



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System

(BGP)

Elder Care Report Performance Measure List and Definitions

Version 12.0
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1.0 Introduction

The Other National Measures (ONM) Report contains clinical quality measures for which national data is desired. The majority of these measures were historically reported in the National Government Performance and Results Act (GPRA) Report as non-GPRA measures. The ONM Report provides valuable information on the quality of care that is being provided to patients and can be used to address other national reporting requirements. Data for these measures will be collected and reported at least once annually.

1.1 CRS Denominator Definitions

1.1.1 For All Denominators

- All patients with name “DEMO, PATIENT” or who are included in the Resource and Patient Management System (RPMS) Demo/Test Patient Search Template (DPST option located in the PCC Management Reports, Other section) 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

1.1.2.1 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 FY2012 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

1.1.2.2 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 FY2012 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.

1.1.3 User Population

1.1.3.1 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

1.1.3.2 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

1.1.4 Active Clinical CHS Population

CHS-Only Sites

1.1.4.1 National GPRA & PART Reporting

- 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

1.1.4.2 Local Reports

- 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

1.1.5 Active Clinical Behavioral Health Population

1.1.5.1 National GPRA and PART Reporting

Urban Outreach and Referral-Only Sites

- Must have two Behavioral Health 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.

1.1.5.2 Local Reports

- Must have two Behavioral Health 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 2012 version 12.0 Selected Measures (Local) Report.

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

Bold italic font indicates new or edited definitions.

~~*Bold Italic Strikethrough*~~ indicates deleted material.

2.1 Diabetes Group

2.1.1 Diabetes Prevalence

No changes from Version 11.1

2.1.1.1 Owner/Contact

Diabetes Program/*Dr. Ann Bullock*

2.1.1.2 Denominators

1. All User Population users ages 55 and older, broken down by gender and age groups.

2.1.1.3 Numerators

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

2.1.1.4 Definition

Diabetes Diagnosis

Diabetes diagnosis is defined as at least one diagnosis 250.00–250.93 recorded in the V POV file.

2.1.1.5 Patient List

List of diabetic patients 55 and older with most recent diagnosis.

2.1.2 Diabetes: Glycemic Control

No changes from Version 11.1

2.1.2.1 Owner/Contact

Diabetes Program/*Dr. Ann Bullock*

2.1.2.2 Denominators

1. Active Diabetic patients ages 55 and older; defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) prior to the report period, and at least two visits in the past year, and two DM-related visits ever. Broken down by age groups.

2.1.2.3 Numerators

1. Hemoglobin A1c documented during the report period, *regardless of result*.
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. Without result. Patients with A1c documented but no value.

2.1.2.4 Definitions

Diabetes

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

A1c

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, 3044F–3046F, 3047F (old code)
 - LOINC taxonomy
 - Site-populated taxonomy DM AUDIT HGB A1C TAX
- Without result is defined as A1c documented but with no value.
- Current Procedural Terminology (CPT) 3044F represents A1c < 7 and will be included in the Ideal Control numerator.

2.1.2.5 Patient List

List of diabetic patients 55 and older with most recent A1c value, if any.

2.1.3 Diabetes: Blood Pressure Control

Changes from Version 11.1, as noted.

2.1.3.1 Owner/Contact

Diabetes Program/*Dr. Ann Bullock*

2.1.3.2 Denominators

1. Active Diabetic patients ages 55 and older, defined as all Active Clinical patients diagnosed with diabetes (POV 250.00–250.93) prior to the report period, *and* at least two visits during the report period, *and* two DM-related visits ever. Broken down by age groups.

2.1.3.3 Numerators

1. Patients with Blood Pressure documented during the report period.
2. **GPRA:** Patients with controlled BP, defined as < 130/80, i.e., the mean systolic value is less than 130 *and* the mean diastolic value is less than 80.
3. Patients with BP that is not controlled.

2.1.3.4 Definitions

Diabetes

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

BP Documented

CRS uses mean of last three Blood Pressures (BPs) documented on non-Emergency Room (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 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) BPs and dividing by three (or two).

If CRS is not able to calculate a mean BP, it will search for CPT 0001F, 2000F, 3074F–3080F *or* **POV V81.1** documented on a non-ER visit during the report period.

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.

