RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System
(BGP)

Selected Measures (Local) Report
Performance Measure List and Definitions

Version 9.0
July 2009

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

REVISION HISTORY

Date	Revision	Description	Author
05/13/09	N/A	Distribution of document.	S. Klepacki
07/29/09	1	(1) Revised denominator description for all topics that use the Active Diabetic denominator to reflect the current wording from the CRS report. There are no actual logic changes. (2) Tobacco Use and Exposure Assessment, Appropriate Medication Therapy after a Heart Attack, Persistence of Appropriate Medication Therapy after a Heart Attack, Appropriate Medication Therapy in High Risk Patients, and HIV Screening, pregnancy definition: Indicated the corrections that were made to CRS programming logic to make it consistent with the CRS textual descriptions of the logic. The textual descriptions of the performance measure definition did not change.	S. Klepacki

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1.0 CRS Selected Measures (Local) Report

The performance measure topics and their definitions that are included in the Clinical Reporting System (CRS) 2009 version 9.0 Selected Measures (Local) Report are shown in Section 2.0. Performance measures that are also included in the National Government Performance and Results Act of 1993 (GPRA) and Program Assessment Rating Tool (PART) Report are shown in Section 1.1.

Many performance measure topics include both the Active Clinical and User Population denominators. For brevity, the User Population denominator is not listed separately. To see which topics include the User Population denominator, refer to the CRS 2009 Administrator Manual.

1.1 Performance Measures Included in the CRS 2009 National GPRA and PART Report

The following performance measures will be reported in the CRS 2009 National GPRA and PART Report.

Note: **Bold** font indicates official GPRA measures reported in the National GPRA and PART Report submitted to Office of Management and Budget (OMB) and Congress.

Italic font indicates changes from CRS version 8.0 Patch 3.

\+ Not an official GPRA measure but is included in the National GPRA and PART Report provided to OMB and Congress to provide context to a GPRA measure(s).
* Not an official GPRA measure and is not included in the National GPRA Report provided to OMB and Congress. This measure is included to provide context to a GPRA measure(s).
** GPRA Developmental measure. Has the potential to become a GPRA measure in the future. This measure is *not* included in the National GPRA and PART Report submitted to OMB and Congress.
*** PART measure included in the GPRA and PART Report submitted to OMB.

DIABETES GROUP

Diabetes Prevalence
+Diabetes Diagnosis Ever
*Diabetes Diagnosis during GPRA Year

Glycemic Control
+Documented Alc
GPRA: Poor Glycemic Control
GPRA: Ideal Glycemic Control

Blood Pressure Control
*BP Assessed
GPRA: Controlled BP

LDL Assessment
GPRA: LDL Assessed
*LDL <= 100

Nephropathy Assessment
GPRA: Estimated GFR and Quantitative
GPRA: Urinary Protein or History of ESRD

Retinopathy Assessment
GPRA: Retinopathy Evaluation or Refusal
*Refusal of Retinopathy Evaluation
**GPRA Developmental: Retinopathy Evaluation (no refusals)*

DENTAL GROUP

Access to Dental
GPRA: Annual Dental Visit or Refusal
*Refusal of Dental Exam
**GPRA Developmental: Annual Dental Visit (no refusals)*

Dental Sealants
GPRA: Dental Sealants or Refusal (count; not rate)
*Refusal of Dental Sealant
**GPRA Developmental: Dental Sealant (no refusals)*

Topical Fluoride
GPRA: Topical Fluoride Application or Refusal (count; not rate)
*Refusal of Topical Fluoride Application
**GPRA Developmental: Topical Fluoride Application (no refusals)*

IMMUNIZATIONS

Adult Immunizations (65+): Influenza
GPRA: Influenza Immunization or Refusal
*Refusal of Influenza Immunization
**GPRA Developmental: Influenza Immunization (no refusals)*

Adult Immunizations (65+): Pneumovax
GPRA: Pneumovax Ever or Refusal
*Refusal of Pneumovax Immunization

***GPRA Developmental: Pneumovax Ever (no refusals)*

Childhood Immunizations (19-35 months)

*Active Clinical Pts w/4:3:1:3:3

GPRA: Active IMM Pts w/4:3:1:3:3 or Refusal

**Active IMM Refusal of 4:3:1:3:3*

***GPRA Developmental: Active IMM 4:3:1:3:3 (no refusals)*

***GPRA Developmental: Active IMM Pts w/4:3:1:3:3:1 or Refusal*

**Active IMM Refusal of 4:3:1:3:3:1*

***GPRA Developmental: Active IMM Pts w/4:3:1:3:3:1 (no refusals)*

***GPRA Developmental: Active IMM Pts w/4:3:1:3:3:1:4 or Refusal*

**Active IMM Refusal of 4:3:1:3:3:1:4*

***GPRA Developmental: Active IMM Pts w/4:3:1:3:3:1:4 (no refusals)*

*4 DTaP

*3 Polio

*1 MMR

*3 HiB

*3 Hepatitis B

**1 Varicella*

**4 Pneumococcal*

CANCER SCREENING

Pap Smear Rates

GPRA: Pap Smear or Refusal

*Refusal of Pap Smear

***GPRA Developmental: Pap Smear (no refusals)*

Mammogram Rates

GPRA: Mammogram or Refusal

*Refusal of Mammogram

***GPRA Developmental: Mammogram (no refusals)*

Colorectal Cancer Screening

GPRA: Fecal Occult Blood Test during Report Period, Flexible Sigmoidoscopy or DCBE in past 5 years, or Colonoscopy in past 10 years, or Refusal

*Refusal of Colorectal Cancer Screening

***GPRA Developmental: Fecal Occult Blood Test during Report Period, Flexible Sigmoidoscopy or DCBE in past 5 years, or Colonoscopy in past 10 years (no refusals)*

*Fecal Occult Blood Test

Tobacco Use and Exposure Assessment

*Tobacco Assessment

*Tobacco Users

*Smokers

*Smokeless Users

*Exposed to Environmental Tobacco Smoke (ETS)

Tobacco Cessation

GPRA: Tobacco Cessation Counseling or Refusal or Smoking Cessation Aid
*Refusal of Tobacco Cessation Counseling
**GPRA Developmental: Tobacco Cessation Counseling or Smoking Cessation Aid (no refusals)*
*Quit Tobacco Use
**Tobacco Cessation Counseling or Refusal, Smoking Cessation Aid, or Quit Tobacco Use*

BEHAVIORAL HEALTH

Alcohol Screening (FAS Prevention)

GPRA: Alcohol Screening or Refusal
*Refusal of Alcohol Screening
**GPRA Developmental: Alcohol Screening (no refusals)*

Intimate Partner Violence/Domestic Violence Screening

GPRA: Intimate Partner Violence/Domestic Violence Screening or Refusal
*Refusal of Intimate Partner Violence/Domestic Violence Screening
**GPRA Developmental: Intimate Partner Violence/Domestic Violence Screening (no refusals)*

Depression Screening

GPRA: Depression Screening or Refusal or Mood Disorder Diagnosis
*Depression Screening
*Mood Disorder Diagnosis
*Refusal of Depression Screening
**GPRA Developmental: Depression Screening or Mood Disorder Diagnosis (no refusals)*

CARDIOVASCULAR DISEASE-RELATED

Obesity Assessment

*Obesity Assessment
*Assessed as Overweight
*Assessed as Obese
*Assessed as Overweight or Obese

Childhood Weight Control (Children 2-5)

**BMI 95% and Up (changed from annual to long-term GPRA measure)*
*BMI 85-94%
*BMI >= 85%

Comprehensive CVD-Related Assessment

GPRA: BP, LDL, and Tobacco Assessed, BMI or Refusal, and Lifestyle Counseling
**With Refusal of BMI*
**GPRA Developmental: BP, LDL, and Tobacco Assessed, BMI (no BMI refusals), and Lifestyle Counseling*
**With BMI (no refusals)*
*Depression Screen

STD GROUP

HIV Screening

GPRA: Prenatal HIV Screening or Refusal

*Refusal of HIV Screening

***GPRA Developmental: Prenatal HIV Screening (no refusals)*

OTHER CLINICAL

Breastfeeding Rates

Patients 45-394 days of age screened for infant feeding choice (IFC) at least once.

Patients 45-394 days of age screened for IFC at the age of two months.

Patients 45-394 days of age screened for IFC at the age of six months.

Patients 45-394 days of age screened for IFC at the age of nine months.

Patients 45-394 days of age screened for IFC at the age of one year.

****PART: 45-394 days of age who were exclusively or mostly breastfed at two months of age*

Patients 45-394 days of age who were exclusively or mostly breastfed at six months of age.

Patients 45-394 days of age who were exclusively or mostly breastfed at nine months of age.

Patients 45-394 days of age who were exclusively or mostly breastfed at the age of one year.

Definitions for all performance measure topics included in CRS begin on Page 8. Definitions for numerators and denominators that are preceded by "GPRA" represent measures that are reported to OMB and Congress. Definitions for numerators and denominators preceded by "PART" are reported for the OMB PART.

1.2 CRS Denominator Definitions

1.2.1 For All Denominators

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

1.2.2 Active Clinical Population for National GPRA and PART Reporting

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the *Clinical Reporting System (CRS) for FY2009 Clinical Measures User Manual* for listing of these clinics.
- Must be alive on the last day of the report period.
- Must be American Indian/Alaska Native (AI/AN) — defined as Beneficiary 01.
- Must reside in a community specified in the site's GPRA community taxonomy, defined as all communities of residence in the defined Contract Health Service (CHS) catchment area.

1.2.3 Active Clinical Population for Local Reports

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the CRS for FY2009 Clinical Measures User for listing of these clinics.
- Must be alive on the last day of the report period.
- User defines population type: AI/AN patients only, non-AI/AN, or both.
- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

1.2.4 User Population for National GPRA and PART Reporting

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

1.2.5 User Population for Local Reports

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

1.2.6 Active Clinical CHS Population for National GPRA and PART Reporting (CHS-only sites)

- Must have two CHS visits in the three years prior to the end of the report period, and the visits must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the report period.
- Must be AI/AN — defined as Beneficiary 01. This data item is entered and updated during the Patient Registration process.
- Must reside in a community included in the site's "official" GPRA community taxonomy, defined as all communities of residence in the CHS catchment area specified in the community taxonomy specified by the user.

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

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

2.0 CRS Selected Measures (Local) Report Performance Measure Topics and Definitions

The following sections define the performance measure topics and their definitions that are included in the CRS 2009 version 9.0 Selected Measures (Local) Report.

Note: ***Bold italic*** font indicates new or edited definitions

2.1 Diabetes Group

2.1.1 Diabetes Prevalence

No changes from Version 8.0 Patch 3.

Owner/Contact

Diabetes Program/Dr. Marie Russell

National Reporting

NATIONAL (included in National GPRA and PART Report; *not* reported to OMB and Congress)

Denominator

User Population patients

Numerator

1) Anyone diagnosed with diabetes (POV 250.00-250.93) ever.
2) Anyone diagnosed with diabetes during the report period.

Definition

1) Age is calculated at the beginning of the report period.
2) Diabetes diagnosis is defined as at least one diagnosis 250.00–250.93 recorded in the V POV file.

Patient List

Diabetic patients with most recent diagnosis.

2.1.2 Diabetes: Comprehensive Care

Changes from version 8.0 Patch 3 for A1c, LDL, and ESRD definitions, as noted in Diabetes: Glycemic Control, Diabetes: Nephropathy Assessment, Diabetes: LDL Assessment sections that follow.

Owner/Contact

Diabetes Program/Dr. Marie Russell

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

Denominator

Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) prior to the report period, *and* at least 2 visits in the past year, *and* 2 DM-related visits ever.

Numerators

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 controlled blood pressure during the report period, defined as < 130/80. This measure is not included in the comprehensive measure (numerator 8 below).
4) Patients with LDL completed during the report period, regardless of result
5) Patients with nephropathy assessment, defined as an estimated GFR and a quantitative urinary protein assessment during the report period *or* with evidence of diagnosis and/or treatment of ESRD at any time before the end of the report period.
6) Patients receiving a qualified retinal evaluation during the report period, or a documented refusal of a diabetic retinal exam.
7) Patients with diabetic foot exam during the report period, or a documented refusal of a diabetic foot exam.
8) Patients with A1c *and* Blood Pressure *and* LDL *and* Nephropathy Assessment *and* Retinal exam *and* Diabetic Foot Exam.

Definition

1) Diabetic Foot Exam:
   A) Exam Code 28 Diabetic Foot Exam, Complete;
   B) Non-DNKA visit with a podiatrist (provider codes 33, 84 or 25),
   C) Non-DNKA visit to Podiatry Clinic (clinic code 65),

D) CPT 2028F, or

E) Documented refusal of foot exam (Exam Code 28)

For other specific definitions, refer to the following topics below: Diabetes: Poor and Ideal Control; Diabetes: Blood Pressure Control; Diabetes: LDL Assessment; Diabetes: Nephropathy Assessment; Diabetic Retinopathy

Patient List

Diabetic patients with documented tests, if any.

2.1.3 Diabetes: Glycemic Control

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Diabetes Program/Dr. Marie Russell

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

1) GPRA: Active Diabetic patients; defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) 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.
2) All User Population patients diagnosed with diabetes prior to the report period.
3) Active Adult Diabetic patients, defined by meeting the following criteria:
   A) who are 19 or older at the beginning of the report period,
   B) whose first ever DM diagnosis occurred prior to the report period;
   C) who had at least 2 DM related visits ever,
   D) at least one encounter with DM POV in a primary clinic with a primary provider during the report period; and
   E) never have had a creatinine value greater than 5.

Numerators

1) Hemoglobin A1c documented during the Report Period.
2) **GPRA**: Poor control: A1c greater than (>) 9.5.
3) Very poor control: A1c equals or greater than (=>) 12.
4) Poor control: A1c greater than (>) 9.5 and less than (<) 12.
5) Fair control A1c equals or greater than (=>) 8 and less than or equal to (<=) 9.5.
6) Good control: A1c equals or greater than (=>) 7 and less than (<) 8
7) **GPRA**: Ideal control: A1c less than (<) 7.
8) Undetermined A1c (no result).

Definition

1) **Diabetes**: First Purpose of Visit 250.00-250.93 recorded in the V POV file prior to the Report Period.
2) **Serum Creatinine**: site-populated taxonomy DM AUDIT CREATININE TAX; or LOINC taxonomy

> **Note**: CPT codes are not included since they do not store the result, which is used in this topic.

3) Searches for most recent A1c test with a result during the report period. ***If more than one A1c test is found on the same day and/or the same visit and one test has a result and the other does not, the test with the result will be used. If an***

A1c test with a result is not found, CRS searches for the most recent A1c test without a result. A1c defined as: CPT 83036, 83037, or 3044F-3047F; LOINC taxonomy; or site-populated taxonomy DM AUDIT HGB A1C TAX. Without result is defined as A1c documented but with no value. CPT 3044F represents A1c < 7 and will be included in the Ideal Control numerator.

GPRA 2009 Description:

Poor Glycemic Control: During FY 2009, achieve the target rate of 18% for the proportion of patients with diagnosed diabetes who have poor glycemic control (defined as A1c > 9.5).

Ideal Glycemic Control: During FY 2009, achieve the target rate of 30% for the proportion of patients with diagnosed diabetes who have ideal glycemic control (defined as A1c < 7).

Patient List

Diabetic patients with most recent A1c value, if any.

2.1.4 Diabetes: Blood Pressure Control

No change from version 8.0 Patch 3.

Owner/Contact

Diabetes Program/Dr. Marie Russell

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

Three denominators (see Diabetes: Poor Glycemic Control topic)

Numerators

1) Total with BP value (at least two (three if available) non-ER BPs documented during the Report Period).
2) **GPRA**: Controlled BP, < 130/80.
3) Not controlled BP.

Definitions

1) **Diabetes**: First DM Purpose of Visit 250.00–250.93 recorded in the V POV file prior to the Report Period.
2) **Serum Creatinine**: site-populated taxonomy DM AUDIT CREATININE TAX; or LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

3) **BP documented**: CRS uses mean of last three Blood Pressures (BPs) documented on non-ER visits during the Report Period. If three BPs are not available, uses mean of last two non-ER BPs. If a visit contains more than one 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) BPs and dividing by 3 (or 2).
4) **Controlled BP**: CRS uses a mean, as described above where BP is <130/80. If the mean systolic and diastolic values do not *both* meet the criteria for controlled, then the value is considered not controlled. If CRS is not able to calculate a mean BP, it will search for the most recent of any of the following CPT codes documented on non-ER visits during the report period: 3074F, 3075F, 3077F, 3078F, 3079F, and 3080F. The systolic and diastolic values do *not* have to be recorded on the same day. If there are multiple values on the same day, the CPT indicating the lowest value will be used. The following combination represents BP <130/80 and will be included in the numerator: CPT 3074F *and* 3078F. All other combinations will *not* be included in the numerator.

GPRA 2009 Description:

During FY 2009, achieve the target rate of 36% for the proportion of patients with diagnosed diabetes who have achieved blood pressure control (defined as <130/80).

Patient List

Diabetic patients with mean BP, if any.

2.1.5 Diabetes: LDL Assessment

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Diabetes Program/Dr. Marie Russell

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

Three denominators (see Diabetes: Poor Glycemic Control topic)

Numerators

1) GPRA: Patients with LDL completed during the report period, regardless of result.
2) LDL < 130; 2A) LDL <= 100; 2B) LDL 101-129details

Definitions

1) Diabetes: First DM Purpose of Visit 250.00-250.93 recorded in the V POV file prior to the report period.
2) Serum Creatinine: site-populated taxonomy DM AUDIT CREATININE TAX; or LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

3) LDL Definition: CPT 80061, 83700, 83701, 83704, 83715 (old code), 83716 (old code), 83721, 3048F, 3049F, 3050F; LOINC taxonomy; site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX. For numerator LDL <130, CPT 3048F and 3049F will count as meeting the measure. For numerator LDL =<100, CPT 3048F will count as meeting the measure.
   Searches for most recent LDL test with a result during the report period***. If more than one LDL test is found on the same day and/or the same visit and one test has a result and the other does not, the test with the result will be used. If an LDL test with a result is not found***, CRS searches for the most recent LDL test without a result.

GPRA 2009 Description:

During FY 2009 achieve the target rate of 60% the proportion of patients with diagnosed diabetes who are assessed for dyslipidemia (LDL cholesterol).

Patient List

Diabetic patients with documented LDL cholesterol test, if any.

2.1.6 Diabetes: Nephropathy Assessment

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Diabetes Program/Dr. Marie Russell

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

Three denominators (see Diabetes: Poor Glycemic Control topic).

Numerator

1) GPRA: Patients with nephropathy assessment, defined as an estimated GFR AND a quantitative urinary protein assessment during the report period or with evidence of diagnosis and/or treatment of ESRD at any time before the end of the report period.

Definitions

1) **Diabetes:** First DM Purpose of Visit 250.00-250.93 recorded in the V POV file prior to the Report period.
2) **Serum Creatinine:** site-populated taxonomy DM AUDIT CREATININE TAX; or LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

3) **Nephropathy assessment:**

(1) Estimated GFR with result during the report period, defined as any of the following: (A) Site-populated taxonomy BGP GPRA ESTIMATED GFR TAX or (B) LOINC taxonomy, *and*

(2) Quantitative Urinary Protein Assessment during the report period, defined as any of the following: (A) CPT 82042, 82043, or 84156; (B) LOINC taxonomy ***(added codes 53121-0, 53530-2, 53531-0, and 53532-8);*** or (C) site-populated taxonomy BGP QUANT URINE PROTEIN; *or*

Note: Be sure and check with your laboratory supervisor that the names you add to your taxonomy reflect quantitative test values.

(3) End Stage Renal Disease diagnosis/treatment defined as any of the following ever: A) V CPT 36145, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, ***90951-90970 (old codes)*** 90918-90925, 90935, 90937, 90939 ***(old code)***, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, G0257, G0308-G0327, ***G0392, G0393***, or

S9339; B) V POV 585.5, 585.6, V42.0, V45.1 ***(old code)***, ***V45.11, V45.12***, or V56.*; C) V Procedure 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6*.

GPRA 2009 Description:

During FY 2009, achieve the target rate of 47% for the proportion of patients with diagnosed diabetes who are assessed for nephropathy.

Patient List

Diabetic patients with nephropathy assessment, if any.

2.1.7 Diabetic Retinopathy

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Diabetes Program/Dr. Mark Horton

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

Three denominators (see Diabetes: Poor Glycemic Control topic).

Numerators

1) GPRA: Patients receiving a qualified retinal evaluation* during the report period, or a documented refusal of a diabetic retinal exam.
   A) Patients receiving diabetic retinal exam during the report period.
   B) Patients who refused a diabetic retinal exam during the report period.
   C) Patients receiving other eye exams during the report period.
2) ***GPRA Developmental Numerator: Patients receiving a qualified retinal evaluation during the report period.***

Note: This numerator does *not* include refusals.

Definitions

1) **Diabetes**: First DM Purpose of Visit 250.00-250.93 recorded in the V POV file prior to the report period.
2) **Serum Creatinine**: site-populated taxonomy DM AUDIT CREATININE TAX; or LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

3) **Qualified retinal evaluation*** is defined as: A) diabetic retinal exam or documented refusal or B) other eye exam.

A) **Diabetic Retinal Exam**: Any of the following during the report period: 1) Exam Code 03 Diabetic Eye Exam (dilated retinal examination ***or validated photographic equivalent***) or Refusal of Exam 03, 2) CPT 2022F Dilated retinal eye exam; 2024F Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist; 2026F Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos; S0620 Routine ophthalmological examination including refraction; new patient; S0621 Routine ophthalmological examination including refraction; established patient; S3000 Diabetic indicator; retinal eye exam, dilated, bilateral.

B) **Other Eye Exam**: (1) Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or validated teleophthalmology retinal evaluation clinics (e.g. JVN, Inoveon, EyeTel, etc.) or (2) non-DNKA visits to an optometrist or ophthalmologist. Searches for the following codes in the following order: Clinic Codes A2, 17, 18, 64; Provider Code 24, 79, 08; CPT 67028, 67038, 67039, 67040, 92002, 92004, 92012, 92014; POV V72.0; Procedure 95.02.

***Qualifying retinal evaluation**: The following methods are qualifying for this measure:

- Dilated retinal evaluation by an optometrist or ophthalmologist.
- Seven standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist.
- Any photographic method formally validated to ETDRS, e.g. JVN, Inoveon, EyeTel, etc.

GPRA 2009 Description:

During FY 2009, achieve the target rate of 47% for the proportion of patients with diagnosed diabetes who receive an annual retinal examination.

Patient List

Diabetic patients with qualified retinal evaluation or refusal, if any.

2.1.8 Diabetic Access to Dental Services

No changes from version 8.0 Patch 3.

Owner/Contact

Dental Program/Dr. Patrick Blahut

National Reporting

Not reported nationally

Denominator

Active Diabetic patients (see Diabetes Comprehensive Care topic for definition).

Numerators

Patients with a documented dental visit during the report period, including refusals.

A) Patients with documented refusal during the report period.

Definitions

1) **Dental Visit**: For non-CHS visits, searches for V Dental ADA Code 0000 or 0190; Exam Code 30; or POV V72.2. 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 refusal of Exam Code 30 or ADA code 0000 or 0190.

Patient List

Diabetic patients and documented dental visit or refusal, if any.

2.2 Dental Group

2.2.1 Access to Dental Services

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Dental Program/Dr. Patrick Blahut

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominator

GPRA: User Population patients, broken down by age groups: 0-5, 6-11, 12-19, 20-34, 35-44, 45-54, 55-74, 75 and older.

Numerators

1) **GPRA**: Patients with documented dental visit during the report period, including refusals.
   A) Patients with documented refusal.
2) ***GPRA Developmental Numerator: Patients with documented dental visit during the report period.***

Note: This numerator does *not* include refusals.

Definitions

1) **Diabetes**: First DM Purpose of Visit 250.00-250.93 recorded in the V POV file prior to the Report period.
2) For non-CHS dental visits, searches for V Dental ADA codes 0000 or 0190 or refusal of ADA code 0000 or 0190; VExam 30 or Refusal Exam 30; or POV V72.2. For CHS dental visits, searches for any visit with an ADA code. CHS visit defined as Type code of C in Visit file.

GPRA 2009 Description:

During FY 2009, achieve the target rate of 24% for the proportion of patients who receive dental services.

