Measure Title: OSTEOPOROSIS SCREENING FOR WOMEN OVER 50 WITH FRACTURE

Disease State: Osteoporosis

Indicator Classification: Screening

Strength of Recommendation: B

Physician Specialties: Family Practice, Gerontology, Internal Medicine, Neurological Surgery, OBGYN, Orthopedic Surgery, Physical Medicine and Rehabilitation, Rheumatology

Clinical Rationale:

Disease Burden:
- The National Health and Nutrition Examination Survey reports approximately 14 million American women 50 years of age are afflicted with osteopenia, and 5 million more have osteoporosis. Increase in age is associated with an increase in risk of osteoporosis and; up to 70 percent of women over age 80 years have osteoporosis.[1, 2]
- Women with osteoporosis are at excess risk to experience fractures. As age and prevalence of osteoporosis increase, so does the incidence of hip fracture. Hip fractures are associated with high rates of mortality and loss of independence.[2]
- Fractures resulting from osteoporosis are a major cause of disability and death, especially among the elderly.[3] Less than one third of patients that experience fractures associated with fragility are treated for osteoporosis.[4]
- In the United States, medical expenditure in the United States for the treatment of fractures related to osteoporosis in adults over 45 year of age neared $14 billion, with the majority being spent on inpatient care. This cost is likely to rise as the median age of the US population increases.[2, 5]

Reason for Indicated Intervention or Treatment:
- Up to 20% of women who suffer a hip fracture will die within one year of the fracture. [6, 7]
- The data show that based on current guidelines, osteoporosis screening is being significantly underused.[8]
- A World Health Organization (WHO) working group determined specific guidelines which would be widely used to diagnose and treat osteoporosis and osteopenia.[2]
- Screening for osteoporosis offers the opportunity to treat before fracture occurs. Among women who have fractures before osteoporosis has been identified, it is important to determine whether osteoporosis is the cause so that it can be treated before additional fractures occur.[9]

Evidence supporting Intervention or Treatment:
- Among different bone measurement tests performed at various anatomical sites, bone density measured at the femoral neck by dual-energy x-ray absorptiometry (DEXA) is the best predictor of hip fracture and is comparable to forearm measurements for predicting fractures at other sites.[10]
- In one cohort study of 3107 older adult patients, those who were screened for osteoporosis had 36% fewer incident hip fractures over 6 years compared with usual treatment. [9]
- By recommendation of National Osteoporosis Foundation, a bone mineral density study is indicated when risk factors are present and a
decision must be made regarding osteoporosis medications to reduce fracture risk. The literature indicates that bone mineral density studies should be used as a prevention strategy and targeted at high-risk patients.[11, 12]

Clinical Recommendations

- The American Association of Clinical Endocrinologists recommends routine screening for osteoporosis for all women 65 years and older, all adult women with a history of one or more fractures not caused by severe trauma, and younger postmenopausal women who have clinical risk factors for fractures (such as low body weight, or a family history of spine or hip fracturing). [13]
- The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF also recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. [10] The Institute for Clinical Systems Improvement makes similar recommendations. [14]
- The National Osteoporosis Foundation recommends screening: all women over age 65, postmenopausal women at any age who present with a fracture, and postmenopausal women at age 50 who have a history of fracture after age 40.[15, 16]

Source
Adapted from HEDIS. HBI decreased age criteria from 67 to 50 based on recommendations for the National Osteoporosis Foundation and added additional denominator exclusion criteria.

Denominator
Continuously enrolled women ages 50 and older, who had a fracture at any time during the one year period ending 6 months prior to the end of the measurement year.

Denominator Exclusion
Members who received at least one bone mineral density study within 12 months prior to the index date, or who had evidence of treatment for osteoporosis 12 months prior to the index date, or no had a fracture in the 60 days prior to the index date or who did not have pharmacy benefits.

Numerator
Members who received at least one bone mineral density study 0-6 months after the index date or who had evidence of treatment for osteoporosis 0-6 months after the index date.

Interpretation of Score
High score implies better performance

Physician Attribution
Score all physicians (in the selected specialties) who saw the member during the 0-6 months following the index fracture date.

External Files Required for Analysis
Filename: Osteoporosis_tx_2006.xls
NCQA, updated annually

References
10. Screening for osteoporosis in postmenopausal women: recommendations and rationale. Am Fam Physician 2002
14. ICSI, Diagnosis and treatment of osteoporosis. 2005, Institute for Clinical Systems Improvement: Bloomington, MN.
Indicator Classification (Adapted from Health Plan Employer Data Information Set (HEDIS®) technical specifications)

**Diagnosis**

Measures applicable to patients receiving diagnostic workups for a symptom or condition that delineate appropriate laboratory or radiological testing to be performed (e.g. evaluation of thyroid nodule; pregnancy test in patients with vaginal bleeding or abdominal pain).

**Effectiveness of Care**

**Prevention**

Measures applicable to asymptomatic individuals that are designed to prevent the onset of the targeted condition (e.g. immunizations).

**Screening**

Measures applicable to asymptomatic patients who have risk factors or pre-clinical disease, but in whom the condition has not become clinically apparent (e.g. pap smears; screening for elevated blood pressure).

**Disease Management**

Measures applicable to individuals diagnosed with a condition that are part of the treatment or management of the condition (e.g. cholesterol reduction in patients with diabetes; radiation therapy following breast conserving surgery; appropriate follow-up after acute event).

**Medication Monitoring**

Measures applicable to patients taking medications with narrow therapeutic windows and/or potential preventable significant side effects or adverse reactions (e.g. thyroid stimulating hormone (TSH) testing after levothyroxine dose change; hepatic enzyme monitoring for patients using antifungal pharmacotherapy).

**Medication Adherence**

Measures applicable to patients taking medications for chronic conditions that are designed to assess patient adherence to medication (e.g. adherence to lipid lowering medication).

**Utilization**

Measures applicable to patients receiving treatment for a symptom or condition that advocate appropriate utilization of laboratory and pharmaceutical resources (e.g. conservative use of imaging for low back pain; inappropriate use of antibiotics for viral upper respiratory infection).
Strength of Recommendation

Strength of Recommendation Based on a Body of Evidence

Is this a key recommendation for clinicians regarding diagnosis or treatment that merits a label? 

Yes

Is the recommendation based on patient-oriented evidence (i.e., an improvement in morbidity, mortality, symptoms, quality of life, or cost)? 

No

Strength of Recommendation = C

Yes

Is the recommendation based on opinion, bench research, a consensus guideline, usual practice, clinical experience, or a case series study? 

No

Is the recommendation based on one of the following?  
- Cochrane Review with a clear recommendation  
- USPSTF Grade A recommendation  
- Clinical Evidence rating of Beneficial  
- Consistent findings from at least two good-quality randomized controlled trials or a systematic review/meta-analysis of same  
- Validated clinical decision rule in a relevant population  
- Consistent findings from at least two good-quality diagnostic cohort studies or systematic review/meta-analysis of same

Yes

Strength of Recommendation = A

No

Strength of Recommendation = B

FIGURE 2. Algorithm for determining the strength of a recommendation based on a body of evidence (applies to clinical recommendations regarding diagnosis, treatment, prevention, or screening). While this algorithm provides a general guideline, authors and editors may adjust the strength of recommendation based on the benefits, harms, and costs of the intervention being recommended. (USPSTF = U.S. Preventive Services Task Force)