinal fusion procedure using any method. Spinal fusion and 6-MONTH follow-up time point window must occur during reporting period of Jan. 1, 20xx - Dec. 31, 20xx.

National Quality Strategy Domain: Effective Clinical Care
Meaningful Measurement Area: Patient's Experience of Care
Care Settings: Ambulatory Care: Clinician Office/Clinic
Type: Proportional Outcome Measure (Patient Reported)
High-Priority: Yes
Number of Performance Rates: 1
Data Submission Method(s): Registry Measure

Denominator Exclusions: Those patients who had not yet reached the minimum 6-month follow-up time point window. The follow-up time point window is defined by the SpineTRACK Guidelines.
Denominator Exceptions: None
Numerator Exclusions: None

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QCDR MEASURES	MEASURE ID

Unplanned Hospital Readmission Following Spinal Fusion Surgery — SPINETRACK9

Calculation of the percent of patients who require unplanned hospital readmission following spine surgical intervention (cervical or lumbar).

Numerator: Number of patients who require unplanned hospital readmission within 90 days of the intervention.

Denominator: Any patient ≥18 years of age (at the time of surgery) who underwent a spinal fusion procedure using any method. Spinal fusion and 90 day follow-up time point window must occur during reporting period of Jan. 1, 20xx - Dec. 31, 20xx.

National Quality Strategy Domain: Effective Clinical Care
Meaningful Measurement Area: Admission and Readmissions to Hospitals
Care Settings: Hospital Inpatient
Type: Inverse Proportional Outcome Measure (Patient Reported)
High-Priority: Yes
Number of Performance Rates: 1
Data Submission Method(s): Registry Measure

Denominator Exclusions: Those patients who had not yet reached the minimum 90 day follow-up time point window. The follow-up time point window is defined by the SpineTRACK Guidelines.
Denominator Exceptions: None
Numerator Exclusions: None

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MIPS QUALITY & ECQM MEASURES*	QUALITY #	eMEASURE ID	NQF #
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	001	CMS122v9	0059

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

National Quality Strategy Domain: Effective Clinical Care
Type: Intermediate Outcome
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Electronic Measure, Registry Measure

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Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	021	---	0268

Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis.

National Quality Strategy Domain: Patient Safety
Type: Process
High-Priority: Yes
Appropriate Use: Yes
Data Submission Method(s): Registry Measure

Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	023	---	0239

Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.

National Quality Strategy Domain: Patient Safety
Type: Process
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Registry Measure

Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older	024	---	0045

Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.

National Quality Strategy Domain: Communication and Care Coordination
Type: Process
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Registry Measure

Screening for Osteoporosis for Women Aged 65-85 Years of Age	039	---	0046

Percentage of female patients aged 65–85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.

National Quality Strategy Domain: Effective Clinical Care
Type: Process
High-Priority: No
Appropriate Use: No
Data Submission Method(s): Registry Measure

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MIPS QUALITY & ECQM MEASURES*	QUALITY #	eMEASURE ID	NQF #

Care Plan

047 --- 0326

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

National Quality Strategy Domain: Communication and Care Coordination
Type: Process
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Registry Measure

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

128 CMS69v9 0421

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/m^2

National Quality Strategy Domain: Community/Population Health
Type: Process
High-Priority: No
Appropriate Use: No
Data Submission Method(s): Electronic Measure, Registry Measure

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Documentation of Current Medications in the Medical Record

130 CMS68v10 0419

Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

National Quality Strategy Domain: Patient Safety
Type: Process
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Electronic Measure, Registry Measure

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Preventive Care and Screening: Screening for Depression and Follow-Up Plan

134 CMS2v10 0418

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.

National Quality Strategy Domain: Community/Population Health
Type: Process
High-Priority: No
Appropriate Use: No
Data Submission Method(s): Electronic Measure, Registry Measure

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Falls: Risk Assessment

154 --- 0101

Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.

National Quality Strategy Domain: Patient Safety
Type: Process
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Registry Measure

Falls: Plan of Care

155 --- 0101

Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.

National Quality Strategy Domain: Communication and Care Coordination
Type: Process
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Registry Measure

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*CMS Quality Measure Specifications are available at https://qpp.cms.gov/about/resource-library.

