



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System (BGP)

Executive Order Quality Transparency Measures Report Performance Measure List and Definitions

Version 8.0 Patch 2
August 2008

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

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1.0 Introduction

The Executive Order (EO) Quality Transparency Measures Report contains performance measures that are in support of Executive Order 13410 for quality transparency reporting by Federal healthcare agencies. Federal facilities are required to run this report. All Federal sites will report their data annually and the information will be available on the new IHS Quality of Care web site.

Users have the option of running the report using the same hard-coded report parameters as the National GPRA Report or selecting their own report parameters.

1.1 CRS Denominator Definitions

1.1.1 For All Denominators

- All patients with name “DEMO,PATIENT” will be excluded automatically for all denominators.
- For all measures except as noted, patient age is calculated as of the beginning of the Report Period.

1.1.2 Active Clinical Population for National GPRA Reporting

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the *Clinical Reporting System (CRS) for FY2008 Clinical Measures User Manual* for listing of these clinics.
- Must be alive on the last day of the Report Period.
- Must be American Indian/Alaska Native (AI/AN) - defined as Beneficiary 01.
- Must reside in a community specified in the site’s GPRA community taxonomy, defined as all communities of residence in the defined CHS catchment area.

1.1.3 Active Clinical Population for Local Reports

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the *Clinical Reporting System (CRS) for FY2008 Clinical Measures User Manual* for listing of these clinics.

- Must be alive on the last day of the Report Period.
- User defines population type: AI/AN patients only, non AI/AN, or both.
- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

1.1.4 User Population for National GPRA Reporting

- Must have been seen at least once in the three years prior to the end of the time period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the Report Period.
- Must be American Indian/Alaska Native (AI/AN) - defined as Beneficiary 01.
- Must reside in a community specified in the site's GPRA community taxonomy, defined as all communities of residence in the defined CHS catchment area.

1.1.5 User Population for Local Reports

- Must have been seen at least once in the three years prior to the end of the time period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the Report Period.
- User defines population type: AI/AN patients only, non AI/AN, or both.
- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

1.1.6 Active Clinical CHS Population for National GPRA Reporting (CHS-only sites)

- Must have two CHS visits in the three years prior to the end of the Report Period, and the visits must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the Report period.
- Must be American Indian/Alaska Native (AI/AN) - defined as Beneficiary 01. This data item is entered and updated during the Patient Registration process.

- Must reside in a community included in the site’s “official” GPRA community taxonomy, defined as all communities of residence in the CHS catchment area specified in the community taxonomy specified by the user.

1.1.7 Active Clinical CHS Population for Local Reports (CHS-only sites)

- Must have two CHS visits in the three years prior to the end of the Report Period, and the visits must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the Report period.
- User defines population type: AI/AN patients only, non AI/AN, or both.
- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

2.0 CRS EO Quality Transparency Measures Report Performance Measure Topics and Definitions

The following sections define the performance measure topics and their definitions that are included in the CRS 2008 Version 8.0 Patch 2 EO Quality Transparency Measures Report.

Note: Measures to be reported on IHS Quality of Care Web Site are in Arial font.

2.1.1 Diabetes: Poor Glycemic Control

Owner/Contact

Diabetes Program/Dr. Marie Russell

Denominator

Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes prior to the Report period, AND at least 2 visits during the Report period, AND 2 DM-related visits ever.

Numerator

Patients with A1c greater than (>) 9.0 or patients with no test or a test with no value.

Definition

- 1) **Diabetes:** First Purpose of Visit 250.00-250.93 recorded in the V POV file prior to the Report Period.
- 2) **A1c:** Searches for most recent A1c test during the Report Period. If it has a result of > 9.0 or has no result, or if the patient does not have an A1c test during the Report Period, the patient will be included in the numerator as having poor A1c control. A1c defined as: CPT 83036, 83037, 3044F, 3045F, 3046F, or 3047F; LOINC taxonomy; or site-populated taxonomy DM AUDIT HGB A1C TAX. A1c tests documented with CPT 3046F indicate a result > 9.0 and will be included in the Poor Control numerator. A1c tests documented with CPT 83036 or 83037 indicate tests with no result and will be included in the Poor Control numerator. A1c tests documented with CPT 3044F, 3045F or 3047F indicate a result of \leq 9.0 and will NOT be included in the numerator.

Patient List

Diabetic patients with most recent A1c value, if any.