BP Documented and Controlled BP

If CRS is not able to calculate a mean BP from blood pressure measurements, it will search for the most recent of any of the following codes documented on non-ER visits during the report period:

- BP Documented: CPT 0001F or 2000F *or POV V81.1*; OR
- **Systolic:** CPT 3074F, 3075F, or 3077F WITH **Diastolic:** CPT 3078F, 3079F, or 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 Controlled BP numerator: CPT 3074F *and* 3078F. All other combinations will *not* be included in the Controlled BP numerator.

2.1.3.5 Patient List

List of diabetic patients 55 and older with BP value, if any.

2.1.4 Diabetes: LDL Assessment

No changes from Version 11.1

2.1.4.1 Owner/Contact

Diabetes Program/*Dr. Ann Bullock*

2.1.4.2 Denominators

1. Active Diabetic patients ages 55 and older; defined as all Active Clinical patients diagnosed with diabetes (POV 250.00–250.93) prior to the report period, and at least two visits in the past year, and two DM-related visits ever. Broken down by age groups.

2.1.4.3 Numerators

1. **GPRA:** Patients with LDL completed during the report period, regardless of result.
2. Patients with LDL results less than (<) 130.

- A. Patients with LDL results less than or equal to (\leq) 100.
- B. Patients with LDL results 101-129.

2.1.4.4 Definitions

Diabetes

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

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 test defined as any of the following:
 - 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.

2.1.4.5 Patient List

List of diabetic patients 55 and older with LDL cholesterol test, if any.

2.1.5 Diabetes: Nephropathy Assessment

No changes from Version 11.1

2.1.5.1 Owner/Contact

Diabetes Program/Dr. Marie Russell

2.1.5.2 Denominators

1. Active Diabetic patients ages 55 and older; defined as all Active Clinical patients diagnosed with diabetes (POV 250.00–250.93) prior to the report period, and at least two visits in the past year, and two DM-related visits ever. Broken down by age groups.

2.1.5.3 Numerators

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

2.1.5.4 Definitions

Diabetes

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

Estimated GFR

- Site-populated taxonomy BGP GPRA ESTIMATED GFR TAX or
- LOINC taxonomy

Quantitative Urine Protein Assessment

- CPT 82042, 82043, 84156
- LOINC taxonomy, or
- Site-populated taxonomy BGP QUANT URINE PROTEIN

Note: Check with your laboratory supervisor to confirm that the names you add to your taxonomy reflect quantitative test values.

ESRD

- End Stage Renal Disease diagnosis/treatment defined as any of the following ever:
 - CPT 36145, 36147, 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), S9339
 - POV 585.5, 585.6, V42.0, V45.1 (old code), V45.11, V45.12, V56.*
 - Procedure 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.6*

2.1.5.5 Patient List

List of patients 55 and older with nephropathy assessment, if any.

2.1.6 Diabetic Retinopathy

No changes from Version 11.1

2.1.6.1 Owner/Contact

Diabetes Program/Dr. Mark Horton

2.1.6.2 Denominators

1. Active Diabetic patients ages 55 and older; defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) prior to the report period, *and* at least two visits in the past year, *and* two DM-related visits ever. Broken down by age groups.

2.1.6.3 Numerators

1. **GPRA:** Patients receiving a qualified retinal evaluation* during the report period.

Note: This numerator does <i>not</i> include refusals.

A. Patients receiving diabetic retinal exam during the report period.

B. Patients receiving other eye exams during the report period.

2. Patients who refused a diabetic retinal exam during the report period.

2.1.6.4 Definitions

Diabetes

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

Qualified Retinal Evaluation

- Diabetic retinal exam or
- Other eye exam.

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 seven standard fields (ETDRS).

Diabetic Retinal Exam

Any of the following during the report period:

- Exam code 03 Diabetic Eye Exam (dilated retinal examination or validated photographic equivalent)
- 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.

Other Eye Exam

- Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or validated tele-ophthalmology retinal evaluation clinics or
- 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 (old code), 67039, 67040, 92002, 92004, 92012, 92014
- POV V72.0
- Procedure 95.02.

Refusal of Diabetic Retinal Exam

Refusal of Exam 03. Refusals are only counted if the patient did not have a diabetic retinal exam or other eye exam. If a patient had a diabetic retinal exam/other eye exam and a refusal, only the diabetic retinal exam/other eye exam will be counted.

