

**Clinical Reporting System (CRS) 2006 Version 6.0**  
**Performance Measure List and Definitions, as of October 24, 2005**

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## CRS 2006 NATIONAL GPRA REPORT

The following performance measures will be reported in the **Clinical Reporting System (CRS) 2006 National GPRA report**. Performance measures marked with an asterisk (\*) will not be reported in the *IHS Annual Report to Congress* but are included for agency use. ***Changes/additions from CRS 2005 Version 5.1 are shown in red, bold italic type.***

Definitions for all performance measure topics included in CRS begin on page 3. Definitions for numerators and denominators that are preceded by “GPRA” represent measures that are reported to Congress.

<p><b>DIABETES GROUP</b>          *Diabetes DX Ever          *Documented A1c          Glycemic Control         <ul style="list-style-type: none"> <li>Poor Glycemic Control</li> <li>Ideal Glycemic Control</li> </ul>         *BP Assessed          Controlled BP          LDL Assessed          Nephropathy Assessed          Retinopathy Exam          *Depression Screen          *Influenza Vaccine          *Pneumovax  <i>(removed Diabetes Dental Access from report)</i></p>	<p><b>DENTAL GROUP</b>          Dental Access General          Dental Sealants          Topical Fluoride         <ul style="list-style-type: none"> <li><b><i>*Applications ( non-GPRA for FY06)</i></b></li> <li>Patients</li> </ul> <b>IMMUNIZATIONS</b>          Influenza Vaccine 65+          Pneumovax 65+          Childhood Immunizations (4:3:1:3:3)         <ul style="list-style-type: none"> <li>Active Clinical Pts</li> <li><b><i>*Active IMM Pkg Pts</i></b></li> </ul> <b>CANCER SCREENING</b>          Pap Smear Rates          Mammogram Rates  <b><i>Colorectal Cancer Screen (GPRA for FY06)</i></b>  <b><i>*Tobacco Assessment (non-GPRA for FY06)</i></b>          *Tobacco Use Prevalence  <b><i>Tobacco Cessation (GPRA for FY06)</i></b></p>	<p><b>BEHAVIORAL HEALTH</b>          FAS Prevention          Intimate Partner Violence/Domestic Violence Screening (IPV/DV)  <b><i>Depression Screen (GPRA for FY06)</i></b></p> <p><b>CARDIOVASCULAR DISEASE-RELATED</b>  <b><i>*Obesity Assessment (non-GPRA for FY06)</i></b>          *Assessed as Obese  <b><i>Childhood Weight Control (GPRA for FY06)</i></b>          CVD and Cholesterol Screening  <b><i>*Comprehensive CVD-Related Assessment</i></b>  <b><i>*BP Assessed</i></b>  <b><i>*LDL Assessed</i></b>  <b><i>*Tobacco Assessed</i></b>  <b><i>*BMI Measured</i></b>  <b><i>*Lifestyle Counseling</i></b>  <b><i>*Depression Screen</i></b>  <b><i>*All Assessments</i></b></p> <p><b>OTHER CLINICAL</b>          Prenatal HIV Testing  <b><i>*Public Health Nursing (non-GPRA for FY06)</i></b> <ul style="list-style-type: none"> <li>Visits in Any Setting</li> <li>Home Visits</li> </ul> </p>
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### DENOMINATOR DEFINITIONS

#### NOTES:

- All patients with name “DEMO,PATIENT” will be automatically excluded for all denominators.
  - For all measures, patient age is calculated as of the beginning of the Report Period.
- Active Clinical Population for National GPRA Reporting***
    - Must have two visits to medical clinics in the past three years. At least one visit must be to a core medical clinic. Refer to the CRS 2005 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.
  - Active Clinical Population for Local Reports***
    - Must have two visits to medical clinics in the past three years. At least one visit must be to a core medical clinic. Refer to the CRS 2005 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 patient (patient panel); or all patients regardless of community of residence.

- ***GPR*** ***User Population for National GPR*** ***A 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.
  - 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 GPR community taxonomy, defined as all communities of residence in the defined CHS catchment area.
- ***GPR*** ***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.
  - 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 patient (patient panel); or all patients regardless of community of residence.

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPR</b> measures in yellow)
<b>DIABETES GROUP</b>	
<b>Diabetes Prevalence</b> Diabetes Program/ Dr. Charlton Wilson  <i>NATIONAL (included in NTL report; not reported to Congress)</i>	<b>No changes from Version 5.1</b> <b>Denominator:</b> User Population patients. <b>Numerators:</b> 1) Anyone diagnosed with diabetes (POV 250.00-250.93) ever. 2) Anyone diagnosed with diabetes during the Report Period. <b>Patient List:</b> List of diabetic patients with most recent diagnosis
<b>Diabetes Comprehensive Care</b> Diabetes Program/ Dr. Charlton Wilson	<b>See related Diabetes topics below for identification of changes for this topic.</b> <b>Denominator:</b> <u>Active Diabetic patients</u> , defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) at least one year prior to the Report Period, AND at least 2 visits in the past year, AND 2 DM-related visits ever. <b>Numerators:</b> 1) Patients with hemoglobin A1c documented during the Report Period, regardless of result. 2) Patients with Blood Pressure documented during the Report Period. 3) Patients with LDL completed during the Report Period, regardless of result. 4) Patients with positive urine protein test or, if urine protein test is negative, any microalbuminuria test, regardless of result, during the Report Period. 5) Patients receiving any retinal screening during the Report Period, or a documented refusal of a diabetic eye exam. 6) Patients with A1c AND Blood Pressure AND LDL AND Nephropathy Assessment AND Retinal exam. <b>Definitions:</b> For specific definitions, refer to the following topics below: Diabetes: Poor and Ideal Control; Diabetes: Blood Pressure Control; Diabetes: Dyslipidemia Assessment; Diabetes: Nephropathy Assessment; Diabetic Retinopathy. <b>Patient List:</b> List of diabetic patients with documented tests, if any.

