



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System (BGP)

Executive Order: Quality Transparency Measures Report Performance Measure List and Definitions

Version 11.0
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Office of Information Technology (OIT)
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1.0 Introduction

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

Users have the option of running the report using the same hard-coded report parameters as the National Government Performance and Results Act (GPRA) & Program Assessment Rating Tool (PART) Report or selecting their own report parameters.

1.1 CRS Denominator Definitions

1.1.1 For All Denominators

- All patients with name “DEMO,PATIENT” or who are included in the *RPMS Demo/Test Patient Search Template (DPST option located in the PCC Management Reports, Other section) for CRS* will be excluded automatically for all denominators.
- For all measures except as noted, patient age is calculated as of the beginning of the report period.

1.1.2 Active Clinical Population for National GPRA & 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 FY2011 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.

1.1.3 Active Clinical Population for Local Reports

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the *Clinical Reporting System (CRS) for FY2011 Clinical Measures User Manual* for listing of these clinics.
- Must be alive on the last day of the report period.
- User defines population type: AI/AN patients only, non AI/AN, or both.
- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

1.1.4 User Population for National GPRA & 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.

1.1.5 User Population for Local Reports

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

1.1.6 Active Clinical CHS Population for National GPRA & 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.

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

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

2.0 EO Report Performance Measure Topics

The following sections define the performance measure topics and their definitions that are included in the CRS 2011 Version 11.0 EO Quality Transparency Measures Report.

Note: “QoC” indicates the numerators and denominators of transparency measures that are or will be reported on the IHS Quality of Care Web Site (<http://www.ihs.gov/NonMedicalPrograms/quality/>).

2.1 Diabetes: Poor Glycemic Control

No changes from Version 10.0 Patch 1

Owner/Contact

Diabetes Program/Dr. Marie Russell

Denominator

QoC: Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits during the report period, *and* two DM-related visits ever.

Numerator

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

Definition

Diabetes

First Purpose of Visit (POV) 250.00–250.93 recorded in the V POV file prior to the report period.

A1c

Searches for most recent A1c test 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 it has a result of > 9.0 or has no result, or if the patient does not have an A1c test during the report period, the patient will be included in the numerator as having poor A1c control. A1c defined as: CPT 83036, 83037, 3044F, 3045F, or 3046F, or 3047F (old code); LOINC taxonomy; or site-populated taxonomy DM AUDIT HGB A1C TAX. A1c tests documented with CPT 3046F indicate a result > 9.0 and will be included in the Poor Control numerator. A1c tests documented with CPT 83036 or 83037 indicate tests with no result and will be

included in the Poor Control numerator. A1c tests documented with CPT 3044F, 3045F or 3047F (old code) indicate a result of ≤ 9.0 and will *not* be included in the numerator.

Patient List

List of diabetic patients with most recent A1c value, if any.

2.2 Diabetes: Blood Pressure Control

No changes from Version 10.0 Patch 1

Owner/Contact

Diabetes Program/Dr. Marie Russell

Denominator

QoC: Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits during the report period, *and* two DM-related visits ever.

Numerator

QoC: Patients with BP level of $<140/90$ during the report period, i.e., the mean systolic value is less than 140 *and* the mean diastolic value is less than 90.

Definition

Blood Pressure

CRS uses mean of last three Blood Pressures documented on non-ER visits during the report period. If three BPs are not available, uses mean of the last two 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 three (or two) systolic values and dividing by three (or two). The mean Diastolic value is calculated by adding the diastolic values from the last three (or two) blood pressures and dividing by three (or two). If the systolic and diastolic values do not *both* meet the specified criteria, then the value is not included in the numerator.

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

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

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

- CPT 3074F and 3078F
- 3074F and 3079F
- 3075F and 3078F
- 3075F and 3079F
- CPT 3076F and 3078F
- CPT 3076F and 3079F

All other combinations will *not* be included in the numerator.

Patient List

Diabetic patients with mean BP, if any.

2.3 Diabetes: LDL Control

No changes from Version 10.0 Patch 1

Owner/Contact

Diabetes Program/Dr. Marie Russell

Denominator

QoC: Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits during the report period, *and* two DM-related visits ever.

Numerator

QoC: Patients with LDL result less than (<) 100.

Definition

LDL Screening

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

The following will be included in the numerator:

- Lab tests with a result of <100
- CPT 3048F

Not included in the numerator are:

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

Patient List

Diabetic patients with most recent LDL test, if any.

2.4 Adult Immunizations: Influenza

Changes from Version 10.0 Patch 1, as noted.

Owner/Contact

Epidemiology Program/ Amy Groom, MPH

Denominators

1. **QoC:** Active Clinical patients ages 50–64.
2. **QoC:** Active Clinical patients ages 65 and older

Numerators

1. **QoC:** 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: The only refusals included in this numerator are documented not medically indicated (NMI) refusals.