Patient List

Patients with documented dental visit or refusal and date.

2.2.2 Dental Sealants

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Dental Program/Dr. Patrick Blahut

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominator

None

Numerators

1) ***GPRA***: Count only (no percentage comparison to denominator). For patients meeting the User Population definition, the total number of dental sealants and refusals during the report period. Age breakouts (HP 2010): <12; 12-18; >18.
   A) Number of documented refusals.
2) ***GPRA Developmental Numerator: for patients meeting the User Population definition, the total number of dental sealants during the report period.***

Note: This numerator does *not* include refusals.

Definitions

1) **Dental Sealant**: ADA code 1351. Only two sealants per tooth will be counted during the report period. Each tooth is identified by the data element Operative Site in RPMS.
2) **Refusal of Dental Sealant**: Refusal of ADA code 1351. Refusals are only counted if a patient did not have a sealant during the report period. If a patient had both a sealant and a refusal, only the sealant will be counted. If a patient has multiple refusals, only one refusal will be counted.

GPRA 2009 Description:

During FY 2009, achieve the target count of 229,147 sealants placed in AI/AN patients.

Patient List

Patients who received or refused dental sealants during report period.

2.2.3 Topical Fluoride

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Dental Program/Dr. Patrick Blahut

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominator

None

Numerators

1) **GPRA**: Count only (no percentage comparison to denominator). For patients meeting the User Population definition, the total number of patients with at least one topical fluoride treatment or refusal during the report period.
   A) Patients with documented refusal in past year.
2) ***GPRA Developmental Numerator: For patients meeting the User Population definition, the total number of patients with at least one topical fluoride treatment during the report period.***

Note: This numerator does *not* include refusals.

Definitions

1) **Topical Fluoride Application**: V Dental ADA codes 1201 (old code), 1203, 1204, 1205 (old code), or 1206; 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.
2) **Refusal of Topical Fluoride Application**: Refusal of ADA code 1201 (old code), 1203, 1204, 1205 (old code), or 1206. Refusals are only counted if a patient did not have a topical fluoride application during the report period. If a patient had both an application and a refusal, only the application will be counted. If a patient has multiple refusals, only one refusal will be counted.

GPRA 2009 Description:

During FY 2009, achieve the target count of 114,716 AI/AN patients who receive at least one topical fluoride application.

Patient List

Patients who received or refused at least one topical fluoride application during report period.

2.3 Immunization Group

2.3.1 Adult Immunizations: Influenza

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Epidemiology Program/Amy Groom, MPH

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

1) Active Clinical patients ages 50 or older.
   A) Ages 50-64.
   B) **GPRA**: Ages 65 and older.
2) Active Diabetic patients (see Diabetes Comprehensive Care above for definition).

Numerators

1) GPRA: Patients with influenza vaccine or refusal documented during the report period or with a contraindication documented at any time before the end of the report period.
   A) Patients with documented refusal.
   B) Patients with a contraindication or a documented NMI refusal.
2) ***GPRA Developmental Numerator: Patients with influenza vaccine documented during the report period or with a contraindication documented at any time before the end of the report period.***

Note: This numerator does *not* include refusals.

Definitions

1) **Influenza Vaccine**: Any of the following during the report period:
   A) Immunization/CVX codes 15, 16, 88, or 111;
   B) POV V04.8 (old code), V04.81, V06.6;
   C) CPT 90655-90662 (old code), G0008, G8108;
   D) ICD Procedure 99.52.
2) **Contraindication to Influenza Vaccine**: Any of the following documented at any time before the end of the report period:
   A) Contraindication in the Immunization Package of "Egg Allergy" or "Anaphylaxis," or
   B) PCC NMI Refusal.

3) **Refusal of Influenza Vaccine**:
   A) Refusal of immunization/CVX codes 15, 16, 88, or 111 as documented in PCC Refusal File (i.e., REF), or
   B) In the Immunization Package as contraindication of "Patient Refusal."

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 62% for the proportion of non-institutionalized adults aged 65 years and older who receive an influenza immunization.

Patient List

Patients ages 50 or older OR with diabetes diagnosis with influenza code and date, if any.

2.3.2 Adult Immunizations: Pneumovax

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Epidemiology Program/Amy Groom, MPH

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

1) **GPRA**: Active Clinical patients ages 65 or older.
2) Active Diabetic patients (see Diabetes: Comprehensive Care for definition).

Numerators

1) **GPRA**: Patients with Pneumococcal vaccine or contraindication documented at any time before the end of the report period or with a refusal in the past year.
   A) Documented REF or NMI.
   B) Contraindication or a documented NMI refusal.
2) ***GPRA Developmental Numerator: Patients with Pneumococcal vaccine or contraindication documented at any time before the end of the report period.***

Note: This numerator does *not* include refusals.

3) For Active Diabetics denominator only. Patients with pneumovax documented in past five years or who have refused a pneumovax vaccine in the past year.
   A) Documented REF or NMI.
   B) Contraindication or a documented NMI refusal.

Definitions

1) **Pneumovax Vaccine**:
   A) Immunization/CVX codes 33, 100, 109;
   B) POV V06.6, V03.82;
   C) ICD Procedure 99.55;
   D) CPT 90732, 90669, G0009, G8115.
2) **Contraindication to Pneumovax Vaccine**:
   A) Contraindication in the Immunization Package of "Anaphylaxis," or
   B) PCC NMI Refusal.
3) **Refusal of Pneumovax Vaccine:**
   A) Immunization codes 33, 100, or 109, as documented in PCC Refusal File (i.e., REF) or
   B) Immunization Package contraindication of "Patient Refusal."

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 82% for the proportion of adult patients age 65 years and older who receive a pneumococcal immunization.

Patient List

Patients 65 or older *or* with diabetes diagnosis, with date of pneumovax, contraindication, or refusal, if any.

2.3.3 Childhood Immunizations

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Epidemiology Program/Amy Groom, MPH

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

1) Active Clinical patients ages 19-35 months at end of report period.
2) GPRA: User Population 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.

Numerators

1) **GPRA**: 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.
2) ***GPRA Developmental Numerator****: 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 contraindications and evidence of disease.*

Note:	This numerator does *not* include refusals.

3) ***GPRA Developmental Numerator***: Patients who have received the 4:3:1:3:3:1 combination (i.e., 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B, 1 Varicella), including refusals, contraindications, and evidence of disease.
4) ***GPRA Developmental Numerator: Patients who have received the 4:3:1:3:3:1 combination (i.e., 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B, 1 Varicella), including contraindications and evidence of disease.***

Note:	This numerator does *not* include refusals.

5) ***GPRA Developmental Numerator***: Patients who have received the 4:3:1:3:3:1:4 combination (i.e., 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B, 1 Varicella, and 4 Pneumococcal), including refusals, contraindications, and evidence of disease.

6) GPRA Developmental Numerator: Patients who have received the 4:3:1:3:3:1:4 combination (i.e., 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B, 1 Varicella, and 4 Pneumococcal), including contraindications and evidence of disease.

Note: This numerator does *not* include refusals.

7) Patients with 4 doses of DTaP, or who have (***DELETED: evidence of the disease***), a contraindication, or a documented refusal.
8) Patients with 3 doses of Polio, or who have evidence of the disease, a contraindication, or a documented refusal.
9) Patients with 1 dose of MMR, or who have evidence of the disease, a contraindication, or a documented refusal.
10) Patients with 3 doses of HiB, or (***DELETED: who have evidence of the disease***), a contraindication, or a documented refusal.
11) Patients with 3 doses of Hepatitis B, or who have evidence of the disease, a contraindication, or a documented refusal.
12) Patients with 1 dose of Varicella, or who have evidence of the disease, a contraindication, or a documented refusal.
13) Patients with 4 doses of Pneumococcal conjugate, or who have evidence of the disease, a contraindication, or a documented refusal.
Also included for numerators 1–13 are the following subnumerators *(exceptions are items 2, 4, and 6)*:
    A) Patients with a documented refusal.
    B) Patients with either (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.
14) **Immunization Program Numerator**: 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.
15) **Immunization Program Numerator**: Patients who have received the 4:3:1:3:3:1 combination (i.e., 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B, and 1 Varicella), *not* including refusals, contraindications, and patients with evidence of disease.
16) **Immunization Program Numerator**: Patients who have received the 4:3:1:3:3:1:4 combination (i.e., 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B, 1 Varicella, and 4 Pneumococcal), *not* including refusals, contraindications, and patients with evidence of disease.

Definitions

1) **Patient Age**: Since the age of the patient is calculated at the beginning of the report period, the age range will be adjusted to 7–23 months at the beginning of the report period, which makes the patient between the ages of 19–35 months at the end of the report period.

2) **Timing of Doses**: Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization.
3) **Active Immunization Package Patients Denominator**: Same as User Population definition *except* includes only patients flagged as active in the Immunization Package.

> **Note:** Only values for the current period will be reported for this denominator since currently there is not a way to determine if a patient was active in the Immunization Package during the previous year or baseline periods.

4) Dosage and Types of Immunizations:

A) **4 Doses of DTaP**:

1) 4 DTaP/DTP/Tdap;
2) 1 DTaP/DTP/Tdap and 3 DT/Td;
3) 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus;
4) 4 DT and 4 Acellular Pertussis;
5) 4 Td and 4 Acellular Pertussis; or
6) 4 each of Diphtheria, Tetanus, and Acellular Pertussis.

B) **3 Doses of Polio**:

1) 3 OPV;
2) 3 IPV; or
3) combination of OPV and IPV totaling 3 doses.

C) **1 Dose of MMR**:

1) MMR;
2) 1 M/R and 1 Mumps;
3) 1 R/M and 1 Measles; or
4) 1 each of Measles, Mumps, and Rubella.

D) 3 doses of Hep B OR 2 doses IF documented with CPT 90743.

E) 3 doses of HIB

F) 1 dose of Varicella

G) 4 doses of Pneumococcal

5) **Refusal, Contraindication, and Evidence of Disease Information**: Except for the Immunization Program Numerators, refusals, evidence of disease and contraindications for individual immunizations will also count toward meeting the definition, as defined below.

A) Each immunization must be refused and documented separately. For example, if a patient refused Rubella only, then there must be an immunization, contraindication, or separate refusal for the Measles and Mumps immunizations.

B) For immunizations where required number of doses is >1, only one refusal is necessary to be counted in the numerator. For example, if there is a single refusal for Hepatitis B, the patient will be included in the numerator.

C) For immunizations where required number of doses is >1, only one contraindication is necessary to be counted in the numerator. For example, if there is a single contraindication for HiB, the patient will be included in the numerator.

D) Evidence of disease will be checked for at any time in the child's life (prior to the end of the report period.).

E) To be counted in subnumerator A, a patient ***must meet the numerator definition*** *and* have a REF refusal in PCC or a Parent or Patient Refusal in the IZ program for any of the immunizations in the numerator. For example, if a patient refused Rubella only but had immunizations for Measles and Mumps, the patient would be included in subnumerator A.

F) To be counted in subnumerator B, a patient ***must meet the numerator definition*** *and* have evidence of disease, a contraindication, or an NMI refusal for any of the immunizations in the numerator. For example, if a patient was Rubella immune but had a Measles and Mumps immunization, the patient would be included in subnumerator B.

6) Refusal Definitions: Refusal Definitions: Parent/Patient Refusal in Immunization package or PCC Refusal type REF or NMI for IZ codes: DTaP: 20, 50, 106, 107, 110, 120, **130**; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113; Tetanus: 35, 112; Acellular Pertussis: 11: OPV: 2, 89; IPV: 10, 89, 110, 120; MMR: 3, 94: M/R: 4; R/M: 38; Measles: 5; Mumps: 7; Rubella: 6; HiB: 17, 22, 46-49; 50, 51, 102, 120; Hepatitis B: 8, 42-45, 51, 102, 104, 110; Varicella: 21, 94; Pneumococcal: 33, 100, 109.

Note: In the definitions for all immunizations shown below, the Immunization Program Numerators will include only CVX and CPT codes.

– DTaP IZ definitions: 1) Immunization (CVX) codes: 20, 50, 106, 107, 110, 120, 130; 2) POV V06.1; 3) CPT: 90696, 90698, 90700, 90721, 90723. DTaP contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

– DTP IZ definitions: 1) Immunization (CVX) codes: 1, 22, 102; 2) POV: V06.1, V06.2, V06.3; 3) CPT: 90701, 90711 (old code), 90720; 4) Procedure 99.39. DTP contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

7) Immunization Definitions:

Note: In the definitions for all immunizations shown below, the Immunization Program Numerators will include only CVX and CPT codes.

A) **DTaP**:

1) Immunization (CVX) codes: 20, 50, 106, 107, 110, 120, 130;

2) POV V06.1;

3) CPT: 90696, 90698, 90700, 90721, 90723. DTaP contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

DTaP contraindication definition: 1) Immunization Package contraindication of “Anaphylaxis.”

B) **DTP**:

1) Immunization (CVX) codes: 1, 22, 102;
2) POV: V06.1, V06.2, V06.3;
3) CPT: 90701, 90711 (old code), 90720;
4) Procedure 99.39.

DTP contraindication definition: 1) Immunization Package contraindication of “Anaphylaxis.”

C) **Tdap**:

1) Immunization (CVX) code: 115;
2) CPT 90715.

Tdap contraindication definition: 1) Immunization Package contraindication of “Anaphylaxis.”

D) **DT**:

1) Immunization (CVX) code 28;
2) POV V06.5; 3) CPT 90702.

DT contraindication definition: 1) Immunization Package contraindication of “Anaphylaxis.”

E) **Td**:

1) Immunization (CVX) code 9, 113;
2) POV V06.5; 3) CPT 90714, 90718.

Td contraindication definition: 1) Immunization Package contraindication of “Anaphylaxis.”

F) **Diphtheria**:

1) POV V03.5;

2) CPT 90719;

3) Procedure 99.36.

(DELETED: Diphtheria evidence of disease definitions: POV or PCC Problem List (active or inactive) V02.4, 032*).

Diphtheria contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

G) **Tetanus**:

1) Immunization (CVX) codes: 35, 112;

2) POV V03.7,

3) CPT 90703;

4) Procedure *99.38.*

(DELETED: Tetanus evidence of disease definition: POV or PCC Problem List (active or inactive) 037*).

Tetanus contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

H) **Acellular Pertussis**:

1) Immunization (CVX) code 11;

2) POV V03.6;

3) Procedure 99.37 ***(old code).***

Acellular Pertussis contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

I) **OPV**:

1) Immunization (CVX) codes:
2, 89; 2) CPT 90712.

OPV contraindication definitions: POV: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; or Immunization Package contraindication of “Anaphylaxis.”

J) **IPV**:

1) Immunization (CVX) codes: 10, 89, 110, 120, 130;

2) POV V04.0, V06.3;

3) CPT: 90696, 90698, 90711 (old code), 90713, 90723;

4) Procedure 99.41.

IPV evidence of disease definitions: POV or PCC Problem List (active or inactive): ***(DELETED: V12.02, 045*, 138)***, 730.70-730.79. IPV contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis" or "Neomycin Allergy."

K) **MMR**:

1) Immunization (CVX) codes: 3, 94;
2) POV V06.4;
3) CPT: 90707, 90710;
4) Procedure 99.48.

MMR contraindication definitions: POV: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; or Immunization Package contraindication of "Anaphylaxis," "Immune Deficiency," "Immune Deficient," or 'Neomycin Allergy."

L) **M/R**:

1) Immunization (CVX) code 4;
2) CPT 90708.

M/R contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

M) **R/M**:

1) Immunization (CVX) code 38;
2) CPT 90709 (old code).

R/M contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

N) **Measles**:

1) Immunization (CVX) code 5;
2) POV V04.2;
3) CPT 90705;
4) Procedure 99.45.

Measles evidence of disease definition: POV or PCC Problem List (active or inactive) 055*.

Measles contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

O) **Mumps**:

1) Immunization (CVX) code 7;
2) POV V04.6;
3) CPT 90704;
4) Procedure 99.46.

Mumps evidence of disease definition: POV or PCC Problem List (active or inactive) 072*.

Mumps contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

P) **Rubella**:

1) Immunization (CVX) code 6;
2) POV V04.3;
3) CPT 90706;
4) Procedure 99.47.

Rubella evidence of disease definitions: POV or PCC Problem List (active or inactive) 056*, 771.0.

Rubella contraindication definition: 1) Immunization Package contraindication of “Anaphylaxis.”

Q) **HiB**:

1) Immunization (CVX) codes: 17, 22, 46-49, 50, 51, 102, 120;

2) POV V03.81;

3) CPT: 90645-90648, 90698, 90720-90721, 90737 ***(old code)***, 90748.

(DELETED: HiB evidence of disease definitions: POV or PCC Problem List (active or inactive) 038.41, 041.5, 320.0, 482.2).

Hib contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

R) **Hepatitis B**:

1) Immunization (CVX) codes: 8, 42-45, 51, 102, 104, 110;

2) CPT: 90636, 90723, 90731 (old code), 90740, 90743-90748, G0010, Q3021 ***(old code),*** *Q3023* ***(old code).***

Hepatitis B evidence of disease definitions: POV or PCC Problem List (active or inactive): V02.61, 070.2, 070.3. Hepatitis B contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

S) **Varicella**:

1) Immunization (CVX) codes: 21, 94;
2) POV V05.4;
3) CPT: 90710, 90716.

Varicella evidence of disease definitions: 1) POV or PCC Problem List (active or inactive) 052*, 053* or 2) Immunization Package contraindication of “Hx of Chicken Pox” or “Immune.”

Varicella contraindication definitions: POV: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; or Immunization Package contraindication of “Anaphylaxis,” “Immune Deficiency,” “Immune Deficient,” or “Neomycin Allergy.”

T) **Pneumococcal**:

1) Immunization (CVX) codes: 33 Pneumo Polysaccaride; 100 Pneumo Conjugate; 109 Pneumo NOS;
2) POV: V06.6; V03.82;
3) CPT: 90669, 90732, G0009, G8115.

Pneumococcal contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 78% for the proportion of AI/AN children ages 19–35 months who have received the recommended immunizations.

Patient List

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.

Note:	Because age is calculated at the beginning of the report period, the patient's age on the list will be between 7–23 months

2.3.4 Adolescent immunizations

No Changes from version 8.0 Patch 3.

Owner/Contact

Epidemiology Program/Dr. Scott Hamstra, Amy Groom, MPH

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

Denominators

1) Active Clinical patients age 13.
2) Female Active Clinical patients age 13.
3) Active Clinical patients ages 13-17.
4) Female Active Clinical patients ages 13-17.

Numerators

1) Patients who have received the 2:3:1 combination (i.e., 2 MMR, 3 Hepatitis B, and 1 Varicella), including refusals, contraindications, and evidence of disease.
2) Patient who have received the 1:3:2:1 combination (i.e., 1 Td/Tdap, 3 Hepatitis B, 2 MMR, 1 Varicella), including refusals, contraindications, and evidence of disease.
3) Patients who have received 1 dose of Tdap/Td ever, including refusals, contraindications, and evidence of disease.
   A) Patients with documented REF refusal in PCC or Parent or Patient refusal in the IZ program.
   B) Patients with either (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI (not medically indicated) refusal.
   C) Patients who have received 1 dose of Tdap ever, including refusals, contraindications, and evidence of disease.
4) Patients who have received 2 doses of MMR ever, including refusals, contraindications, and evidence of disease.
5) Patients who have received 3 doses of Hepatitis B ever, including refusals, contraindications, and evidence of disease.
6) Patients who have received 1 dose of Varicella ever, including refusals, contraindications, and evidence of disease.
7 Patients who have received 1 dose of meningococcal ever, including refusals, contraindications, and evidence of disease.
7) Patients who have received 3 doses of HPV ever, including refusals, contraindications, and evidence of disease.

Note: Included for Female Active Clinical age 13 and Female Active Clinical ages 13–17 only.

Also included for numerators 1-8 are subnumerators:

A) Patients with a documented refusal.

B) Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

Definitions

1) **Timing of Doses**: Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization.
2) **Dosage and Types of Immunizations**:
   A) 1 dose of Td or Tdap
   B) 2 doses of MMR:
      1) 2 MMRs;
      2) 2 M/R and 2 Mumps;
      3) 2 R/M and 2 Measles; or
      4) 2 each of Measles, Mumps, and Rubella.
   C) 3 doses of Hep B OR 2 doses IF documented with CPT 90743.
   D) 1 dose of Varicella
   E) 1 dose of Meningococcal
   F) 3 doses of HPV
3) **Refusal, Contraindication, and Evidence of Disease Information**: Refusals, evidence of disease, and contraindications for individual immunizations will also count toward meeting the definition, as defined below.
   A) Each immunization must be refused and documented separately. For example, if a patient refused Rubella only, then there must be an immunization, contraindication, or separate refusal for the Measles and Mumps immunizations.
   B) For immunizations where required number of doses is >1, only one refusal is necessary to be counted in the numerator. For example, if there is a single refusal for Hepatitis B, the patient will be included in the numerator.
   C) For immunizations where required number of doses is >1, only one contraindication is necessary to be counted in the numerator. For example, if there is a single contraindication for HiB, the patient will be included in the numerator.
   D) Evidence of disease will be checked for at any time in the child's life (prior to the end of the report period.)
   E) To be counted in sub-numerator A, a patient must have a REF refusal in PCC or a Parent or Patient Refusal in the IZ program for any of the immunizations in the numerator. For example, if a patient refused Rubella only but had immunizations for Measles and Mumps, the patient would be included in sub-numerator A.

F) To be counted in sub-numerator B, a patient must have evidence of disease, a contraindication, or an NMI refusal for any of the immunizations in the numerator. For example, if a patient was Rubella immune but had a Measles and Mumps immunization, the patient would be included in subnumerator B.

4) **Refusal Definitions**: Parent/Patient Refusal in Immunization package or PCC Refusal type REF or NMI for IZ codes: MMR: 3, 94: M/R: 4; R/M: 38; Measles: 5; Mumps: 7; Rubella: 6; Hepatitis B: 8, 42-45, 51, 102, 104, 110; Varicella: 21, 94; Tdap: 115; Td: 9, 113; Meningococcal: 32, 108, 114, HPV: 62, 118.

5) **Immunization Definitions**:

A) **MMR**:

1) Immunization (CVX) codes: 3, 94;
2) POV V06.4;
3) CPT: 90707, 90710;
4) Procedure 99.48.

MMR contraindication definitions: POV: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; or Immunization Package contraindication of "Anaphylaxis," "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."

B) **M/R**:

1) Immunization (CVX) code 4;
2) CPT 90708.

M/R contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

C) **R/M**:

1) Immunization (CVX) code 38;
2) CPT 90709 (old code).

R/M contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

D) **Measles**:

1) Immunization (CVX) code 5;
2) POV V04.2;
3) CPT 90705;
4) Procedure 99.45.

Measles evidence of disease definition: POV or PCC Problem List (active or inactive) 055*.

Measles contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

E) **Mumps**:

1) Immunization (CVX) code 7;
2) POV V04.6;
3) CPT 90704;
4) Procedure 99.46.

Mumps evidence of disease definition: POV or PCC Problem List (active or inactive) 072*.

Mumps contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

F) **Rubella**:

1) Immunization (CVX) code 6;
2) POV V04.3;
3) CPT 90706;
4) Procedure 99.47.

Rubella evidence of disease definitions: POV or PCC Problem List (active or inactive) 056*, 771.0.

Rubella contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

G) **Hepatitis B**:

1) Immunization (CVX) codes: 8, 42-45, 51, 102, 104, 110;
2) CPT: 90636, 90723, 90731 (old code), 90740, 90743-90748, G0010, Q3021, Q3023.

Hepatitis B evidence of disease definitions: POV or PCC Problem List (active or inactive): V02.61, 070.2, 070.3.

Hepatitis B contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

H) **Varicella**:

1) Immunization (CVX) codes: 21, 94;
2) POV V05.4; 3) CPT: 90710, 90716.

Varicella evidence of disease definitions: 1) POV or PCC Problem List (active or inactive) 052*, 053* or 2) Immunization Package contraindication of "Hx of Chicken Pox" or "Immune."

Varicella contraindication definitions: POV: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; or Immunization Package contraindication of "Anaphylaxis," "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."

I) **Tdap**:

1) Immunization (CVX) code: 115;
2) CPT 90715.