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRAs</b> measures in yellow)
<p><b>Diabetes: Poor Glycemic Control</b>  <b>Diabetes: Ideal Glycemic Control</b>            Diabetes Program/ Dr. Charlton Wilson</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominators:</b> 1) <b>GPRAs: Active Diabetic patients</b>; defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) at least one year prior to the Report Period, AND at least 2 visits in the past year, AND 2 DM-related visits ever. Key denominator for this and all diabetes-related topics below.</p> <p>2) All GPRAs User Population patients diagnosed with diabetes prior to the Report Period.</p> <p>3) Active Adult Diabetic patients, defined by meeting the following criteria: 1) who are 19 or older at the beginning of the Report Period, 2) whose first ever DM diagnosis occurred prior to the Report Period; 3) who had at least 2 DM related visits ever, 4) at least one encounter with DM POV in a primary clinic with a primary provider during the Report Period; and 5) never have had a creatinine value greater than 5.</p> <p><b>Numerators:</b></p> <p>1) Hemoglobin A1c documented during the Report Period.</p> <p>2) <b>GPRAs: Poor control: A1c greater than (&gt;) 9.5</b></p> <p>3) <b>Very poor control:</b> A1c equals or greater than (=&gt;) 12</p> <p>4) <b>Poor control:</b> A1c greater than (&gt;) 9.5 or less than (&lt;) 12</p> <p>5) <b>Fair control:</b> A1c equals or greater than (=&gt;) 8 and less than or equal to (&lt;=) 9.5</p> <p>6) <b>Good control:</b> A1c equals or greater than (=&gt;) 7 and less than (&lt;) 8</p> <p>7) <b>GPRAs: Ideal control: A1c less than (&lt;) 7</b></p> <p>8) Undetermined A1c (no result)</p> <p><b>Definitions:</b></p> <p>1) <b>A1c:</b> CPT 83036, LOINC taxonomy or site-populated taxonomy DM AUDIT HGB A1C TAX</p> <p>2) <b>Creatinine (for Active Adult Diabetic denominator):</b> CPT 82540, 82565-75; LOINC taxonomy; site-populated taxonomy DM AUDIT CREATININE TAX.</p> <p><b>GPRAs Description - Poor Glycemic Control:</b> During FY 2006, assure that the proportion of patients with diagnosed diabetes that have poor glycemic control (defined as A1c &gt; 9.5) does not increase above the FY 2005 level.</p> <p><b>GPRAs Description - Improved Glycemic Control:</b> During FY 2006, maintain the proportion of patients with diagnosed diabetes that have demonstrated improved glycemic control (defined as A1c &lt; 7) at the FY 2005 level .</p> <p><b>Patient List:</b> All patients diagnosed with Diabetes, with date and value of A1c, if any.</p>
<p><b>Diabetes: Blood Pressure Control</b>            Diabetes Program/ Dr. Charlton Wilson</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><b>Changes from Version 5.1, as noted below.</b></p> <p><b>Denominators:</b> Three denominators (see Diabetes: Poor Glycemic Control topic above).</p> <p><b>Numerators:</b> 1) Total with BP value (at least 2 (3 if available) non-ER BPs documented during the Report Period)</p> <p>2) <b>GPRAs: Controlled BP, &lt; 130/80</b></p> <p>3) Not controlled BP</p> <p><b>Definitions:</b></p> <p>1) <b>Blood Pressure</b> - 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. <i>If a visit contains more than 1 BP, the lowest BP will be used.</i> 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 criteria for controlled, then the value is considered not controlled.</p> <p>2) <b>Creatinine (for Active Adult Diabetic denominator):</b> CPT 82540, 82565-75; LOINC taxonomy; site-populated taxonomy DM AUDIT CREATININE TAX.</p> <p><b>GPRAs Description:</b> During FY 2006, maintain the proportion of patients with diagnosed diabetes that have achieved blood pressure control at the FY 2005 level.</p> <p><b>Patient List:</b> All patients diagnosed with Diabetes, with mean BP value if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRO measures in yellow</b> )
<p><b>Diabetes: Lipids Assessment</b> Diabetes Program/ Dr. Charlton Wilson</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominators:</b> Three denominators (see Diabetes: Poor Glycemic Control topic above).</p> <p><b>Numerators:</b></p> <p>1) Documented Lipid Profile OR LDL, HDL and TG (all three), regardless of result</p> <p><b>2) GPRO:</b> Patients with LDL completed during the Report Period, regardless of result</p> <p>3) LDL &lt; 130; 3A) LDL &lt;= 100; 3B) LDL 101-129</p> <p><b>Definitions:</b> 1) <b>Lipid Profile:</b> CPT 80061; LOINC taxonomy; site-populated taxonomy DM AUDIT LIPID PROFILE TAX.</p> <p>2) <b>LDL:</b> CPT 83721; LOINC taxonomy; site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX</p> <p>3) <b>HDL:</b> CPT 83718; LOINC taxonomy; site-populated taxonomy DM AUDIT HDL TAX</p> <p>4) <b>Triglyceride (TG):</b> CPT 84478; LOINC taxonomy; site-populated taxonomy DM AUDIT TRIGLYCERIDE TAX</p> <p>5) <b>Creatinine (for Active Adult Diabetic denominator):</b> CPT 82540, 82565-75; LOINC taxonomy; site-populated taxonomy DM AUDIT CREATININE TAX</p> <p><b>GPRO Description:</b> During FY 2006, <i>increase the proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol) over the FY 2005 level.</i></p> <p><b>Patient List:</b> All patients diagnosed with Diabetes, with date of tests and LDL value, if any.</p>
<p><b>Diabetes: Nephropathy Assessment</b> Diabetes Program/ Dr. Charlton Wilson</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominators:</b> Three denominators (see Diabetes: Poor Glycemic Control topic above).</p> <p><b>Numerators:</b></p> <p><b>1) GPRO:</b> Patients with positive urine protein test or, if urine protein test is negative, any microalbuminuria test, regardless of result, during the Report Period.</p> <p>2) Patients with Estimated GFR with result during the Report Period.</p> <p>3) Patients who have had 1) positive urine protein test or if urine protein was negative, then microalbuminuria test, regardless of result AND 2) an Estimated GFR with result during the Report Period.</p> <p><b>Definitions:</b> 1) <b>Urine Protein:</b> LOINC taxonomy; site-populated taxonomy DM AUDIT URINE PROTEIN TAX. Positive value for urine protein is defined as: 1) First character of result is "P", "p", "<b>M</b>", "<b>m</b>", "<b>L</b>", "<b>V</b>", "<b>S</b>", or "<b>s</b>"; 2) Contains a + sign; 3) Contains a &gt; symbol; 4) numeric value (if the result is a number) is &gt; (greater than) 29.</p> <p>2) <b>Microalbuminuria:</b> CPT codes 82043, 82044; LOINC taxonomy; site-populated taxonomy DM AUDIT MICROALBUMINURIA TAX <i>or DM AUDIT A/C RATIO taxonomy.</i></p> <p>3) <b>Estimated GFR:</b> Taxonomy BGP ESTIMATED GFR TAX, LOINC 33914-3</p> <p>4) <b>Creatinine (for Active Adult Diabetic denominator):</b> CPT 82540, 82565-75; LOINC taxonomy; site-populated taxonomy DM AUDIT CREATININE TAX.</p> <p><b>GPRO Description:</b> During FY 2006, maintain the proportion of patients with diagnosed diabetes assessed for nephropathy at the FY 2005 level.</p> <p><b>Patient List:</b> All patients diagnosed with Diabetes, with date of tests and value, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRAs</b> measures in yellow)
<p><b>Diabetic Retinopathy</b> Diabetes Program/ Dr. Mark Horton</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Except for removal of CPT 92250, all other changes shown below are only to text and there are no other programming logic changes.</i></p> <p><b>Denominators:</b> Three denominators (see Diabetes: Poor Glycemic Control topic above).</p> <p><b>Numerator:</b> <b>GPRAs: Patients receiving a qualified retinal evaluation during the Report Period, or a documented refusal of a diabetic retinal exam.</b></p> <p><b>Definitions:</b></p> <p>1) <b>Qualified retinal evaluation*</b> is defined as: (A) diabetic retinal exam or documented refusal or (B) other eye exam.</p> <p><b>Diabetic retinal exam defined as:</b> Clinic Code A2 Diabetic Retinopathy or Exam Code 03 Diabetic Eye Exam.</p> <p><b>Other Eye Exam defined as:</b> (1) Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or <i>qualifying*</i> tele-ophthalmology retinal evaluation clinics (<i>i.e. JVN, Inoveon, EyeTel</i>) or (2) non-DNKA visits to an optometrist or ophthalmologist. Searches for the following codes in the following order: Clinic Codes 17, 18, 64; Provider Code 24, 79, 08; CPT 92002, 92004, 92012, 92014, 92015 (<i>removed 92250</i>).</p> <p><b>*Qualified retinal evaluation: The following methods are qualified for this measure:</b></p> <ul style="list-style-type: none"> <li>- Dilated retinal examination by an optometrist or ophthalmologist</li> <li>- 7 standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist</li> <li>- Any photographic method validated to ETDRS, <i>i.e. JVN, Inoveon, EyeTel</i></li> </ul> <p>2) <b>Refusal of Diabetic Eye Exam:</b> Exam Code 03</p> <p>3) <b>Creatinine (for Active Adult Diabetic denominator):</b> CPT 82540, 82565-75; LOINC taxonomy; site-populated taxonomy DM AUDIT CREATININE TAX.</p> <p><b>GPRAs Description:</b> During FY 2006, maintain the proportion of patients with diagnosed diabetes who receive an annual retinal examination at designated sites at the FY 2005 level <b>and establish the baseline of patients with diagnosed diabetes who receive an annual retinal examination at all sites.</b></p> <p><b>Patient List:</b> All patients diagnosed with Diabetes, with date of screening and code, if any.</p>
<p><b>Oral Health – Diabetic Access to Dental Services</b> Dental Program/ Dr. Patrick Blahut</p>	<p><b>Changed to non-GPRAs measure and removed from National GPRAs report.</b></p> <p><b>Denominator:</b> Active Diabetic patients (see Diabetes Comprehensive Care above for definition).</p> <p><b>Numerators:</b> Patients with a documented dental visit during the Report Period, including refusals.</p> <p>A) Patients with documented refusal during the Report Period.</p> <p><b>Definitions:</b> 1) <b>Dental Visit:</b> For non-CHS visits, searches for V Dental ADA Code 0000 or 0190 or Exam Code 30. For CHS visits, searches for any visit with an ADA code. CHS visit defined as Type code of C in Visit file.</p> <p>2) <b>Refusal of Dental Exam:</b> For non-CHS visits, searches for Exam Code 30</p> <p><b>Patient List:</b> All diabetic patients with date of dental visit or refusal and code, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRAs</b> measures in yellow)
<b>DENTAL GROUP</b>	
<b>Oral Health – Access to Dental Services</b> Dental Program/ Dr. Patrick Blahut  <i>NATIONAL (reported to Congress)</i>	<b>No changes from Version 5.1</b> <b>Denominator:</b> <b>GPRAs</b> : GPRAs User Population patients. <b>Numerators:</b> <b>GPRAs</b> : Patients with documented dental visit during the Report Period, including refusals. A) Patients with documented refusal. <b>Definitions:</b> 1) <b>Dental Visit:</b> For non-CHS visits, searches for V Dental ADA Code 0000 or 0190, Exam Code 30. For CHS visits, searches for any visit with an ADA code. CHS visit defined as Type code of C in Visit file. 2) Refusal of Dental Exam: For non-CHS visits, searches for Exam Code 30 <b>GPRAs Description:</b> During FY 2006, maintain the proportion of patients that obtain access to dental services at the FY 2005 level. <b>Patient List:</b> Patients with documented dental visit or refusal, with date and code.
<b>Oral Health – Dental Sealants</b> Dental Program/ Dr. Patrick Blahut  <i>NATIONAL (reported to Congress)</i>	<b>No changes from Version 5.1</b> <b>GPRAs Numerator:</b> Count only (no percentage comparison to denominator). Total number of dental sealants during the Report Period. Age breakouts (HP 2010): <12; 12-18; >18. <b>Definitions:</b> <b>Dental Sealant:</b> ADA Code 1351 <b>GPRAs Description:</b> During FY 2006, maintain the number of sealants placed per year in American Indian and Alaska Native patients at the FY 2005 level. <b>Patient List:</b> Patients who had sealants and the number of sealants received.
<b>Oral Health – Topical Fluoride</b> Dental Program/Dr. Patrick Blahut  <i>NATIONAL (reported to Congress)</i>	<b>Changes from Version 5.1, as noted below.</b> <b>Numerators:</b> 1) Count only (no percentage comparison to denominator). The total number of appropriate topical fluoride applications based on a maximum of four per patient per year. ( <i>Changed to non-GPRAs measure</i> ) 2) <b>GPRAs</b> : Count only (no percentage comparison to denominator). The total number of patients with at least one topical fluoride treatment during the Report Period. <b>Definitions:</b> 1) <b>Topical Fluoride Application:</b> V Dental ADA codes 1201, 1203, 1204, 1205; or V POV V07.31. A maximum of one application per patient per visit is allowed. A maximum of four topical fluoride applications are allowed per patient per year for the applications measure. <b>GPRAs Description:</b> During FY 2006, maintain the number of American Indian and Alaska Native patients receiving at least one topical fluoride application at the FY 2005 level. <b>Patient List:</b> Patients who received at least one topical fluoride application during Report Period.

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPR</b> A measures in yellow)
<b>IMMUNIZATION GROUP</b>	
<p><b>Adult Immunizations: Influenza</b> Epidemiology Program/ Amy Groom, MPH</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominators:</b> 1) Active Clinical patients ages 50 or older. A) Ages 50-64. B) <b>GPR</b>A: Ages 65 and older.</p> <p>2) Active Diabetic patients (see Diabetes Comprehensive Care above for definition).</p> <p><b>Numerators:</b> 1) <b>GPR</b>A: Patients with influenza vaccine documented during the Report Period or with documented refusal.</p> <p>2) Documented patient refusals (REF) or not medically indicated (NMI).</p> <p><b>Definitions:</b> 1) <b>Influenza Vaccine:</b> Immunization/CVX codes 15, 16, 88, or 111; POV V04.8, V04.81, V06.6; CPT 90655, 90656, 90657-90660, 90724; ICD Procedure 99.52</p> <p>2) <b>Refusal of Influenza Vaccine:</b> Immunization/CVX codes: 15, 16, 88, or 111</p> <p><b>GPR</b>A Description: In FY 2006, maintain FY 2005 influenza vaccination rates among non-institutionalized adults aged 65 years and older.</p> <p><b>Patient List:</b> Patients ages 50 or older OR with diabetes diagnosis, with date of vaccine and code, if any.</p>
<p><b>Adult Immunizations: Pneumovax</b> Epidemiology Program/ Amy Groom, MPH</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominators:</b> 1) <b>GPR</b>A: Active Clinical patients ages 65 or older.</p> <p>2) Active Diabetic patients (see Diabetes Comprehensive Care above for definition).</p> <p><b>Numerators:</b> <b>GPR</b>A: Patients with Pneumococcal vaccine documented at any time before the end of the Report Period, including refusals in past year.</p> <p>A) <b>For Active Diabetics denominator only.</b> Patients with pneumovax documented in past five years or who have refused a pneumovax vaccine in the past year.</p> <p>B) Documented patient refusals (REF) or not medically indicated (NMI).</p> <p><b>Definitions:</b> 1) <b>Pneumovax Vaccine:</b> Immunization/CVX codes 33, 100, 109; POV V06.6, V03.82, V03.89; ICD Procedure 99.55; CPT 90732, 90669</p> <p>2) <b>Refusal of Pneumovax Vaccine:</b> Immunization/CVX codes 33, 100, 109</p> <p><b>GPR</b>A Description: In FY 2006, <i>increase the rate for pneumococcal vaccination levels among adult patients age 65 years and older to 72%.</i></p> <p><b>Patient List:</b> Patients 65 or older OR with diabetes diagnosis, with date and code of vaccine, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRA measures in yellow</b> )
<p><b>Childhood Immunizations</b> Epidemiology Program/ Amy Groom, MPH</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominators:</b></p> <ol style="list-style-type: none"> <li>1) <b>GPRA:</b> Active Clinical patients ages 19-35 months at end of Report Period</li> <li>2) <i>Patients active in the Immunization Package who are 19-35 months at end of Report period. NOTE: Sites must be running the RPMS Immunization package for this denominator. Sites not running the package will have a value of zero for this denominator.</i></li> </ol> <p><b>Numerators:</b></p> <ol style="list-style-type: none"> <li>1) <b>GPRA:</b> Patients who have received the 4:3:1:3:3 combination (i.e. 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B), including refusals, contraindications, and evidence of disease.</li> <li>2) Patients with 4 doses of DTaP, or who have evidence of the disease, a contraindication, or a documented refusal.</li> <li>3) Patients with 3 doses of Polio, or who have evidence of the disease, a contraindication, or a documented refusal.</li> <li>4) Patients with 1 dose of MMR, or who have evidence of the disease, a contraindication, or a documented refusal.</li> <li>5) Patients with 3 doses of HiB, or who have evidence of the disease, a contraindication, or a documented refusal.</li> <li>6) Patients with 3 doses of Hepatitis B, or who have evidence of the disease, a contraindication, or a documented refusal.</li> <li>7) Patients with 1 dose of Varicella, or who have evidence of the disease, a contraindication, or a documented refusal.</li> </ol> <p><b>Also included for numerators 1-7 are sub-numerators:</b></p> <ol style="list-style-type: none"> <li>A) Patients with a documented refusal.</li> <li>B) Patients with either (1) evidence of the disease, (2) a contraindication, or (3) a documented not medically indicated (NMI) refusal.</li> </ol> <ol style="list-style-type: none"> <li>8) Patients who have received all of their childhood immunizations (i.e. 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B, 1 Varicella, including refusals, contraindications, and evidence of disease).</li> <li>9) <i>DELETED: Patients who have received the 4:3:1 combination (i.e. 4 DTaP, 3 Polio, 1 MMR), including refusals, contraindications, and evidence of disease.</i></li> <li>10) <b>Immunization Program Numerator:</b> Patients who have received all of their childhood immunizations, defined as 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B, 1 Varicella (i.e., 4:3:1:3:3:1) NOT including refusals, contraindications, and patients with evidence of disease.</li> <li>11) <i>DELETED: Immunization Program Numerator: Patients who have received the 4:3:1 combination (i.e. 4 DTaP, 3 Polio, 1 MMR) NOT including refusals, contraindications, and patients with evidence of disease.</i></li> <li>12) <b>Immunization Program Numerator:</b> Patients who have received the 4:3:1:3:3 combination (i.e. 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B), NOT including refusals, contraindications, and patients with evidence of disease.</li> </ol> <p><b>Definitions:</b> Active <i>Immunization Package Patients denominator: Same as Active Clinical definition EXCEPT includes only patients flagged as active in the Immunization Package and does not require patients to have two visits to specified medical clinics in the past 3 years.</i></p> <p><i>Added Tdap (CVX 115 or CPT 90715 or refusal of CVX 115) to definition for DTaP.</i> Detailed descriptions of all codes for these immunizations are listed in the CRS 2005 User Manual, due to length.</p> <p><b>GPRA Description:</b> During FY 2006, maintain baseline rates for recommended immunizations for AI/AN children 19-35 months compared to FY 2005.</p> <p><b>Patient List:</b> Patients 19-35 months with IZ, if any. If a patient did not have all doses in a multiple dose vaccine, the IZ will not be listed. For example, if a patient only had 2 DTaP, no IZ will be listed for DTaP.</p>