- A. Patients with a contraindication or a documented NMI refusal.
2. Patients with documented refusal

Definition

Age

Age of the patient is calculated at the beginning of the report period.

Influenza Vaccine

Any of the following documented during the report period unless otherwise noted:

Influenza immunization

- Any of the following documented during the report period, defined as:
 - Immunization (CVX) codes 88-Influenza Virus Vaccine, NOS; 15 Inf Virus Vac SV; 16 Inf Virus Vac WV; 111 Inf Virus Vac Intranasal; 135 Inf High Dose Seasonal; **140 Inf Virus Vac SV Preservative Free;** **141 Inf Virus Vac SV**

- POV V04.8 (old code), V04.81 NOT documented with 90663, 90664, 90666-90668, 90470, G9141 or G9142, or V06.6 NOT documented with 90663, 90664, 90666-90668, 90470, G9141 or G9142;
- CPT 90654-90662, 90724 (old code), G0008, G8108;

Contraindication

- Any of the following documented at any time before the end of the report period, defined as:
 - Contraindication in the Immunization Package of “Egg Allergy” or “Anaphylaxis”
 - PCC NMI Refusal
- Refusal of immunization codes 88, 111, 135, **140**, **141**, 15, or 16, as documented in PCC Refusal File (i.e., REF) or in the Immunization Package as contraindication of “Patient Refusal.”

Patient List

List of patients 50 years and older with influenza immunization, contraindication, or refusal, if any.

2.5 Adult Immunizations: Pneumovax

No changes from Version 10.0 Patch 1

Owner/Contact

Epidemiology Program/Amy Groom, MPH

Denominator

QoC: Active Clinical patients ages 65 and older

Numerators

1. **QoC:** 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.

Note: The only refusals included in this numerator are documented NMI refusals.

- A. Patients with a contraindication or a documented NMI refusal.
2. Patients with documented refusal.

Definition

Age

Age of the patient is calculated at the beginning of the report period.

Pneumovax

Defined as any of the following documented anytime before the end of the report period unless otherwise noted.

Pneumococcal Immunization

- Any of the following documented any time before the end of the report period, defined as:
 - Immunization (CVX) codes 33 Pneumo Polysaccharide; 100 Pneumo Conjugate; 109 Pneumo NOS, 133 Pneumo Conjugate
 - POV V06.6 or V03.82
 - Procedure 99.55
 - CPT 90669, 90670, 90732, G0009, G8115

Contraindication

- Any of the following documented any time before the end of the report period defined as:
 - Contraindication in the Immunization Package of "Anaphylaxis"
 - PCC NMI Refusal.

Refusal

- Any of the following documented during the report period:
 - Immunization (CVX) codes 33, 100, or 109, as documented in PCC Refusal File (i.e., REF)
 - Immunization Package as contraindication of "Patient Refusal"

Patient List

List of patients 65 years or older with pneumovax, contraindication, or refusal, if any.

2.6 Use of Appropriate Medications for People with Asthma

Changes from Version 10.0 Patch 1, as noted.

Owner/Contact

Drs. Charles (Ty) Reidhead and Charles North

Denominators

1. **QoC:** 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).

- A. Active Clinical patients ages 5–9.
- B. Active Clinical patients ages 10–17.
- C. Active Clinical patients ages 18–56

Numerator

QoC: Patients who had at least one dispensed prescription for preferred asthma therapy medication during the report period.

Denominator Exclusions

Patients diagnosed with emphysema or Chronic Obstructive Pulmonary Disease (COPD) at any time on or before the end of the report period are excluded from the denominator.

Definition**Age**

Age of the patient is calculated at the beginning of the report period.

Emphysema

Any visit with POV codes: 492.*, 506.4, 518.1, 518.2

COPD

Any visit with POV codes: 491.20, 491.21, 491.22, 493.2*, 496, 506.4

Persistent Asthma

Meeting any of the following four criteria below within the year prior to the beginning of the report period *and* during the report period:

- At least one visit to Clinic Code 30 (Emergency Medicine) with primary diagnosis 493* (asthma).
- At least one acute inpatient discharge with primary diagnosis 493.*. Acute inpatient discharge defined as Service Category of H.
- 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).
- At least 4 asthma medication dispensing events (see definition below). If the sole medication was leukotriene modifiers, then *must* 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*

Meeting the following criteria below:

- 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

- 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. Example: Rx Date = 11/15/2010, Discontinued Date = 11/19/2010, Recalculated # Days Prescribed = 4.

Asthma medication codes for denominator

- 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). **Medications must not have a comment of RETURNED TO STOCK.**

Preferred Asthma Therapy

To be included in the numerator, patient must have a non-discontinued prescription for preferred asthma therapy (see list of medications below) during the report period.