2.1.2 Diabetes: Blood Pressure Control

Owner/Contact

Diabetes Program/Dr. Marie Russell

Denominator

Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes prior to the Report period, AND at least 2 visits during the Report period, AND 2 DM-related visits ever.

Numerators

Patients with BP level of <140/90 during the Report Period, i.e., the mean systolic value is less than 140 AND the mean diastolic value is less than 90.

Definition

Blood Pressure: CRS uses mean of last 3 Blood Pressures documented on non-ER visits during the Report Period. If 3 BPs are not available, uses mean of last 2 non-ER BPs. If a visit contains more than 1 BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last 3 (or 2) systolic values and dividing by 3 (or 2). The mean Diastolic value is calculated by adding the diastolic values from the last 3 (or 2) blood pressures and dividing by 3 (or 2). If the systolic and diastolic values do not BOTH meet the specified criteria, then the value is not included in the numerator.

If CRS is not able to calculate a mean BP, it will search for the most recent of any of the following CPT codes documented on non-ER visits during the Report Period. The systolic and diastolic values do NOT have to be recorded on the same day. If there are multiple values on the same day, the CPT indicating the lowest value will be used.

Systolic: 3074F, 3075F, 3076F (old code), or 3077F WITH Diastolic: 3078F, 3079F, or 3080F.

The following combinations represent BP <140/90 and will be included in the numerator:

- 1) CPT 3074F AND 3078F,
- 2) 3074F AND 3079F,
- 3) 3075F AND 3078F,
- 4) 3075F AND 3079F,
- 5) CPT 3076F AND 3078F,
- 6) CPT 3076F AND 3079F.

All other combinations will NOT be included in the numerator.

Patient List

Diabetic patients with mean BP, if any.

2.1.3 Diabetes: LDL Control

Owner/Contact

Diabetes Program/Dr. Marie Russell

Denominators

Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes prior to the Report period, AND at least 2 visits during the Report period, AND 2 DM-related visits ever.

Numerators

Patients with LDL result less than (<) 100.

Definition

LDL Screening: Searches for most recent LDL test during the Report Period. LDL defined as: CPT 80061, 83700, 83701, 83704, 83715 (old code), 83716 (old code), 83721, 3048F, 3049F, or 3050F; LOINC taxonomy; or site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX.

The following will be included in the numerator:

- 1) Lab tests with a result of <100,
- 2) CPT 3048F.

Not included in the numerator are:

- 1) LDL tests with no result or result =>100,
- 2) CPT 80061, 83700, 83701, 83704, 83715, 83716, 83721, 3049F, 3050F.

Patient List

Diabetic patients with most recent LDL test, if any.

2.1.4 Adult Immunizations: Influenza

Owner/Contact

Epidemiology Program/ Amy Groom, MPH

Denominators

Active Clinical patients ages 50-64.

Numerators

- 1) Patients with influenza vaccine or refusal documented during the Report Period or with a contraindication documented at any time before the end of the Report Period.
- 2) Patients with documented refusal.
- 3) Patients with a contraindication or a documented NMI (not medically indicated) refusal.

Definition

- 1) **Age:** Age of the patient is calculated at the beginning of the Report Period.
- 2) **Influenza Vaccine:** Any of the following documented during the Report Period unless otherwise noted:
 - A) Influenza immunization, defined as: A) Immunization (CVX) codes: 88- Influenza Virus Vaccine, NOS; 15 Inf Virus Vac SV; 16 Inf Virus Vac WV; 111 Inf Virus Vac Intranasal; B) POV: V04.8 (old code), V04.81, or V06.6; C) CPT: 90655-90662, 90724 (old code), G0008, G8108; D) ICD Procedure code: 99.52;
 - B) Contraindication documented at any time before the end of the Report Period, defined as: A) Contraindication in the Immunization Package of “Egg Allergy” or “Anaphylaxis” or B) PCC NMI Refusal;
 - C) Refusal of immunization codes 88, 111, 15, or 16, as documented in PCC Refusal File (i.e. REF) or in the Immunization Package as contraindication of “Patient Refusal.”

Patient List

Patients 50-64 yrs with Influenza immunization, contraindication, or refusal, if any.

2.1.5 Use of Appropriate Medications for People with Asthma

Owner/Contact

Drs. Charles (Ty) Reidhead and Charles North

Denominators

Active Clinical patients ages 5-56 with persistent asthma within the year prior to the beginning of the Report Period and during the Report Period, without a documented history of emphysema or chronic obstructive pulmonary disease (COPD).

Numerators

Patients who had at least one dispensed prescription for primary asthma therapy medication during the Report Period.