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<b>CANCER SCREENING GROUP</b>	
<p><b>Cancer Screening: Pap Smear Rates</b> Epidemiology Program/ Dr. Nathaniel Cobb</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominator:</b> <b>GPRA:</b> Female Active Clinical patients ages 21 through 64 without a documented history of hysterectomy.</p> <p><b>Numerators:</b> <b>GPRA:</b> Patients with documented pap smear in past three years or refusal in past year.</p> <p>A) Patients with documented refusal in past year.</p> <p><b>Definitions:</b> 1) <b>Hysterectomy:</b> V Procedure: 68.4-68.8; CPT 51925, 56308, 58150, 58152, 58200-58294, 58550-54, 58951, 58953-58954, 59135, 59525.</p> <p>2) <b>Pap Smear:</b> A) V Lab: PAP SMEAR; B) POV: V76.2, V72.31 Gynecological Examination, Pap Cervical Smear as Part of General GYN exam, V72.32 Gynecological Examination, Pelvic Examination (annual) (periodic), V72.3 Gynecological Examination (old code, to be counted for visits prior to 10/1/04 only), V76.47 Vaginal Pap Smear for Post-Hysterectomy Patients, V76.49 Pap Smear for Women w/o a Cervix; C) V Procedure: 91.46; D) V CPT: 88141-88167, 88174-88175, Q0091 Screening Pap Smear; E) Women's Health: Procedure called Pap Smear; F) LOINC taxonomy; G) Site-populated taxonomy BGP GPRA PAP SMEAR; H) Refusal Lab Test Pap Smear</p> <p><b>GPRA Description:</b> During FY 2006, maintain the proportion of female patients ages 21 through 64 without a documented history of hysterectomy who have had a Pap screen within the previous three years at the FY 2005 level.</p> <p><b>Patient List:</b> All patients in the denominator, with date and code of test, if any.</p>
<p><b>Cancer Screening: Mammogram Rates</b> Epidemiology Program/ Dr. Nathaniel Cobb</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominator:</b> <b>GPRA:</b> Female Active Clinical patients ages 52 through 64, without a documented bilateral mastectomy or two separate unilateral mastectomies.</p> <p><b>Numerators:</b> <b>GPRA:</b> Patients with documented mammogram in past two years or refusal in past year.</p> <p>A) Patients with documented refusal in past year.</p> <p><b>Definitions:</b> 1) <b>Bilateral Mastectomy:</b> V CPT: 19180.50 or 19180 w/modifier 09950 (modifier codes .50 and 09950 indicate bilateral); 19200.50 or 19200 w/modifier 09950; 19220.50 or 19220 w/modifier 09950; 19240.50 or 19240 w/modifier 09950; ICD Operation codes: 85.42; 85.44; 85.46; 85.48</p> <p>2) <b>Unilateral Mastectomy:</b> Requires two separate occurrences for either CPT or procedure codes on 2 different dates of service. V CPT: 19180, 19200, 19220, 19240; V Procedures: 85.41, 85.43, 85.45, 85.47</p> <p>3) <b>Mammogram:</b> A) V Radiology or V CPT: 76090, 76091, 76092, G0206 (Diagnostic Mammography, Unilateral), G0204 (Diagnostic Mammography, Bilateral), G0202 (Screening Mammography, Bilateral); B) POV: V76.11, V76.12; C) V Procedures: 87.36, 87.37 (removed 87.35); D) Women's Health: Screening Mammogram, Mammogram Dx Bilat, Mammogram Dx Unilat</p> <p>4) <b>Refusal Mammogram:</b> V Radiology MAMMOGRAM for CPT 76090, 76091, 76092, G0206, G0204, G0202.</p> <p><b>GPRA Description:</b> During FY 2006, maintain the proportion of female patients ages 50 through 64 who have had mammography screening within the last 2 years at the FY 2005 level.</p> <p><b>Patient List:</b> Patients in the denominator, with date and code of procedure, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRA measures in yellow</b> )
<p><b>Colorectal Cancer Screening</b> Epidemiology Program/ Dr. Nathaniel Cobb</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominator:</b> <b>GPRA:</b> Active Clinical patients ages 51-80 without a documented history of colorectal cancer, broken out by gender.</p> <p><b>Numerators:</b> 1) <b>GPRA:</b> Patients who have had colorectal screening or a documented refusal, defined as any of the following: a Fecal Occult Blood test (FOBT) in the past two years; flexible sigmoidoscopy or double contrast barium enema in the past five years; or colonoscopy in the past 10 years.</p> <p>A) Patients with documented refusal in the past year. B) Patients with Fecal Occult Blood test in the past two years.</p> <p>2) Patients with Rectal Exam in past two years.</p> <p><b>Definitions:</b> 1) Colorectal Cancer: POV: 153.*, 154.0, 154.1, 197.5, V10.05. 2) <b>Fecal Occult Blood lab test (FOBT):</b> CPT 82270, 82274, G0107, 89205 (old); LOINC taxonomy, or site-populated taxonomy BGP GPRA FOB TESTS 3) <b>Rectal Exam:</b> V76.41; V Procedure 48.24-29, 89.34; V Exam 14 or refusal in past year for Exam 14. 4) <b>Flexible Sigmoidoscopy:</b> V Procedure 45.24, 45.42, 45.42; CPT 45330-45345, G0104 5) <b>Double Contrast Barium Enema:</b> CPT or VRad: 74270-74280, G0106, G0120 6) <b>Colonoscopy:</b> V Procedure 45.22, 45.23, 45.25, V POV 76.51; CPT 44388-44394, 44397, 45355, 45378-45387 (added 45386), 45325 (old), G0105, G0121 7) <b>Screening Refusals:</b> A. <b>FOBT:</b> V Lab Fecal Occult Blood test, V Radiology CPT 82270, 82274, G0107, 89205; B. <b>Flexible Sigmoidoscopy:</b> V Radiology CPT 45330-45345, G0104; C. <b>Double contrast barium enema:</b> V Radiology CPT: 74270-74280, G0106, G0120; D. <b>Colonoscopy:</b> V Radiology CPT 44388-44394, 44397, 45355, 45378-45387, 45325 (old), G0105, G0121.</p> <p><b>GPRA Description:</b> During FY 2006, establish baseline rate of colorectal screening for clinically appropriate patients ages 50 and older.</p> <p><b>Patient List:</b> Patients ages 51-80, with date and code of any related test or procedure, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRAs measures in yellow</b> )
<p><b>Tobacco Use Assessment</b> Mary Wachacha/Epidemiology Program, Dr. Nat Cobb</p> <p><i>NATIONAL (included in NTL report; <u>not</u> reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominators:</b> 1) Active Clinical patients ages 5 and older, broken down by gender and age groups: 5-13, 14-17, 18-24, 25-44, 45-64, 65 and older (HP 2010). <i>(Changed to non-GPRA denominator)</i></p> <p>2) Pregnant female patients with no documented miscarriage or abortion during the past 20 months.</p> <p><b>Numerators:</b> 1) Patients screened for tobacco use during the Report Period (during the past 20 months for pregnant female patients denominator). <i>(Changed to non-GPRA numerator)</i></p> <p>2) Patients identified during the Report Period (during the past 20 months for pregnant female patients denominator) as current tobacco users.</p> <p>A) Current smokers.</p> <p>B) Current smokeless tobacco users</p> <p>3) Patients exposed to environmental tobacco smoke (ETS) during the Report Period (during the past 20 months for pregnant female patients denominator).</p> <p><b>Definitions:</b> 1) <b>Pregnancy:</b> At least 2 visits with POV: V22.0-V23.9, 640.*-648.*, 651.*-676.* during the past 20 months, with one diagnosis occurring during the reporting period.</p> <p>2) <b>Miscarriage:</b> Occurring after the second pregnancy POV. POV: 630, 631, 632, 633*, 634*, CPT: 59812, 59820, 59821, 59830</p> <p>3) <b>Abortion:</b> Occurring after the second pregnancy POV. POV: 635*, 636*, 637*, CPT: 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857</p> <p>4) <b>Tobacco Screening:</b> A) Any Health Factor for category Tobacco. B) POV or Current PCC Problem List 305.1, V15.82 (tobacco-related diagnosis). C) Dental code 1320. D) Patient Education codes containing “TO-”, “-TO”, or “-SHS”.</p> <p>5) <b>Tobacco Users:</b> A) Health Factors: Current Smoker, Current Smokeless, Current Smoker and Smokeless. B) POV 305.1 or V15.82. C) Dental 1320</p> <p>6) <b>Current Smokers:</b> A) Health Factors: Current Smoker, Current Smoker and Smokeless. B) 305.1 or V15.82. C) Dental code 1320</p> <p>7) <b>Current Smokeless:</b> A) Health Factors: Current Smokeless, Current Smoker and Smokeless</p> <p>8) <b>Environmental Tobacco Smoke (ETS):</b> Health Factors: Smoker in Home, Exposure to Environmental Tobacco Smoke</p> <p><b>Patient List:</b> Patients with no screening identified.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRAs</b> measures in yellow)
<p><b>Tobacco Cessation</b> Mary Wachacha/Epidemiology Program, Dr. Nat Cobb</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominator:</b> <b>GPRAs:</b> Active Clinical patients identified as current tobacco users prior to the Report Period, <i>broken down by gender and age groups: &lt;12, 12-17, 18 and older.</i></p> <p><b>Numerators:</b> 1) <b>GPRAs:</b> Patients who have received tobacco cessation counseling during the Report Period, <i>including documented refusal in past year.</i></p> <p>2) <i>Deleted: Patients counseled during the Report Period on smoking cessation medications.</i></p> <p>2) Patients identified during the Report Period as having quit tobacco use.</p> <p><b>Definitions:</b></p> <p>1) <b>Current Tobacco Users:</b> A) Health Factors: Current Smoker, Current Smokeless, Current Smoker and Smokeless, <i>Cessation-Smoker, Cessation-Smokeless, Cessation-Smoker and Smokeless;</i> B) Tobacco-related Diagnoses (POV or active Problem List): 305.1, <i>305.10-305.12 (old codes),</i> or V15.82. C) Dental code 1320</p> <p>2) <b>Tobacco Cessation Counseling:</b> Patient Education codes containing <i>"TO-", "-TO", or "-SHS" (changed from "TO-Q", "TO-LA");</i> Clinic Code 94, or Dental Code 1320 <i>or documented refusal of patient education codes containing "TO-", "-TO", or "-SHS" during Report Period.</i></p> <p>3) <b>Quit Smoking:</b> POV or Current Active Problem List 305.13, Health Factors Previous Smoker, Previous Smokeless <i>(deleted Cessation-Smoker, Cessation-Smokeless, which are now used to identify Current Tobacco Users since they represent patients trying to quit but who have not quit for &gt;12 months).</i></p> <p><b>GPRAs Description:</b> <i>During FY 2006, establish the proportion of tobacco using patients that receive tobacco cessation intervention.</i></p> <p><b>Patient List:</b> Patients with counseling, if any.</p>
<b>BEHAVIORAL HEALTH GROUP</b>	
<p><b>Alcohol Screening (Fetal Alcohol Syndrome (FAS) Prevention)</b> Wilbur Woodis</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominator:</b> <b>GPRAs:</b> Female Active Clinical patients ages 15 to 44 (child-bearing age).</p> <p><b>Numerators:</b> <b>GPRAs:</b> Patients screened for alcohol use, who have alcohol-related diagnoses, or who have received alcohol-related education or counseling during the Report Period, <i>including refusals in the past year.</i></p> <p>A) Patients with <i>exam code</i>, Alcohol health factor or screening diagnosis.</p> <p>B) Patients with alcohol-related diagnoses.</p> <p>C) Patients with alcohol-related patient education or counseling.</p> <p><i>D) Patients with documented refusal in past year.</i></p> <p><b>Definitions:</b></p> <p>1) <b>Alcohol Screening:</b> <i>PCC Exam code 35;</i> Any Alcohol Health Factor; Other Screening: V11.3; V79.1, or BHS problem code 29.1</p> <p>2) <b>Alcohol-related Diagnoses:</b> POV, Current PCC or BHS Problem List: 303.*, 305.0*; 291.*; 357.5*; BHS POV 10, 27, 29</p> <p>3) <b>Alcohol Education:</b> All Patient Education codes containing "AOD-" or "-AOD" or old codes containing "CD-" or "-CD"</p> <p><b>GPRAs Description:</b> <i>During FY 2006, increase the screening rate for alcohol use in female patients ages 15 to 44.</i></p> <p><b>Patient List:</b> Women <u>not</u> screened.</p>