MIPS QUALITY & ECQM MEASURES*	QUALITY #	eMEASURE ID	NQF #
Rheumatoid Arthritis (RA): Functional Status Assessment Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months. **National Quality Strategy Domain:** Effective Clinical Care **Type:** Process **High-Priority:** No **Appropriate Use:** No **Data Submission Method(s):** Registry Measure	178	---	---
Rheumatoid Arthritis (RA): Glucocorticoid Management Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months. **National Quality Strategy Domain:** Effective Clinical Care **Type:** Process **High-Priority:** No **Appropriate Use:** No **Data Submission Method(s):** Registry Measure	180	---	---
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention 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. **National Quality Strategy Domain:** Community/Population Health **Type:** Process **High-Priority:** No **Appropriate Use:** No **Data Submission Method(s):** Electronic Measure, Registry Measure	226	CMS138v9	0028
Falls: Screening for Future Fall Risk Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period. **National Quality Strategy Domain:** Patient Safety **Type:** Process **High-Priority:** Yes **Appropriate Use:** No **Data Submission Method(s):** Electronic Measure, Registry Measure	318	CMS139v9	0101
Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy Percentage of patients regardless of age undergoing a total knee replacement with documented shared decision-making with discussion of conservative (non-surgical) therapy (e.g., non-steroidal anti-inflammatory drug (NSAIDs), analgesics, weight loss, exercise, injections) prior to the procedure. **National Quality Strategy Domain:** Communication and Care Coordination **Type:** Process **High-Priority:** Yes **Appropriate Use:** No **Data Submission Method(s):** Registry Measure	350	---	---
Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation Percentage of patients regardless of age undergoing a total knee replacement who are evaluated for the presence or absence of venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure (e.g. history of Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE), Myocardial Infarction (MI), Arrhythmia and Stroke). **National Quality Strategy Domain:** Patient Safety **Type:** Process **High-Priority:** Yes **Appropriate Use:** No **Data Submission Method(s):** Registry Measure	351	---	---

*CMS Quality Measure Specifications are available at https://qpp.cms.gov/about/resource-library.

MIPS QUALITY & ECQM MEASURES*	QUALITY #	eMEASURE ID	NQF #
Unplanned Reoperation within the 30 Day Postoperative Period	**355**	**---**	**---**

Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period.

National Quality Strategy Domain: Patient Safety
Type: Outcome
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Registry Measure

Unplanned Hospital Readmission within 30 Days of Principal Procedure **356** **---** **---**

Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure.

National Quality Strategy Domain: Effective Clinical Care
Type: Outcome
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Registry Measure

Surgical Site Infection (SSI) **357** **---** **---**

Percentage of patients aged 18 years and older who had a surgical site infection (SSI).

National Quality Strategy Domain: Effective Clinical Care
Type: Outcome
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Registry Measure

Patient-Centered Surgical Risk Assessment and Communication **358** **---** **---**

Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.

National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes
Type: Process
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Registry Measure

Closing the Referral Loop: Receipt of Specialist Report **374** **CMS50v9** **---**

Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

National Quality Strategy Domain: Communication and Care Coordination
Type: Process
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Electronic Measure, Registry Measure

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Functional Status Assessment for Total Knee Replacement **375** **CMS66v9** **---**

Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.

National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes
Type: Process
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Electronic Measure, Registry Measure

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Functional Status Assessment for Total Hip Replacement **376** **CMS56v9** **---**

Percentage of patients 18 years of age and older who received an elective primary total hip arthroplasty (THA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.

National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes
Type: Process
High-Priority: Yes
Appropriate Use: No
Data Submission Method(s): Electronic Measure, Registry Measure

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MIPS QUALITY & ECQM MEASURES*	QUALITY #	eMEASURE ID	NQF #
Opioid Therapy Follow-up Evaluation	**408**	**---**	**---**

All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.

National Quality Strategy Domain: Effective Clinical Care
Type: Process
High-Priority: No
Appropriate Use: No
Data Submission Method(s): Registry Measure

Documentation of Signed Opioid Treatment Agreement	**412**	**---**	**---**

All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.

National Quality Strategy Domain: Effective Clinical Care
Type: Process
High-Priority: No
Appropriate Use: No
Data Submission Method(s): Registry Measure

Evaluation or Interview for Risk of Opioid Misuse	**414**	**---**	**---**

All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAPP-R) or patient interview documented at least once during Opioid Therapy in the medical record.

National Quality Strategy Domain: Effective Clinical Care
Type: Process
High-Priority: No
Appropriate Use: No
Data Submission Method(s): Registry Measure

Osteoporosis Management in Women Who Had a Fracture	**418**	**---**	**0053**

The percentage of women age 50–85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.

National Quality Strategy Domain: Effective Clinical Care
Type: Process
High-Priority: No
Appropriate Use: No
Data Submission Method(s): Registry Measure

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