2.1.6.5 Patient List

List of diabetic patients 55 and older with qualified retinal evaluation or refusal, if any.

2.1.7 Diabetic Access to Dental Services

No changes from Version 11.1

2.1.7.1 Owner/Contact

Dental Program/Dr. Patrick Blahut

2.1.7.2 Denominators

1. Active Diabetic patients ages 55 and older; 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. Broken down by age groups.

2.1.7.3 Numerators

1. Patients with a documented dental visit during the report period.

Note: This numerator does not include refusals.

2. Patients with documented dental exam refusal during the report period.

2.1.7.4 Definitions

Diabetes

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

Documented Dental Visit

For non-CHS visits, searches for any of the following:

- Dental ADA code 0000, 0190
- ~~CPT codes D0000, D0190~~
- VExam code 30
- 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.

Documented Refusal

Non-CHS dental visit with refusal of any of the following:

- ADA code 0000, 0190
- ~~CPT code D0000, D0190~~
- Exam 30

Refusals are only counted if the patient did not have a documented dental visit.

2.1.7.5 Patient List

List of diabetic patients 55 and older and documented dental visit or refusal, if any.

2.2 Dental Group

2.2.1 Access to Dental Services

No changes from Version 11.1

2.2.1.1 Owner/Contact

Dental Program/Dr. Patrick Blahut

2.2.1.2 Denominators

1. User Population patients ages 55 and older, broken down by age groups.

2.2.1.3 Numerators

1. **GPRA:** Patients with documented dental visit during the report period.

Note: This numerator does not include refusals.

2. Patients with documented dental exam refusal during the report period.

2.2.1.4 Definitions**Documented Dental Visit**

For non-CHS dental visits, searches for any of the following:

- Dental ADA codes 0000, 0190
- ~~CPT codes D0000, D0190~~
- VExam 30
- 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.

Documented Refusal

Non-CHS dental visit with refusal of any of the following:

- ADA code 0000, 0190
- ~~CPT code D0000, D0190~~
- Exam 30

Refusals are only counted if the patient did not have a documented dental visit.

2.2.1.5 Patient List

List of patients 55 and older with documented dental visit or refusal and date.

2.3 Immunization Group**2.3.1 Adult Immunizations: Influenza**

Changes from Version 11.1, as noted.

2.3.1.1 Owner/Contact

Epidemiology Program/Amy Groom, MPH

2.3.1.2 Denominators

1. Active Clinical patients ages 55 and older, broken down by age groups.

2.3.1.3 Numerators

1. **GPRA:** Patients with influenza vaccine documented during the report period or with a contraindication documented at any time before the end of the report period.

<p>Note: The only refusals included in this numerator are not medically indicated (NMI) refusals.</p>
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- A. Patients with a contraindication or a documented NMI refusal.
2. Patients with documented influenza refusal during the report period.

2.3.1.4 Definitions**Influenza Vaccine**

Any of the following during the report period:

- 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, **144 Inf Virus Vac SV Intradermal**

- 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 (old code), G0008, G8108 (old code)
- ICD Procedure code: 99.52

Contraindication to Influenza Vaccine

Any of the following documented at any time before the end of the report period:

- Contraindication in the Immunization Package of “Egg Allergy” or “Anaphylaxis”
- PCC NMI Refusal

Refusal of Influenza Vaccine

Any of the following documented during the report period:

- Refusal of immunization/CVX codes 15, 16, 88, 111, 135, 140, 141, **144** as documented in PCC Refusal File (i.e., REF)
- ***CPT codes 90654-90662, 90724 (old code), G0008, G8108 (old code) as documented in PCC Refusal File (i.e. REF)***
- In the Immunization Package as contraindication of “Patient Refusal”

2.3.1.5 Patient List

List of patients 55 and older with influenza immunization/contraindication, or refusal and date, if any.

2.3.2 Adult Immunizations: Pneumovax

Changes from Version 11.1, as noted.

2.3.2.1 Owner/Contact

Epidemiology Program/Amy Groom, MPH

2.3.2.2 Denominators

1. Active Clinical patients ages 55 and older, broken down by age groups.

2.3.2.3 Numerators

1. **GPRA:** Patients with Pneumococcal vaccine or contraindication documented at any time before the end of the report period.