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<p><b>Intimate Partner (Domestic) Violence Screening</b> Dr. Theresa Cullen/ Denise Grenier, LCSW</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominators:</b> Female Active Clinical patients ages 13 and older at beginning of Report Period.</p> <p>A) <b>GPRA:</b> Female Active Clinical patients ages 15-40.</p> <p><b>Numerators: GPRA:</b> Patients screened for or diagnosed with intimate partner (domestic) violence during the Report Period, including documented refusals in past year.</p> <p>A) Patients with documented IPV/DV exam. B) Patients with IPV/DV related diagnoses. C) Patients provided with IPV/DV patient education or counseling. D) Patients with documented refusal in past year of an IPV/DV exam or IPV/DV-related education.</p> <p><b>Definitions:</b> 1) <b>IPV/DV Screening:</b> PCC Exam Code 34 or BHS IPV/DV exam 2) <b>IPV/DV Related Diagnoses:</b> POV, Current PCC or BHS Problem List 995.80-83, 995.85, V15.41, V15.42, V15.49; BHS POV 43.*, 44.* 3) <b>IPV/DV Patient Education:</b> Patient Education codes containing "DV-" or "-DV" 4) <b>IPV/DV Counseling:</b> POV V61.11 5) <b>Refusals:</b> A) <u>Any</u> PCC refusal in past year with Exam Code 34 or BHS refusal in past year of IPV/DV exam; B) <u>Any</u> refusal in past year with Patient Education codes containing "DV-" or "-DV".</p> <p><b>GPRA Description:</b> During FY 2006, <i>increase the screening rate for domestic violence in female patients ages 15 through 40.</i></p> <p><b>Patient List:</b> Women <u>not</u> screened and without documented refusal.</p>
<p><b>Depression Screening</b> <i>(renamed from Depression/Anxiety Screening)</i> Denise Grenier, LCSW/ Dr. David Sprenger</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominators:</b> 1) <b>GPRA:</b> Active Clinical patients ages 18 and older (changed from 40 and older), broken down by gender.</p> <p>2) Active Diabetes 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. 3) All patients diagnosed with ischemic heart disease prior to the Report Period and with at least two CVD-related visits during the Report Period.</p> <p><b>Numerators: GPRA:</b> Patients screened for depression (removed counseling for depression) or diagnosed with mood disorder (removed diagnoses for anxiety and adjustment disorders) at any time during the Report Period, including documented refusals in past year.</p> <p>A) Patients screened for depression during the Report Period. B) Patients with a diagnosis of <i>a mood disorder during the Report Period (removed anxiety and adjustment diagnoses).</i> <i>C) Patients with documented refusal in past year.</i></p> <p><b>Definitions:</b> 1) <b>Diabetes:</b> POV 250.00-250.93 2) <b>Ischemic Heart Disease:</b> POV 410.0-412.*, 414.0-414.9, 428.*, 429.2. 3) <b>Depression Screening:</b> <i>Exam Code 36</i>, POV V79.0, or BHS problem code 14.1 (screening for depression) (removed all patient education codes for counseling). 4) <b>Mood Disorders:</b> <i>At least two visits in PCC or BHS during the Report period with POV for: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS, Bipolar I or II Disorder, Cyclothymic Disorder, Bipolar Disorder NOS, Mood Disorder Due to a General Medical Condition, Substance-induced Mood Disorder, or Mood Disorder NOS. These POV codes are: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, or 311 or BHS POV 14 or 15.</i> 5) <b>Refusal:</b> <i>Any PCC refusal in past year with Exam Code 36.</i></p> <p><b>GPRA Description:</b> <i>During FY 2006, establish a baseline rate of annual screening for depression in adults ages 18 and over.</i></p> <p><b>Patient List:</b> List of patients not screened for depression/<i>diagnosed with mood disorder.</i></p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRA measures in yellow</b> )
<p><b>Antidepressant Medication Management</b> Denise Grenier, LCSW/ Dr. David Sprenger</p>	<p><b><i>New measure for Version 6.0</i></b></p> <p><b>Denominator:</b> As of the 120th day of the Report period, Active Clinical patients 18 years and older who were diagnosed with a new episode of depression and treated with antidepressant medication in the past year.</p> <p><b>Numerators:</b> 1) <b>Optimal Practitioner Contacts:</b> Patients with at least three mental health visits with a non-mental health or mental health provider within 12 weeks (84 days) after diagnosis, two of which must be face-to-face visits and one of which must be with a prescribing provider.</p> <p>2) <b>Effective Acute Phase Treatment:</b> Patients who filled a sufficient number of separate prescriptions/refills of antidepressant medication for continuous treatment of at least 84 days (12 weeks).</p> <p>3) <b>Effective Continuation Phase Treatment:</b> Patients who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 180 days (6 months).</p> <p><b>Definitions:</b> 1) <b>Major Depression:</b> POV 296.2*, 296.3*, 298.0, 300.4, 309.1, 311.</p> <p>2) <b>Antidepressant Medications:</b> Medication taxonomy BGP ANTIDEPRESSANT MEDS. (Medications are: Tricyclic antidepressants (TCA) and other cyclic antidepressants, Selective serotonin reuptake inhibitors (SSRI), Monoamine oxidase inhibitors (MAOI), Serotonin-norepinephrine reuptake inhibitors (SNRI), and other antidepressants.)</p> <p>3) <b>Index Episode Start Date:</b> The date of the patient's earliest visit during this period. For inpatient visits, the discharge date will be used.</p> <p><b><u>To be included in the denominator, patient must meet BOTH of the following conditions:</u></b></p> <p>1) One of the following from the 121st day of the year prior to the Report period to the 120th day of the Report period: 1) one visit in any setting with major depression DX (see list of codes below) as primary POV, 2) two outpatients visits occurring on different dates of service with secondary POV of major depression, or 3) an inpatient visit with secondary POV of major depression.</p> <p>For example, if Report period is July 1, 2005 - June 30, 2006, patient must have one of the three scenarios above during 11/1/2004 - 10/29/2005.</p> <p>2) Filled a prescription for an antidepressant medication (see list of medications below) within 30 days before the Index Episode Start Date or 14 days on or after that date. In V Medication, Date Discontinued must not be equal to the prescription (i.e. visit) date. The Index Prescription Date is the date of earliest prescription for antidepressant medication filled during that time period.</p> <p><b><u>Denominator Exclusions:</u></b></p> <p>1) Patients who have had any diagnosis of depression within the previous 120 days (4 months) of the Index Episode Start Date. The POVs to be checked for prior depressive episodes is more comprehensive and include the following: POV 296.2*-296.9*, 298.0, 300.4, 309.0, 309.1, 309.28, 311, or</p> <p>2) Patients who had a new or refill prescription for antidepressant medication (see list of medications below) within 90 days (3 months) prior to the Index Prescription Date are excluded as they do not represent new treatment episodes, or</p> <p>3) Patients who had an acute mental health or substance abuse inpatient stay during the 245 days after the Index Episode Start Date treatment period. Acute mental health stays are defined as Service Category of H and primary POV 290*, 293*-302*, 306*-316*. Substance abuse inpatient stays are defined as Service Category of H and primary POV 291*-292*, 303*-305* or primary POV 960*-979* AND secondary POV of 291*-292*, 303*-305*.</p> <p><b><u>Optimal Practitioner Contacts numerator, patient must have one of the following:</u></b></p> <p>1) Three face-to-face follow-up outpatient, non-ER visits (clinic code not equal to 30) or intermediate treatment with either a non-mental health or mental health provider within 84 days after the Index Episode Start Date, or</p>

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<p><b>Antidepressant Medication Management (cont'd)</b> Denise Grenier, LCSW/ Dr. David Sprenger</p>	<p>2) Two face-to-face outpatient, non-ER visits (clinic code not equal to 30) and one telephone visit (Service Category T) with either a non-mental health or mental health provider within 84 days after the Index Episode Start Date. For either option, one of the visits must be to a prescribing provider, defined as provider codes 00, 08, 11, 16-18, 21, 24-25, 30, 33, 41, 44-45, 47, 49, 64, 67-68, 70-83, 85-86, A1, A9, or B1-B6. NOTE: If patient was diagnosed with two secondary diagnoses of depression, the second visit may be counted toward the numerator.</p> <p><b>Outpatient mental health provider visits are defined as BHS or PCC visit with primary provider code of 06, 12, 19, 48, 49, 50, 62, 63, 81, or 92-96, AND</b></p> <ol style="list-style-type: none"> <li>1. A) Service category A, S, or O, and B1) CPT 90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, 99384-99387, 99394-99397, 99401-99404 or B2) POV 290*, 293*-302*, 306*-316*, OR</li> <li>2. A) Service category of A, S, or O and B1) Location of Encounter = Home (as designated in Site Parameters) or B2) clinic code = 11, OR</li> <li>3. Service category of T.</li> </ol> <p><b>Outpatient non-mental health provider visits are defined as BHS or PCC visits with:</b></p> <ol style="list-style-type: none"> <li>1. A) Service category A, S, or O, and B) CPT 90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, OR</li> <li>2. A1) Service category A, S, O, or T or A2) Location of Encounter = Home (as designated in Site Parameters) or A3) clinic code 11 and B) POV 290*, 293*-302*, 306*-316*, OR</li> <li>3. A) Service category A, S, or O, and B) CPT 99384-99387, 99394-99397, 99401-99404 and C) POV 290*, 293*-302*, 306*-316*.</li> </ol> <p><b>Effective Acute Phase Treatment numerator:</b> For all antidepressant medication prescriptions filled (see list of medications below) within 114 days of the Index Prescription Date, from V Medication CRS counts the days prescribed (i.e. treatment days) from the Index Prescription Date until a total of 84 treatment days has been established. If the patient had a total gap exceeding 30 days or if the patient does not have 84 treatment days within the 114 day timeframe, the patient is not included in the numerator.</p> <p><b>NOTE:</b> 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=11/15/2004, Discontinued Date=11/19/2004, Recalculated # Days Prescribed=4.</p> <p><b>Example of Patient Included in Numerator:</b></p> <ul style="list-style-type: none"> <li>- 1st RX is Index Rx Date: 11/1/2004, # Days Prescribed=30 Rx covers patient through 12/1/2004</li> <li>- 2nd RX: 12/15/2004, # Days Prescribed=30 Gap #1 = (12/15/2004-12/1/2004) = 14 days Rx covers patient through 1/14/2005</li> <li>- 3rd RX: 1/10/2005, # Days Prescribed=30 No gap days. Rx covers patient through 2/13/2005</li> <li>- Index Rx Date 11/1/2004 + 114 days = 2/23/2005</li> <li>- Patient's 84th treatment day occurs on 2/7/2005, which is &lt;= 2/23/2005 AND # gap days of 14 is less than 30.</li> </ul>