Denominator Exclusions

Patients diagnosed with emphysema or COPD at any time on or before the end of the Report Period are excluded from the denominator.

Definition

- 1) **Age:** Age of the patient is calculated at the beginning of the Report Period.
- 2) **Emphysema:** Any visit with POV codes: 492.*, 506.4, 518.1, 518.2.
- 3) **Chronic Obstructive Pulmonary Disease (COPD):** Any visit with POV codes: 491.20, 491.21, 491.22, 493.2*, 496, 506.4.
- 4) **Persistent Asthma:**
 - A) Meeting any of the following four criteria below within the year prior to the beginning of the Report period AND during the Report period:
 - i) At least one visit to Clinic Code 30 (Emergency Medicine) with primary diagnosis 493* (asthma).
 - ii) At least one acute inpatient discharge with primary diagnosis 493.*. Acute inpatient discharge defined as Service Category of H.
 - iii) At least four outpatient visits, defined as Service Categories A, S, or O, with primary or secondary diagnosis of 493.* AND at least two asthma medication dispensing events (see definition below).
 - iv) At least 4 asthma medication dispensing events (see definition below). If the sole medication was leukotriene modifiers, then MUST also meet criteria in 1-3 above or have at least one visit with POV 493.* in the same year as the leukotriene modifier (i.e. during the Report period or within the year prior to the beginning of the Report period.).
 - OR meeting the following criteria:
 - B) Categorized in the Asthma Register System (ARS) at ANY time before the end of the Report period as Active patient with Severity 2, 3 or 4.

Dispensing Event: One prescription of an amount lasting 30 days or less. For RXs longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day RX is equal to three dispensing events ($100/30 = 3.33$, rounded down to 3). Also, two different RXs dispensed on the same day are counted as two different dispensing events. Inhalers should also be counted as one dispensing event.

Note: If the medication was started and then discontinued, CRS will recalculate the # Days Prescribed by subtracting the prescription date (i.e. visit date) from the V Medication Discontinued Date. Example: Rx Date=11/15/2003, Discontinued Date=11/19/2003, Recalculated # Days Prescribed=4.

Asthma medication codes for denominator defined with medication taxonomies: BGP HEDIS ASTHMA MEDS, BGP HEDIS ASTHMA LEUK MEDS, BGP HEDIS ASTHMA INHALED MEDS. (Medications are: Antiasthmatic Combinations (Dyphylline-Guaifenesin, Guaifenesin-Theophylline, Potassium Iodide-Theophylline), Inhaled Steroid Combinations (Budesonide-Formoterol, Fluticasone-Salmeterol), Inhaled Corticosteroids (Belclomethasone, Budesonide, Flunisolide, Fluticasone CFC Free, Mometasone, Triamcinolone), Lekotriene Modifiers (Montelukast, Zafirlukast, Zileuton), Long-Acting, Inhaled Beta-2 Agonist (Aformoterol, Formoterol, Salmeterol), Mast Cell Stabilizers (Cromolyn, Nedocromil), Methylxanthines (Aminophylline, Dyphylline, Oxtriphylline, Theophylline), Short-Acting, Inhaled Beta-2 Agonists (Albuterol, Bitolterol, Levalbuterol, Pirbuterol).)

- 5) **Primary Asthma Therapy:** To be included in the numerator, patient must have a non-discontinued prescription for primary asthma therapy (see list of medications below) during the Report period.

Primary asthma therapy medication codes for numerator defined with medication taxonomy: BGP HEDIS PRIMARY ASTHMA MEDS. (Medications are: Antiasthmatic Combinations (Dyphylline-Guaifenesin, Guaifenesin-Theophylline, Potassium Iodide-Theophylline), Inhaled Steroid Combinations (Budesonide-Formoterol, Fluticasone-Salmeterol), Inhaled Corticosteroids (Belclomethasone, Budesonide, Flunisolide, Fluticasone CFC Free, Mometasone, Triamcinolone), Lekotriene Modifiers (Montelukast, Zafirlukast, Zileuton), Mast Cell Stabilizers (Cromolyn, Nedocromil), Methylxanthines (Aminophylline, Dyphylline, Oxtriphylline, Theophylline).

Patient List

Asthmatic patients with primary asthma therapy medications, if any.

2.1.6 Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia

Owner/Contact

Dr. Charles (Ty) Reidhead

Denominators

Number of visits for User Population patients ages 18 and older diagnosed with community-acquired bacterial pneumonia at an outpatient visit during the Report Period.