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

- A. Patients with a contraindication or a documented NMI refusal
2. Patients with documented Pneumococcal refusal during the report period.

2.3.2.4 Definitions

Pneumococcal Immunization

Any of the following documented any time before the end of the report period:

- Immunization/CVX codes 33 Pneumo Polysaccharide, 100 Pneumo Conjugate, 109 Pneumo NOS, 133 Pneumo Conjugate
- POV V06.6, V03.82
- Procedure 99.55
- CPT 90669, 90670, 90732, G0009, G8115 (old code)

Pneumococcal Contraindication

Any of the following documented any time before the end of the report period:

- Contraindication in the Immunization Package of “Anaphylaxis”
- PCC NMI Refusal

Pneumococcal Refusal

Any of the following documented during the report period:

- Immunization codes 33, 100, 109, 133, as documented in PCC Refusal File (i.e., REF)
- *CPT codes 90669, 90670, 90732, G0009, G8115 (old code) as documented in PCC Refusal File (i.e. REF)*
- Immunization Package contraindication of “Patient Refusal”

2.3.2.5 Patient List

List of patients 55 and older with pneumovax immunization/contraindication, or refusal and date, if any.

2.4 Cancer Screen Group

2.4.1 Cancer Screening: Mammogram Rates

No changes from Version 11.1

2.4.1.1 Owner/Contact

Carolyn Aoyama

2.4.1.2 Denominators

1. Female Active Clinical patients ages 55 and older without a documented history of bilateral mastectomy or two separate unilateral mastectomies, broken down by age groups.

2.4.1.3 Numerators

1. **GPRA:** All patients with documented mammogram in past two years.

Note: This numerator does not include refusals.

2. Patients with documented mammogram refusal in past year.

2.4.1.4 Definitions

Age

Age of the patient is calculated at the beginning of the report period. For the denominator, patients must be at least the minimum age as of the beginning of the report period.

Bilateral Mastectomy

- CPT 19300.50–19307.50 *or* 19300–19307 with modifier 09950 (.50 and 09950 modifiers indicate bilateral), or old codes 19180, 19200, 19220, or 19240, with modifier of .50 or 09950 or
- ICD Operation codes 85.42, 85.44, 85.46, 85.48

Unilateral Mastectomy

Requires two separate occurrences for either CPT or procedure codes on two different dates of service.

- CPT 19300–19307, or old codes 19180, 19200, 19220, 19240 or
- Procedures 85.41, 85.43, 85.45, 85.47

Mammogram

- V Radiology or CPT 77052-77059, 76090 (old code), 76092 (old code), G0206, G0204, G0202
- 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
- Procedure 87.36 Xerography of breast, 87.37 Other Mammography
- Women's Health: Mammogram Screening, Mammogram Dx Bilat, Mammogram Dx Unilat, and where the mammogram result does *not* have "ERROR/DISREGARD"

Refusal Mammogram

Any of the following in the past year:

- V Radiology MAMMOGRAM for CPT 77052-77059, 76090 (old code), 76091 (old code), 76092 (old code), G0206, G0204, G0202

2.4.1.5 Patient List

List of female patients 55 and older with mammogram/refusal, if any.

2.4.2 Colorectal Cancer Screening

No changes from Version 11.1

2.4.2.1 Owner/Contact

Epidemiology Program/Don Haverkamp

2.4.2.2 Denominators

1. Active Clinical patients ages 55 and older without a documented history of colorectal cancer or total colectomy, broken out by gender and age groups.

2.4.2.3 Numerators

1. **GPRA:** Patients who have had *any* CRC colorectal screening, defined as any of the following:
 - A. Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) during the report period
 - B. Flexible sigmoidoscopy or double contrast barium enema in the past five years
 - C. Colonoscopy in the past ten years

Note: This numerator does not include refusals.

2. Patients with documented CRC screening refusal in the past year.
3. Patients with FOBT or FIT during the report period.
4. Patients with a flexible sigmoidoscopy or double contrast barium enema in the past five years or a colonoscopy in the past ten years.
5. Patients with a flexible sigmoidoscopy in the past five years or a colonoscopy in the past ten years.
6. Patients with a flexible sigmoidoscopy and double contrast barium enema in the past five years or a colonoscopy in the past ten years.