Tdap contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

J) **Td**:

1) Immunization (CVX) code 9, 113;
2) POV V06.5;
3) CPT 90714, 90718.

Td contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

K) **Meningococcal**:

1) Immunization (CVX) codes: 32, 108, 114;
2) CPT 90733, 90734.

Meningococcal contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

L) **HPV**:

1) Immunization (CVX) codes: 62, 118; 2) CPT 90649, 90650.

HPV contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."

Patient List

Patients 13-17 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 Hep B, no IZ will be listed for Hep B.

2.4 Childhood Diseases Group

2.4.1 Appropriate Treatment for Children with Upper Respiratory Infection

No changes from version 8.0 Patch 3.

Owner/Contact

Dr. Scott Hamstra

National Reporting

Not reported Nationally

Denominator

Active Clinical patients who were ages 3 months through 18 years who were diagnosed with an upper respiratory infection during the period six months (180 days) prior to the report period through the first six months of the report period.

Numerator

Patients who were *not* prescribed an antibiotic on or within three days after diagnosis. In this measure, appropriate treatment is not to receive an antibiotic.

Definitions

1) Age: Age is calculated as follows: Children 3 months as of six months (180 days) of the year prior to the Report period to 18 years as of the first six months of the report period.
2) Upper Respiratory Infection: POV 460 or 465.*.
3) Outpatient Visit: Service Category A, S, or O.
4) Antibiotic Medications:
   A) Medication taxonomy BGP HEDIS ANTIBIOTIC MEDS. (Medications are: Amoxicillin, Amox/Clavulanate, Ampicillin, Azithromycin, Cefaclor, Cefadroxil hydrate, Cefazolin, Cefdinir, Cefixime, Cefditoren, Ceftibuten, Cefpodoxime proxetil, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, Cephradine, Ciprofloxacin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Ery E-Succ/Sulfisoxazole, Gatifloxacin, Levofloxacin, Lomefloxacin, Loracarbef, Minocycline, Ofloxacin, Penicillin VK, Penicillin G, Sparfloxacin, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-Sulfamethoxazol.)
   B) V Procedure 99.21.

To be included in the denominator, *all* of the following conditions must be met:

1) Patient's diagnosis of an upper respiratory infection (URI) must have occurred at an outpatient visit.

2) If outpatient visit was to clinic code 30 (Emergency Medicine), it must not have resulted in a hospitalization, defined as service category H, either on the same day or the next day with URI diagnosis.
3) Patient's visit must ONLY have a diagnosis of URI. If any other diagnosis exists, the visit will be excluded.
4) The patient did not have a new or refill prescription for antibiotics within 30 days prior to the URI visit date.
5) The patient did not have an active prescription for antibiotics as of the URI visit date. “Active” prescription defined as:
   Rx Days Supply >= (URI Visit Date - Prescription Date)

If there are multiple visits that meet the above criteria, the first visit will be used.

Patient List

Patients 3 months to 18 years with upper respiratory infection, with antibiotic prescription, if any.

2.4.2 Appropriate Testing for Children with Pharyngitis

No changes from version 8.0 Patch 3.

Owner/Contact

Dr. Scott Hamstra

National Reporting

Not reported Nationally

Denominator

Active Clinical patients who were ages 2–18 years who were diagnosed with pharyngitis and prescribed an antibiotic during the period six months (180 days) prior to the report period through the first six months of the report period.

Numerator

Patients who received a Group A strep test.

Definitions

1) **Age**: Age is calculated as follows: Children 2 years as of six months (180 days) of the year prior to the report period to 18 years as of the first six months of the report period.
2) **Pharyngitis**: POV 462, 463, or 034.0.
3) **Outpatient Visit**: Service Category A, S, or O.
4) **Antibiotic Medications**:
   A) Medication taxonomy BGP HEDIS ANTIBIOTIC MEDS. (Medications are: Amoxicillin, Amox/Clavulanate, Ampicillin, Azithromycin, Cefaclor, Cefadroxil hydrate, Cefazolin, Cefdinir, Cefixime, Cefditoren, Ceftibuten, Cefpodoxime proxetil, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, Cephradine, Ciprofloxacin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Ery E-Succ/Sulfisoxazole, Gatifloxacin, Levofloxacin, Lomefloxacin, Loracarbef, Minocycline, Ofloxacin, Penicillin VK, Penicillin G, Sparfloxacin, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-Sulfamethoxazol.)
   B) V Procedure 99.21.
5) **Group A Streptococcus Test:**
   A) CPT 87430 (by enzyme immunoassay), 87650-87652 (by nucleic acid), 87880 (by direct optical observation), 87081 (by throat culture)
   B) site-populated taxonomy BGP GROUP A STREP; and C) LOINC taxonomy.

To be included in the denominator, ALL of the following conditions must be met:

1) Patient's diagnosis of pharyngitis must have occurred at an outpatient visit.
2) If outpatient visit was to clinic code 30 (Emergency Medicine), it must not have resulted in a hospitalization, defined as service category H, either on the same day or the next day with pharyngitis diagnosis.

3) Patient's visit must ONLY have a diagnosis of pharyngitis. If any other diagnosis exists, the visit will be excluded.
4) The patient did not have a new or refill prescription for antibiotics within 30 days prior to the pharyngitis visit date.
5) The patient did not have an active prescription for antibiotics as of the pharyngitis visit date. “Active” prescription defined as:
   Rx Days Supply >= (URI Visit Date - Prescription Date)
6) The patient filled a prescription for antibiotics on or within three days after the pharyngitis visit.

If there are multiple visits that meet the above criteria, the first visit will be used.

To be included in the numerator, a patient must have received a Group A Streptococcus test within the 7-day period beginning three days prior through three days after the Pharyngitis visit date.

Patient List

Patients 2–18 years with pharyngitis and a Group A Strep test, if any.

2.5 Cancer Screen Group

2.5.1 Cancer Screening: Pap Smear Rates

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Carolyn Aoyama

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominator

GPRA: Female Active Clinical patients ages 21 through 64 without a documented history of hysterectomy. Patients must be at least 21 years of age at the beginning of the Report Period and less than 65 years of age as of the end of the report period.

Numerators

1) **GPRA**: Patients with documented Pap smear in past three years or refusal in past year.
1) Patients with documented refusal in past year.
2) ***GPRA Developmental Numerator: Patients with a Pap smear documented in the past 3 years.***

Note: This numerator does *not* include refusals.

Definitions

1) **Hysterectomy**: defined as any of the following ever: 1) V Procedure: 68.4-68.8; 2) CPT 51925, 56308 (old code), 58150, 58152, 58200-58294, 58548, 58550-58554, ***58570-58573***, 58951, 58953-58954, 58956, 59135; 3) V POV 618.5; or 4) Women's Health procedure called Hysterectomy.
2) **Pap Smear**:
   1) V Lab: Pap Smear;

   2) POV: V67.01 Follow-up Vaginal Pap Smear, V76.2 Screen Mal Neop-Cervix, V72.31 Routine Gynecological Examination, V72.32 Encounter for Pap Cervical Smear to Confirm Findings of Recent Normal Smear Following Initial Abnormal Smear, V72.3 Gynecological Examination, Pap Cervical Smear as Part of General Gynecological Exam, Pelvic Exam (annual) (periodic) (old code, to be counted for visits prior to 10/1/04 only), V76.47 Vaginal Pap Smear for Post-Hysterectomy Patients, 795.0*, ***795.10-16, 795.19***;

   3) V Procedure: 91.46;

4) V CPT: 88141-88167, 88174-88175, ***(DELETED: G0101)***, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091;

5) Women's Health: procedure called Pap Smear;

6) LOINC taxonomy ***(added 47528-5)***;

7) Site-populated taxonomy BGP PAP SMEAR TAX;

8) Refusal (in past year) Lab Test Pap Smear.

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 59% for 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.

Patient List

Women 21–64 with documented test/refusal, if any.

2.5.2 Cancer Screening: Mammogram Rates

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Carolyn Aoyama

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

1) **GPRA**: Female Active Clinical patients ages 52 through 64, without a documented bilateral mastectomy or two separate unilateral mastectomies.
2) Female Active Clinical patients ages 42 and older without a documented history of bilateral mastectomy or two separate unilateral mastectomies.
   For all denominators, patients must be at least the minimum age as of the beginning of the report period. For the 52–64 denominator, the patients must be less than 65 years of age as of the end of the report period.

Numerators

1) **GPRA**: Patients with documented mammogram in past two years or refusal in past year.
   A. Patients with documented refusal in past year.
2) ***GPRA Developmental Numerator: All patients who had a Mammogram documented in the past 2 years.***

Note: This numerator does *not* include refusals.

Definitions

1) **Bilateral Mastectomy**:
   A) V CPT: 19300.50-19307.50 OR 19300-19307 w/modifier 09950 (.50 and 09950 modifiers indicate bilateral), or old codes 19180, 19200, 19220, or 19240, w/modifier of .50 or 09950; or
   B) ICD Operation codes: 85.42; 85.44; 85.46; 85.48.
2) **Unilateral Mastectomy**: Requires two separate occurrences for either CPT or procedure codes on two different dates of service.
   A) V CPT: 19300-19307, or old codes 19180, 19200, 19220, 19240 or
   B) V Procedures: 85.41, 85.43, 85.45, 85.47.
3) **Mammogram:**

1) V Radiology or V CPT: ***(DELETED: 77051, 77052),*** *77053-77059, 76090* (old code), ***(DELETED: 76083*** (old code)***)***, 76092 (old code), G0206; G0204, G0202;

2) POV: V76.11 screening mammogram for high risk patient; V76.12 other screening mammogram; 793.80 Abnormal mammogram, unspecified; 793.81 Mammographic microcalcification; 793.89 Other abnormal findings on radiological exam of breast;

3) V Procedure: 87.36 Xerography of breast, 87.37 Other Mammography;

4) Women's Health: Mammogram Screening, Mammogram Dx Bilat, Mammogram Dx Unilat;

4) **Refusal Mammogram**: V Radiology MAMMOGRAM for CPT 77053-77059, 76090 (old code), 76091 (old code), 76092 (old code), G0206, G0204, G0202.

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 45% for the proportion of female patients ages 52 through 64 who have had mammography screening within the last 2 years.

Patient List

Women 42 + with mammogram/refusal, if any.

2.5.3 Colorectal Cancer Screening

Changes from version 8.0 Patch as noted below.

Owner/Contact

Epidemiology Program/Dr. Nathaniel Cobb

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominator

GPRA: Active Clinical patients ages 51-80 without a documented history of colorectal cancer or total colectomy, broken out by gender.

Numerators

1) **GPRA**: Patients who have had *any* CRC colorectal screening, defined as any of the following:
   A) Fecal Occult Blood Test (FOBT*)* during the report period;
   B) Flexible sigmoidoscopy or double contrast barium enema in the past five years;
   C) Colonoscopy in the past 10 years, or
   D) A documented refusal in the past year.
   E) Patients with documented refusal in the past year.

2) GPRA Developmental Numerator: Patients who have had ANY CRC screening, defined as any of the following:
   1) ***Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) during the Report period;***
   2) ***Flexible sigmoidoscopy or double contrast barium enema in the past 5 years; or***
   3) ***Colonoscopy in the past 10 years.***

Note: This numerator does *not* include refusals.

3) Patients with FOBT or Fecal during the report period.
4) Patients with a flexible sigmoidoscopy or double contrast barium enema in the past 5 years or a colonoscopy in the past 10 years.
5) Patients with a flexible sigmoidoscopy in the past 5 years or a colonoscopy in the past 10 years.
6) Patients with a flexible sigmoidoscopy and double contrast barium enema in the past 5 years or a colonoscopy in the past 10 years.

Definitions

1) **Colorectal Cancer**: POV: 153.*, 154.0, 154.1, 197.5, V10.05; CPT G0213-G0215, G0231.

2) **Total Colectomy**: CPT 44150-44151, 44152 (old code), 44153 (old code), 44155-44158, 44210-44212; V Procedure 45.8 old code.
3) **Colorectal Cancer Screening**: The most recent of any of the following during applicable timeframes (changed to look at most recent screening):
   A) **FOBT or FIT:** CPT 82270, 82274, 89205 (old code), G0107 (old code), G0328, G0394 ***(old code)***, LOINC taxonomy ***(added 50196-5)***, or site-populated taxonomy BGP GPRA FOB TESTS.
   B) **Flexible Sigmoidoscopy**: V Procedure 45.24, ***(DELETED: 45.42) (moved ICD9 procedure code 45.42 from flexible sigmoidoscopy to colonoscopy for both screening and refusal of screening)***; CPT 45330-45345, G0104
   C) **Double Contrast Barium Enema**: CPT or VRad: 74280, G0106, G0120
   D) **Colonoscopy**: V POV V76.51 Colon screening; V Procedure 45.22, 45.23, 45.25, ***45.42 (moved ICD9 procedure code 45.42 from flexible sigmoidoscopy to colonoscopy for both screening and refusal of screening)***, 45.43; CPT 44388-44394, 44397, ***(DELETED: 45325) (removed old CPT code 45325 from Colonoscopy and refusal of Colonoscopy definitions due to information that this code was never included in any IHS CPT file, thus it would never be used as a colonoscopy)***.45355, 45378-45387, 45391, 45392, G0105, G0121
4) **Screening Refusals**:
   A) **FOBT or FIT:** Refusal of V Lab Fecal Occult Blood test or CPT code 82270, 82274, 89205 (old code), G0107 (old code), G0328, or G0394 ***old code***;
   B) **Flexible Sigmoidoscopy:** Refusal of V Procedure ***45.24, (DELETED: 45.42) (moved ICD9 procedure code 45.42 from flexible sigmoidoscopy to colonoscopy for both screening and refusal of screening),*** or CPT 45330-45345, G0104;
   C) **Double Contrast Barium Enema:** Refusal of V Radiology CPT: 74280, G0106, G0120;
   D) **Colonoscopy:** Refusal of V Procedure 45.22, 45.23, 45.25, 45.42 ***(moved ICD9 procedure code 45.42 from flexible sigmoidoscopy to colonoscopy for both screening and refusal of screening),*** 45.43 or V CPT 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, or G0121, ***(DELETED***: ***45325)***, ***(removed old CPT code 45325 from Colonoscopy and refusal of Colonoscopy definitions due to information that this code was never included in any IHS CPT file, thus it would never be used as a colonoscopy).***

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 29% for the proportion of clinically appropriate patients ages 51–80 who have received colorectal screening.

Patient List

Patients ages 51–80 with CRC screening or refusal, if any.

2.5.4 Tobacco Use and Exposure Assessment

No changes from version 8.0 Patch 3.

Owner/Contact

Mary Wachacha and Chris Lamer, PharmD/Epidemiology Program, Dr. Nat Cobb

National Reporting

NATIONAL (included in National GPRA and PART Report; *not* reported to OMB and Congress)

Denominators

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).
2) Pregnant female User Population patients with no documented miscarriage or abortion.

Numerators

1) Patients screened for tobacco use during the report period (during the past 20 months for pregnant female patients denominator).
2) Patients identified during the report period (during the past 20 months for pregnant female patients denominator) as current tobacco users.
   A) Current smokers
   B) Current smokeless tobacco users
3) Patients exposed to environmental tobacco smoke (ETS) during the report period (during the past 20 months for pregnant female patients denominator).

Definitions

1) Pregnancy: At least 2 visits with POV: V22.0-V23.9, V72.42, 640.*-649.*, 651.*-676.* during the past 20 months, with one diagnosis occurring during the reporting period. ***For pregnancy definition, (1) revised logic from looking for the last two pregnancy diagnoses during the 20-month period to the first two diagnoses during the 20-month period. (2) Corrected logic to look for an abortion/miscarriage after the second pregnancy diagnosis. Previously, the logic was looking after the date of the first pregnancy diagnosis it found (which represented the patient's next to last diagnosis). (3) Corrected the logic used to determine if the patient has at least one pregnancy diagnosis that occurs during the report period. Previously, the logic required the next to the last pregnancy diagnosis to occur during the report period. Now, it looks at all of the patient's pregnancy diagnoses during the 20-month period to determine if at least one of them occurs during the report period. It does not require that the first two diagnoses occur during the report period.***
2) **Miscarriage**: Occurring after the second pregnancy POV and during the past 20 months. POV: 630, 631, 632, 633*, 634*, CPT: 59812, 59820, 59821, 59830.
3) **Abortion**: Occurring after the second pregnancy POV and during the past 20 months. POV: 635*, 636*, 637*, CPT: 59100, 59120, 59130, 59136, 59150,

59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260-S2267, Procedure: 69.01, 69.51, 74.91, 96.49.

4) **Tobacco Screening**: An additional 8 months is included for patients who were pregnant during the report period but who had their tobacco assessment prior to that.
   A) Any Health Factor for category Tobacco.
   B) POV or Current PCC Problem List 305.1, 305.1* (old codes), 649.00-649.04, or V15.82 (tobacco-related diagnosis).
   C) Dental code 1320.
   D) Patient Education codes containing "TO-", "-TO", "-SHS," 305.1, 305.1* (old codes), 649.00-649.04, or V15.82.
   E) CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (Current Tobacco Smoker), 1035F (Current Smokeless Tobacco User), or 1036F (Current Tobacco Non-User).
5) **Tobacco Users**:
   A) Health Factors: Current Smoker, Current Smokeless, Current Smoker and Smokeless, Cessation-Smoker, Cessation-Smokeless.
   B) POV 305.1, 305.10-305.12 (old codes), or 649.00-649.04.
   C) , 1034F or 1035F.
6) **Current Smokers**:
   A) Health Factors: Current Smoker, Current Smoker and Smokeless, Cessation-Smoker.
   B) POV 305.1, 305.10-305.12 (old codes), or 649.00-649.04.
   C) CPT **,** 1034F.
7) **Current Smokeless**:
   A) Health Factors: Current Smokeless, Current Smoker and Smokeless, or Cessation-Smokeless.
   B) CPT 1035F.
8) **Environmental Tobacco Smoke (ETS)**: Health Factors: Smoker in Home, Exposure to Environmental Tobacco Smoke

Patient List

Patients with no documented tobacco screening.

2.5.5 Tobacco Cessation

Changes from version 8.0 Patch 3 noted below.

> **Note:** In CRS version 8.0 Patch 3, the Other National Measures (ONM) Report contained a new set of denominators, numerators, and logic. This logic is developmental GPRA logic and *may* be used as the future GPRA logic after analysis of the results is performed. This logic is included *only* in the ONM Report.

Owner/Contact

Mary Wachacha and Chris Lamer, PharmD/Epidemiology Program, Dr. Nat Cobb

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominator

1) **GPRA**: Active Clinical patients identified as current tobacco users prior to the Report Period, broken down by gender and age groups: <12, 12-17, 18 and older.

Numerators

2) **GPRA**: Patients who have received or refused tobacco cessation counseling or received a prescription for a smoking cessation aid during the report period.
   A) Patients who refused tobacco cessation counseling.

GPRA Developmental Numerator: Patients who have received tobacco cessation counseling or received a prescription for a smoking cessation aid during the report period.

> **Note**: This numerator does *not* include refusals.

3) Patients identified during the report period as having quit their tobacco use.

Definitions

1) **Current Tobacco Users**: Any of the following documented prior to the report period:
   A) Health Factors (looks at the last documented): Current Smoker, Current Smokeless, Current Smoker and Smokeless, Cessation-Smoker, Cessation-Smokeless
   B) Last documented Tobacco-related Diagnoses (POV or active Problem List): 305.1, 305.10-305.12 (old codes), or 649.00-649.04
   C) Last documented CPT , 1034F or 1035F.

   If any of the above are found, the patient is considered a tobacco user.

2) Tobacco Cessation Counseling: Any of the following during the Report Period:

A) Patient Education codes containing "TO-", "-TO", "-SHS", 305.1, 305.1* (old codes), or 649.00-649.04

B) Clinic Code 94

C) Dental Code 1320

D) CPT code , G0375 , G0376 or 4000F

E) Documented refusal of patient education codes containing "TO-", "-TO", or "-SHS". Refusals will only be counted if a patient did not receive counseling or a prescription for tobacco cessation aid.

3) **Prescription for Tobacco Cessation Aid**: Any of the following:
   A) Medication in the site-populated BGP CMS SMOKING CESSATION MEDS taxonomy;
   B) Any medication with name containing “NICOTINE PATCH”, “NICOTINE POLACRILEX”, “NICOTINE INHALER”, or “NICOTINE NASAL SPRAY”;
   C) CPT 4001F.
4) **Quit Tobacco Use**: POV or Current Active Problem List 305.13 (old code) or V15.82; Health Factors Previous Smoker, Previous Smokeless (looks at the last documented health factor).

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 21% for the proportion of tobacco-using patients who receive tobacco cessation intervention.

Patient List

Tobacco users with tobacco intervention, if any, or who have quit tobacco use.

2.6 Behavioral Health Group

2.6.1 Alcohol Screening (Fetal Alcohol Syndrome [FAS] Prevention)

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Wilbur Woodis, Dr. Peter Stuart

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominator

1) **GPRA**: Female Active Clinical patients ages 15 to 44 (child-bearing age).

Numerators

1) **GPRA**: Patients screened for alcohol use, had an alcohol-related diagnosis or procedure, received alcohol-related patient education, or refused alcohol screening during the report period.
   A) Patients with alcohol screening.
   B) Patients with alcohol-related diagnosis or procedure.
   C) Patients with alcohol-related patient education.
   D) Patients with documented refusal in past year.
2) ***GPRA Developmental Numerator: Patients screened for alcohol use, had an alcohol-related diagnosis or procedure, or received alcohol-related patient education during the Report Period.***

Note: This numerator does *not* include refusals.

Definitions

1) **Alcohol Screening:**
   A) PCC Exam code 35;
   B) Any Alcohol Health Factor;
   C) Screening Diagnosis: V11.3; V79.1, or BHS problem code 29.1;
   D) CPT 99408, 99409, G0396, G0397, H0049, or
   E) V Measurement in PCC or BH of AUDT, AUDC, or CRFT.
2) **Alcohol-related Diagnosis or Procedure:**
   A) Alcohol-related Diagnosis (POV, Current PCC or BHS Problem List): 303.*, 305.0*; 291.*; 357.5*; BHS POV 10, 27, 29
   B) Alcohol-related Procedure (V Procedure): 94.46, 94.53, 94.61-94.63, 94.67-94.69

3) **Alcohol-related Patient Education**: All Patient Education codes containing "AOD-" or "-AOD", "CD-" or "-CD" (old codes), or V11.3, V79.1, 303.*, 305.0*, 291.* or 357.5*

4) Refusal of Alcohol Screening: Refusal of

A) PCC Exam code 35.

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 47% for the proportion of female patients ages 15 to 44 who receive screening for alcohol use.

Patient List

Female patients with no documented alcohol screening.

2.6.2 Alcohol Screening and Brief Intervention (ASBI) in the ER

No changes from version 8.0 Patch 3.

Owner/Contact

Drs. David Boyd and Peter Stuart

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

Denominators

1) Number of visits for Active Clinical patients age 15-34 seen in the ER for injury during the report period. Broken out by gender and age groups of 15-24 and 25-34.
2) Number of visits for Active Clinical patients age 15-34 seen in the ER for injury and screened positive for hazardous alcohol use during the report period. Broken out by gender and age groups of 15-24 and 25-34.

Numerators

1) Number of visits where patients were screened in the ER for hazardous alcohol use.
   A) Number of visits where patients were screened positive (also used as denominator #2)
2) Number of visits where patients were provided a brief negotiated interview (BNI) at or within 7 days of the ER visit (used only with denominator #2).
   A) Number of visits where patients were provided a BNI at the ER visit.
   B) Number of visits where patients were provided a BNI not at the ER visit but within 7 days of the ER visit.

Denominator and Numerator Logic:

If a patient has multiple ER visits for injury during the report period, each visit will be counted in the denominator. For the screening numerator, each ER visit with injury at which the patient was screened for hazardous alcohol use will be counted. For the positive alcohol use screen numerator, each ER visit with injury at which the patient screened positive for hazardous alcohol use will be counted. For the BNI numerators, each visit where the patient was either provided a BNI at the ER or within 7 days of the ER visit will be counted.

An example of this logic is shown in the following table.