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<p><i>Antidepressant Medication Management (cont'd)</i></p> <p>Denise Grenier, LCSW/ Dr. David Sprenger</p>	<p><b>Example of Patient Not Included in Numerator:</b></p> <ul style="list-style-type: none"> <li>- 1st Rx is Index Rx Date: 11/1/2004, # Days Prescribed=30 Rx covers patient through 12/1/2004</li> <li>- 2nd Rx: 12/15/2004, # Days Prescribed=30 Gap #1 = (12/15/2004-12/1/2004) = 14 days Rx covers patient through 1/14/2005</li> <li>- 3rd Rx: 2/01/2005, # Days Prescribed=30 Gap #2 = (2/01/2005-1/14/2005) = 18, total # gap days = 32, so patient is not included in the numerator</li> </ul> <p><b>Effective Continuation Phase Treatment numerator:</b> For all antidepressant medication prescriptions (see list of medications below) filled within 231 days of the Index Prescription Date, CRS counts the days prescribed (i.e. treatment days) (from V Medication) from the Index Prescription Date until a total of 180 treatment days has been established. If the patient had a total gap exceeding 51 days or if the patient does not have 180 treatment days within the 231 day timeframe, the patient is not included in the numerator.</p> <p>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=11/15/2004, Discontinued Date=11/19/2004, Recalculated # Days Prescribed=4.</p>

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<b>CARDIOVASCULAR DISEASE RELATED GROUP</b>	
<p><b>Obesity Assessment</b> Nutrition Program, Jean Charles-Azure/ Diabetes Program, Dr. Martin Kileen</p> <p><i>NATIONAL (included in NTL report; <u>not</u> reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominators:</b> Active Clinical patients ages 2 through 74, broken down by gender and age groups: 2-5, 6-11, 12-19, 20-24, 25-34, 35-44, 45-54, 55-74 (<i>changed to non-GPRA denominator</i>)</p> <p><b>Numerators:</b> All patients for whom BMI can be calculated, <i>including refusals in the past year (changed to non-GPRA numerator)</i></p> <p>A) Of Numerator 1, patients considered overweight, adults BMI 25-29, age 18 and under based on standard tables.</p> <p>B) Of Numerator 1, patients considered obese, adults BMI =&gt;30, age 18 and under based on standard tables.</p> <p>C) Of Numerator 1, total overweight and obese.</p> <p><i>D) Of Numerator 1, patients with documented refusal in past year.</i></p> <p><b>Definitions:</b> 1) <b>BMI:</b> Calculated using NHANES II. For 18 and under, a height and weight must be taken on the same day any time during the Report Period. For 19 through 50, height and weight within last five years, not required to be on same day. For over 50, height and weight within last two years, not required to be on same day.</p> <p><i>2) Refusals: Include REF (refused), NMI (not medically indicated) and UAS (unable to screen) and must be documented during the past year. For ages 18 and under, both the height and weight must be refused on the same visit at any time during the past year. For ages 19 and older, the height and the weight must be refused during the past year and are not required to be on the same visit.</i></p> <p><b>Patient List:</b> Patients for whom a BMI could NOT be calculated.</p>

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<p><b>Childhood Weight Control</b> Nutrition Program, Jean Charles-Azure/ Diabetes Program, Dr. Martin Kileen</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominator:</b> <b>GPRAs:</b> Active Clinical Patients 2-5 for whom a BMI could be calculated, broken out by age groups.</p> <p><b>Numerators:</b> 1) Patients with BMI 85-94%. 2) <b>GPRAs:</b> Patients with a BMI 95% and up. 3) Patients with a BMI =&gt;85%.</p> <p><b>Definitions:</b> 1) <b>Age:</b> All patients who are between the ages of 2 and 5 at the beginning of the Report Period and who do not turn age 6 during the Report Period are included in this measure. Age in the age groups is calculated based on the date of the most current BMI found. For example, a patient may be 2 at the beginning of the time period but is 3 at the time of the most current BMI found. That patient will fall into the Age 3 group.</p> <p>2) <b>BMI:</b> CRS looks for the most recent BMI in the Report Period. CRS calculates BMI at the time the report is run, using NHANES II. A height and weight must be taken on the same day any time during the Report Period. The BMI values for this measure are reported differently than in Obesity Assessment since this age group is children ages 2-6, whose BMI values are age-dependent. The BMI values are categorized as At-risk for Overweight for patients with a BMI between 85-94% and Overweight for patients with a BMI of 95%. Patients whose BMI either is greater or less than the Data Check Limit range shown below will not be included in the report counts for At-risk for Overweight or Overweight.</p> <p style="text-align: center;"><b>BMI STANDARD REFERENCE DATA</b></p> <table border="1" data-bbox="506 814 1552 1178"> <thead> <tr> <th rowspan="2">Low-High Ages</th> <th rowspan="2">Sex</th> <th>BMI</th> <th>BMI</th> <th colspan="2">Data Check Limits</th> </tr> <tr> <th>&gt;= (Risk-Overwt.)</th> <th>&gt;= (Overwt)</th> <th>BMI &gt;</th> <th>BMI &lt;</th> </tr> </thead> <tbody> <tr> <td rowspan="2">2-2</td> <td>Male</td> <td>17.7</td> <td>18.7</td> <td>36.8</td> <td>7.2</td> </tr> <tr> <td>Female</td> <td>17.5</td> <td>18.6</td> <td>37.0</td> <td>7.1</td> </tr> <tr> <td rowspan="2">3-3</td> <td>Male</td> <td>17.1</td> <td>18.0</td> <td>35.6</td> <td>7.1</td> </tr> <tr> <td>Female</td> <td>17.0</td> <td>18.1</td> <td>35.4</td> <td>6.8</td> </tr> <tr> <td rowspan="2">4-4</td> <td>Male</td> <td>16.8</td> <td>17.8</td> <td>36.2</td> <td>7.0</td> </tr> <tr> <td>Female</td> <td>16.7</td> <td>18.1</td> <td>36.0</td> <td>6.9</td> </tr> <tr> <td rowspan="2">5-5</td> <td>Male</td> <td>16.9</td> <td>18.1</td> <td>36.0</td> <td>6.9</td> </tr> <tr> <td>Female</td> <td>16.9</td> <td>18.5</td> <td>39.2</td> <td>6.8</td> </tr> </tbody> </table> <p><b>GPRAs Description:</b> During FY 2006, establish the baseline proportion of children ages 2-5 years, with a BMI of 95% or higher.</p> <p><b>Patient List:</b> Patients ages 2-5 with current BMI.</p>	Low-High Ages	Sex	BMI	BMI	Data Check Limits		>= (Risk-Overwt.)	>= (Overwt)	BMI >	BMI <	2-2	Male	17.7	18.7	36.8	7.2	Female	17.5	18.6	37.0	7.1	3-3	Male	17.1	18.0	35.6	7.1	Female	17.0	18.1	35.4	6.8	4-4	Male	16.8	17.8	36.2	7.0	Female	16.7	18.1	36.0	6.9	5-5	Male	16.9	18.1	36.0	6.9	Female	16.9	18.5	39.2	6.8
Low-High Ages	Sex			BMI	BMI	Data Check Limits																																																	
		>= (Risk-Overwt.)	>= (Overwt)	BMI >	BMI <																																																		
2-2	Male	17.7	18.7	36.8	7.2																																																		
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3-3	Male	17.1	18.0	35.6	7.1																																																		
	Female	17.0	18.1	35.4	6.8																																																		
4-4	Male	16.8	17.8	36.2	7.0																																																		
	Female	16.7	18.1	36.0	6.9																																																		
5-5	Male	16.9	18.1	36.0	6.9																																																		
	Female	16.9	18.5	39.2	6.8																																																		
<p><b>Nutrition and Exercise Education For At Risk Patients</b> Patient Education Program/ Mary Wachacha Nutrition Program/ Jean Charles-Azure</p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominators:</b> 1) Active Clinical patients ages 6 and older considered overweight (including obese), defined as adults with BMI =&gt;25, ages 18 and under based on standard tables.</p> <p>A) Patients considered obese, defined as adults with BMI =&gt;30, ages 18 and under based on standard tables. Broken out by gender and age groups: 6-11, 12-19, 20-39, 40-59, =&gt;60 (HP 2010).</p> <p>2) Active Diabetic patients (see Diabetes Comprehensive Care above for definition).</p> <p><b>Numerators:</b> During the Report Period: 1) Patients provided with medical nutrition counseling. 2) Patients provided with nutrition education. 3) Patients provided with exercise education. 4) Patients provided with other related education.</p> <p><b>Definitions:</b> 1) <b>Medical Nutrition Counseling:</b> CPT 97802-97804, G0270, G0271; or provider codes 07, 29, 97 or 99; or clinic codes 67 or 36</p> <p>2) <b>Nutrition Education:</b> Patient Education codes ending "-N" or "-MNT" or old codes containing "-DT" (diet); POV V65.3</p> <p>3) <b>Exercise Education:</b> Patient Education codes ending "-EX"; POV V65.41</p> <p>4) <b>Other Related Education:</b> Patient Education codes ending "-LA" or containing "OBS-"</p> <p><b>Patient List:</b> Patients defined as at risk, with date and codes, if any.</p>																																																						