Preferred asthma therapy medication codes for numerator

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). *Medications must not have a comment of RETURNED TO STOCK.*

Patient List

Asthmatic patients with primary asthma therapy medications, if any.

2.7 Community-Acquired Pneumonia (CAP) Assessment of Oxygen Saturation

No changes from Version 10.0 Patch 1

Owner/Contact

Dr. Charles (Ty) Reidhead

Denominator

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

Definition

Age

Age of the patient is calculated at the beginning of the report period.

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.

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 the Resource and Patient Management System (RPMS) does not store the date of onset, visit date will be used as a surrogate for onset date.

Oxygen Saturation Assessment

- Having any of the following arterial blood gas (ABG) or pulse oximetry tests performed at the visit:
 - V Measurement O2 Saturation
 - CPT 94760-94762, 82803, 82805, 82810, or 3028F, where 3028F has no modifier of 1P, 2P, 3P, or 8P
 - Lab test ABG
 - Site-populated lab taxonomy BGP CMS ABG TESTS
 - LOINC taxonomy

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.

No Assessment

Patients whose 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.

2.8 Persistence of Beta-Blocker Treatment after a Heart Attack

Changes from Version 10.0 Patch 1, as noted.

Owner/Contact

~~Dr. Eric Brody/Mary Wachacha~~ Dr. Dena Wilson & Chris Lamer, PharmD

Denominators

1. **QoC:** Active Clinical patients 18 and older diagnosed with an AMI six months prior to the report period through the first six months of the report period and do not have a contraindication/previous adverse reaction to beta-blocker therapy. Broken down by gender.
 - A. Male Active Clinical patients 18 and older diagnosed with an AMI six months prior to the report period through the first six months of the report period and do not have a contraindication/previous adverse reaction to beta-blocker therapy.
 - B. Female Active Clinical patients 18 and older diagnosed with an AMI six months prior to the report period through the first six months of the report period and do not have a contraindication/previous adverse reaction to beta-blocker therapy.

Numerator

QoC: Patients with a 135-day course of treatment with beta-blockers following first discharge date or visit date, including previous active prescriptions.

Definition

Denominator Exclusions are as follows

- If inpatient visit, patients with Discharge Type of Irregular (AMA), Transferred, or contains “Death.”
- **Patients with contraindications to beta-blockers**, defined as occurring anytime through discharge date:
 - Asthma–2 diagnoses (POV) of 493* on different visit dates
 - Hypotension–1 diagnosis of 458*
 - 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
 - Sinus bradycardia–1 diagnosis of 427.81; or
 - COPD–2 diagnoses on different visit dates of 491.2*, 496, or 506.4, or a combination of any of these diagnoses, such as one visit with 491.20 and one with 496

- **Documented beta blocker allergy/ADR**, defined as occurring anytime through discharge/visit date:
 - POV 995.0–995.3 AND E942.0
 - “beta block*” entry in ART (Patient Allergies File); or
 - “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

Age

Age is calculated at the beginning of the report period

Acute Myocardial Infarction (AMI)

Defined as POV 410.*0 or 410.*1. 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.

Numerator Logic

To be included in the numerator, patients must have a beta-blocker days' supply ≥ 135 days in the 180 days following discharge date for inpatient visits or visit date for ambulatory visits. **Medications must not have a comment of RETURNED TO STOCK.** Prior active beta-blocker prescriptions can be included if the treatment days fall within the 180 days following discharge/visit date. Prior active prescription defined as most recent beta-blocker prescription (see codes below) prior to admission/visit date with the number of days supply equal to or greater than the discharge/visit date minus the prescription date.

Note: If the medication was started and then discontinued, CRS will recalculate the # Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. Example: Rx Date = 11/15/2010, Discontinued Date = 11/19/2010, Recalculated # Days Prescribed = 4

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

- Admission Date: 2/1/2011, Discharge Date: 2/15/2011
- Must have 135 days prescribed by 8/13/2011 (Discharge Date+180)
- Prior Beta-Blocker Rx Date: 1/15/2011
- # Days Prescribed: 60 (treats patient through 3/15/2011)

- Discharge Date minus Rx Date: 2/15/2011–1/15/2011 = 31, 60 is \geq 31, prescription is considered Prior Active Rx
- 3/15/2011 is between 2/15 and 8/13/2011, thus remainder of Prior Active Rx can be counted toward 180-day treatment period
- # Remaining Days Prescribed from Prior Active Rx: $(60 - (\text{Discharge Date} - \text{Prior Rx Date})) = 60 - (2/15/2011 - 1/15/2011) = 60 - 31 = 29$
- Rx #2: 4/1/2011, # Days Prescribed: 90
- Rx #3: 7/10/2011, #Days Prescribed: 90
- Total Days Supply Prescribed between 2/15 and 8/13/2011: $29 + 90 + 90 = 209$

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

Patient List

List of patients with AMI, with all beta-blocker prescriptions during the 180-day timeframe, if any.