ER Visit w/Injury	Denom Count	Scm Num	Post Scm Num Count	BNI Num Count
John Doe, 07/17/08, Screened Positive at ER, BNI at ER				
John Doe, 09/01/08, Screened Positive at ER, No BNI				
John Doe, 11/15/08, No Screen				
Counts:	3	2	2	1

Definitions

1) **Emergency Room (ER) Visit**: Clinic code 30.
2) **Injury**: Primary or secondary POV 800.0–999.9 or E800.0-E989.
3) **ER Screening for Hazardous Alcohol Use**: Any of the following conducted during the ER visit:
   A) PCC exam code 35,
   B) any Alcohol Health Factor (i.e., CAGE),
   C) POV V79.1 Screening for Alcoholism,
   D) CPT , , H0049, , , or
4) **Positive Screen for Hazardous Alcohol Use**: Any of the following for the screening performed at the ER visit:
   A) Exam Code 35 Alcohol Screening result of "Positive,"
   B) Health factor of CAGE result of 1/4, 2/4, 3/4 or 4/4,
5) **Brief Negotiated Interview (BNI)**: Any of the following documented at the ER visit or within 7 days of the ER visit at a face-to-face visit, which excludes chart reviews and telecommunication visits:
   A) CPT G0396, G0397, H0050, 99408, or 99409, or
   B) Patient education code AOD-INJ.

Patient List

Patients seen in the ER for an injury, who were screened for hazardous alcohol use, with results of screen and BNI, if any.

2.6.3 Intimate Partner (Domestic) Violence Screening

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Denise Grenier, LCSW and Dr. Peter Stuart

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

1) Female Active Clinical patients ages 13 and older at beginning of report period.
   A) **GPRA**: Female Active Clinical patients ages 15-40.

Nominators

1) **GPRA**: Patients screened for or diagnosed with intimate partner (domestic) violence during the report period, including documented refusals in past year.
   A) Patients with documented IPV/DV exam.
   B) Patients with IPV/DV related diagnosis.
   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.

2) GPRA Developmental Numerator: Patients screened for intimate partner (domestic) violence at any time during the report period.

Note: This numerator does *not* include refusals.

Definitions

1) **IPV/DV Screening**: PCC Exam Code 34 or BHS IPV/DV exam
2) **IPV/DV Related Diagnosis**: POV, Current PCC or BHS Problem List 995.80-83, 995.85, V15.41, V15.42, V15.49; BHS POV 43.*, 44.*
3) **IPV/DV Patient Education**: Patient Education codes containing “DV-” or “-DV”, 995.80-83, 995.85, V15.41, V15.42, or V15.49
4) **IPV/DV Counseling**: POV V61.11
5) **Refusals**:
   A) Any PCC refusal in past year with Exam Code 34 or BHS refusal in past year of IPV/DV exam;
   B) Any refusal in past year with Patient Education codes containing "DV-" or “-DV.”

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 42% for the proportion of female patients ages 15 to 40 who receive screening for domestic violence.

Patient List

Women *not* screened and without documented refusal.

2.6.4 Depression Screening

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Denise Grenier, LCSW and Drs. David Sprenger and Peter Stuart

National Reporting

NATIONAL (included in National and PART GPRA Report; reported to OMB and Congress)

Denominators

1) Active Clinical patients ages 8-17.
2) GPRA: Active Clinical patients ages 18 and older, broken down by gender.
   A) Active Clinical patients ages 65 and older, broken down by gender.
3) 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.
4) Active IHD patients, defined as all Active Clinical patients diagnosed with ischemic heart disease (IHD) prior to the report period, *and* at least 2 visits during the report period, *and* 2 IHD-related visits ever.

Numerators

1) **GPRA**: Patients screened for depression or diagnosed with mood disorder at any time during the report period, including documented refusals in past year.
   A) Patients screened for depression during the report period.
   B) Patients with a diagnosis of a mood disorder during the report period.
   C) Patients with documented refusal in past year.

2) GPRA Developmental Numerator: Patients screened for depression or diagnosed with a mood disorder at any time during the report period.

Note: This numerator does *not* include refusals.

3) Patients with depression-related education or refusal of education in past year.

Note: Depression-related patient education does not count toward the GPRA numerator and is included as a separate numerator only.

Definitions

1) Diabetes: POV 250.00-250.93
2) Ischemic Heart Disease: 410.0-412.*, 414.0-414.9, 428.*, 429.2 recorded in the V POV file.
3) Depression Screening: Any of the following:
   A) Exam Code 36,

B) POV V79.0,

C) BHS problem code 14.1 (screening for depression), or

4) **Mood Disorders**: 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.
5) **Screening Refusal**: Any PCC refusal in past year with Exam Code 36.
6) **Depression-related patient education or refusal**: Any of the following during the report period:
   A) Patient education codes containing "DEP-" (depression), 296.2* or 296.3*, "BH-" (behavioral and social health), 290-319, 995.5*, or 995.80-995.85, "SB-" (suicidal behavior) or 300.9, or "PDEP-" (postpartum depression) or 648.44; or
   B) Refusal of patient education codes containing "DEP-" , "BH-" , "SB-" or "PDEP-."

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 35% for the proportion of adults ages 18 and older who receive annual screening for depression.

Patient List

Patients not screened for depression/diagnosed with mood disorder.

2.6.5 Antidepressant Medication Management

No changes from version 8.0 Patch 3.

Owner/Contact

Denise Grenier, LCSW and Dr. David Sprenger

National Reporting

Not reported Nationally

Denominator

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.

Numerators

1) Optimal Practitioner Contacts: 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.
2) Effective Acute Phase Treatment: Patients who filled a sufficient number of separate prescriptions/refills of antidepressant medication for continuous treatment of at least 84 days (12 weeks).
3) Effective Continuation Phase Treatment: 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).

Definitions

1) **Major Depression**: POV 296.2*, 296.3*, 298.0, 300.4, 309.1, 311.
2) **Antidepressant Medications**: Medication taxonomy BGP HEDIS ANTIDEPRESSANT MEDS. (Medications are: Tricyclic antidepressants (TCA) and other cyclic antidepressants, Selective serotonin reuptake inhibitors (SSRI), Monoamine oxidase inhibitors (MAOI), Serotonin-norepinepherine reuptake inhibitors (SNRI), and other antidepressants.)
3) **Index Episode Start Date**: The date of the patient's earliest visit during this period. For inpatient visits, the discharge date will be used.

To be included in the denominator, patient must meet *both* of the following conditions:

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) 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.
   For example, if report period is July 1, 2005 – June 30, 2006, patient must have one of the three scenarios above during November 01, 2004 – October 29, 2005.

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.

Denominator Exclusions:

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 are more comprehensive and include the following: POVs 296.2*-296.9*, 298.0, 300.4, 309.0, 309.1, 309.28, 311, or
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
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*.

Optimal Practitioner Contacts numerator, patient must have one of the following:

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
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.

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*

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 (old code), 90875, 90876, 99384-99387, 99394-99397, 99401-99404, G0155, G0176, G0177, H0002, H0004, H0331, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485 or B2) POV 290*, 293*-302*, 306*-316*, *or*

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*
3. Service category of T.

Outpatient non-mental health provider visits are defined as BHS or PCC visits with:

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 (old code), 90875, 90876, G0155, G0176, G0177, H0002, H0004, H0331, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485, *or*
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*
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*.

Effective Acute Phase Treatment numerator:

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.

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. For example: Rx Date=11/15/2004, Discontinued Date=11/19/2004, Recalculated # Days Prescribed=4.

Example of Patient Included in Numerator:

- 1st RX is Index Rx Date: 11/1/2004, # Days Prescribed=30
  Rx covers patient through 12/1/2004
- 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
- 3rd RX: 1/10/2005, # Days Prescribed=30
  No gap days.
  Rx covers patient through 2/13/2005
- Index Rx Date 11/1/2004 + 114 days = 2/23/2005
- Patient's 84th treatment day occurs on 2/7/2005, which is <= 2/23/2005 AND # gap days of 14 is less than 30.

Example of Patient Not Included in Numerator:

- 1st Rx is Index Rx Date: 11/1/2004, # Days Prescribed=30
  Rx covers patient through 12/1/2004
- 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
- 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.

Effective Continuation Phase Treatment Numerator:

For all antidepressant medication prescriptions (see list of medications above) 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.

> **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. For example: Rx Date=11/15/2004, Discontinued Date=11/19/2004, Recalculated # Days Prescribed=4.

Patient List

Patients with new depression DX and optimal practitioner contact (OPC), acute phase treatment (APT) and continuation phase treatment (CONPT), if any.

2.7 Cardiovascular Disease Related Group

2.7.1 Obesity Assessment

No changes from version 8.0 Patch 3.

Owner/Contact

Nutrition Program, Jean Charles-Azure

National Reporting

NATIONAL (included in National GPRA Report; *not* reported to OMB and Congress)

Denominator

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.

Numerators

1) All patients for whom BMI can be calculated, including refusals in the past year.
   A Of Numerator 1, patients considered overweight, adults BMI 25-29, age 18 and under based on standard tables.
   B) Of Numerator 1, patients considered obese, adults BMI =>30, age 18 and under based on standard tables.
   C) Of Numerator 1, total overweight and obese.
   D) Of Numerator 1, patients with documented refusal in past year.

Definitions

1) **BMI**: 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.
2) **Refusals**: Include REF, NMI, 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.

Patient List

Patients for whom a BMI could *not* be calculated

2.7.2 Childhood Weight Control

Changes from Version 8.0 Patch 3 noted below.

Owner/Contact

Nutrition Program, Tammy Brown

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominator

GPRA: Active Clinical Patients 2–5 for whom a BMI could be calculated, broken out by age groups.

Numerators

1) Patients with BMI in the ***85th to 94th percentile***
2) **GPRA Numerator**: ***Patients*** with a ***BMI at or above the 95th percentile***.
3) Patients with a BMI ***at or above the 85th percentile***.

Definitions

1) **Age**: All patients for whom a BMI could be calculated and 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.
2) **BMI**: 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 reported differently than in Obesity Assessment since this age group is children ages 2-5, whose BMI values are age-dependent. The BMI values are categorized ***as Overweight*** for patients with a BMI ***in the 85th to 94th percentile*** and ***Obese*** for patients with a BMI ***at or above the 95th percentile (Changed "at risk for overweight" to "overweight" and "overweight" to "obese." This is to be consistent with AAP and AMA recommendations from late 2007).***

A patient who's BMI either is greater or less than the Data Check Limit range shown below will not be included in the report counts for ***Overweight or Obese***.

Low-High Ages	Sex	BMI (Overweight)	BMI (Obese)	Data Check Limits	
				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

GPRA 2009 Description:

In FY 2009, this measure is eliminated as an annual measure and is changed to a long term measure and has no annual target.

Patient List

Patients ages 2–5, with current BMI.

2.7.3 Nutrition and Exercise Education for At Risk Patients

No changes from version 8.0 Patch 3.

Owner/Contact

Patient Education Program/Mary Wachacha and Chris Lamer, PharmD
Nutrition Program/Jean Charles-Azure

National Reporting

Not reported Nationally

Denominators

1) Active Clinical patients ages 6 and older considered overweight (including obese), defined as adults with BMI =>25, ages 18 and under based on standard tables.
   A) Patients considered obese, defined as adults with BMI =>30, ages 18 and under based on standard tables. Broken out by gender and age groups: 6-11, 12-19, 20-39, 40-59, =>60 (HP 2010).
2) Active Diabetic patients (see Diabetes Comprehensive Care above for definition).

Numerators

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.

Definitions

1) **Diabetes**: First DM Purpose of Visit 250.00-250.93 recorded in the V POV file prior to the Report period.
2) **Medical Nutrition Counseling**: CPT 97802-97804, G0270, G0271; or provider codes 07, 29, 97 or 99; or clinic codes 67 or 36.
3) **Nutrition Education**: Patient Education codes ending “-N” or "-MNT" or containing V65.3, or old codes containing “-DT” (diet); POV V65.3.
4) **Exercise Education**: Patient Education codes ending in “-EX” or containing V65.41; POV V65.41.
5) **Other Related Education**: Patient Education codes ending “-LA” or containing “OBS-” or 278.00 or 278.01.

Patient List

At risk patients, with education if any.

2.7.4 Cardiovascular Disease and Cholesterol Screening

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Dr. Eric Brody/Mary Wachacha and Chris Lamer, Pharm

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

Denominators

1) Active Clinical patients age 23 and older; broken out by gender.
2) Active IHD patients, defined as all Active Clinical patients diagnosed with ischemic heart disease (IHD) prior to the report period, *and* at least 2 visits during the report period, *and* 2 IHD-related visits ever. Broken down by gender.

Numerators

1) Patients with documented blood total cholesterol screening any time during past five years, regardless of result.
   A) With high cholesterol, defined as => 240.
2) With LDL completed, regardless of result.
   A) LDL <= 100
   B) LDL 101-130
   C) LDL 131-160
   D) LDL >160

Definitions

1) **Total Cholesterol Panel**: Searches for most recent cholesterol test with a result during the report period. ***If more than one cholesterol test is found on the same day and/or the same visit and one test has a result and the other does not, the test with the result will be used. If a cholesterol test with a result is not found***, CRS searches for the most recent cholesterol test without a result. Total Cholesterol definition: CPT 82465; LOINC taxonomy; site-populated taxonomy DM AUDIT CHOLESTEROL TAX.
2) **LDL**: Searches for most recent LDL test with a result during the Report Period. ***If more than one LDL test is found on the same day and/or the same visit and one test has a result and the other does not, the test with the result will be used. If an LDL test with a result is not found***, CRS searches for the most recent LDL test without a result. LDL Definition: CPT 80061, 83700, 83701, 83704, 83715 (old code), 83716 (old code), 83721, 3048F, 3049F, 3050F; LOINC taxonomy; site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX. For numerator LDL =<100, CPT 3048F will count as meeting the measure.
3) **Ischemic Heart Disease (IHD)**: 410.0-412.*, 414.0-414.9, 428.*, or 429.2 recorded in the V POV file.

Patient List

Patients with cholesterol or LDL value, if any.

2.7.5 Cardiovascular Disease and Blood Pressure Control

No changes from version 8.0 Patch 3.

Owner/Contact

Dr. Eric Brody/Mary Wachacha and Chris Lamer, PharmD

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

Denominators

1) All Active Clinical patients ages 20 and over, broken down by gender.
2) Active IHD patients, defined as all Active Clinical patients diagnosed with ischemic heart disease (IHD) prior to the report period, *and* at least 2 visits during the report period, *and* 2 IHD-related visits ever. Broken down by gender.

Numerators

1) Patients with BP values documented.
   A) Patients with normal BP, <120/80.
   B) Pre-hypertension I, => 120/80 and < 130/80.
   C) Pre-hypertension II, =>130/80 and < 140/90.
   D) Stage 1 hypertension, => 140/90 and <160/100.
   E) Stage 2 hypertension, => 160/100.

Definitions

1) **BP Values (all numerators)**: CRS uses mean of last 3 BPs 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. For the BP documented numerator only, if CRS is not able to calculate a mean BP, it will search for CPT 3074F-3080F documented on a non-ER visit during the report period.
2) **Ischemic Heart Disease (IHD)**: 410.0-412.*, 414.0-414.9, 428.*, or 429.2 recorded in the V POV file.

Patient List

Patients => 20 or who have IHD w/ denominator identified and mean BP, if any.

2.7.6 Controlling High Blood Pressure

Changes from version 8.0 Patch 3 noted below

Owner/Contact

Dr. Eric Brody/Mary Wachacha and Chris Lamer, PharmD

National Reporting

Not Reported Nationally

Denominator

Active Clinical patients ages 18 (changed from 46) through 85 diagnosed with hypertension and no documented history of ESRD, broken down by age groups of 18-45 and 46–85 and gender.

Numerators

1) Patients with BP values documented.
   A) Patients with normal BP (<120/80)
   B) Pre-hypertension I (=>120/80 and <130/80)
   C) Pre-hypertension II (=>130/80 and <140/90)
   D) Stage 1 hypertension (=>140/90 and <160/100)
   E) Stage 2 hypertension (=>160/100)

Definitions

1) **Hypertension**: Diagnosis (POV or problem list) 401.* prior to the report period, and at least one hypertension POV during the report period.
2) **BP Values (all numerators)**: Uses mean of last 3 BPs documented on non-ER visits during the report period. If 3 BPs are not available, uses mean of last 2, non-ER BPs. If a visit contains more than 1 BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last 3 (or 2) systolic values and dividing by 3 (or 2). The mean Diastolic value is calculated by adding the diastolic values from the last 3 (or 2) blood pressures and dividing by 3 (or 2). If the systolic and diastolic values do not *both* meet the current category, then the value that is least controlled determines the category. For the BP documented numerator only, if CRS is not able to calculate a mean BP, it will search for CPT 3074F-3080F, 3074F-3076F, 3078F-3079F documented on a non-ER visit during the report period.
3) **ESRD**: Any of the following ever:

A) CPT: 36145, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90918-90925 ***(old codes)***, 90935, 90937, 90939 ***(old code)***, 90940, 90945, 90947, ***90951-90970***, 90989, 90993, 90997, 90999, 99512, G0257, G0308-G0327, ***G0392, G0393,*** or S9339;

B) POV 585.5, 585.6 or V45.1 ***(old code), V45.11 V45.12***; or

C) Procedure 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6*.

Patient List

Patients with hypertension and BP value, if any.

2.7.7 Comprehensive CVD-Related Assessment

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Dr. Eric Brody/Mary Wachacha and Chris Lamer, PharmD

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

1) **GPRA**: Active IHD patients ages 22 and older, defined as all Active Clinical patients diagnosed with ischemic heart disease (IHD) prior to the Report Period, *and* at least 2 visits during the Report Period, *and* 2 IHD-related visits ever.
   A) Active IHD patients 22 and older who are not diabetic.
   B) Active IHD patients 22 and older who are diabetic.

Numerators

1) Patients with BP 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) BMI Available: Patients for whom a BMI could be calculated, including refusals in the past year.
   A: BMI Available: Patients who refused a height or weight measurement and for whom a BMI could not be calculated.
5) Lifestyle Counseling: Patients who have received any lifestyle adaptation counseling, including medical nutrition counseling, or nutrition, exercise or other lifestyle education during the current report period.
6) GPRA Numerator: Patients with comprehensive CVD assessment, defined as having BP, LDL, and tobacco use assessed, BMI calculated or refusal, and lifestyle counseling.

Note: This does *not* include depression screening.

7) GPRA Developmental Numerator: Patients with comprehensive CVD assessment, defined as having BP, LDL, and tobacco use assessed, BMI calculated, and lifestyle counseling.

Note: This does *not* include depression screening and does *not* include refusals of BMI.

8) BMI Available: Patients for whom a BMI could be calculated.

Note: This numerator does *not* include refusals.

9) Depression Screening: Patients screened for depression or diagnosed with a mood disorder at any time during the report period, including documented refusals in past year.

Definitions

1) **Diabetes**: Diagnosed with diabetes (first POV in V POV with 250.00-250.93) prior to the current report period, *and* at least 2 visits during the current report period, *and* 2 DM-related visits ever. Patients not meeting these criteria are considered non-diabetics.
2) **Ischemic Heart Disease (IHD)**: 410.0-412.*, 414.0-414.9, 428.* or 429.2 recorded in the V POV file.
3) **Blood Press**ure: Having a minimum of 2 BPs documented on non-ER visits in past 2 years. If CRS does not find 2 BPs, it will search for CPT 3074F-3080F (added codes 3074F-3076F, 3078F-3079F) documented on non-ER visit during the past 2 years.
4) **LDL**: Finds the most recent test done in the last 5 years, regardless of the results of the measurement. LDL Definition: CPT 80061, 83700, 83701, 83704, 83715 (old code), 83716 (old code), 83721, 3048F, 3049F, 3050F; LOINC taxonomy; site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX.
5) **Tobacco Screening**: At least one of the following:
   A. Any health factor for category Tobacco documented during current report period;
   B. Tobacco-related diagnoses (POV or current Active Problem List) 305.1, 305.1* (old codes), 649.00-649.04, or V15.82;
   C. Dental code 1320;
   D. Any patient education code containing "TO-", "-TO", "-SHS", 305.1, 305.1* (old codes), 649.00-649.04, or V15.82;
   E. CPT **,** **,** 1034F, 1035F, or 1036F.
6) **BMI**: CRS calculates BMI at the time the report is run, using NHANES II. 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 and UAS (unable to screen) and must be documented 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.
7) **Medical Nutrition Counseling**: CPT 97802-97804, G0270, G0271; Provider codes 07, 29, 97, 99; Clinic codes 67 (dietary) or 36 (WIC). Nutrition education defined as: POV V65.3 dietary surveillance and counseling; patient education codes ending “-N” (Nutrition) or “-MNT” or containing V65.3 (or old code “-DT” (Diet)). Exercise education defined as: POV V65.41 exercise counseling; patient education codes ending “-EX” (Exercise) or containing V65.41. Related

exercise and nutrition counseling defined as: patient education codes ending "-LA" (lifestyle adaptation) or containing "OBS-" (obesity) or 278.00 or 278.01.

8) **Depression Screening/Mood Disorder DX**: Any of the following during the report period:
   A) Depression Screening:
      1) Exam Code 36,
      2) POV V79.0,
      3) BHS problem code 14.1 (screening for depression),
      or
      5) refusal, defined as any PCC refusal in past year with Exam Code 36.
   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.

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 30% for the proportion of at-risk patients who have a comprehensive assessment.

Patient List

List of patients with assessments received, if any.

2.7.8 Appropriate Medication Therapy after a Heart Attack

Changes from Version 8.0 Patch 3 noted below.

Owner/Contact

Dr. Eric Brody/ Mary Wachacha and Chris Lamer, PharmD

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; **NOT** reported to OMB and Congress)

Denominator

Active Clinical patients 35 and older discharged for an AMI during the first 51 weeks of the report period and were not readmitted for any diagnosis within seven days of discharge. Broken down by gender.

Numerators

1) Patients with active prescription for, refusal of, or who have a contraindication/previous adverse reaction to beta-blockers.
2) Patients with active prescription for, refusal of, or who have a contraindication/ previous adverse reaction to ASA (aspirin) or other anti-platelet agent.
3) Patients with active prescription for, refusal of, or who have a contraindication/ previous adverse reaction to ACEIs/ARBs.
4) Patients with active prescription for, refusal of, or who have a contraindication/ previous adverse reaction to statins.

Definitions

1) **Acute Myocardial Infarction (AMI)**: 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.
2) **ALT**: Site-populated taxonomy DM AUDIT ALT TAX or LOINC taxonomy.
3) **AST**: Site-populated taxonomy DM AUDIT AST TAX or LOINC taxonomy.
4) **Creatine Kinase**: Site-populated taxonomy BGP CREATINE KINASE TAX or LOINC taxonomy.

Denominator Exclusions: Patients meeting any of the following conditions will be excluded from the denominator.

1) Patients with Discharge Type of Irregular (AMA), Transferred, or contains "Death."
2) Patients readmitted for any diagnosis within seven days of discharge.
3) Patients with a Diagnosis Modifier of C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable), R (Resolved), S (Suspect, Suspicious), or T (Status Post).

4) Patients with a Provider Narrative beginning with "Consider"; "Doubtful"; "Maybe"; "Possible"; "Perhaps"; "Rule Out"; "R/O"; "Probable"; "Resolved"; "Suspect"; "Suspicious"; or "Status Post."

To be included in the numerators, a patient must meet one of the 3 conditions below:

1) An active prescription (not discontinued as of [discharge date + 7 days]) that was prescribed prior to admission, during the inpatient stay, or within seven days after discharge. "Active" prescription defined as: Days Prescribed > ((Discharge Date + 7 days) - Order Date); *or*
2) A refusal of the medication at least once during hospital stay through 7 days after discharge date; *or*
3) Have a contraindication/previous adverse reaction to the indicated medication.

Refusals and contraindications/previous adverse drug reactions (ADR)/allergies are only counted if a patient did not have a prescription for the indicated medication. Patients without a prescription who have a refusal and/or contraindication/ADR/allergy will be counted in sub-numerators B-C. Because a patient may have both a refusal and a contraindication/ADR/allergy, the subnumerator totals of A-C may not add up the to the numerator total.

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. For example: Rx Date=11/15/2003, Discontinued Date=11/19/2003, Recalculated # Days Prescribed=4.

Numerator Logic: In the logic below, "ever" is defined as anytime through the end of the Report Period.