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<p><b>Cardiovascular Disease and Cholesterol Screening</b> Dr. James Galloway/ Mary Wachacha</p> <p><i>NATIONAL (reported to Congress)</i></p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominators:</b></p> <ol style="list-style-type: none"> <li>1) <b>GPR</b>A: Active Clinical patients ages 23 and older; broken out by gender.</li> <li>2) Active Clinical patients diagnosed with ischemic heart disease prior to the Report Period and with at least two IHD-related visits any time during the Report Period. Broken down by gender.</li> </ol> <p><b>Numerators:</b> 1) <b>GPR</b>A: Patients with documented cholesterol screening any time during past five years, regardless of result.</p> <ol style="list-style-type: none"> <li>2) With high cholesterol, defined as =&gt; 240.</li> <li>3) With LDL completed, regardless of result.</li> <li>4) LDL &lt;= 100. 5) LDL 101-130. 6) LDL 131-160. 7) LDL &gt;160.</li> </ol> <p><b>Definitions:</b> 1) <b>Total Cholesterol Panel:</b> CPT 82465; LOINC taxonomy; site-populated taxonomy DM AUDIT CHOLESTEROL TAX.</p> <p>2) <b>LDL:</b> CPT 83721; LOINC taxonomy; site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX</p> <p>3) <b>Ischemic Heart Disease (IHD):</b> One visit prior to the Report Period AND 2 or more visits any time during the Report Period with diagnosis of ischemic heart disease (Purpose of Visit 410.0-412.*, 414.0-414.9, 428.* or 429.2 recorded in the V POV file).</p> <p><b>GPR</b>A Description: <i>During FY 2006, increase the proportion of patients ages 23 and older that receive blood cholesterol screening.</i></p> <p><b>Patient List:</b> Patients in the denominator, with date and test, if any.</p>
<p><b>Cardiovascular Disease and Blood Pressure Control</b> Dr. James Galloway/ Mary Wachacha</p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominators:</b> 1) All Active Clinical patients ages 20 and over, broken down by gender (removed exclusion for patients with any diabetes diagnosis).</p> <p>2) All User Population patients ages 20 and older, broken down by gender (removed exclusion for patients with any diabetes diagnosis).</p> <p>3) Active Clinical patients diagnosed with ischemic heart disease prior to the Report period and with at least two IHD-related visits any time during the Report period. Broken down by gender.</p> <p><b>Numerators:</b> 1) Patients with BP values documented.</p> <ol style="list-style-type: none"> <li>2) Patients with normal BP, &lt;120/80.</li> <li>3) Pre-hypertension I, =&gt; 120/80 and &lt; 130/80.</li> <li>4) Pre-hypertension II, =&gt;130/80 and &lt; 140/90.</li> <li>5) Stage 1 hypertension, =&gt; 140/90 and &lt;160/100.</li> <li>6) Stage 2 hypertension, =&gt; 160/100.</li> </ol> <p><b>Definitions:</b> 1) <b>BP Values (all numerators):</b> <i>CRS uses mean of last 3 Blood Pressures documented on non-ER visits in the past two years. 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 current category, then the value that is least controlled determines the category.</i></p> <p><i>(Revised definition to match that used in the Diabetes measures, which uses 3 BPs if available. Also added logic to use lowest BP if multiple values exist for a single visit.)</i></p> <p>2) <b>Ischemic Heart Disease (IHD):</b> One visit prior to the Report period AND 2 or more visits any time during the Report period with diagnosis of ischemic heart disease (Purpose of Visit 410.0-412.*, 414.0-414.9, 428.* or 429.2 recorded in the V POV file).</p> <p><b>Patient List:</b> Patients =&gt; 20 w/ denominator identified &amp; mean BP, if any.</p>

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<p><b>Controlling High Blood Pressure</b> Dr. James Galloway/ Mary Wachacha</p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominator:</b> Active Clinical patients ages 46 through 85 diagnosed with hypertension and no documented history of ESRD, broken down by gender.</p> <p><b>Numerators:</b> 1) Patients with BP values documented. 2) Patients with normal BP, &lt;120/80. 3) Pre-hypertension I, =&gt; 120/80 and &lt; 130/80. 4) Pre-hypertension II, =&gt;130/80 and &lt; 140/90. 5) Stage 1 hypertension, =&gt; 140/90 and &lt;160/100. 6) Stage 2 hypertension, =&gt; 160/100.</p> <p><b>Definitions:</b> 1) <b>Hypertension:</b> Diagnosis (POV or problem list) 401.* prior to the Report Period, and at least one hypertension POV during the Report Period. 2) <b>BP Values (all numerators):</b> Uses mean of last <b>3 Blood Pressures (previously used 2)</b> documented on non-ER visits during the Report Period. If 3 BPs are not available, uses mean of last 2, non-ER BPs. <i>If a visit contains more than 1 BP, the lowest BP will be used, defined as having the lowest systolic value.</i> 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 current category, then the value that is least controlled determines the category. 3) <b>ESRD:</b> CPT 90921, 90925 or POV <b>585.1-585.9 (changed from 585).</b></p> <p><b>Patient List:</b> Patients in the denominator, with BP value, if any.</p>
<p><b>Comprehensive CVD-Related Assessment</b> Dr. James Galloway/ Mary Wachacha</p> <p><i>NATIONAL (included in NTL report; <u>not</u> reported to Congress)</i></p>	<p><b>See related CVD topics for identification of further changes for this topic.</b></p> <p><b>Denominators:</b> 1) Patients ages 46 and older who are not diabetic. 2) Active Diabetic patients (see Diabetes Comprehensive Care above for definition) ages 46 and older. 3) Active Clinical patients diagnosed with ischemic disease prior to the Report period and with at least two CVD-related visits any time during the Report period.</p> <p><b>Numerators:</b> 1) Patients with Blood Pressure value documented at least twice in prior two years. 2) With LDL completed in past five years, regardless of result. 3) Screened for tobacco use during the Report Period. 4) For whom a BMI could be calculated, <i>including refusals in the past year.</i> 5) Who have received any lifestyle adaptation counseling, including medical nutrition counseling, or nutrition, exercise or other lifestyle education during the Report Period. 6) Screened for <i>depression or diagnosed with a mood disorder (removed anxiety and adjustment disorder diagnoses and all patient education counseling codes) during the Report Period, including documented refusals in past year.</i> 7) Patients with ALL assessments above.</p> <p><b>Definitions:</b> 1) <b>Ischemic Heart Disease (IHD):</b> One visit prior to the Report period AND 2 or more visits any time during the Report period with diagnosis of ischemic heart disease (Purpose of Visit 410.0-412.*, 414.0-414.9, 428.* or 429.2 recorded in the V POV file). 2) <b>Patients without diabetes:</b> No diabetes diagnosis ever (POV 250.00-250.93). 3) <b>BP:</b> Having a minimum of 2 Blood Pressures documented on non-ER visits during the Report period.</p> <p><b>NOTE:</b> For specific definitions and changes to those definitions, refer to the following topics above: Diabetes and Lipids Assessment; Tobacco Use Assessment; Obesity Assessment; Nutrition and Exercise Education for At Risk Patients; and Depression Screening.</p> <p><b>Patient List:</b> List of patients with assessments received, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRM measures in yellow</b> )
<p><b>Beta-Blocker Treatment After A Heart Attack</b> Dr. James Galloway/ Mary Wachacha</p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominator:</b> Active Clinical patients 35 and older discharged for an AMI during the first 51 weeks of the Report period, were not readmitted for any diagnosis within seven days of discharge, and do not have a contraindication/previous adverse reaction to beta-blocker therapy. <i>Broken down by gender.</i></p> <p><b>Numerator:</b> Patients with active prescription for beta-blockers no later than 7 days after first discharge (i.e. prescribed during stay or at discharge or current at time of admission).</p> <p><b>Definitions:</b> 1) <b>Acute Myocardial Infarction (AMI):</b> POV 410.*1 (i.e. first eligible episode of an AMI) with Service Category H. If patient has more than one episode of AMI during the first 51 weeks of the Report period, CRS will include only the first discharge.</p> <p>2) <b>Beta-blockers:</b> To be included in the numerator, patient must have an active prescription (not discontinued as of [discharge date + 7 days]) either prescribed prior to admission, during the inpatient stay, or within seven days after discharge. "Active" prescription defined as: Days Prescribed &gt; ((Discharge Date + 7 days) - Order Date). Beta blockers defined with Medication taxonomy BGP CMS BETA BLOCKER MEDS or all meds with VA Drug Class CV100.</p> <p><b>Denominator Exclusions:</b></p> <p>1) Patients with Discharge Type of Irregular (AMA), Transferred, or contains "Death." 2) Patients with contraindications to beta-blockers, defined as occurring anytime through discharge date: A) Asthma - 2 diagnoses (POV) of 493* on different visit dates; B) Hypotension - 1 diagnosis of 458*; C) Heart block &gt;1 degree - 1 diagnosis of 426.0, 426.12, 426.13, 426.2, 426.3, 426.4, 426.51, 426.52, 426.53, 426.54, or 426.7; D) Sinus bradycardia - 1 diagnosis of 427.81; or E) COPD - 2 diagnoses on different visit dates of 491.20, 491.21, 496, or 506.4, or a combination of any of these codes, such as 1 visit with 491.20 and 1 with 496. 3) Documented beta blocker allergy/ADR, defined as occurring anytime through discharge date: A) POV 995.0-995.3 AND E942.0; B) "beta block*" entry in ART (Patient Allergies File); or C) "beta block*", "bblock*" or "b block*" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8. 4) Patients readmitted for any diagnosis within seven days of discharge.</p> <p><b>Patient List:</b> Patients with AMI, with beta-blocker prescription, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRA measures in yellow</b> )
<p><b>Persistence of Beta-Blocker Treatment After A Heart Attack</b> Dr. James Galloway/ Mary Wachacha</p>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominator:</b> Active Clinical patients 35 and older diagnosed with an AMI six months prior to the Report period through the first six months of the Report period and do not have a contraindication/previous adverse reaction to beta-blocker therapy. <i>Broken down by gender.</i></p> <p><b>Numerator:</b> Patients with a 180-day course of treatment with beta-blockers following first discharge date or visit date, including previous active prescriptions.</p> <p><b>Definitions:</b> 1) <b>Acute Myocardial Infarction (AMI):</b> POV 410.*0 or 410.*1, which may be diagnosed at inpatient or outpatient visit.</p> <p>2) <b>Inpatient visit:</b> Service Category of H (Hospitalization) and must occur between six months prior to Report period through first six months of the Report period. If patient has more than one episode of AMI during the timeframe, CRS will include only the first hospital discharge or ambulatory visit.</p> <p>3) <b>Beta-blocker Treatment:</b> To be included in the numerator, patients must have a beta-blocker days' supply <math>\geq 135</math> days in the 180 days following discharge date for inpatient visits or visit date for ambulatory visits. Prior active beta-blocker prescriptions can be included if the treatment days fall within the 180 days following discharge/visit date. Prior active prescription defined as most recent beta-blocker prescription (see codes below) prior to admission/visit date with the number of days supply equal to or greater than the discharge/visit date minus the prescription date.</p> <p><b>NOTE:</b> 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.</p> <p>4) Beta-blockers: Medication taxonomy BGP CMS BETA BLOCKER MEDS or all meds with VA Drug Class CV100.</p> <p>Example of patient included in the numerator who has prior active prescription:</p> <ul style="list-style-type: none"> <li>- Admission Date: 2/1/2004, Discharge Date: 2/15/2004</li> <li>- Must have 135 days prescribed by 8/13/2004 (Discharge Date+180)</li> <li>- Prior Beta-Blocker Rx Date: 1/15/2004</li> <li>- # Days Prescribed: 60 (treats patient through 3/15/2004)</li> <li>- Discharge Date minus Rx Date: 2/15/2004-1/15/2004 = 31, 60 is <math>\geq 31</math>, prescription is considered Prior Active Rx</li> <li>- 3/15/2004 is between 2/15 and 8/13/2004, thus remainder of Prior Active Rx can be counted toward 180-day treatment period</li> <li>- # Remaining Days Prescribed from Prior Active Rx: (60-(Discharge Date-Prior Rx Date) = 60-(2/15/2004-1/15/2004) = 60-31 = 29</li> <li>- Rx #2: 4/1/2004, # Days Prescribed: 90</li> <li>- Rx #3: 7/10/2004, #Days Prescribed: 90</li> <li>- Total Days Supply Prescribed between 2/15 and 8/13/2004: 29+90+90=209</li> </ul> <p><b>Denominator Exclusions:</b> 1) If inpatient visit, patients with Discharge Type of Irregular (AMA), Transferred, or contains "Death."</p> <p>2) Patients with contraindications to beta-blockers occurring anytime through discharge/ visit date: A) Asthma - 2 diagnoses (POV) of 493* on different visit dates; B) Hypotension - 1 diagnosis of 458*; C) Heart block <math>&gt;1</math> degree - 1 diagnosis of 426.0, 426.12, 426.13, 426.2, 426.3, 426.4, 426.51, 426.52, 426.53, 426.54, or 426.7; D) Sinus bradycardia - 1 diagnosis of 427.81; or E) COPD - 2 diagnoses on different visit dates of 491.20, 491.21, 496, or 506.4, or a combination of any of these diagnoses, such as one visit with 491.20 and one with 496.</p> <p>3) Documented beta blocker allergy/ADR occurring anytime through discharge/visit date: A) POV 995.0-995.3 AND E942.0; B) "beta block*" entry in ART (Patient Allergies File); or C) "beta block*", "bblock*" or "b block*" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.</p> <p><b>Patient List:</b> Patients with AMI, with all beta-blocker prescriptions during the 180-day timeframe, if any.</p>