2.4.2.4 Definitions

Denominator Exclusions

Any diagnosis ever of one of the following:

- Colorectal Cancer
 - POV 153.*, 154.0, 154.1, 197.5, V10.05
 - CPT G0213-G0215 (old codes), G0231 (old code)

- Total Colectomy
 - CPT 44150-44151, 44152 (old code), 44153 (old code), 44155-44158, 44210-44212
 - Procedure 45.8 (old code)

Colorectal Cancer Screening

The most recent of any of the following during applicable timeframes (changed to look at most recent screening):

- FOBT or FIT
 - CPT 82270, 82274, 89205 (old code), G0107 (old code), G0328, G0394 (old code)
 - LOINC taxonomy
 - Site-populated taxonomy BGP GPRA FOB TESTS
- Flexible Sigmoidoscopy
 - Procedure 45.24
 - CPT 45330-45345, G0104
- Double Contrast Barium Enema
 - CPT or V Radiology 74280, G0106, G0120
- Colonoscopy
 - POV V76.51 Colon screening
 - Procedure 45.22, 45.23, 45.25, 45.42, 45.43
 - CPT 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121

Screening Refusals in Past Year

- FOBT or FIT
 - Refusal of V Lab Fecal Occult Blood test
 - CPT code 82270, 82274, 89205 (old code), G0107 (old code), G0328, G0394 (old code)
- Flexible Sigmoidoscopy
 - Refusal of Procedure 45.24
 - CPT 45330-45345, G0104
- Double Contrast Barium Enema
 - Refusal of V Radiology CPT 74280, G0106, G0120
- Colonoscopy

- Refusal of Procedure 45.22, 45.23, 45.25, 45.42, 45.43
- CPT 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121

2.4.2.5 Patient List

List of patients 55 and older with CRC screening/refusal, if any.

2.4.3 Tobacco Use and Exposure Assessment

No changes from Version 11.1

2.4.3.1 Owner/Contact

Mary Wachacha and Chris Lamer, PharmD/Epidemiology Program, Dayle Knutson

2.4.3.2 Denominators

1. Active Clinical patients ages 55 and older, broken down by gender and age groups.

2.4.3.3 Numerators

1. Patients screened for tobacco use during the report period.
2. Patients identified during the report period as current tobacco users.
 - A. Current smokers
 - B. Current smokeless tobacco users
3. Patients exposed to environmental tobacco smoke (ETS) during the report period.

2.4.3.4 Definitions

Tobacco Screening

- Any Health Factor for category Tobacco, TOBACCO (SMOKING), TOBACCO (SMOKELESS – CHEWING/DIP), TOBACCO (EXPOSURE)

- POV or Current PCC Problem List 305.1, 305.1* (old codes), 649.00–649.04, V15.82 (tobacco-related diagnosis)
- Dental code 1320
- Patient Education codes containing “TO-”, “-TO”, “-SHS,” 305.1, 305.1* (old codes), 649.00-649.04, V15.82, D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455-G8457 (old codes), G8402 (old code), G8453 (old code)
- CPT D1320, 99406, 99407, G0375 (old code), G0376 (old code), G8455-G8457 (old codes), G8402 (old code), G8453 (old code), 1034F (Current Tobacco Smoker), 1035F (Current Smokeless Tobacco User), 1036F (Current Tobacco Non-User), 1036F (Current Tobacco Non-User), 1000F (Tobacco Use Assessed)

Tobacco Users

- Health Factors: Current Smoker, Current Smokeless, Current Smoker and Smokeless, Cessation-Smoker, Cessation-Smokeless, Current Smoker, status unknown, Current smoker, every day, Current smoker, some day
- POV 305.1, 305.10–305.12 (old codes), 649.00-649.04
- CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, G8455 (old code), G8456 (old code), G8402 (old code), G8453 (old code)

Current Smokers

- Health Factors: Current Smoker, Current Smoker and Smokeless, Cessation-Smoker, Current Smoker, status unknown, Current smoker, every day, Current smoker, some day
- POV 305.1, 305.10–305.12 (old codes), 649.00-649.04
- CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, G8455 (old code), G8402 (old code), G8453 (old code)

Current Smokeless

- Health Factors: Current Smokeless, Current Smoker and Smokeless, Cessation-Smokeless
- CPT 1035F, G8456 (old code)

Environmental Tobacco Smoke (ETS)

- Health Factors: Smoker in Home, Exposure to Environmental Tobacco Smoke

2.4.3.5 Patient List

List of patients 55 and older with no documented tobacco screening.