Beta-Blocker Numerator Logic:

Beta-blocker medication codes defined with medication taxonomy BGP HEDIS BETA BLOCKER MEDS. ***(Medications are: Noncardioselective Beta Blockers: Carteolol, Carvedilol, Labetalol, Nadolol, Penbutolol, Pindolol, Propranolol, Timolol, Sotalol; Cardioselective Beta Blockers: Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol; and Antihypertensive Combinations: Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothiazide-metoprolol, Hydrochlorothiazide-propranolol, and Hydrochlorothiazide-timolol.) (Updated list of medications.)***

Refusal of beta-blocker: REF refusal of any beta-blocker medication in site-populated medication taxonomy BGP HEDIS BETA BLOCKER MEDS at least once during hospital stay through 7 days after discharge date.

Contraindications to beta-blockers defined as any of the following occurring ever unless otherwise noted:

A) Asthma – 2 diagnoses (POV) of 493* on different visit dates;

B) Hypotension – 1 diagnosis of 458*;

C) Heart block >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;

E) COPD - 2 diagnoses on different visit dates of 491.2*, 496, or 506.4, or a combination of any of these codes, such as 1 visit with 491.20 and 1 with 496;

F) NMI (not medically indicated) refusal for any beta-blocker at least once during hospital stay through 7 days after discharge date; or

G) CPT G8011 (Clinician documented that AMI patient was not an eligible candidate for beta-blocker at arrival) at least once during hospital stay through 7 days after discharge date.

Adverse drug reaction/documented beta blocker allergy defined as any of the following occurring ever:

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.

ASA (aspirin)/Other Anti-Platelet Numerator Logic:

ASA medication codes defined with medication taxonomy DM AUDIT ASPIRIN DRUGS.

Other anti-platelet medication codes defined with medication taxonomy site-populated BGP ANTI-PLATELET DRUGS taxonomy.

Refusal of ASA/other anti-platelet: REF refusal of any ASA or anti-platelet medication in site-populated medication taxonomies DM AUDIT ASPIRIN DRUGS or BGP ANTI-PLATELET DRUGS at least once during hospital stay through 7 days after discharge date.

Contraindications to ASA/other anti-platelet defined as any of the following occurring ever unless otherwise noted:

A) Patients with active prescription for Warfarin/Coumadin at time of arrival or prescribed at discharge, using site-populated BGP CMS WARFARIN MEDS taxonomy;

B) Hemorrhage diagnosis (POV 459.0);

C) NMI (not medically indicated) refusal for any aspirin at least once during hospital stay through 7 days after discharge date; or

D) CPT G8008 (Clinician documented that AMI patient was not an eligible candidate to receive aspirin at arrival) at least once during hospital stay through 7 days after discharge date.

Adverse drug reaction/documented ASA/other anti-platelet allergy defined as any of the following occurring ever:

A) POV 995.0-995.3 AND E935.3;

B) "aspirin" entry in ART (Patient Allergies File); or

C) "ASA" or "aspirin" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

ACEI/ARB Numerator Logic:

Ace Inhibitor (ACEI) medication codes defined with medication taxonomy BGP HEDIS ACEI MEDS. ACEI medications are: ***Angiotensin Converting Enzyme Inhibitors*** (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolopril).

Antihypertensive Combinations (Amlodipine-benazepril, Benazepril-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Fosinopril-hydrochlorothiazide, Hydrochlorothiazide-lisinopril, Hydrochlorothiazide-moexipril, Hydrochlorothiazide-quinapril, Hydrochlorothiazide-verapamil).
(DELETED: ACEI-Combination Products: Amlodipine-benazepril (Lotrel), Benazepril + HCTZ (Lotensin HCT), Captopril + HCTZ (Capozide, Hydrochlorothiazide + Capropril), Enalapril + HCTZ (Vaseretic), Enalapril-felodipine (Lexxel), Enalapril-diltiazem (Teczem), Fosinopril + HCTZ (Monopril HCT), Lisinopril + HCTZ (Prinzide, Zestoreti, Hydrochlorothiazide + Lisinopril), Moexipril + HCTZ (Uniretic), Quinapril + HCTZ (Accuretic, Quinaretic)).

Refusal of ACEI: REF refusal of any ACE Inhibitor medication in site-populated medication taxonomy BGP HEDIS ACEI MEDS at least once during hospital stay through 7 days after discharge date.

Contraindications to ACEI defined as any of the following:

1) Diagnosis ever for moderate or severe aortic stenosis (POV 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, or 747.22) or

2) NMI (not medically indicated) refusal for any ACEI at least once during hospital stay through 7 days after discharge date.

Adverse drug reaction/documented ACEI allergy defined as any of the following occurring ever:

1) POV 995.0-995.3 AND E942.6;

2) "ace inhibitor" or "ACEI" entry in ART (Patient Allergies File); or

3) "ace i*" or "ACEI" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

ARB (Angiotensin Receptor Blocker) medication codes defined with medication taxonomy BGP HEDIS ARB MEDS. ARB medications: ***Angiotensin II Inhibitors*** (Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan.)

Antihypertensive Combinations (Candesartan-hydrochlorothiazide, Eprosartan-hydrochlorothiazide, Hydrochlorothiazide-Irbesartan, Hydrochlorothiazide-Losartan, Hydrochlorothiazide-olmesartan, Hydrochlorothiazide-Telmisartan, Hydrochlorothiazide-Valsartan).
(DELETED: ARB Combination Products: Candesartan + HCTZ (Atacand HCT), Eprosartan + HCTZ (Teveten HCT), Irbesartan + HCTZ (Avalide HCT), Losartan + HCTZ (Hyzaar HCT), Olmesartan + HCTZ (Benicar HCT), Telmisartan + HCTZ (Micardis HCT), Valsartan + HCTZ (Diovan HCT)).

Refusal of ARB: REF refusal of any ARB medication in site-populated medication taxonomy BGP HEDIS ARB MEDS at least once during hospital stay through 7 days after discharge date.

Contraindications to ARB defined as any of the following:

1) Diagnosis ever for moderate or severe aortic stenosis (POV 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22) or
2) NMI (not medically indicated) refusal for any ARB at least once during hospital stay through 7 days after discharge date.

Adverse drug reaction/documented ARB allergy defined as any of the following occurring ever:

1) POV 995.0-995.3 AND E942.6;
2) "Angiotensin Receptor Blocker" or "ARB" entry in ART (Patient Allergies File); or
3) "Angiotensin Receptor Blocker" or "ARB" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

Statins Numerator Logic:

Statin medication codes defined with medication taxonomy BGP HEDIS STATIN MEDS. Statin medications: Atorvostatin (Lipitor), Fluvastatin (Lescol), Lovastatin (Altocor), Mevacor, Pravastatin (Pravachol), Simvastatin (Zocor), Rosuvastatin (Crestor).

Statin Combination Products: Advicor, Caduet, PraviGard Pac, Vytorin.

Refusal of Statin: REF refusal of any statin medication in site-populated medication taxonomy BGP HEDIS STATIN MEDS at least once during hospital stay through 7 days after discharge date.

Contraindications to Statins defined as any of the following:

1) Pregnancy, defined as at least two visits during the Report Period with POV or Problem diagnosis (V22.0-V23.9, V72.42, 640.*-649.*, 651.*-676.*) and with no documented miscarriage or abortion occurring after the second pregnancy POV. ***For pregnancy definition, (1) revised logic from looking for the last two pregnancy diagnoses during the Report Period to the first two diagnoses during the Report Period. (2) Corrected logic to look for an abortion/miscarriage after the second pregnancy diagnosis. Previously, the logic was looking after the date of the first pregnancy diagnosis it found (which represented the patient's next to last diagnosis).***

Miscarriage definition: (1) POV: 630, 631, 632, 633*, 634*,
(2) CPT 59812, 59820, 59821, 59830.

Abortion definition: (1) POV: 635*, 636* 637*,
(2) CPT: 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260-S2267,
(3) Procedure: 69.01, 69.51, 74.91, 96.49;

2) Breastfeeding, defined as POV V24.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, BF-N during the Report Period;
3) Acute Alcoholic Hepatitis, defined as POV 571.1 during the report period, or
4) NMI (not medically indicated) refusal for any statin at least once during hospital stay through 7 days after discharge date.

Adverse drug reaction/documented statin allergy defined as any of the following:

1) ALT and/or AST > 3x the Upper Limit of Normal (ULN) (i.e., Reference High) on 2 or more consecutive visits during the Report Period;
2) Creatine Kinase (CK) levels > 10x ULN or CK > 10,000 IU/L during the Report Period;
3) Myopathy/Myalgia, defined as any of the following during the Report Period: POV 359.0-359.9, 729.1, 710.5, or 074.1;
4) Any of the following occurring ever:
   A) POV 995.0-995.3 AND E942.9;
   B) "Statin" or "Statins" entry in ART (Patient Allergies File); or
   C) "Statin" or "Statins" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

All Medications Numerator Logic:

To be included in this numerator, a patient must have a prescription, refusal, or a contraindication for ALL of the four medication classes (i.e., beta-blocker, ASA/other anti-platelet, ACEI/ARB, AND statin).

Patient List

Patients with AMI, with appropriate medication therapy, if any.

2.7.9 Persistence of Appropriate Medication Therapy after a Heart Attack

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Dr. Eric Brody/Mary Wachacha and Chris Lamer, PharmD

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

Denominator

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. Broken down by gender.

Numerators

1) Patients with a 135-day course of treatment with beta-blockers, who refused beta-blockers in the 180 days after AMI, or who have a contraindication/previous adverse reaction to beta-blocker therapy.
2) Patients with a 135-day course of treatment with ASA (aspirin) or other anti-platelet agent, who refused ASA/anti-platelet in the 180 days after AMI, or who have a contraindication/ previous adverse reaction to ASA/anti-platelet therapy.
3) Patients with a 135-day course of treatment with ACEIs/ARBs, who refused ACEIs/ARBs in the 180 days after AMI, or who have a contraindication/previous adverse reaction to ACEI/ARB therapy.
4) Patients with a 135-day course of treatment with statins, who refused statins in the 180 days after AMI, or who have a contraindication/previous adverse reaction to statin therapy.

   Also included for numerators 1–4 are subnumerators:

   A) Patients with 135-day treatment for the specified medication.
   B) Patients with documented refusal of the specified medication.
   C) Patients with contraindication/previous adverse reaction to the specified medication.
5) Patients with a 135-day course of treatment for all post-AMI medications, (i.e., beta-blocker, ASA/anti-platelet, ACEI/ARB, AND statin) following first discharge date or visit date, including previous active prescriptions; with refusal, and/or who have a contraindication/ previous adverse reaction.

Definitions

1) **Acute Myocardial Infarction (AMI)**: POV or Problem List 410.0*-410.9* or 412. AMI diagnosis may be made at an inpatient or outpatient visit but must occur between six months prior to beginning of report period through first six months of

the Report period. Inpatient visit defined as Service Category of H (Hospitalization). If patient has more than one episode of AMI during the timeframe, CRS will include only the first hospital discharge or ambulatory visit.

2) **ALT**: Site-populated taxonomy DM AUDIT ALT TAX or LOINC taxonomy.
3) **AST**: Site-populated taxonomy DM AUDIT AST TAX or LOINC taxonomy.
4) **Creatine Kinase**: Site-populated taxonomy BGP CREATINE KINASE TAX or LOINC taxonomy.

Denominator Exclusions: Patients meeting any of the following conditions will be excluded from the denominator.

1) If inpatient visit, patients with Discharge Type of Irregular (AMA), Transferred, or contains "Death."
2) Patients with a Diagnosis Modifier of C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable), R (Resolved), S (Suspect, Suspicious), or T (Status Post).
3) Patients with a Provider Narrative beginning with "Consider"; "Doubtful"; "Maybe"; "Possible"; "Perhaps"; "Rule Out"; "R/O"; "Probable"; "Resolved"; "Suspect"; "Suspicious"; or "Status Post."

To be included in the numerators, a patient must meet one of the 3 conditions below:

1) A total days' supply >= 135 days in the 180 days following discharge date for inpatient visits or visit date for ambulatory visits. Prior active prescriptions can be included if the treatment days fall within the 180 days following discharge/visit date. Prior active prescription defined as most recent 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; *or*
2) A refusal of the medication at least once at time of diagnosis through the 180 days after AMI; *or*
3) Have a contraindication/previous adverse reaction to the indicated medication.

Refusals and contraindications/previous adverse drug reactions (ADR)/allergies are only counted if a patient did not have a prescription for the indicated medication. Patients without a prescription who have a refusal and/or contraindication/ADR/allergy will be counted in sub-numerators B-C. Because a patient may have both a refusal and a contraindication/ADR/ allergy, the sub-numerator totals of A-C may not add up the to the numerator total.

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. For example: Rx Date=11/15/2003, Discontinued Date=11/19/2003, Recalculated # Days Prescribed=4.

Example of patient included in the beta-blocker numerator who has prior active prescription:

- Admission Date: 2/1/2004, Discharge Date: 2/15/2004
- Must have 135 days prescribed by 8/13/2004 (Discharge Date+180)
- Prior Beta-Blocker Rx Date: 1/15/2004
- # Days Prescribed: 60 (treats patient through 3/15/2004)
- Discharge Date minus Rx Date: 2/15/2004-1/15/2004 = 31, 60 is >= 31, prescription is considered Prior Active Rx
- 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
- # Remaining Days Prescribed from Prior Active Rx: (60-(Discharge Date-Prior Rx Date) = 60-(2/15/2004-1/15/2004) = 60-31 = 29
- Rx #2: 4/1/2004, # Days Prescribed: 90
- Rx #3: 7/10/2004, #Days Prescribed: 90
- Total Days Supply Prescribed between 2/15 and 8/13/2004: 29+90+90=209

Numerator Logic: In the logic below, "ever" is defined as anytime through the end of the report period.

Beta-Blocker Numerator Logic:

Beta-blocker medication codes defined with medication taxonomy BGP HEDIS BETA BLOCKER MEDS. ***(Medications are: Noncardioselective Beta Blockers: Carteolol, Carvedilol, Labetalol, Nadolol, Penbutolol, Pindolol, Propranolol, Timolol, Sotalol; Cardioselective Beta Blockers: Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol; and Antihypertensive Combinations: Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothiazide-metoprolol, Hydrochlorothiazide-propranolol, and Hydrochlorothiazide-timolol.) (Updated list of medications.)***

Refusal of beta-blocker: REF refusal of any beta-blocker medication in site-populated medication taxonomy BGP HEDIS BETA BLOCKER MEDS at least once during the period admission/visit date through the 180 days after discharge/visit date.

Contraindications to beta-blockers defined as any of the following occurring ever unless otherwise noted:

A) Asthma – 2 diagnoses (POV) of 493* on different visit dates;

B) Hypotension – 1 diagnosis of 458*;

C) Heart block >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;

E) COPD – 2 diagnoses on different visit dates of 491.2*, 496, or 506.4, or a combination of any of these codes, such as 1 visit with 491.20 and 1 with 496;

F) NMI (not medically indicated) refusal for any beta-blocker at least once during the period admission/visit date through the 180 days after discharge/visit date; or

G) CPT G8011 (Clinician documented that AMI patient was not an eligible candidate for beta-blocker at arrival) at least once during the period admission/visit date through the 180 days after discharge/visit date.

Adverse drug reaction/documented beta blocker allergy defined as any of the following occurring anytime up to the 180 days after 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.

ASA (aspirin) Numerator Logic:

ASA medication codes defined with medication taxonomy DM AUDIT ASPIRIN DRUGS.

Other anti-platelet medication codes defined with medication taxonomy site-populated BGP ANTI-PLATELET DRUGS taxonomy.

Refusal of ASA/other anti-platelet: REF refusal of any ASA or anti-platelet medication in site-populated medication taxonomies DM AUDIT ASPIRIN DRUGS or BGP ANTI-PLATELET DRUGS at least once during the period admission/visit date through the 180 days after discharge/visit date.

Contraindications to ASA/other anti-platelet defined as any of the following occurring ever unless otherwise noted:

A) Patients with prescription for Warfarin/Coumadin using site-populated BGP CMS WARFARIN MEDS taxonomy during the period admission/visit date through the 180 days after discharge/visit date;

B) Hemorrhage diagnosis (POV 459.0);

C) NMI (not medically indicated) refusal for any aspirin at least once during the period admission/visit date through the 180 days after discharge/visit date; or

D) CPT G8008 (Clinician documented that AMI patient was not an eligible candidate to receive aspirin at arrival) at least once during the period admission/visit date through the 180 days after discharge/visit date.

Adverse drug reaction/documented ASA/other anti-platelet allergy defined as any of the following occurring anytime up to the 180 days after discharge/visit date:

A) POV 995.0-995.3 AND E935.3;

B) "Aspirin" entry in ART (Patient Allergies File); or

C) "ASA" or "aspirin" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

ACEI/ARB Numerator Logic:

Ace Inhibitor (ACEI) medication codes defined with medication taxonomy BGP HEDIS ACEI MEDS. ACEI medications: ***Angiotensin Converting Enzyme Inhibitors*** (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolopril).

Antihypertensive Combinations (Amlodipine-benazepril, Benazepril-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Fosinopril-hydrochlorothiazide, Hydrochlorothiazide-lisinopril, Hydrochlorothiazide-moexipril, Hydrochlorothiazide-quinapril, Hydrochlorothiazide-verapamil).
(DELETED: ACEI-Combination Products: Amlodipine-enazepril (Lotrel), Benazepril + HCTZ (Lotensin HCT), Captopril + HCTZ (Capozide, Hydrochlorothiazide + Capropril), Enalapril + HCTZ (Vaseretic), Enalapril-felodipine (Lexxel), Enalapril-diltiazem (Teczem), Fosinopril + HCTZ (Monopril HCT), Lisinopril + HCTZ (Prinzide, Zestoreti, Hydrochlorothiazide + Lisinopril), Moexipril + HCTZ (Uniretic), Quinapril + HCTZ (Accuretic, Quinaretic)).

Refusal of ACEI: REF refusal of any ACE Inhibitor medication in site-populated medication taxonomy BGP HEDIS ACEI MEDS at least once during the period admission/visit date through the 180 days after discharge/visit date.

Contraindications to ACEI defined as any of the following:

1) Diagnosis ever for moderate or severe aortic stenosis (POV 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, or 747.22) or
2) NMI (not medically indicated) refusal for any ACEI at least once during the period admission/visit date through the 180 days after discharge/visit date.

Adverse drug reaction/documented ACEI allergy defined as any of the following occurring anytime up to the 180 days after discharge/visit date:

1) POV 995.0-995.3 AND E942.6;
2) "Ace inhibitor" or "ACEI" entry in ART (Patient Allergies File); or
3) "Ace i*" or "ACEI" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

ARB (Angiotensin Receptor Blocker) medication codes defined with medication taxonomy BGP HEDIS ARB MEDS. ARB medications: ***Angiotensin II Inhibitors*** (Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan.)

Antihypertensive Combinations (Candesartan-hydrochlorothiazide, Eprosartan-hydrochlorothiazide, Hydrochlorothiazide-Irbesartan, Hydrochlorothiazide-Losartan, Hydrochlorothiazide-olmesartan, Hydrochlorothiazide-Telmisartan, Hydrochlorothiazide-Valsartan).
(DELETED: ARB Combination Products: Candesartan + HCTZ (Atacand HCT), Eprosartan + HCTZ (Teveten HCT), Irbesartan + HCTZ (Avalide HCT), Losartan + HCTZ (Hyzaar HCT), Olmesartan + HCTZ (Benicar HCT), Telmisartan + HCTZ (Micardis HCT), Valsartan + HCTZ (Diovan HCT)).

Refusal of ARB: REF refusal of any ARB medication in site-populated medication taxonomy BGP HEDIS ARB MEDS at least once during the period admission/visit date through the 180 days after discharge/visit date.

Contraindications to ARB defined as any of the following:

1) Diagnosis ever for moderate or severe aortic stenosis (POV 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22) or
2) NMI (not medically indicated) refusal for any ARB at least once during the period admission/visit date through the 180 days after discharge/visit date.

Adverse drug reaction/documented ARB allergy defined as any of the following occurring anytime up to the 180 days after discharge/visit date:

1) POV 995.0-995.3 AND E942.6;
2) "Angiotensin Receptor Blocker" or "ARB" entry in ART (Patient Allergies File); or
3) "Angiotensin Receptor Blocker" or "ARB" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

Statins Numerator Logic:

Statin medication codes defined with medication taxonomy BGP HEDIS STATIN MEDS. Statin medications: Atorvostatin (Lipitor), Fluvastatin (Lescol), Lovastatin (Altocor), Mevacor, Pravastatin (Pravachol), Simvastatin (Zocor), Rosuvastatin (Crestor).

Statin Combination Products: Advicor, Caduet, PraviGard Pac, Vytorin.

Refusal of Statin: REF refusal of any statin medication in site-populated medication taxonomy BGP HEDIS STATIN MEDS at least once during admission/visit date through the 180 days after discharge/visit date.

Contraindications to Statins defined as any of the following:

1) Pregnancy, defined as at least two visits during the period admission/visit date through the 180 days after discharge/visit date with POV or Problem diagnosis (V22.0-V23.9, V72.42, 640.*-649.*, 651.*-676.*) and with no documented miscarriage or abortion occurring after the second pregnancy POV. ***For pregnancy definition, (1) revised logic from looking for the last two pregnancy diagnoses during the Report Period to the first two diagnoses during the Report Period. (2) Corrected logic to look for an abortion/miscarriage after the second pregnancy diagnosis. Previously, the logic was looking after the date of the first pregnancy diagnosis it found (which represented the patient's next to last diagnosis).***

Miscarriage definition: (1) POV: 630, 631, 632, 633*, 634*,
(2) CPT 59812, 59820, 59821, 59830.

Abortion definition: (1) POV: 635*, 636* 637*,
(2) CPT: 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260-S2267,
(3) Procedure: 69.01, 69.51, 74.91, 96.49; 2) Breastfeeding, defined as POV V24.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, BF-N during the period admission/visit date through the 180 days after discharge/visit date;

2) Acute Alcoholic Hepatitis, defined as POV 571.1 during the period admission/visit date through the 180 days after discharge/visit date; or
3) NMI (not medically indicated) refusal for any statin at least once during the period admission/visit date through the 180 days after discharge/visit date.

Adverse drug reaction/documented statin allergy defined as any of the following:

1) ALT and/or AST > 3x the Upper Limit of Normal (ULN) (i.e., Reference High) on 2 or more consecutive visits during the period admission/visit date through the 180 days after discharge/visit date;
2) Creatine Kinase (CK) levels > 10x ULN or CK > 10,000 IU/L during the period admission/visit date through the 180 days after discharge/visit date;
3) Myopathy/Myalgia, defined as any of the following during the period admission/visit date through the 180 days after discharge/visit date: POV 359.0-359.9, 729.1, 710.5, or 074.1; 4) any of the following occurring anytime up to the 180 days after discharge/visit date:
   A) POV 995.0-995.3 AND E942.9;
   B) "Statin" or "Statins" entry in ART (Patient Allergies File); or
   C) "Statin" or "Statins" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

All Medications Numerator Logic:

To be included in this numerator, a patient must have a prescription, refusal, or a contraindication for ALL of the four medication classes (i.e., beta-blocker, ASA/other anti-platelet, ACEI/ARB, AND statin).

Patient List

Patients with AMI, with persistent medication therapy, if any

2.7.10 Appropriate Medication Therapy in High Risk Patients

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Dr. Eric Brody/Mary Wachacha and Chris Lamer, PharmD

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

Denominators

1) Active IHD patients ages 22 and older, defined as all Active Clinical patients diagnosed with ischemic heart disease (IHD) prior to the Report Period, *and* at least 2 visits during the Report Period, *and* 2 IHD-related visits ever.
   A) Active IHD patients age 22 and older who are not Active Diabetic.
   B) Active IHD patients age 22 and older who are Active Diabetic.

Numerators

1) Patients with a 180-day course of treatment with or refusal of beta-blockers during the report period, or who have a contraindication/previous adverse reaction to beta-blocker therapy.
2) Patients with a 180-day course of treatment with or refusal of ASA (aspirin) or other anti-platelet agent during the report period, or who have a contraindication/previous adverse reaction to ASA/anti-platelet therapy.
3) Patients with a 180-day course of treatment with or refusal of ACEIs/ARBs during the report period, or who have a contraindication/previous adverse reaction to ACEI/ARB therapy.
4) Patients with a 180-day course of treatment with or refusal of statins during the report period, or who have a contraindication/previous adverse reaction to statin therapy.
   Also included for numerators 1-4 are sub-numerators:
   A) Patients with 180-day treatment for the specified medication.
   B) Patients with documented refusal of the specified medication.
   C) Patients with contraindication/previous adverse reaction to the specified medication.
5) Patients with a 180-day course of treatment for all medications (i.e., beta-blocker, aspirin/anti-platelet, ACEI/ARB, AND statin) during the report period, with refusal, and/or who have a contraindication/previous adverse reaction.