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<b>Cholesterol Management After Acute CVD Event</b> Dr. James Galloway/ Mary Wachacha	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominator:</b> Active Clinical patients ages 18 to 75 diagnosed within the year prior to beginning of the Report period with acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA). Broken down by gender.</p> <p><b>Numerators:</b> 1) Patients with LDL completed 60-365 days after diagnosis, regardless of result.            2) Patients with LDL &lt;=100, completed 60-365 days after diagnosis.            3) Patients with LDL 101-130, completed 60-365 days after diagnosis.  <b>4) Patients with LDL &gt;130, completed 60-365 days after diagnosis.</b></p> <p><b>Definitions:</b> 1) <b>AMI:</b> POV 410.*0 or 410.*1.            2) <b>PTCA:</b> A) V Procedure 36.01, 36.02, 36.05, 36.09 or B) CPT 33140, 92980-92982, 92984, 92995, 92996.            3) <b>CABG:</b> 1) V Procedure 36.1*, 36.2 or 2) CPT 33510-33514, 33516-33519, 33521-33523, 33533-33536. If diagnosis occurred at an inpatient visit, discharge date will be used instead of visit date.            4) <b>LDL:</b> CPT 83721; LOINC taxonomy; site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX. For each of the numerators, finds the most recent LDL test from the Report period end date that is between 60 and 365 days after diagnosis.</p> <p><b>Patient List:</b> Patients with AMI, CABG, or PTCA w/LDL value, if any.</p>
<b>STD-RELATED GROUP</b>	
<b>Prenatal HIV Testing and Education</b> Drs. Theresa Cullen, Charlton Wilson, Jim Cheek, and John Redd  <i>NATIONAL (reported to Congress)</i>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominator:</b> <b>GPRA:</b> All pregnant patients with no documented miscarriage or abortion during the past 20 months and NO recorded HIV diagnosis ever.</p> <p><b>Numerators:</b> 1) Patients who received counseling and/or patient education about HIV and testing during the past 20 months.            2) <b>GPRA:</b> Patients who received HIV test during the past 20 months, including refusals.            A) Number of documented refusals.</p> <p><b>Definitions:</b> 1) <b>Pregnancy:</b> At least 2 visits with POV: V22.0-V23.9, 640.*-648.*, 651.*-676.* during the past 20 months, with one diagnosis occurring during the reporting period.            2) <b>Miscarriage:</b> Occurring after the second pregnancy POV and during the past 20 months. POV: 630, 631, 632, 633*, 634*, CPT: 59812, 59820, 59821, 59830            3) <b>Abortion:</b> Occurring after the second pregnancy POV and during the past 20 months. POV: 635*, 636*, 637*, CPT: 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857            4) <b>HIV:</b> V POV or Problem List: 042.0-044.9, V08, 795.71            5) <b>HIV Counseling/Patient Education:</b> POV: V65.44, Patient Education codes containing "HIV-" or "-HIV" or HIV diagnosis 042.0-044.9, V08, 795.71            6) <b>HIV Test:</b> CPT: 86689, 86701-86703, 87390, 87391; LOINC taxonomy; site-populated taxonomy BGP GPRA HIV TESTS            7) <b>Refusal of HIV Test:</b> Lab Test HIV</p> <p><b>GPRA Description:</b> <i>In FY 2006, increase the proportion of pregnant female patients screened for HIV.</i></p> <p><b>Patient List:</b> Patients not screened.</p>

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<p><b>HIV Quality of Care</b> Drs. Theresa Cullen, Charlton Wilson, and Jonathan Iralu</p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominator:</b> Patients 13 and older with at least 2 direct care visits (i.e. not contract/CHS) during the Report Period with HIV diagnosis AND 1 HIV visit in last 6 months. Broken out by gender.</p> <p><b>Numerators:</b> 1) Patients who received CD4 test only (without PCR viral load) during the Report Period.</p> <p>2) Patients who received HIV Viral load only (without CD4), as measured by PCR or a comparable test, during the Report Period.</p> <p>3) Patients who received both CD4 and HIV viral load tests during the Report Period.</p> <p>4) Total patients receiving tests.</p> <p><b>Definitions:</b> 1) <b>HIV:</b> POV or Problem List 042.0-044.9, V08, or 795.71</p> <p>2) <b>CD4:</b> CPT 86361; LOINC taxonomy; site-populated taxonomy BGP CD4 TAX</p> <p>3) <b>HIV Viral Load:</b> CPT 87536, 87539; LOINC taxonomy; site-populated taxonomy BGP HIV VIRAL TAX</p> <p><b>Patient List:</b> None</p>
<p><b>Chlamydia Screening</b> Epidemiology Program/ Dr. Jim Cheek, Lori DeRavello, MPH</p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominator:</b> Female Active Clinical patients ages 16 through 25, broken down into age groups 16-20 and 21-25.</p> <p><b>Numerator:</b> Patients tested for Chlamydia trachomatis during the Report Period.</p> <p><b>Definitions: Chlamydia:</b> V73.88, V73.98; CPT: 87110, 87270, 87320, (removed 87485-87487; not for genital Chlamydia infection), 87490-87492, 87810; site-populated taxonomy BGP GPR A CHLAMYDIA TESTS; LOINC taxonomy.</p> <p><b>Patient List:</b> Patients with no documented screening.</p>

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<b>OTHER CLINICAL MEASURES GROUP</b>	
<b>Osteoporosis Management</b> Drs. Bruce Finke and Lisa Sumner	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominator:</b> Female Active Clinical patients ages 67 and older who had a new fracture occurring six months (180 days) prior to the Report period through the first six months of the Report period with no osteoporosis screening or treatment in year prior to the fracture.</p> <p><b>Numerator:</b> Patients treated or tested for osteoporosis after the fracture.</p> <p><b>Definitions:</b> 1) <b>Fracture:</b> Does not include fractures of finger, toe, face, or skull. CRS will search for the first (i.e. earliest) fracture during the period six months (180) days prior to the beginning of the Report period and the first six months of the Report period. If multiple fractures are present, only the first fracture will be used.</p> <p>The Index Episode Start Date is the date the fracture was diagnosed. If the fracture was diagnosed at an outpatient visit (Service Category A, S, or O), the Index Episode Start Date is equal to the Visit Date. If diagnosed at an inpatient visit (Service Category H), the Index Episode Start Date is equal to the Discharge Date.</p> <p><b>Fracture codes:</b> A) CPTs: 21800, 21805, 21810, 21820, 21825, 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22328, 23500, 23505, 23515, 23570, 23575, 23585, 23600, 23605, 23615, 23616, 23620, 23625, 23630, 23665, 23670, 23675, 23680, 24500, 24505, 24515, 24516, 24530, 24535, 24538, 24545, 24546, 24560, 24565, 24566, 24575, 24576, 24577, 24579, 24582, 24586, 24587, 24620, 24635, 24650, 24655, 24665, 24666, 24670, 24675, 24685, 25500, 25505, 25515, 25520, 25525, 25526, 25530, 25535, 25545, 25560, 25565, 25574, 25575, 25600, 25605, 25611, 25620, 25622, 25624, 25628, 25630, 25635, 25645, 25650, 25651, 25652, 25680, 25685, 26600, 26605, 26607, 26608, 26615, 27193, 27194, 27200, 27202, 27215, 27216, 27217, 27218, 27220, 27222, 27226, 27227, 27228, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248, 27254, 27500, 27501, 27502, 27503, 27506, 27507, 27508, 27509, 27510, 27511, 27513, 27514, 27520, 27524, 27530, 27532, 27535, 27536, 27538, 27540, 27750, 27752, 27756, 27758, 27759, 27760, 27762, 27766, 27780, 27781, 27784, 27786, 27788, 27792, 27808, 27810, 27814, 27816, 27818, 27822, 27823, 27824, 27825, 27826, 27827, 27828, 28400, 28405, 28406, 28415, 28420, 28430, 28435, 28436, 28445, 28450, 28455, 28456, 28465, 28470, 28475, 28476, 28485; B) POVs: 733.1, 805*-806*, 807.0-807.3, 808*-815*, 818*-825*, 827*, 828*;            C) V Procedure: 79.00-79.03, 79.05-79.07, 79.09, 79.10-79.13, 79.15-79.17, 79.19, 79.20-79.23, 79.25-79.27, 79.29, 79.30-79.33, 79.35-79.37, 79.39, 79.60-79.63, 79.65-79.67, 79.69.</p> <p>2) <b>Osteoporosis Treatment and Testing:</b> A) For fractures diagnosed at an outpatient visit: I) A non-discontinued prescription within six months (180 days) of the Index Episode Start Date (i.e. visit date) or II) a BMD test within six months of the Index Episode Start Date. B) For fractures diagnosed at an inpatient visit, a BMD test performed during the inpatient stay.</p> <p>3) <b>BMD Test:</b> A) CPT: 76070, 76071, 76075, 76076, 76078, 76499, 76977, 76999, 78350, 78351; B) V Procedure 88.98.</p> <p>4) <b>Osteoporosis Treatment Medication:</b> Medication taxonomy BGP <b>HEDIS</b> OSTEOPOROSIS MEDS. (Medications are Alendronate, Risedronate, Calcitonin, Raloxifene, Estrogen, and Teriparatide.)</p> <p><b>Denominator Exclusions:</b></p> <p>1) Patients receiving osteoporosis screening or treatment in the year (365 days) prior to the Index Episode Start Date. Osteoporosis screening or treatment is defined as a Bone Mineral Density (BMD) test (see below for codes) or receiving any osteoporosis therapy medication (see below for codes).</p> <p>2) Patients with a fracture diagnosed at an outpatient visit who ALSO had a fracture within 60 days prior to the Index Episode Start Date.</p> <p>3) Patients with a fracture diagnosed at an inpatient visit who ALSO had a fracture within 60 days prior to the ADMISSION DATE.</p> <p><b>Patient List:</b> Female patients with new fracture who have had osteoporosis treatment or testing, if any.</p>

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<p><b><i>Osteoporosis Screening in Women</i></b> Drs. Bruce Finke and Lisa Sumner</p>	<p><b><i>New measure for Version 6.0</i></b></p> <p><b>Denominator:</b> Female Active Clinical patients ages 65 and older without a documented history of osteoporosis.</p> <p><b>Numerators:</b> Patients who had osteoporosis screening documented in the past 2 years, including documented refusals in past year.</p> <p>A) Patients with documented refusal in past year.</p> <p><b>Definitions:</b> 1) <b>Patients without Osteoporosis:</b> No osteoporosis diagnosis ever (POV 733.*). 2) <b>Osteoporosis Screening:</b> Any one of the following in the past two years or documented refusal in the past year: A) <b>Central DEXA:</b> CPT 76075; B) <b>Peripheral DEXA:</b> CPT 76076; C) <b>Central CT:</b> CPT 76070; D) <b>Peripheral CT:</b> CPT 76071; E) <b>US Bone Density:</b> CPT 76977; F) <b>Quantitative CT:</b> V Procedure 88.98.</p> <p><b>Patient List:</b> Female patients ages 65 and older with osteoporosis screening, if any.</p>
<p><b>Asthma</b> Drs. Charles Reidhead and Charles North</p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominators:</b> Active Clinical patients, broken out by age groups: &lt;5, 5-64; 65 and older (HP 2010)</p> <p><b>Numerators:</b> 1) Patients who have had 2 asthma-related visits during the Report Period OR who are Active patients in the Asthma Register System (ARS) and categorized as persistent (i.e. Severity 2, 3 or 4). 2) Patients from the first numerator who have hospital visits for asthma during the Report Period.</p> <p><b>Definitions:</b> 1) <b>Asthma:</b> POV 493.* 2) <b>Hospital Visit:</b> Service Category H with <u>primary</u> POV 493.*</p> <p><b>Patient List:</b> Patients in the numerator.</p>