Numerators

- 1) Number of visits where patients had oxygen saturation documented and reviewed.
- 2) Number of visits where patients refused oxygen saturation assessment.
- 3) Number of visits where patients did not have their oxygen saturation documented and reviewed.

Definition

- 1) **Age:** Age of the patient is calculated at the beginning of the Report Period.
- 2) **Community-acquired Bacterial Pneumonia:** Non-CHS outpatient visit (defined as (visit) Type not equal to "C" and Service Category of A (Ambulatory), S (Day Surgery), or O (Observation)) with POV 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, or 487.0.
If a patient has more than one visit for community-acquired bacterial pneumonia during the Report Period, each visit will be counted as long as it has been more than 45 days since the date of the prior visit. For example, a patient was diagnosed on January 1, 2008 and 35 days later he was diagnosed again with pneumonia. That second diagnosis does not count as a separate visit. However, if the patient were diagnosed again on February 16, 2008 (46 days after onset), that diagnosis counts as a separate visit. Because RPMS does not store the date of onset, visit date will be used as a surrogate for onset date.
- 3) **Oxygen Saturation Assessment:** Having any of the following arterial blood gas (ABG) or pulse oximetry tests performed at the visit: 1) V Measurement O2 Saturation; 2) V CPT 94760-94762, 82803, 82805, 82810, or 3028F, where 3028F has no modifier of 1P, 2P, 3P, or 8P; 3) lab test ABG; 4) site-populated lab taxonomy BGP CMS ABG TESTS; or 5) LOINC taxonomy.
- 4) **Refusal of Oxygen Saturation Assessment:** Patients whose oxygen saturation was not assessed due to a patient refusal of assessment on visit date. Refusal is defined as refusal of any of the tests listed above.
- 5) **No Assessment:** Patients who oxygen saturation was not assessed or refused.

Patient List

Patients with community-acquired bacterial pneumonia, with oxygen saturation assessment or documented reason for no assessment, if any.

2.1.7 Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge

Owner/Contact

Dr. Eric Brody

Denominators

Number of visits for User Population patients ages 18 and older who were discharged with ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation.

Numerators

- 1) Number of visits where patients received a prescription for anticoagulant at discharge.
- 2) Number of visits where patients refused anticoagulant therapy.
- 3) Number of visits where patients did not receive anticoagulation therapy.

Definition

- 1) **Age:** Age is calculated as of the beginning of the report period.
- 2) **Ischemic Stroke or Transient Ischemic Attack (TIA) with Atrial Fibrillation:** Non-CHS inpatient visit (Type not equal to C and Service Category=H) and POV of any of the following: (433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, or 435.9) AND POV 427.31 (atrial fibrillation).
- 3) **Anticoagulant Therapy:** Patient must meet one of the conditions below to be counted as receiving anticoagulant therapy.
 - A) Active prescription for Warfarin, aspirin, or other anti-platelet as of discharge date. "Active" prescription defined as:
Rx Days Supply \geq (Discharge Date - Prescription Date), where the prescription has not been discontinued as of the discharge date.
 - B) Prescription for Warfarin, aspirin, or other anti-platelet on discharge date.
- 4) **Warfarin Medication:** Any medication in site-populated BGP CMS WARFARIN MEDS taxonomy.
- 5) **Aspirin Medication:** Any medication in site-populated DM AUDIT ASPIRIN DRUGS taxonomy or CPT G8006.
- 6) **Other Anti-Platelet/Anticoagulant Medication:** Any medication in the site-populated BGP ANTI-PLATELET DRUGS taxonomy, any medication with VA Drug Class BL700, or CPT 4073F or 4075F, where the CPT code does not have a modifier of 1P, 2P, or 8P.
- 7) **Refusal of Anticoagulant Therapy:** Refusal of any of the following documented on discharge date:

- A) Any medication in site-populated taxonomies BGP CMS WARFARIN MEDS, DM AUDIT ASPIRIN DRUGS, or BGP ANTI-PLATELET DRUGS; or
- B) any medication with VA Drug Class BL700; C) CPT G8006, 4073F, or 4075F.
- 8) **No Anticoagulant Therapy:** Patients who did not have an active prescription for anticoagulant therapy at time of discharge and did not receive or refuse anticoagulant therapy at discharge.

Patient List

Patients with stroke/TIA and atrial fibrillation with anticoagulant therapy, if any.

3.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4297

Web: <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

Email: support@ihs.gov