Definitions

1) **Ischemic Heart Disease (IHD)**: 410.0-412.*, 414.0-414.9, 428.* or 429.2 recorded in the V POV file.
2) **Diabetes**: Diagnosed with diabetes (first POV in V POV with 250.00-250.93) prior to the Current Report period, AND at least 2 visits during the current report

period, AND 2 DM-related visits ever. Patients not meeting these criteria are considered non-diabetics.

3) **ALT**: Site-populated taxonomy DM AUDIT ALT TAX or LOINC taxonomy.
4) **AST**: Site-populated taxonomy DM AUDIT AST TAX or LOINC taxonomy.
5) **Creatine Kinase**: Site-populated taxonomy BGP CREATINE KINASE TAX or LOINC taxonomy

To be included in the numerators, a patient must meet one of the 3 conditions below:

1) Prescription(s) for the indicated medication with a total days supply of 180 days or more during the report period; *or*
2) A refusal of the medication during the report period; *or*
3) Have a contraindication/previous adverse reaction to the indicated medication.

Refusals and contraindications/previous adverse drug reactions (ADR)/allergies are only counted if a patient did not have a prescription for the indicated medication. Patients without a prescription who have a refusal and/or contraindication/ADR/allergy will be counted in subnumerators B-C. Because a patient may have both a refusal and a contraindication/ADR/ allergy, the subnumerator totals of A-C may not add up the to the numerator total.

For prescriptions, the days supply requirement may be met with a single prescription or from a combination of prescriptions for the indicated medication that were filled during the report period and prescriptions filled prior to the report period but which are still active (i.e., prior active prescription). Prior active prescriptions can be included if the treatment days fall within the report period. Prior active prescription defined as most recent prescription for the indicated medication (see codes below) prior to report period Start Date with the number of days supply equal to or greater than the report period Start Date minus the prescription date.

Note: If a prescription for a 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. For example: Rx Date=11/15/2006, Discontinued Date=11/19/2006, Recalculated # Days Prescribed=4.

Example of patient included in the beta-blocker numerator with prior active prescription:

- Report Period: 07/01/2005 – 06/30/2006
- Must have 180 days supply of indicated medication 6/30/2006 (end of Report Period)
- Prior Beta-Blocker Rx Date: 06/01/2005
- # Days Prescribed: 60 (treats patient through 07/31/2005)
- Report Period Start Date minus Rx Date: 07/01/2005-06/01/2005 = 30; 60 (#Days Prescribed) is >= 30, prescription is considered Prior Active Rx
- 07/31/2005 is between the Report Period of 07/01/2005 and 06/30/2006, thus remainder of Prior Active Rx can be counted toward 180-days supply
- # Remaining Days Prescribed from Prior Active Rx: (# Days Prescribed-(Report Period Start Date-Prior Rx Date) = 60-(07/01/2005-06/01/2005) = 60-30 = 30
- Rx #2: 08/05/2005, # Days Prescribed: 90
- Rx #3: 11/10/2005, #Days Prescribed: 90
- Total Days Supply Prescribed between 07/01/2005 and 06/30/2006, including prior active prescription: 30+90+90=210

Numerator Logic: In the logic below, "ever" is defined as anytime through the end of the report period.

Beta-Blocker Numerator Logic:

(Medications are: Noncardioselective Beta Blockers: Carteolol, Carvedilol, Labetalol, Nadolol, Penbutolol, Pindolol, Propranolol, Timolol, Sotalol; Cardioselective Beta Blockers: Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol; and Antihypertensive Combinations: Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothiazide-metoprolol, Hydrochlorothiazide-propranolol, and Hydrochlorothiazide-timolol). (Updated list of medications).

Refusal of beta-blocker: REF refusal of any beta-blocker medication in site-populated medication taxonomy BGP HEDIS BETA BLOCKER MEDS at least once during the report period.

Contraindications to beta-blockers defined as any of the following occurring ever unless otherwise noted:

A) Asthma – 2 diagnoses (POV) of 493* on different visit dates;

B) Hypotension – 1 diagnosis of 458*;

C) Heart block >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;

E) COPD – 2 diagnoses on different visit dates of 491.2*, 496, or 506.4, or a combination of any of these codes, such as 1 visit with 491.20 and 1 with 496;

F) NMI (not medically indicated) refusal for any beta-blocker at least once during the report period; or

G) CPT G8011 (Clinician documented that AMI patient was not an eligible candidate for beta-blocker at arrival) at least once during the report period.

Adverse drug reaction/documented beta blocker allergy defined as any of the following occurring ever:

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.

ASA (aspirin)/Other Anti-Platelet Numerator Logic:

ASA medication codes defined with medication taxonomy DM AUDIT ASPIRIN DRUGS.

Other anti-platelet medication codes defined with medication taxonomy site-populated BGP ANTI-PLATELET DRUGS taxonomy.

Refusal of ASA/other anti-platelet: REF refusal of any ASA or anti-platelet medication in site-populated medication taxonomies DM AUDIT ASPIRIN DRUGS or BGP ANTI-PLATELET DRUGS at least once during the Report Period.

Contraindications to ASA/other anti-platelet defined as any of the following occurring ever unless otherwise noted:

A) Patients with a 180-day course of treatment for Warfarin/Coumadin during the report period, using site-populated BGP CMS WARFARIN MEDS taxonomy;

B) Hemorrhage diagnosis (POV 459.0);

C) NMI (not medically indicated) refusal for any aspirin at least once during the report period; or

D) CPT G8008 (Clinician documented that AMI patient was not an eligible candidate to receive aspirin at arrival) at least once during the report period.

Adverse drug reaction/documented ASA/other anti-platelet allergy defined as any of the following occurring anytime ever:

A) POV 995.0-995.3 AND E935.3;

B) "aspirin" entry in ART (Patient Allergies File); or

C) "ASA" or "aspirin" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

ACEI/ARB Numerator Logic:

Ace Inhibitor (ACEI) medication codes defined with medication taxonomy BGP HEDIS ACEI MEDS. ACEI medications: ***Angiotensin Converting Enzyme Inhibitors*** (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolopril).

Antihypertensive Combinations (Amlodipine-benazepril, Benazepril-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Fosinopril-hydrochlorothiazide, Hydrochlorothiazide-lisinopril, Hydrochlorothiazide-moexipril, Hydrochlorothiazide-quinapril, Hydrochlorothiazide-verapamil).
(DELETED: ACEI-Combination Products: Amlodipine-benazepril (Lotrel), Benazepril + HCTZ (Lotensin HCT), Captopril + HCTZ (Capozide, Hydrochlorothiazide + Capropril), Enalapril + HCTZ (Vaseretic), Enalapril-felodipine (Lexxel), Enalapril-diltiazem (Teczem), Fosinopril + HCTZ (Monopril HCT), Lisinopril + HCTZ (Prinzide, Zestoreti, Hydrochlorothiazide + Lisinopril), Moexipril + HCTZ (Uniretic), Quinapril + HCTZ (Accuretic, Quinaretic)).

Refusal of ACEI: REF refusal of any ACE Inhibitor medication in site-populated medication taxonomy BGP HEDIS ACEI MEDS at least during the report period.

Contraindications to ACEI defined as any of the following:

1) Diagnosis ever for moderate or severe aortic stenosis (POV 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, or 747.22) or
2) NMI (not medically indicated) refusal for any ACEI at least once during the Report Period.

Adverse drug reaction/documented ACEI allergy defined as any of the following occurring anytime through the end of the report period:

1) POV 995.0-995.3 AND E942.6;
2) "Ace inhibitor" or "ACEI" entry in ART (Patient Allergies File); or
3) "Ace i*" or "ACEI" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

ARB (Angiotensin Receptor Blocker) medication codes defined with medication taxonomy BGP HEDIS ARB MEDS. ARB medications: ***Angiotensin II Inhibitors*** (Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan.)

Antihypertensive Combinations (Candesartan-hydrochlorothiazide, Eprosartan-hydrochlorothiazide, Hydrochlorothiazide-Irbesartan, Hydrochlorothiazide-Losartan, Hydrochlorothiazide-olmesartan, Hydrochlorothiazide-Telmisartan, Hydrochlorothiazide-Valsartan).
(DELETED: ARB Combination Products: Candesartan + HCTZ (Atacand HCT), Eprosartan + HCTZ (Teveten HCT), Irbesartan + HCTZ (Avalide HCT), Losartan HCTZ (Hyzaar HCT), Olmesartan + HCTZ (Benicar HCT), Telmisartan + HCTZ (Micardis HCT), Valsartan + HCTZ (Diovan HCT)).

Refusal of ARB: REF refusal of any ARB medication in site-populated medication taxonomy BGP HEDIS ARB MEDS at least once during the report period.

Contraindications to ARB defined as any of the following: Diagnosis ever for moderate or severe aortic stenosis (POV 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22) or 2) NMI (not medically indicated) refusal for any ARB at least once during the report period.

Adverse drug reaction/documented ARB allergy defined as any of the following occurring anytime through the end of the report period:

1) POV 995.0-995.3 AND E942.6;
2) "Angiotensin Receptor Blocker" or "ARB" entry in ART (Patient Allergies File); or
3) "Angiotensin Receptor Blocker" or "ARB" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

Statins Numerator Logic:

Statin medication codes defined with medication taxonomy BGP HEDIS STATIN MEDS. Statin medications: Atorvostatin (Lipitor), Fluvastatin (Lescol), Lovastatin (Altocor), Mevacor, Pravastatin (Pravachol), Simvastatin (Zocor), Rosuvastatin (Crestor).

Statin Combination Products: Advicor, Caduet, PraviGard Pac, Vytorin.

Refusal of Statin: REF refusal of any statin medication in site-populated medication taxonomy BGP HEDIS STATIN MEDS at least once during the Report Period.

Contraindications to Statins defined as any of the following:

1) Pregnancy, defined as at least two visits during the report period with POV or Problem diagnosis (V22.0-V23.9, V72.42, 640.*-649.*, 651.*-676.*) and with no documented miscarriage or abortion occurring after the second pregnancy POV. ***For pregnancy definition, (1) revised logic from looking for the last two pregnancy diagnoses during the report period to the first two diagnoses during the report period. (2) Corrected logic to look for an abortion/miscarriage after the second pregnancy diagnosis. Previously, the logic was looking after the date of the first pregnancy diagnosis it found (which represented the patient's next to last diagnosis).***

   Miscarriage definition: (1) POV: 630, 631, 632, 633*, 634*,
   (2) CPT 59812, 59820, 59821, 59830.

   Abortion definition: (1) POV: 635*, 636* 637*,
   (2) CPT: 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260-S2267,
   (3) Procedure: 69.01, 69.51, 74.91, 96.49;

2) Breastfeeding, defined as POV V24.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, BF-N during the Report Period;
3) Acute Alcoholic Hepatitis, defined as POV 571.1 during the report period, or

4) NMI (not medically indicated) refusal for any statin at least once during the report period.

Adverse drug reaction/documented statin allergy defined as any of the following:

1) ALT and/or AST > 3x the Upper Limit of Normal (ULN) (i.e., Reference High) on 2 or more consecutive visits during the report period;
2) Creatine Kinase (CK) levels > 10x ULN or CK > 10,000 IU/L during the Report Period;
3) Myopathy/Myalgia, defined as any of the following during the report period: POV 359.0-359.9, 729.1, 710.5, or 074.1;
4) any of the following occurring anytime through the end of the report period:
   A) POV 995.0-995.3 AND E942.9;
   B) "Statin" or "Statins" entry in ART (Patient Allergies File); or
   C) "Statin" or "Statins" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.

All Medications Numerator Logic:

To be included in this numerator, a patient must have a prescription, refusal, or a contraindication for *all* of the four medication classes (i.e., beta-blocker, ASA/other anti-platelet, ACEI/ARB, *and* statin).

Patient List

IHD patients 22+ with 180-day medication therapy during the report period, if any.

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

Topic added from the EO Quality Transparency Measures Report included in CRS version 8.0 Patch 3. Changes from CRS version 8.0 Patch 3 are noted below.

Owner/Contact

Dr. Eric Brody

Denominators

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

Numerators

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

Definition

1) **Age**: Age is calculated as of the beginning of the report period.

2) **Ischemic Stroke or Transient Ischemic Attack (TIA) with Atrial Fibrillation**: Non-CHS inpatient visit (Type not equal to C and Service Category=H) and POV of any of the following: (433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, or 435.9) AND POV 427.31 (atrial fibrillation).
3) **Anticoagulant Therapy**: Patient must meet one of the conditions below to be counted as receiving anticoagulant therapy.
   A) Active prescription for Warfarin, aspirin, or other anti-platelet as of discharge date. "Active" prescription defined as:

      Rx Days Supply >= (Discharge Date - Prescription Date), where the prescription has not been discontinued as of the discharge date.

   B) Prescription for Warfarin, aspirin, or other anti-platelet on discharge date.
4) **Warfarin Medication**: Any medication in site-populated BGP CMS WARFARIN MEDS taxonomy.
5) **Aspirin Medication**: Any medication in site-populated DM AUDIT ASPIRIN DRUGS taxonomy ***(DELETED: or CPT G8006).***
6) **Other Anti-Platelet/Anticoagulant Medication**: Any medication in the site-populated BGP ANTI-PLATELET DRUGS taxonomy, any medication with VA Drug Class BL700 ***(DELETED: or CPT 4073F or 4075F, where the CPT code does not have a modifier of 1P, 2P, or 8P).***
7) **Refusal of Anticoagulant Therapy**: Refusal of any of the following documented on discharge date:
   A) Any medication in site-populated taxonomies BGP CMS WARFARIN MEDS, DM AUDIT ASPIRIN DRUGS, or BGP ANTI-PLATELET DRUGS; or
   B) Any medication with VA Drug Class BL700
   C) ***(DELETED: CPT G8006, 4073F, or 4075F)***
8) **No Anticoagulant Therapy**: Patients who did not have an active prescription for anticoagulant therapy at time of discharge and did not receive or refuse anticoagulant therapy at discharge.

Patient List

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

2.7.12 Cholesterol Management for Patients with Cardiovascular Conditions

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Dr. Eric Brody/Mary Wachacha and Chris Lamer, PharmD

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

Denominator

Active Clinical patients ages 18 to 75 who, during the first 10 months of the year prior to the beginning of the report period, were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), *or* who were diagnosed with ischemic vascular disease (IVD) during the Report Period and the year prior to the report period (changed timeframe for IVD). Broken down by gender.

Numerators

1) Patients with LDL completed during the report period, regardless of result.
   A) Patients with LDL <=100, completed during the report period.
   B) Patients with LDL 101-130, completed during the report period.
   C) Patients with LDL >130, completed during the report period

Definitions

1) **AMI**: POV 410.*0 or 410.*1.
2) **PTCA**:
   A) V Procedure 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06-36.07, or 36.09 or
   B) CPT 33140, 92980, ***(DELETED: 92981),*** 92982, ***(DELETED: 92984)***, 92995, ***(DELETED: 92996).***
3) **CABG:**
   A) V Procedure 36.1*, 36.2 or
   B) CPT 33510-33514, 33516-33519, 33521-33523, 33533-33536, ***(DELETED: 35600, 33572)***, S2205-S2209.
4) **IVD**: 411.*, 413.*, 414.0*, ***414.2,*** 414.8, 414.9, 429.2, 433.*-434.*, 440.1, 440.2*, ***440.4***, 444.*, or 445.*.
5) **LDL**: Searches for most recent LDL test with a result during the Report Period. ***If more than one LDL test is found on the same day and/or the same visit and one test has a result and the other does not, the test with the result will be used. If an LDL test with a result is not found, CRS searches for the most recent*** LDL test without a result. LDL defined as: CPT 80061, 83700, 83701, 83704, 83715

(old code), 83716 (old code), 83721, 3048F, 3049F, 3050F; LOINC taxonomy; site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX. For numerator LDL =<100, CPT 3048F will count as meeting the measure.

Patient List

Patients with AMI, CABG, PTCA, or IVD w/LDL value, if any.

2.7.13 Heart Failure and Evaluation of LVS Function

No changes from version 8.0 Patch 3.

Owner/Contact

Dr. Eric Brody/ Mary Wachacha and Chris Lamer, PharmD

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

Denominator

Active Clinical ages 18 or older discharged with heart failure during the Report Period.

Numerator

Patients whose LVS function was evaluated before arrival, during hospitalization, or is planned for after discharge.

Definitions

1) **Heart Failure**: Primary diagnosis code of 398.91, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9, 429.1, or 997.1 *and* with Service Category H (hospitalization).

Note:	If a patient has multiple admissions matching these criteria during the Report Period, the earliest admission will be used.

2) **Comfort Measures**: V66.7 (Encounter for palliative care) documented during hospital stay.
3) **LVAD/Heart Transplant**: Any of the following during hospital stay: V Procedure 33.6, 37.41, 37.51-37.54, 37.61-37.66, 37.68.
4) **Evaluation of LVS (Left Ventricular Systolic) Function:** Any of the following:
   A) An ejection fraction ordered or documented anytime one year prior to discharge date, defined as any of the following:

      1) V Measurement “CEF”;
      2) V Procedure 88.53, 88.54;
      3) V CPT 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314-93318, 93350, 93543, 93555.

   B) RCIS order for Cardiovascular Disorders referral that is ordered during the hospital stay but no later than the hospital discharge date. (RCIS referral defined as: ICD Diagnostic Category "Cardiovascular Disorders" combined with any of the following CPT Categories: “Evaluation and/or Management, “Non-surgical Procedures” or “Diagnostic Imaging.”)

C) Any of the following documented anytime one year prior to discharge date:
1) Echocardiogram: V Procedure 88.72, 37.28, 00.24;
2) Nuclear Medicine Test: V Procedure 92.2*;
3) Cardiac Catheterization with a Left Ventriculogram: V Procedure 37.22, 37.23, 88.53, 88.54.

Denominator Exclusions:

Defined as any of the following:

1) Patients receiving comfort measures only (i.e., patients who received palliative care and usual interventions were not received because a medical decision was made to limit care).
2) Patients with a Discharge Type of Transferred or Irregular or containing "Death."
3) Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospitalization.

Patient List

Active Clinical heart failure patients 18+ who received evaluation of LVS function, if any.

2.8 STD-Related Group

2.8.1 HIV Screening

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Drs. Scott Giberson, Marie Russell, Jim Cheek, and John Redd

National Reporting

NATIONAL (included in National GPRA and PART Report; reported to OMB and Congress)

Denominators

1) **GPRA**: All pregnant Active Clinical patients with no documented miscarriage or abortion during the past 20 months and *no* recorded HIV diagnosis ever.
2) User Population patients ages 13–64 with no recorded HIV diagnosis ever.

Numerators

1) **GPRA Numerator**: Patients who were screened for or refused an HIV test during the past 20 months.
   A: Number of documented refusals.
2) ***GPRA Developmental Numerator: Patients who were screened for HIV during the past 20 months.***

Note: This numerator does *not* include refusals. Patients who were screened for HIV, including refusals.

3) Number of HIV screens provided to User Population patients during the report period, where the patient was not diagnosed with HIV anytime prior to the screen. This does not include refusals of HIV screening.

Definitions

1) **Pregnancy**: At least 2 visits with POV: V22.0-V23.9, V72.42, 640.*-649.*, 651.*-676.* during the past 20 months, with one diagnosis occurring during the reporting period. ***For pregnancy definition, (1) revised logic from looking for the last two pregnancy diagnoses during the Report Period to the first two diagnoses during the Report Period. (2) Corrected logic to look for an abortion/miscarriage after the second pregnancy diagnosis. Previously, the logic was looking after the date of the first pregnancy diagnosis it found (which represented the patient's next to last diagnosis).***
2) **Miscarriage**: Occurring after the second pregnancy POV and during the past 20 months. POV: 630, 631, 632, 633*, 634*, CPT: 59812, 59820, 59821, 59830
3) **Abortion**: Occurring after the second pregnancy POV and during the past 20 months. POV: 635*, 636*, 637*, CPT: 59100, 59120, 59130, 59136, 59150,

59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260-S2267, Procedure: 69.01, 69.51, 74.91, 96.49.

4) **HIV**: Any of the following documented anytime prior to the end of the report period: V POV or Problem List: 042, 042.0-044.9 (old codes), 079.53, V08, 795.71.
5) **HIV Counseling/Patient Education**: POV: V65.44, Patient Education codes containing "HIV-" or "-HIV" or HIV diagnosis 042, 042.0-044.9 (old codes), V08, 795.71.
6) **HIV Screening**: CPT 86689, 86701-86703, 87390, 87391, 87534-87539; LOINC taxonomy; site-populated taxonomy BGP HIV TEST TAX; or Refusal of any laboratory test in site-populated taxonomy BGP HIV TEST TAX. For the number of HIV screens provided to User Population patients numerator (count only), a maximum of one HIV screen per patient per day will be counted and refusals are not included.

> **Note:** The time frame for both screening and refusals for the pregnant patient's denominator is anytime during the past 20 months and for User Population patients 13–64 is anytime during the report period. Refusals are allowed during the past 20 months for pregnant patients (vs. only during the report period) in the event the patient is at the end of her pregnancy at the beginning of the report period and refused the HIV test earlier in her pregnancy during the previous year.

7) **Refusal of HIV Screening**: Refusal of any laboratory test in site-populated taxonomy BGP HIV TEST TAX

GPRA 2009 Description:

During FY 2009, maintain the FY 2008 rate of 75% for the proportion of pregnant patients who are screened for HIV.

Patient List

Pregnant patients or User Population patients 13–64 without documented HIV test or refusal.

2.8.2 HIV Quality of Care

No Changes from version 8.0 Patch 3.

Owner/Contact

Drs. Scott Giberson, Marie Russell, and Jonathan Iralu

National Reporting

Not reported Nationally

Denominator

User Population 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.

Numerators

1) Patients who received CD4 test only (without PCR viral load) during the report period.
2) Patients who received HIV Viral load only (without CD4), as measured by PCR or a comparable test, during the report period.
3) Patients who received both CD4 and HIV viral load tests during the report period.
4) Total patients receiving tests.

Definitions

1) **HIV**: POV or Problem List 042, 042.0-044.9 (old codes), 079.53, V08, or 795.71
2) **CD4**: CPT 86359, 86360, 86361; LOINC taxonomy; site-populated taxonomy BGP CD4 TAX
3) **HIV Viral Load**: CPT 87536, 87539; LOINC taxonomy; site-populated taxonomy BGP HIV VIRAL TAX

Patient List

List of patients 13 and older diagnosed with HIV, with CD4 test, if any

2.8.3 Chlamydia Testing

No changes from version 8.0 Patch 3.

Owner/Contact

Epidemiology Program/Dr. Jim Cheek, Lori DeRavello, MPH

National Reporting

Not reported Nationally

Denominator

Female Active Clinical patients ages 16 through 25, broken down into age groups 16–20 and 21–25.

Numerator

Patients tested for Chlamydia trachomatis during the Report Period.

Definitions

Chlamydia: V73.88, V73.98; CPT: 86631, 86632, 87110, 87270, 87320, 87490-87492, 87810; site-populated taxonomy BGP GPRA CHLAMYDIA TESTS; LOINC taxonomy.

Patient List

Patients with documented screening, if any.

2.8.4 Sexually Transmitted Infection (STI) Screening

No changes from version 8.0 Patch.

Owner/Contact

Dr. Scott Giberson

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

Denominators

1) Screenings needed for incidents of key sexually transmitted infections (STIs) for Active Clinical patients that occurred during the period 60 days prior to the beginning of the report period through the first 300 days of the report period. Key STIs defined as Chlamydia, gonorrhea, HIV/AIDS, and syphilis. Broken down by gender.
2) Chlamydia screenings needed for key STI incidents for Active Clinical patients that occurred during the defined period. Broken down by gender.
3) Gonorrhea screenings needed for key STI incidents for Active Clinical patients that occurred during the defined period. Broken down by gender.
4) HIV/AIDS screenings needed for key STI incidents for Active Clinical patients that occurred during the defined period. Broken down by gender.
5) Syphilis screenings needed for key STI incidents for Active Clinical patients that occurred during the defined period. Broken down by gender.