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<p><b>Asthma Quality of Care</b> Drs. Charles Reidhead and Charles North</p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominator:</b> Active Clinical patients ages 5-56 with persistent asthma within the year prior to the beginning of the Report period without a documented history of emphysema or chronic obstructive pulmonary disease (COPD), broken down by age groups.</p> <p><b>Numerator:</b> Patients who had at least one dispensed prescription for primary asthma therapy medication during the Report period.</p> <p><b>Definitions:</b> 1) <b>Emphysema:</b> Any visit at any time on or before the end of the Report period with POV codes: 492.*, 506.4, 518.1, 518.2.</p> <p>2) <b>Chronic obstructive pulmonary disease (COPD):</b> Any visit at any time on or before the end of the Report period with POV codes: 491.20, 491.21, 496, 506.*.</p> <p>3) <b>Persistent Asthma:</b> Any of the following with in the year prior to the beginning of the Report period:</p> <p>A) At least one visit to Clinic Code 30 (Emergency Medicine) with primary diagnosis 493* (asthma),</p> <p>B) At least one acute inpatient discharge with primary diagnosis 493.*. Acute inpatient discharge defined as Service Category of H,</p> <p>C) 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), or</p> <p>D) At least 4 asthma medication dispensing events (see definition below). If the sole medication was leukotriene modifiers, then <b>MUST</b> also meet criteria in 1-3 above or have at least one visit with POV 493.* within the year prior to the beginning of the Report period.</p> <p><b>Dispensing Event:</b> 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.</p> <p><b>NOTE:</b> 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.</p> <p>4) <b>Primary Asthma Therapy:</b> 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.</p> <p><b>Primary asthma therapy medication codes defined with medication taxonomies:</b> BGP ASTHMA CONTROLLERS, BGP ASTHMA INHALED STEROIDS, AND BGP ASTHMA LEUKOTRIENE. (Medications are: Inhaled Corticosteroids, Nedocromil, Cromolyn Sodium, Leukotriene Modifiers or Methylxanthines.)</p> <p><b>Patient List:</b> Asthmatic patients with primary asthma therapy medications, if any.</p>
<p><b>Chronic Kidney Disease Assessment</b> Kidney Disease Program/ Dr. Andrew Narva</p>	<p><b>No changes from Version 5.1</b></p> <p><b>Denominator:</b> All patients 18 and older with serum creatinine test in past year.</p> <p><b>Numerators:</b> 1) Patients with Estimated GFR result (lab test Estimated GFR). A) with GFR &lt;60</p> <p><b>Definitions:</b> 1) <b>Creatinine:</b> CPT 82540, 82565-75; LOINC; site-populated taxonomy DM AUDIT CREATININE TAX.</p> <p>2) <b>Estimated GFR:</b> site-populated taxonomy BGP GPR ESTIMATED GFR TAX, LOINC code 33914-3.</p> <p><b>Patient List:</b> Patients with Creatinine test, with GFR and value, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions, <b>GPRA measures in yellow</b> )
<p><b><i>Prediabetes/Metabolic Syndrome</i></b> Drs. Stephen J. RithNajarian and Kelly Moore</p>	<p><b><i>New measure for Version 6.0</i></b></p> <p><b>Denominator:</b> Active Clinical patients ages 18 and older diagnosed with prediabetes/metabolic syndrome without a documented history of diabetes.</p> <p><b>Numerators:</b> 1) Patients with Blood Pressure documented at least twice during the Report Period.</p> <p>2) Patients with LDL completed, regardless of result, during the Report Period.</p> <p>3) Patients with fasting glucose test, regardless of result, during the Report Period.</p> <p>4) Patients with positive urine protein test or, if urine protein test is negative, any microalbuminuria test, regardless of result, during the Report Period.</p> <p>5) Patients who have been screened for tobacco use during the Report Period.</p> <p>6) Patients for whom a BMI could be calculated, including refusals in the past year.</p> <p>7) Patients who have received any lifestyle adaptation counseling, including medical nutrition counseling, or nutrition, exercise or other lifestyle education during the Report Period.</p> <p>8) Patients screened for depression or diagnosed with a mood disorder at any time during the Report period, including documented refusals in past year.</p> <p>9) Patients with all screenings.</p> <p><b>Definitions:</b> 1) <b>Prediabetes/Metabolic Syndrome:</b> Diagnosis of prediabetes/metabolic syndrome, defined as: two visits during the Report Period with POV 277.7, OR any three or more of the following occurring during the Report Period except as otherwise noted:</p> <p>A) BMI =&gt; 30 OR Waist Circumference &gt;40 inches for men or &gt;35 inches for women,</p> <p>B) Triglyceride value &gt;=150,</p> <p>C) HDL value &lt;40 for men or &lt;50 for women,</p> <p>D) Patient diagnosed with hypertension OR mean Blood Pressure value =&gt; 130/85 where systolic is =&gt;130 OR diastolic is =&gt;85,</p> <p>E) Fasting Glucose value =&gt;100 AND &lt;126. NOTE: Waist circumference and fasting glucose values will be checked last.</p> <p>2) <b>Patients without Diabetes:</b> No diabetes diagnosis ever (POV 250.00-250.93).</p> <p>3) <b>BMI:</b> CRS calculates BMI at the time the report is run, using NHANES II. For 18 and under, a height and weight must be taken on the same day any time during the Report Period. For 19 through 50, height and weight must be recorded within last 5 years, not required to be on the same day. For over 50, height and weight within last 2 years, not required to be recorded on same day. Refusals include REF (refused), NMI (not medically indicated) and UAS (unable to screen) and must be documented during the past year. For ages 18 and under, both the height and weight must be refused on the same visit at any time during the past year. For ages 19 and older, the height and the weight must be refused during the past year and are not required to be on the same visit.</p> <p>4) <b>Triglyceride:</b> CPT 84478; LOINC taxonomy; or site-populated taxonomy DM AUDIT TRIGLYCERIDE TAX.</p> <p>5) <b>HDL:</b> CPT 83718; LOINC taxonomy; or site-populated taxonomy DM AUDIT HDL TAX.</p> <p>6) <b>Fasting Glucose:</b> POV 790.21; LOINC taxonomy; or site-populated taxonomy DM AUDIT FASTING GLUCOSE TAX.</p> <p>7) <b>LDL:</b> Finds last test done during the Report period; defined as: CPT 83721; LOINC taxonomy; or site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX.</p> <p>8) <b>Blood Pressure:</b> 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).</p> <p>9) <b>Hypertension:</b> Diagnosis of (POV or problem list) 401.* occurring prior to the Report period, and at least one hypertension POV during the Report period.</p>

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<p><i>Prediabetes/Metabolic Syndrome (Cont'd)</i></p> <p>Drs. Stephen J. RithNajarian and Kelly Moore</p>	<p>10) <b>Urine Protein/Microalbuminuria:</b> CRS searches for last microalbuminuria test done during the Report period, regardless of result. If none found, searches for last urine protein test with positive (Y) value in same time period. Positive value for urine protein is defined as: 1) First character of result is "P", "p", "M", "m", "L", "l", "S", or "s"; 2) Contains a + sign; 3) Contains a &gt; symbol; 4) numeric value (if the result is a number) is &gt; (greater than) 29. 1) Urine protein defined as: LOINC taxonomy; site-populated taxonomy DM AUDIT URINE PROTEIN TAX. 2) Microalbuminuria defined as: CPT codes 82043, 82044; LOINC taxonomy; site-populated taxonomy DM AUDIT MICROALBUMINURIA TAX or DM AUDIT A/C RATIO taxonomy.</p> <p>11) <b>Tobacco Screening:</b> At least one of the following during the Report Period: 1. Any health factor for category Tobacco documented during Current Report period; 2. Tobacco-related diagnoses (POV or current Active Problem List) 305.1 or V15.82; 3. Dental code 1320; 4. Any patient education code containing "TO-", "-TO" or "-SHS."</p> <p>12) <b>Lifestyle Counseling:</b> Any of the following during the Report Period:</p> <p>A) Medical nutrition counseling defined as: CPT 97802-97804, G0270, G0271; Provider codes 07, 29, 97, 99; Clinic codes 67 (dietary) or 36 (WIC),</p> <p>B) Nutrition education defined as: POV V65.3 dietary surveillance and counseling; patient education codes ending "-N" (Nutrition) or "-MNT" (or old code "-DT" (Diet)),</p> <p>C) Exercise education defined as: POV V65.41 exercise counseling; patient education codes ending "-EX" (Exercise),</p> <p>D) Related exercise and nutrition counseling defined as: patient education codes ending "-LA" (lifestyle adaptation) or containing "OBS-" (obesity).</p> <p>13) <b>Depression Screening/Mood Disorder DX:</b> Any of the following during the Report Period: A) Depression Screening: Exam Code 36, POV V79.0, or BHS problem code 14.1 (screening for depression) or refusal, defined as any PCC refusal in past year with Exam Code 36; or B) Mood Disorder DX: At least two visits in PCC or BHS during the Report period with POV for: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS, Bipolar I or II Disorder, Cyclothymic Disorder, Bipolar Disorder NOS, Mood Disorder Due to a General Medical Condition, Substance-induced Mood Disorder, or Mood Disorder NOS. These POV codes are: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, or 311 or BHS POV 14 or 15.</p> <p><b>Patient List:</b> Patients 18 and older with Prediabetes/Metabolic Syndrome with assessments received, if any.</p>

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<b>Medications Education</b> Patient Education Program/ Mary Wachacha	<p><b>No changes from Version 5.1</b></p> <p><b>Denominator:</b> Active Clinical patients with medications dispensed <u>at their facility</u> during the Report Period.</p> <p><b>Numerator:</b> Patients who were provided patient education about their medications in ANY location.</p> <p><b>Definitions:</b> 1) <b>Dispensed Medications:</b> Any entry in the VMed file for your facility.            2) <b>Medication Education:</b> Patient Education codes M-I, M-DI, M-FU, M-L, DMC-IN, or any Patient Education containing “-M”.</p> <p><b>Patient List:</b> Patients in the denominator, with date and Patient Education codes, if any.</p>
<b>Public Health Nursing</b> Cheryl Peterson, RN  <i>NATIONAL (included in NTL report; <u>not</u> reported to Congress)</i>	<p><i>Changes from Version 5.1, as noted below.</i></p> <p><b>Denominators:</b> 1) User Population patients.            2) Number of <u>visits</u> by PHNs in any setting, including Home, broken down into age groups: 0-28 days (neonate), 29 days-12 months (infants), 1-64 years, 65 and older (elders). (<i>Changed to non-GPRA denominator</i>)                A) Number of PHN driver/interpreter (provider code 91) visits.            3) Number of <u>visits</u> by PHNs in Home setting, broken down into age groups: 0-28 days (neonate), 29 days-12 months (infants), 1-64 years, 65 and older (elders).                A) Number of PHN driver/interpreter (provider code 91) visits.</p> <p><b>Numerators:</b>            1) For User Population denominator only, the number of patients in the denominator served by PHNs in any setting.            2) For User Population only, the number of patients in the denominator served by a PHN driver/interpreter in any setting.            3) For User Population denominator only, the number of patients in the denominator served by PHNs in a Home setting.            4) For User Population only, the number of patients in the denominator served by a PHN driver/interpreter in a HOME setting.</p> <p><b>Definitions:</b> 1) <b>PHN Visit-Any Setting:</b> Any visit with primary or secondary provider codes 13 or 91.            2) <b>PHN Visit-Home:</b> Any visit with A) clinic code 11 and a primary or secondary provider code of 13 or 91 or B) Location Home (as defined in Site Parameters) <u>and</u> a primary or secondary provider code 13 or 91.</p> <p><b>Patient List:</b> Any patient who received any PHN visit.</p>