2.5 Behavioral Health Group

2.5.1 Intimate Partner (Domestic) Violence Screening

No changes from Version 11.1

2.5.1.1 Owner/Contact

Denise Grenier, LCSW and Dr. Peter Stuart

2.5.1.2 Denominators

1. Female Active Clinical patients ages 55 and older, broken down by age groups.

2.5.1.3 Numerators

1. **GPRA:** Patients screened for or diagnosed with intimate partner (domestic) violence during the report period.

Note: This numerator does not include refusals.

- A. Patients with documented Intimate Partner Violence/Domestic Violence (IPV/DV) exam.
 - B. Patients with IPV/DV related diagnosis.
 - C. Patients provided with IPV/DV patient education or counseling.
2. Patients with documented refusal in past year of an IPV/DV exam or IPV/DV-related education.

2.5.1.4 Definitions

IPV/DV Screening

Defined as at least one of the following:

- IPV/DV Screening

- PCC Exam code 34
- BHS IPV/DV exam
- 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.*
- IPV/DV Patient Education
 - Patient Education codes containing “DV-” or “-DV”, 995.80-83, 995.85, V15.41, V15.42, V15.49
- IPV/DV Counseling
 - POV V61.11

Refusals

Defined as:

- Any PCC refusal in past year with Exam code 34 or BHS refusal in past year of IPV/DV exam
- Any refusal in past year with Patient Education codes containing "DV-" or “-DV”

2.5.1.5 Patient List

List of female patients 55 and older not screened for domestic violence and without documented refusal.

2.5.2 Depression Screening

No changes from Version 11.1

2.5.2.1 Owner/Contact

Cheryl Peterson, RN, MSN ~~Denise Grenier, LCSW and Drs. David Sprenger and Peter Stuart~~

2.5.2.2 Denominators

1. Active Clinical patients ages 55 and older, broken down by gender and age groups.

2.5.2.3 Numerators

1. **GPRA:** Patients screened for depression or diagnosed with mood disorder at any time during the report period.

Note: This numerator does not include refusals.

- A. Patients screened for depression during the report period.
 - B. Patients with a diagnosis of a mood disorder during the report period.
2. Patients with documented depression screening refusal in past year.
 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.

2.5.2.4 Definitions

Depression Screening

Any of the following:

- Exam code 36
- POV V79.0
- CPT 1220F
- BHS problem code 14.1 (screening for depression)
- V Measurement in PCC or BH of PHQ2 or PHQ9

Mood Disorders

At least two visits in Patient Care Component (PCC) or Behavioral Health System (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, 311 or BHS POV 14, 15

Screening Refusal

Any PCC refusal in past year with Exam code 36.

Depression-Related Patient Education or Refusal

Any of the following during the report period:

- Patient education codes containing “DEP-” (depression), 296.2*, 296.3*, “BH-” (behavioral and social health), 290-319, 995.5*, 995.80-995.85, “SB-” (suicidal behavior), 300.9, “PDEP-” (postpartum depression), 648.44
- Refusal of patient education codes containing “DEP-”, “BH-”, “SB-”, “PDEP-”

2.5.2.5 Patient List

List of patients 55 and older not screened for depression/diagnosed with mood disorder.

2.6 Cardiovascular Disease Related Group

2.6.1 Obesity Assessment

No changes from Version 11.1

2.6.1.1 Owner/Contact

Nutrition Program, Jean Charles-Azure

2.6.1.2 Denominators

1. Active Clinical patients ages 55 through 74, broken down by gender and age groups.

2.6.1.3 Numerators

1. All patients for whom Body Mass Index (BMI) can be calculated.

Note: This numerator does not include refusals.

- A. For those with a BMI calculated, patients considered overweight but not obese using BMI and standard tables.
 - B. For those with a BMI calculated, patients considered obese using BMI and standard tables.
 - C. Total of overweight and obese.
2. Patients with documented refusal in past year.

2.6.1.4 Definitions

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 five years, not required to be on the same day. For over 50, height and weight within last two years, not required to be recorded on same day. Overweight but not obese is defined as BMI of 25 through 29 for adults 19 and older. Obese is defined as BMI of 30 or more for adults 19 and older. For ages 2-18, definitions based on standard tables.