Numerators

1) No denominator; count only. The total count of Active Clinical patients who were diagnosed with one or more key sexually transmitted infections (STIs) during the period 60 days prior to the report period through the first 300 days of the report period. Broken down by gender.
2) No denominator; count only. The total count of separate key STI incidents for Active Clinical patients during the defined period. Broken down by gender.
3) For use with denominator #1: Total number of needed screenings performed or refused from one month prior to the date of relevant STI incident through two months after.
4) For use with denominator #2: Number of needed Chlamydia screenings performed or refused from one month prior to the date of first STI diagnosis of each incident through two months after.
5) For use with denominator #3: Number of needed Gonorrhea screenings performed or refused from one month prior to the date of first STI diagnosis of each incident through two months after.
6) For use with denominator #4: Number of needed HIV/AIDS screenings performed or refused from one month prior to the date of first STI diagnosis of each incident through two months after.

7) For use with denominator #5: Number of needed Syphilis screenings performed or refused from one month prior to the date of first STI diagnosis of each incident through two months after.
   A) Number of documented screening refusals (for use with numerators #3-7).

Definitions

1) **Key Sexually Transmitted Infections (STIs)**: Chlamydia, gonorrhea, HIV/AIDS, and syphilis. Key STIs defined with the following POVS:
   A) Chlamydia: 077.98, 078.88, 079.88, 079.98, 099.41, 099.50-099.59
   B) Gonorrhea: 098.0-098.89
   C) HIV/AIDS: 042, 042.0-044.9, 079.53, 795.71, V08
   D) Syphilis: 090.0-093.9, 094.1-097.9

Logic for Identifying Patients Diagnosed with Key STI (numerator #1):

Any patient with one or more diagnoses of any of the key STIs defined above during the period 60 days prior to the beginning of the report period through the first 300 days of the report period.

Logic for Identifying Separate Incidents of Key STIs (numerator #2):

One patient may have one or multiple occurrences of one or multiple STIs during the year. Incidents of an STI are identified beginning with the date of the first key STI diagnosis (see definition above) occurring between 60 days prior to the beginning of the report period through the first 300 days of the report period. A second incident of the same STI is counted if another diagnosis with the same STI occurs two months or more after the initial diagnosis. A different STI diagnosis that occurs during the same 60-day time period as the first STI counts as a separate incident.

Example of Patient with Multiple Incidents of Single STI:

Date	Visit	Total Incidents
08/01/08	Patient screened for Chlamydia	0
08/08/08	Patient diagnosed with Chlamydia	1
10/15/08	Patient diagnosed with Chlamydia	2
10/25/08	Follow-up for Chlamydia	2
11/15/08	Patient diagnosed with Chlamydia	2
03/01/09	Patient diagnosed with Chlamydia	

Denominator Logic for Needed Screenings (denominator #1):

One patient may need multiple screening tests based on one or more STI incidents occurring during the time period.

To be included in the needed screening tests denominator, the count will be derived from the number of separate STI incidents and the type(s) of screenings recommended for each incident. The recommended screenings for each key STI are listed in the following table.

STI	Screenings Needed
Chlamydia	Gonorrhea, HIV/AIDS, Syphilis
Gonorrhea	Chlamydia, HIV/AIDS, Syphilis
HIV/AIDS	Chlamydia, Gonorrhea, Syphilis
Syphilis	Chlamydia, Gonorrhea, HIV/AIDS

"Needed" screenings are recommended screenings that are further evaluated for contraindications. The following are reasons that a recommended screening is identified as not needed (i.e., contraindicated).

1) The patient has a documented STI diagnosis corresponding to the screening type in the same time period. For example, a patient with both a Chlamydia and a gonorrhea diagnosis on the same visit does not need the recommended Chlamydia screening based on the gonorrhea diagnosis.
2) Only one screening for each type of STI is needed during the relevant time period, regardless of the number of different STI incidents identified. For example, if a patient is diagnosed with Chlamydia and Gonorrhea on the same visit, only one screening each is needed for HIV/AIDS and Syphilis.
3) A patient with HIV/AIDS diagnosis prior to any STI diagnosis that triggers a recommended HIV/AIDS screening does not need the screening ever.

Numerator Logic:

To be counted in the numerator, each needed screening in the denominator must have a corresponding lab test or test refusal documented in the period from one month prior to the relevant STI diagnosis date through two months after the STI incident.

Chlamydia Screening: Any of the following during the specified time period: 1) POV V73.88, V73.98; 2) CPT 86631-86632, 87110, 87270, 87320, 87490-87492, 87810; 3) site-populated taxonomy BGP CHLAMYDIA TESTS TAX; or 4) LOINC taxonomy.

Gonorrhea Screening: Any of the following during the specified time period: 1) CPT 87590-87592, 87850; 2) site-populated taxonomy BKM GONORRHEA TEST TAX; or 3) LOINC taxonomy.

HIV/AIDS Screening: Any of the following during the specified time period: 1) CPT 86689, 86701-86703, 87390-87391, 87534-87539; 2) site-populated taxonomy BGP HIV TEST TAX; or 3) LOINC taxonomy.

Syphilis Screening: Any of the following during the specified time period: 1) CPT 86592-86593, 86781, 87285; 2) site-populated taxonomy BKM FTA-ABS TESTS TAX or BKM RPR TESTS TAX; 3) LOINC taxonomy.

Refusal of Any Screening: Any refusal type (REF, NMI, etc.) for any of the four screening tests as defined above during the specified time period.

Logic Examples:

Example of Patient with Single Diagnosis of Single STI

08/01/08: Patient screened for Chlamydia

08/08/08: Patient diagnosed with Chlamydia - 3 screens needed: Gonorrhea, HIV/AIDS, Syphilis

08/13/08: Patient screened for Gonorrhea, HIV/AIDS, Syphilis

Result: Denominator: 3 screens needed, Numerator: 3 screens performed

Example of Patient with Multiple Diagnoses of Single STI

08/01/08: Patient screened for Chlamydia

08/08/08: Patient diagnosed with Chlamydia (Incident #1) - 3 screens needed: Gonorrhea, HIV/AIDS, Syphilis

08/13/08: Patient screened for Gonorrhea, HIV/AIDS, Syphilis

12/01/08: Patient screened for Chlamydia

12/08/08: Patient diagnosed with Chlamydia (Incident #2) - 3 screens needed: Gonorrhea, HIV/AIDS, Syphilis

Result: Denominator: 6 screens needed (2 each of 3 types), Numerator: 3 screens performed (1 each of 3 types)

Example of Patient with Single Diagnosis of Multiple STIs

10/15/08: Patient screened for Chlamydia, Gonorrhea, HIV/AIDS, Syphilis

10/18/08: Patient diagnosed with Chlamydia - 3 screens needed: Gonorrhea, HIV/AIDS, Syphilis

10/20/08: Patient diagnosed with Syphilis - removes needed screen for Syphilis (see above)

Result: Denominator: 2 screens needed, Numerator: 2 screens performed prior to triggering diagnoses but within timeframe)

Example of Patient with Multiple Diagnoses of Multiple STIs

06/15/04: Patient diagnosed with HIV/AIDS

08/01/08: Patient screened for Chlamydia and Gonorrhea

08/08/08: Patient diagnosed with Chlamydia and Gonorrhea (Incident #1) - 1 screen needed: Syphilis (HIV/AIDS not needed since prior diagnosis)

08/08/08: Patient screened for HIV/AIDS and Syphilis - since only the Syphilis screen is needed, the HIV/AIDS screen is not counted at all

12/01/08: Patient screened for Chlamydia

12/08/08: Patient diagnosed with Chlamydia (Incident #2) - 2 screens needed: Gonorrhea and Syphilis

12/10/08: Patient screened for Syphilis

Result: Denominator: 3 screens needed (2 Syphilis and 1 Gonorrhea), Numerator: 2 screens performed (2 Syphilis)

Patient List

Patients diagnosed with one or more STIs during the defined time period with related screenings.

2.9 Other Clinical Measures Group

2.9.1 Osteoporosis Management

No changes from version 8.0 Patch 3.

Owner/Contact

Drs. Bruce Finke and Lisa Sumner

National Reporting

Not reported Nationally

Denominator

1) 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.

Numerator

1) Patients treated or tested for osteoporosis after the fracture.

Definitions

1) Fracture: 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.
   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.

   Fracture codes:

   A) CPTs: 21800-21825, 22305-22328, 22520, 22521, 22523, 22524, 23500-23515, 23570-23630, 23665-23680, 24500-24587, 24620, 24635, 24650-24685, 25500-25609, 25611 (old code), 25620 (old code), 25622-25652, 25680, 25685, 27193-27248, 27254, 27500-27514, 27520-27540, 27750-27828, S2360, S2362;

   B) POVs: 733.1*, 805*-806*, 807.0*-807.4, 808*-815*, 818*-825*, 827*, 828*;

   C) V Procedure: 79.01-79.03, 79.05-79.07, 79.11-79.13, 79.15-79.17, 79.21-79.23, 79.25-79.27, 79.31-79.33, 79.35-79.37, 79.61-79.63, 79.65-79.67, 81.65, 81.66.

2) **Osteoporosis Treatment and Testing**:

A) For fractures diagnosed at an outpatient visit: I) A nondiscontinued 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.

3) **BMD Test**:
   A) CPT: 77078, 76070 (old code), 77079, 76071 (old code), 77080, 76075 (old code), 77081, 76076 (old code), 77083, 76078 (old code), 76977, 78350, 78351, G0130;
   B) V Procedure 88.98;
   C) POV V82.81.
4) **Osteoporosis Treatment Medication**: Medication taxonomy BGP HEDIS OSTEOPOROSIS MEDS. (Medications are Alendronate, Alendronate-Cholecalciferol (Fosomax Plus D), Ibandronate (Boniva), Risedronate, Calcitonin, Raloxifene, Estrogen, Injectable Estrogens, and Teriparatide.

Denominator Exclusions:

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 above for codes) or receiving any osteoporosis therapy medication (see above for codes).
2) Patients with a fracture diagnosed at an outpatient visit, which ALSO had a fracture within 60 days prior to the Index Episode Start Date.
3) Patients with a fracture diagnosed at an inpatient visit, which ALSO had a fracture within 60 days prior to the ADMISSION DATE.

Patient List

Female patients with new fracture who have had osteoporosis treatment or testing, if any.

2.9.2 Osteoporosis Screening in Women

No changes from version 8.0 Patch 3.

Owner/Contact

Drs. Bruce Finke and Lisa Sumner

National Reporting

Not reported Nationally

Denominator

Female Active Clinical patients ages 65 and older without a documented history of osteoporosis.

Numerator

Patients who had osteoporosis screening documented in the past two years, including documented refusals in past year.

A) Patients with documented refusal in past year

Definitions

1) **Patients without Osteoporosis**: No osteoporosis diagnosis ever (POV 733.*).
2) **Osteoporosis Screening**: Any one of the following in the past two years or documented refusal in the past year:
   A) **Central DEXA**: CPT 77080, 76075 (old code);
   B) **Peripheral DEXA**: CPT 77081, 76076 (old code);
   C) **SEXA**: CPT G0130;
   D) **Central CT**: CPT 77078, 76070 (old code);
   E) **Peripheral CT**: CPT 77079, 76071 (old code);
   F) **US Bone Density**: CPT 76977;
   G) **Quantitative CT**: V Procedure 88.98;
   H) **POV V82.81** Special screening for other conditions, Osteoporosis

Patient List

Female patients ages 65 and older with osteoporosis screening, if any.

2.9.3 Rheumatoid Arthritis Medication Monitoring

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Dr. Lisa Sumner

National Reporting

Not reported Nationally

Denominator

Active Clinical patients ages 16 and older diagnosed with rheumatoid arthritis (RA) prior to the report period and with at least two RA-related visits any time during the report period who were prescribed maintenance therapy medication chronically during the report period.

Numerator

Patients who received appropriate monitoring of chronic medication during the report period.

Definitions

1) **Rheumatoid Arthritis (RA)**: diagnosis (POV or Problem List) 714.* prior to the report period, and at least two RA POVs during the report period.
2) **Maintenance Therapy Medications and Monitoring**: For all maintenance therapy medications *except* intramuscular gold, each medication must be prescribed within the past 465 days of the end of the report period (i.e. the Medication Period) and the sum of the days supply =>348. This means the patient must have been on the medication at least 75% of the medication period. The following two examples illustrate this logic.
   Example of Patient Not on Chronic Medication (not included in Denominator)

   Report Period: Jan 1 – Dec 31, 2005

   Medication Period: 465 days from end of report period (Dec 31, 2005): Sep 22, 2004 – Dec 31, 2005

   Medication Prescribed:

   Diclofenac: 1st Rx: Oct 15, 2004, Days Supply=90; 2nd Rx: Jan 1, 2005: Days Supply=90; 3rd Rx: Mar 15, 2005: Days Supply=90.

   Total Days Supply=270. 270 is not >348. Patient is not considered on chronic medication and is not included in the denominator.

   The days supply requirement may be met with a single prescription or from a combination of prescriptions for the same medication that were filled during the medication period. However, for all medications, there must be at least one prescription filled during the Report period.

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. For example: Rx Date=11/15/2003, Discontinued Date=11/19/2003, Recalculated # Days Prescribed=4.

For intramuscular gold, the patient must have 12 or more injections during the report period.

Appropriate monitoring of rheumatoid arthritis medications is defined with lab tests and varies by medication, as shown in the table below. If patient is prescribed two or more types of medications, patient must meet criteria for all of the medications.

Maintenance Therapy Medications defined as

A) Medications shown in table below. *except* for Gold, Intramuscular, all medications requiring more than one of each type of test during the report period, there must be a minimum of 10 days between tests. For example, if a Sulfasalazine test was performed on March 1, March 7, and March 21, 2005, the March 7 test will not be counted since it was performed only 6 days after the March 1 test.

Medication	Required Monitoring Test(s) and Frequency
Gold, Intramuscular	CBC and Urine Protein on same day as each injection during report period.
Azathrioprine or Sulfasalazine	4 CBCs during the report period.
Leflunomide or Methotrexate	6 each of CBC, Serum Creatinine, and Liver Function Test during the Report Period.
Cyclosporin	CBC, Liver Function Tests, and Potassium within past 180 days from Report Period end date. 12 Serum Creatinine tests during the report period
Gold, Oral or Penicillamine	4 each of CBC and Urine Protein during the report period.
Mycophenolate	CBC within past 180 days from report period end date.

The medications in the previous table are defined with medication taxonomies: BGP RA IM GOLD MEDS, BGP RA AZATHIOPRINE MEDS, BGP RA LEFLUNOMIDE MEDS, BGP RA METHOTREXATE MEDS, BGP RA CYCLOSPORINE MEDS, BGP RA ORAL GOLD MEDS, BGP RA MYCOPHENOLATE MEDS, BGP RA PENICILLAMINE MEDS, BGP RA SULFASALAZINE MEDS.

B) NSAID Medications: All of the following NSAID medications must have Creatinine, Liver Function Tests, and CBC during the report period: Diclofenac, Etodolac, Indomethacin, Ketorolac, Sulindac, Tolmetin, Meclofenamate, Mefanamic Acid, Nabumetone, Meloxicam, Piroxicam, Fenoprofen, Flurbiprofen, Ibuprofen, Ketoprofen, Naproxen, Oxaprozin, Aspirin, Choline Magnesium Trisalicylate, Diflunisil, Magnesium Salicylate, Celocoxib. All of these medications EXCEPT aspirin are defined with medication taxonomy BGP RA OA NSAID MEDS. Aspirin defined with medication taxonomy DM AUDIT ASPIRIN DRUGS.

C) Glucocorticoid Medications: Dexamethasone, Methylprednisolone, Prednisone, Hydrocortisone, Betamethasone, Prednisonolone, Triamcinolone. These medications defined with medication taxonomy BGP RA GLUCOCORTICOIDS MEDS. Glucocorticoids must have a glucose test, which must be performed during the Report Period.

Example of Patient Not Included in Numerator:

Medications Prescribed and Required Monitoring:

Gold, Oral, last Rx Jun 15, 2005. Requires CBC and Urine Protein within past 90 days of Report Period end date.

CBC performed on Dec 1, 2005, which is within past 90 days of report period end date of Dec 31, 2005. No Urine Protein performed during that period. Patient is not in numerator.

Example of Patient Included in Numerator:

Medications Prescribed and Required Monitoring:

Diclofenac, last Rx Sep 1, 2005. Requires LFT and CBC during report period. Mycophenolate, last Rx Mar 10, 2005. Requires CBC within past 180 days from report period end date.

LFT and CBC performed during report period. CBC performed Nov 1, 2005, which is within past 180 days of report period end date of Dec 31, 2005. Patient is in numerator.

3) **CBC (Complete Blood Count)**: CPT 85025, 85027; site-populated taxonomy BGP CBC TESTS; or LOINC taxonomy.
4) **Urine Protein**: Site-populated taxonomy DM AUDIT URINE PROTEIN TAX or LOINC taxonomy ***(added codes 50556-0, 50561-0, 50564-4)***.
5) **Serum Creatinine**: CPT 82540, 82565-75; site-populated taxonomy DM AUDIT CREATININE TAX; or LOINC taxonomy.
6) **Liver Function Tests**: Any one of the following:

A) ALT: CPT 84460, site-populated taxonomy DM AUDIT ALT, or LOINC taxonomy;

B) AST: CPT 84450, site-populated taxonomy DM AUDIT AST, or LOINC taxonomy; OR

C) Liver Function: CPT 80076, site-populated taxonomy BGP LIVER FUNCTION, or LOINC taxonomy.

7) **Glucose**: CPT 82947, 82948, 82950, 82951, 82952, 82962; site-populated taxonomy DM AUDIT GLUCOSE TESTS TAX; or LOINC taxonomy.

8) **Potassium**: CPT 84132; site-populated taxonomy BGP POTASSIUM; or LOINC taxonomy.

Patient List

RA patients 16 and older prescribed maintenance therapy medication with monitoring laboratory tests, if any. The numerator values for patients who meet the measure are prefixed with "YES" and patients who did not meet the measure are prefixed with "NO". The chronic medications and all lab tests the patient *did* have are displayed

2.9.4 Osteoarthritis Medication Monitoring

No changes from version 8.0 Patch 3.

Owner/Contact

Dr. Charles (Ty) Reidhead

National Reporting

Not reported Nationally

Denominator

Active Clinical patients ages 40 and older diagnosed with osteoarthritis (OA) prior to the report period and with at least two OA-related visits any time during the report period and prescribed maintenance therapy medication chronically during the report period.

Numerator

Patients who received appropriate monitoring of chronic medication during the report period.

Definitions

1) **Osteoarthritis (OA)**: Diagnosis (POV or Problem List) 715.* prior to the report period, and at least two OA POVs during the report period.
2) **Maintenance Therapy Medications and Monitoring**: For all maintenance therapy medications, each medication must be prescribed within the past 465 days of the end of the report period (i.e., the medication period) and the sum of the days supply =>348. This means the patient must have been on the medication at least 75% of the medication period. The following two examples illustrate this logic.

   Example of Patient Not on Chronic Medication (not included in Denominator):

   Report Period: Jan 1 – Dec 31, 2005

   Medication Period: 465 days from end of report period (Dec 31, 2005): Sep 22, 2004 – Dec 31, 2005

   Medication Prescribed:

   Diclofenac: 1st Rx: Oct 15, 2004, Days Supply=90; 2nd Rx: Jan 1, 2005: Days Supply=90; 3rd Rx: Mar 15, 2005: Days Supply=90.

   Total Days Supply=270. 270 is not >348. Patient is not considered on chronic medication and is not included in the denominator.

   Example of Patient on Chronic Medication (included in Denominator):

   Report Period: Jan 1 – Dec 31, 2005

Medication Period: 465 days from end of Report Period (Dec 31, 2005): Sep 22, 2004 – Dec 31, 2005

Medication Prescribed:

Etodolac: 1st Rx: Sep 30, 2004, Days Supply=90; 2nd Rx: Dec 30, 2004, Days Supply=90; 3rd Rx: Mar 15, 2005: Days Supply=180.

Total Days Supply=360. 360 is >348. Patient is considered on chronic medication and included in denominator.

The days supply requirement may be met with a single prescription or from a combination of prescriptions for the same medication that were filled during the medication period. However, for all medications, there must be at least one prescription filled during the report period.

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. For example: Rx Date=11/15/2003, Discontinued Date=11/19/2003, Recalculated # Days Prescribed=4.

Appropriate monitoring of osteoarthritis medications is defined with laboratory tests and varies by medication, as shown in below.

Maintenance Therapy Medications defined as:

NSAID Medications: All of the following NSAID medications must have Creatinine, Liver Function Tests, and CBC during the report period: Diclofenac, Etodolac, Indomethacin, Ketorolac, Sulindac, Tolmetin, Meclofenamate, Mefanamic Acid, Nabumetone, Meloxicam, Piroxicam, Fenoprofen, Flurbiprofen, Ibuprofen, Ketoprofen, Naproxen, Oxaprozin, Aspirin, Choline Magnesium Trisalicylate, Diflunisil, Magnesium Salicylate, Celocoxib. All of these medications EXCEPT aspirin are defined with medication taxonomy BGP RA OA NSAID MEDS. Aspirin defined with medication taxonomy DM AUDIT ASPIRIN DRUGS.

Example of Patient Included in Numerator:

Medications Prescribed and Required Monitoring:

- Diclofenac, last Rx Sep 1, 2005. Requires Creatinine, LFT, and CBC during Report Period.
- Creatinine, LFT, and CBC performed during Report Period.
- Patient is in the numerator.

3) **Serum Creatinine**: CPT 82540, 82565-75; LOINC taxonomy; site-populated taxonomy DM AUDIT CREATININE TAX.
4) **CBC (Complete Blood Count)**: CPT 85025, 85027; site-populated taxonomy BGP CBC TESTS; or LOINC taxonomy.

5) **Liver Function Tests**: Any one of the following:
   A) ALT: CPT 84460, site-populated taxonomy DM AUDIT ALT, or LOINC taxonomy;
   B) AST: CPT 84450, site-populated taxonomy DM AUDIT AST, or LOINC taxonomy; OR
   C) Liver Function: CPT 80076, site-populated taxonomy BGP LIVER FUNCTION, or LOINC taxonomy.

Patient List

OA patients 40 and older prescribed maintenance therapy medication with monitoring laboratory tests, if any.

2.9.5 Asthma

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Drs. Charles (Ty) Reidhead and Charles North

National Reporting

Not reported Nationally

Denominator

1) Active Clinical patients, broken out by age groups: <5, 5-64; 65 and older (HP 2010).
2) Patients who have had two asthma-related visits during the report period or with persistent asthma).

Numerator

1) Patients who have had two asthma-related visits during the report period ***(DELETED: OR who are Active patients in the Asthma Register System (ARS) and categorized as persistent (i.e. Severity 2, 3 or 4) (also used as second denominator)***, or with ***persistent asthma***.
   A) Patients from Numerator 1 who have been hospitalized at any hospital for asthma during the report period.

Definitions

1) Age is calculated at beginning of the report period. Asthma visits are defined as diagnosis (POV) 493.*.
2) ***Persistent asthma is defined with any of the following: (Revised method for checking for persistent asthma from checking for active patients in ARS to patients with an active entry in the PCC problem list for 493.* with a severity of 2, 3, or 4 at any time before the end of the report period. This change was needed because the ARS application was retired).***
   A) ***Active entry in PCC Problem List for 493.* with Severity of 2, 3 or 4 at ANY time before the end of the report period or***
   B) ***Most recent visit-related asthma entry (i.e., V Asthma) with Severity of 2, 3, or 4 documented ANY time before the end of the report period.***
3) Hospitalizations defined as service category H with primary POV 493.*.

Patient List

Patients diagnosed with asthma and any asthma-related hospitalizations.

2.9.6 Asthma Quality of Care

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Drs. Charles (Ty) Reidhead and Charles North

National Reporting

Not reported Nationally

Denominator

1) Active Clinical patients ages 5–56 with persistent asthma within the year prior to the beginning of the report period and during the report period, without a documented history of emphysema or chronic obstructive pulmonary disease (COPD), broken down by age groups.
   A) Active Clinical patients ages 5-9.
   B) Active Clinical patients ages 10-17.
   C) Active Clinical patients ages 18-56.

Numerator

Patients who had at least one dispensed prescription for ***(DELETED: primary) preferred*** asthma therapy medication during the report period.