2.9 Controlling High Blood Pressure

Changes from Version 10.0 Patch 1, as noted.

Owner/Contact

~~Dr. Eric Brody/Mary Wachacha~~ Dr. Dena Wilson & Chris Lamer, PharmD

Denominator

QoC: All Active Clinical patients ages 18 through 85 diagnosed with hypertension and no documented history of end stage renal disease (ESRD)

Numerators

1. **QoC:** Number of patients with Blood Pressure value documented during the report period

2. **QoC:** Patients with adequately controlled blood pressure, defined as <140/90, i.e., the mean systolic value is less than 140 *and* the mean diastolic value is less than 90.

Definitions

Age

Age of the patient is calculated at beginning of the report period.

ESRD

Diagnosis/treatment defined as any of the following ever:

- 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 (*old codes*), G0392 (*old code*), G0393 (*old code*), or S9339
- POV 585.5, 585.6, V42.0, V45.1 (old code), V45.11, V45.12, or V56.*
- Procedure 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6*

Hypertension

Hypertension is defined as diagnosis (POV or problem list) 401.* prior to the report period, and at least one hypertension POV during the report period.

BP Values

CRS uses mean of last three Blood Pressures documented on non-ER visits during the report period. If three BPs are not available, uses mean of the last two 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 three (or two) systolic values and dividing by three (or two). The mean Diastolic value is calculated by adding the diastolic values from the last three (or two) blood pressures and dividing by three (or two). 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 non-ER visit during the report period.

Patient List

List of patients with hypertension and BP value, if any.

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

Changes from Version 10.0 Patch 1, as noted.

Owner/Contact

Dr. Eric Brody Dr. Dena Wilson

Denominator

QoC: Number of visits for User Population patients ages 18 and older who were hospitalized during the report period with ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation.

Numerators

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

Definition

Age

Age is calculated as of the beginning of the report period.

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).

Note: The patient must be admitted to the hospital during the report period with a condition described above but the discharge may occur after the report period.

Anticoagulant Therapy

Patient must meet one of the conditions below to be counted as receiving anticoagulant therapy. ***For all prescriptions, medications must not have a comment of RETURNED TO STOCK.***

- Active prescription for Warfarin, aspirin, or other anti-platelet as of discharge date. "Active" prescription defined as: Rx Days Supply \geq (Discharge Date – Prescription Date), where the prescription has not been discontinued as of the discharge date.
- Prescription for Warfarin, aspirin, or other anti-platelet on discharge date.

Warfarin Medication

Any medication in site-populated BGP CMS WARFARIN MEDS taxonomy.

Aspirin Medication

Any medication in site-populated DM AUDIT ASPIRIN DRUGS taxonomy.

Other Anti-Platelet/Anticoagulant Medication

Any medication in the site-populated BGP ANTI-PLATELET DRUGS taxonomy, any medication with VA Drug Class BL700.

Refusal of Anticoagulant Therapy

Refusal of any of the following documented on discharge date:

- Any medication in site-populated taxonomies BGP CMS WARFARIN MEDS, DM AUDIT ASPIRIN DRUGS, or BGP ANTI-PLATELET DRUGS; or
- Any medication with VA Drug Class BL700.

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.

2.11 Cholesterol Management for Patients with Cardiovascular Conditions

Changes from Version 10.0 Patch 1, as noted.

Owner/Contact

Dr. Eric Brody Dr. Dena Wilson

Denominator

QoC: 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 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.

Numerators

1. **QoC:** Patients with LDL completed during the report period, regardless of result.

2. QoC: Patients with LDL <100 during the report period.

Definition

Age

Age of the patient is calculated at the beginning of the report period.

AMI

Defined as POV 410.*0 or 410.*1

PTCA

Defined as:

- Procedure 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06-36.07, or 36.09 or
- CPT 33140, 92980, 92982, 92995

CABG

Defined as:

- Procedure 36.1*, 36.2 or
- CPT 33510-33514, 33516-33519, 33521-33523, 33533-33536, S2205-S2209

IVD

Defined as:

- POV 411.*, 413.*, 414.0*, 414.2, 414.8, 414.9, 429.2, 433.*-434.*, 440.1, 440.2*, 440.4, 444.*, or 445.*

LDL Screening

Searches for an LDL test during the report period.

- 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.

LDL <100

Searches for most recent LDL test 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.

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.

The following will be included in the numerator:

- Laboratory tests with a result of <100
- CPT 3048F

Not included in the numerator are:

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

Patient List

List of patients with AMI, CABG, PTCA, or IVD w/LDL value, if any.

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