Definitions

1) Age of the patient is calculated at the beginning of the report period.
2) **Emphysema**: Any visit at any time on or before the end of the report period with POV codes: 492.*, 506.4, 518.1, 518.2.
3) **Chronic obstructive pulmonary disease (COPD)**: Any visit at any time on or before the end of the report period with POV codes: 491.20, 491.21, 491.22, 493.2*, 496, 506.4.
4) **Persistent Asthma**:
   A) Meeting any of the following four criteria below within the year prior to the beginning of the report period *and* during the report period:
      1. At least one visit to Clinic Code 30 (Emergency Medicine) with primary diagnosis 493.* (asthma),
      2. At least one acute inpatient discharge with primary diagnosis 493.*. Acute inpatient discharge defined as Service Category of H,
      3. 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),

4. At least 4 asthma medication dispensing events (see definition below). If the sole medication was leukotriene modifiers, then *must* (DELETED: also meet criteria in 1–3 above or) also have at least one visit with POV 493.* in the same year as the leukotriene modifier (i.e. during the report period or within the year prior to the beginning of the report period.), *or*

B) Meeting any of the following criteria below:

1. ***(DELETED: Categorized in the Asthma Register System (ARS)) Active entry in PCC Problem List for 493.* with Severity of 2, 3 or 4 at ANY time before the end of the report period or***
2. ***Most recent visit-related asthma entry (i.e. V Asthma) with Severity of 2, 3, or 4 documented ANY time before the end of the report period.***

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

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

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

5) ***(DELETED: Primary)*** Preferred Asthma Therapy: To be included in the numerator, patient must have a nondiscontinued prescription for ***(DELETED: primary) preferred*** asthma therapy (see list of medications below) during the report period.

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

Patient List

List of asthmatic patients with ***(DELETED: primary) preferred*** asthma therapy medications, if any.

2.9.7 Asthma and Inhaled Steroid Use

Changes from Version 8.0 Patch 3 noted below.

Owner/Contact

Drs. Charles (Ty) Reidhead and Charles North

National Reporting

Not reported Nationally

Denominator

Active Clinical patients ages 1 or older ***(DELETED: who are categorized in ARS as with)*** persistent asthma or who have had two asthma-related visits during the report period. Broken down into age groups: 1–4, 5–19, 20–44, 45–64, and 65+.

Numerator

Patients prescribed an inhaled corticosteroid during the report period.

Definitions

1) **Denominator Exclusion**: Patients with intermittent asthma, ***(DELETED: defined as active in the Asthma Register System (ARS) and with a severity of 1 during the report period) defined as any of the following:***

1) ***An Active entry in PCC Problem List for 493.* with a Severity of 1 at ANY time before the end of the report period, or***
2) ***Most recent visit-related asthma entry (i.e. V Asthma) with Severity of 1 documented ANY time before the end of the report period.***

2) Asthma definition:

A) CRS will first search ***(DELETED: the Asthma Register System (ARS))*** to see if the patient has persistent asthma, which is ***(DELETED: defined as active in the ARS and has a severity of 2, 3, or 4 during the report period)*** defined as any of the following:

1) ***An Active entry in PCC Problem List for 493.* with a Severity of 2, 3, or 4 at ANY time before the end of the report period or***
2) ***Most recent visit-related asthma entry (i.e., V Asthma) with Severity of 2, 3, or 4 documented ANY time before the end of the report period.***

B) If the patient does not meet any of the above criteria, then CRS will search for two asthma-related visits during the report period. Asthma-related visit defined as any primary or secondary POV of asthma 493.*.

NOTE: For facilities not using asthma staging (severity assessment) in ***the (DELETED: ARS) PCC Problem List***, CRS will rely on visit criteria for this assessment. This will result in patients with intermittent asthma being included in the denominator. The Expert Guideline driven method for managing patients with asthma is by staging them in ***the (DELETED: ARS) PCC Problem List***. Doing so will improve the accuracy of the information reported by CRS.

1) **Inhaled Corticosteroid**: To be included in the numerator, patient must have a non-discontinued prescription for an inhaled corticosteroid during the Report period. Inhaled corticosteroid medications defined with medication taxonomy BGP ASTHMA INHALED STEROIDS. (Medications are: Mometasone (Asmanex), Beclovent, Qvar, Vancenase, Vanceril, Vanceril DS, Bitolerol (Tornalate), Pulmicort, Pulmicort Respules, Pulmicort Turbohaler, Salmeterol/fluticasone (Advair), Triamcinolone (Azmacort), Fluticasone (Flovent), Budesonide-Formoterol (Symbicort).

Patient List

Patients with asthma with inhaled corticosteroid prescription, if any.

2.9.8 Community-Acquired Bacterial Pneumonia (CAP) Assessment of Oxygen Saturation

Topic added from the EO Quality Transparency Measures Report included in CRS version 8.0 Patch 3. Changes from CRS version 8.0 Patch 3 are noted below.

Owner/Contact

Dr. Charles (Ty) Reidhead

Denominators

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

Numerators

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

Definition

1) **Age**: Age of the patient is calculated at the beginning of the report period.
2) **Community-acquired Bacterial Pneumonia**: Non-CHS outpatient visit (defined as (visit) Type not equal to "C" and Service Category of A (Ambulatory), S (Day Surgery), or O (Observation)) with POV 481, 482.0, 482.1, 482.2, 482.30, 482.31,

482.32, 482.39, 482.40, 482.41, ***482.42***, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, or 487.0. 482.42
If a patient has more than one visit for community-acquired bacterial pneumonia during the report period, each visit will be counted as long as it has been more than 45 days since the date of the prior visit. For example, a patient was diagnosed on January 1, 2008 and 35 days later he was diagnosed again with pneumonia. That second diagnosis does not count as a separate visit. However, if the patient were diagnosed again on February 16, 2008 (46 days after onset), that diagnosis counts as a separate visit. Because RPMS does not store the date of onset, visit date will be used as a surrogate for onset date.

3) **Oxygen Saturation Assessment**: Having any of the following arterial blood gas (ABG) or pulse oximetry tests performed at the visit: 1) V Measurement O2 Saturation; 2) V CPT 94760-94762, 82803, 82805, 82810, or 3028F, where 3028F has no modifier of 1P, 2P, 3P, or 8P; 3) laboratory test ABG; 4) site-populated lab taxonomy BGP CMS ABG TESTS; or 5) LOINC taxonomy.
4) **Refusal of Oxygen Saturation Assessment**: Patients whose oxygen saturation was not assessed due to a patient refusal of assessment on visit date. Refusal is defined as refusal of any of the tests listed above.
5) **No Assessment**: Patients who oxygen saturation was not assessed or refused.

Patient List

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

2.9.9 Chronic Kidney Disease Assessment

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Kidney Disease Program/Dr. Andrew Narva

Denominator:

Active Clinical patients ages 18 and older with serum creatinine test during the report period.

Numerators:

1) Patients with Estimated GFR.
   A) Patients with GFR less than (<) 60.
   B) Patients with normal GFR (i.e. >=60).

Definitions:

1) Age is calculated at beginning of the report period.
2) **Creatinine definition**: CPT 82540, 82565-75; LOINC taxonomy; site-populated taxonomy DM AUDIT CREATININE TAX.
3) **Estimated GFR (Glomerular Filtration Rate) definition**: site-populated taxonomy BGP GPRA ESTIMATED GFR TAX; LOINC code 33914-3.
   For the GFR <60 numerator, CRS will include GFR results containing a numeric value less than 60 or with a value of "<60". For the normal GFR (>=60) numerator, CRS will include GFR results containing a numeric value equal to or greater than 60 or with a value of ">60".

Patient List:

Patients with Creatinine test, with GFR and value, if any.

2.9.10 Prediabetes/Metabolic Syndrome

Changes from version 8.0 Patch 3 noted below.

Owner/Contact

Drs. Stephen J. Rith Najarian and Kelly Moore

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

Denominator

Active Clinical patients ages 18 and older diagnosed with prediabetes/metabolic syndrome without a documented history of diabetes.

Numerators

1) Patients with BP documented at least twice during the report period.
2) Patients with LDL completed, regardless of result, during the report period.
3) Patients with fasting glucose test, regardless of result, during the report period.
4) Patients with nephropathy assessment, defined as an estimated GFR and a quantitative urinary protein assessment (changed from positive urine protein or any microalbuminuria) during the report period *or* with evidence of diagnosis and/or treatment of ESRD at any time before the end of the report period.
5) Patients who have been screened for tobacco use during the report period.
6) Patients for whom a BMI could be calculated, including refusals in the past year.
7) Patients who have received any lifestyle adaptation counseling, including medical nutrition counseling, or nutrition, exercise or other lifestyle education during the report period.
8) Patients screened for depression or diagnosed with a mood disorder at any time during the report period, including documented refusals in past year.
9) Patients with all screenings.

Definitions

1) **Age** is calculated at beginning of the report period.
2) **Prediabetes/Metabolic Syndrome**: Diagnosis of prediabetes/metabolic syndrome, defined as: two visits during the report period with POV 277.7, *or* one each of at least three different conditions listed below, occurring during the report period except as otherwise noted:
   A) BMI => 30 *or* Waist Circumference >40 inches for men or >35 inches for women,
   B) Triglyceride value >=150,
   C) HDL value <40 for men or <50 for women,
   D) Patient diagnosed with hypertension *or* mean BP value => 130/85 where systolic is =>130 *or* diastolic is =>85,
   E) Fasting Glucose value =>100 AND <126.

Note: Waist circumference and fasting glucose values will be checked last.

3) **Patients without Diabetes**: No diabetes diagnosis ever (POV 250.00-250.93).
4) **BMI**: 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, NMI and UAS 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.
5) **Triglyceride**: LOINC taxonomy; or site-populated taxonomy DM AUDIT TRIGLYCERIDE TAX with a non-null, numeric result.
6) **HDL**: CPT 83718; LOINC taxonomy; or site-populated taxonomy DM AUDIT HDL TAX with a non-null, numeric result.
7) **Fasting Glucose**:
   Denominator definition: LOINC taxonomy or site-populated taxonomy DM AUDIT FASTING GLUCOSE TESTS with a non-null, numeric result;

   Numerator definition: POV 790.21; LOINC taxonomy; or site-populated taxonomy DM AUDIT FASTING GLUCOSE TESTS.

8) **LDL**: Finds last test done during the report period; defined as: CPT 80061, 83700, 83701, 83704, 83715 (old code), 83716 (old code), 83721, 3048F, 3049F, 3050F; LOINC taxonomy; or site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX.
9) **Blood Pressure**: CRS uses the mean of the last 3 Blood Pressures documented on non-ER visits during the report period. If 3 BPs are not available, use the mean of the 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).
   For the BP documented numerator, if CRS is not able to calculate a mean BP, it will search for CPT 3074F-3080F 3074F-3076F, 3078F-3079F) documented on a non-ER visit during the report period.
10) **Hypertension**: Diagnosis of (POV or problem list) 401.* occurring prior to the Report period, and at least one hypertension POV during the report period.
11) **Estimated GFR**: Any of the following: Site-populated taxonomy BGP GPRA ESTIMATED GFR TAX or LOINC taxonomy.
12) **Quantitative Urine Protein Assessment**: Any of the following: CPT 82042, 82043, or 84156; LOINC taxonomy; or site-populated taxonomy BGP QUANT URINE PROTEIN

Note: Be sure and check with your laboratory supervisor that the names you add to your taxonomy reflect quantitative test values.

13) **End Stage Renal Disease Diagnosis/Treatmen**t:

End Stage Renal Disease diagnosis/treatment defined as any of the following ever:

A) V CPT 36145, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, ***90951-90970*** or **(old codes)** 90918-90925, 90935, 90937, 90939 ***(old code)***, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, G0257, G0308-G0327, ***G0392, G0393***, or S9339; B) V POV 585.5, 585.6, V42.0, V45.1 ***(old code), V45.11, V45.12***, or V56.*; C) V Procedure 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6*.

14) **Tobacco Screening**: At least one of the following during the report period:

A) Any health factor for category Tobacco documented during current report period;

B) Tobacco-related diagnoses (POV or current Active Problem List) 305.1, 305.1* (old codes), 649.00-649.04, or V15.82;

C) Dental code 1320; D) Any patient education code containing "TO-", "-TO", "-SHS", 305.1, 305.1* (old codes), 649.00-649.04, or V15.82; E) CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, or 1036F.

15) **Lifestyle Counseling**: Any of the following during the report period:

A) Medical nutrition counseling defined as: CPT 97802-97804, G0270, G0271; Provider codes 07, 29, 97, 99; Clinic codes 67 (dietary) or 36 (WIC),

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)) or containing V65.3,

C) Exercise education defined as: POV V65.41 exercise counseling; patient education codes ending "-EX" (Exercise), or containing V65.41,

D) Related exercise and nutrition counseling defined as: patient education codes ending "-LA" (lifestyle adaptation) or containing "OBS-" (obesity) or 278.00 or 278.01.

17) **Depression Screening/Mood Disorder DX**: Any of the following during the report period:

A) Depression Screening:

1) Exam Code 36,
2) POV V79.0,
3) BHS problem code 14.1 (screening for depression),
4) V Measurement in PCC or BH of PHQ2 or PHQ9, or
5) refusal, defined as any PCC refusal in past year with Exam Code 36.

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.

Patient List

Patients 18 and older with Prediabetes/Metabolic Syndrome with assessments received, if any.

2.9.11 Medications Education

No changes from version 8.0 Patch 3

Owner/Contact

Patient Education Program/ Cheryl Peterson, RN.

National Reporting

Not reported Nationally

Denominator

Active Clinical patients with medications dispensed at their facility during the report period.

Numerator

Patients who were provided patient education about their medications in *any* location.

Definitions

1) **Dispensed Medications**: Any entry in the VMed file for your facility.
2) **Medication Education**: Any Patient Education code containing "M-" or "-M" or Patient Education codes DMC-IN, FP-DPO, FP-OC, ASM-NEB, ASM-MDI, PL-NEB, PL-MDI, or FP-TD.

Patient List

Patients receiving medications with med education, if any

2.9.12 Public Health Nursing

No changes from version 8.0 Patch 3.

Owner/Contact

Cheryl Peterson, RN

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

Denominators

1) User Population patients.
2) Number of visits to User Population patients 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).
   A) Number of PHN driver/interpreter (provider code 91) visits.
3) Number of visits to User Population patients 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

Numerator

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.

Definitions

1) **PHN Visit-Any Setting**: Any visit with primary or secondary provider codes 13 or 91.
2) **PHN Visit-Home**: 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) AND a primary or secondary provider code 13 or 91.

Patient List

Patients with PHN visits documented.

2.9.13 Breastfeeding Rates

No changes from version 8.0 Patch 3.

> **Note:** This measure is used in conjunction with the Childhood Weight Control GPRA measure to support the reduction of the incidence of childhood obesity.

Owner/Contact

Cheryl Peterson, RN

National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

Denominators

1) Active Clinical patients who are 45–394 days old.
2) Active Clinical patients who are 45–394 days old who were screened for infant feeding choice at the age of two months (45–89 days).
3) Active Clinical patients who are 45–394 days old who were screened for infant feeding choice at the age of six months (165–209 days).
4) Active Clinical patients who are 45–394 days old who were screened for infant feeding choice at the age of nine months (255–299 days).
5) Active Clinical patients who are 45–394 days old who were screened for infant feeding choice at the age of 1 year (350–394 days)

Numerators

1) Patients who were screened for infant feeding choice at least once.
2) Patients who were screened for infant feeding choice at the age of two months (45–89 days).
3) Patients were screened for infant feeding choice at the age of six months (165–209 days).
4) Patients who were screened for infant feeding choice at the age of nine months (255–299 days).
5) Patients who were screened for infant feeding choice at the age of 1 year (350–394 days).
6) Patients who, at the age of two months (45–89 days), were either exclusively or mostly breastfed.
7) Patients who, at the age of six months (165–209 days), were either exclusively or mostly breastfed.
8) Patients who, at the age of nine months (255–299 days), were either exclusively or mostly breastfed.
9) Patients who, at the age of 1 year (350–394 days), were either exclusively or mostly breastfed.

Definitions

1) **Infant Feeding Choice**: The documented feeding choice from the file V Infant Feeding Choice that is closest to the exact age that is being assessed will be used. For example, if a patient was assessed at 45 days old as 1/2 breastfed and 1/2 formula and assessed again at 65 days old as mostly breastfed, the mostly breastfed value will be used since it is closer to the exact age of 2 months (i.e. 60 days). Another example is a patient who was assessed at 67 days as mostly breastfed and again at 80 days as mostly formula. In this case, the 67 days value of mostly breastfed will be used. The other exact ages are 180 days for 6 months, 270 days for 9 months, and 365 days for 1 year.
   In order to be included in the age-specific screening numerators, the patient must have been screened at the specific age range. For example, if a patient was screened at 6 months and was exclusively breastfeeding but was not screened at 2 months, then the patient will only be counted in the 6 months numerator.

Patient List

Patients 45–394 days old, with infant feeding choice value, if any.

2.9.14 Drugs to be Avoided in the Elderly

No changes from version 8.0 Patch 3.

Owner/Contact

Dr. Bruce Finke

National Reporting

Not reported Nationally

Denominator

Active Clinical patients ages 65 and older, broken down by gender.

Numerators

1) Patients who received at least one drug to be avoided in the elderly during the report period.
2) Patients who received at least two different drugs to be avoided in the elderly during the report period.

Definitions

1) **Drugs to be Avoided in the Elderly** (i.e. potentially harmful drugs): Defined with medication taxonomies:
   A) BGP HEDIS ANTIANXIETY MEDS (Meprobamate [Equagesic, Equanil, Miltown])
   B) BGP HEDIS ANTIEMETIC MEDS (Trimethobenzamide [Tigan])
   C) BGP HEDIS ANALGESIC MEDS (Ketorolac [Tordal])
   D) BGP HEDIS ANTIHISTAMINE MEDS (Cyproheptadine [Periactin], Dexchlorpheniramine [Polaramine], Diphenhydramine [Benadryl], Ephedrine, Hydroxyzine [Vistaril, Atarax], Promethazine [Phenergan], Theophylline, Tripelennamine)
   E) BGP HEDIS ANTIPSYCHOTIC MEDS (Thioridazine [Mellaril])
   F) BGP HEDIS AMPHETAMINE MEDS (Amphetamine Mixtures [Adderall], Benzphetamine [Didrex], Dextroamphetamine [Dexedrine], Dexmethylphenidate, Diethylproprion [Tenuate], Methamphetamine [Desoxyn], Methylphenidate [e.g., Ritalin, Methylin], Phendimetrazine [Prelu-2], Phenteramine [Ionamin, Adipex])
   G) BGP HEDIS BARBITUATE MEDS (Amobarbital/Secobarbital [Tuinal], Amytal, Aprobarbital [Alurate], Butabarbital [Butisol], Mephobarbital [Mebaral], Pentobarbital [Nembutal], Phenobarbital, Secobarbital [Seconal])
   H) BGP HEDIS BENZODIAZEPINE MEDS (Chlordiazepoxide [Librium], Chlordiazepoxide/Amitriptyline [Limbitrol], Diazepam [Valium], Flurazepam [Dalmane])
   I) BGP HEDIS OTHER BENZODIAZEPINE (Clidinium/Chlordiazepoxide [Librax])

J) BGP HEDIS CALCIUM CHANNEL MEDS (Nifedipine [Procardia, Adalat] - short acting only)

K) BGP HEDIS GASTRO ANTISPASM MEDS (Dicyclomine [Bentyl], Propantheline [Pro-Banthine])

L) BGP HEDIS BELLADONNA ALKA MEDS (Atropine sulfate, Belladonna, Hyoscyamine [Anaspaz, Cystospaz, Levsin, Levsinex], in combination [Barbidonna, Bellergal-S, Butibel, Donnatal], Scopolamine [Scopace, Transderm-Scope])

M) BGP HEDIS SKEL MUSCLE RELAX MED (Carisoprodol [Soma], Chlorzoxazone [Paraflex], Cyclobenzaprine [Flexeril], Metaxalone [Skelaxin], Methocarbamol [Robaxin], Orphenadrine [Norflex])

N) BGP HEDIS ORAL ESTROGEN MEDS (Estradiol, Ethinyl estradiol, Premarin, Ogen, Menest)

O) BGP HEDIS ORAL HYPOGLYCEMIC MED (Chlorpropamide [Diabinese])

P) BGP HEDIS NARCOTIC MEDS (Meperidine, Pentazocine [Talacen, Talwin, Talwin Cpd, Talwin NX], Propoxyphene combinations [Darvon CPD, Darvon N, Darvocet-N], Propoxyphene [Darvon])

Q) BGP HEDIS VASODILATOR MEDS (Dipyridamole [Persantine] short acting only, Ergot mesyloids [Hydergine], Isoxsuprine [Vasodilan])

R) BGP HEDIS OTHER MEDS AVOID ELD (Atropine injectable, Cyclandelate, Desiccated thyroid, Diazepam injectable, Dicyclomine injectable, Diphenhydramine injectable, Dipyridamole injectable, Hydroxyzine injectable, Ketorolac injectable, Meperidine injectable, Methocarbamol injectable, Mesoridazine, Methyltestosterone [Android, Virilon, Testrad], Nitrofurantoin [Macrodantin], Orphenadrine injectable, Pemoline, Pentazocine, Pentobarbital, Promethazine, Premarin injectable, Rectal Diastat, Scopolamine injectable, patches, Trimethobenzamide)

For each medication, the days supply must be >0. 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. For example: Rx Date=11/15/2006, Discontinued Date=11/19/2006, Recalculated # Days Prescribed=4.

Patient List

Patients 65 and older with at least one prescription for a potentially harmful drug.

2.9.15 Functional Status in Elders

No changes from version 8.0 Patch 3.

Owner/Contact

Dr. Bruce Finke

National Reporting

Not reported Nationally

Denominator

1) Active Clinical patients ages 55 and older, broken down by gender.

Numerator

1) Patients screened for functional status at any time during the report period.

Definitions

1) **Functional Status**: Any non-null values in V Elder Care for 1) at least one of the following ADL fields: toileting, bathing, dressing, transfers, feeding, or continence *and* 2) at least one of the following IADL fields: finances, cooking, shopping, housework/chores, medications or transportation during the report period.

Patient List

Patients =>55 with functional status codes, if any.

2.9.16 Fall Risk Assessment in Elders

No changes from version 8.0 Patch 3.

Owner/Contact

Dr. Bruce Finke

National Reporting

Not reported Nationally

Denominator

1) Active Clinical patients ages 65 and older, broken down by gender.

Numerator

1) Patients who have been screened for fall risk or with a fall-related diagnosis in the past year, including documented refusals.
    A) Patients who have been screened for fall risk in the past year.
    B) Patients with a documented history of falling in the past year.
    C) Patients with a fall-related injury diagnosis in the past year.
    D) Patients with abnormality of gait/balance or mobility diagnosis in the past year.
    E) Patients with a documented refusal of fall risk screening exam in the past year.

Definitions

1) **Fall Risk Screen**: Any of the following:
    A) **Fall Risk Exam** defined as: V Exam Code 37;
    B) **History of Falling** defined as: POV V15.88 (Personal History of Fall);
    C) **Fall-related Injury Diagnosis** defined as: V POV (Cause Codes #1-3) E880.*, E881.*, E883.*, E884.*, E885.*, E886.*, E888.*;
    D) **Abnormality of Gait/Balance or Mobility** defined as: V POV 781.2, 781.3, 719.7, 719.70 (old code), 719.75-719.77 (old codes), 438.84, 333.99, 443.9;
    E) **Refusal** defined as: Refusal Exam 37.

Patient List

Patients 65 years or older with fall risk assessment, if any.

2.9.17 Palliative Care

No changes from version 8.0 Patch 3.

Owner/Contact

Dr. Bruce Finke

National Reporting

Not reported Nationally

Denominator

No denominator, count only.

Numerators

1) No denominator; count only. For patients meeting the Active Clinical definition, the total number of patients with at least one palliative care visit during the report period; broken down by age groups.
2) No denominator; count only. For patients meeting the Active Clinical definition, the total number of palliative care visits during the report period; broken down by age groups.

Definition

1) **Palliative Care Visit**: POV V66.7.

Patient List

Patients with a palliative care visit

3.0 Contact Information

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

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

Fax: (505) 248-4363

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

Email: support@ihs.gov