Patients whose BMI either is greater or less than the Data Check Limit range shown in the BMI Standard Reference Data Table in PCC will not be included in the report counts for Overweight or Obese.

Refusals

Include REF (refused), 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 weight must be refused during the past year and are not required to be on the same visit.

2.6.1.5 Patient List

List of patients 55-74 for whom BMI could *not* be calculated.

2.6.2 Cardiovascular Disease and Blood Pressure Control

Changes from Version 11.1, as noted.

2.6.2.1 Owner/Contact

Dr. Dena Wilson and Chris Lamer, PharmD

2.6.2.2 Denominators

1. All Active Clinical patients ages 55 and over, broken down by gender and age groups.

2.6.2.3 Numerators

1. Patients with Blood Pressure value documented at least twice in prior two years.
 - A. Patients with normal BP, defined as $< 120/80$, i.e., the mean systolic value is less than ($<$) 120 AND the mean diastolic value is less than ($<$) 80.
 - B. Patients with Pre Hypertension I BP, defined as $\Rightarrow 120/80$ and $< 130/80$, i.e., the mean systolic value is equal to or greater than (\Rightarrow) 120 and less than ($<$) 130 AND the mean diastolic value is equal to 80.
 - C. Patients with Pre Hypertension II BP, defined as $\Rightarrow 130/80$ and $< 140/90$, i.e., the mean systolic value is equal to or greater than (\Rightarrow) 130 and less than ($<$) 140 AND the mean diastolic value is equal to or greater than (\Rightarrow) 80 and less than ($<$) 90.
 - D. Patients with Stage 1 Hypertension Blood Pressure (BP), defined as $\Rightarrow 140/90$ and $< 160/100$, i.e., the mean systolic value is equal to or greater than (\Rightarrow) 140 and less than ($<$) 160 AND the mean diastolic value is equal to or greater than (\Rightarrow) 90 and less than ($<$) 100.
 - E. Patients with Stage 2 Hypertension BP, defined as $\Rightarrow 160/100$, i.e., the mean systolic value is equal to or greater than (\Rightarrow) 160 AND the mean diastolic value is equal to or greater than (\Rightarrow) 100.

2.6.2.4 Definitions

BP Values (all numerators)

CRS uses mean of last three BPs documented on non-ER visits in the past two years. 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 0001F, 2000F, 3074F-3080F *or POV V81.1* documented on a non-ER visit during the report period.

2.6.2.5 Patient List

List of patients 55 and older with mean BP, if any.

2.6.3 Cardiovascular Disease and Cholesterol Screening

No changes from Version 11.1

2.6.3.1 Owner/Contact

Dr. Dena Wilson and Chris Lamer, PharmD

2.6.3.2 Denominators

1. Active Clinical patients ages 55 and older; broken out by gender and age groups.

2.6.3.3 Numerators

1. Patients with documented blood total cholesterol screening any time in the past five years.
 - A. Patients with high total cholesterol levels, defined as equal to or greater than (\Rightarrow) 240.

2. Patients with LDL completed in the past five years, regardless of result.
 - A. Patients with LDL \leq 100
 - B. Patients with LDL 101-130
 - C. Patients with LDL 131-160
 - D. Patients with LDL $>$ 160

2.6.3.4 Definitions

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

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 \leq 100, CPT 3048F will count as meeting the measure

2.6.3.5 Patient List

List of patients 55 and older with cholesterol or LDL value if any.

2.7 Other Clinical Measures Group

2.7.1 Osteoporosis Management

No changes from Version 11.1

2.7.1.1 Owner/Contact

Drs. Bruce Finke and Lisa Sumner

2.7.1.2 Denominators

1. Female Active Clinical patients ages 55 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. Broken down by age groups.

2.7.1.3 Numerators

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

2.7.1.4 Definitions

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.

Denominator Exclusions

- Patients receiving osteoporosis screening or treatment in the year (365 days) prior to the Index Episode Start Date. Osteoporosis screening or treatment is defined as a Bone Mineral Density (BMD) test (see below for codes) or receiving any osteoporosis therapy medication (see below for codes).
- Patients with a fracture diagnosed at an outpatient visit, which *also* had a fracture within 60 days prior to the Index Episode Start Date.
- Patients with a fracture diagnosed at an inpatient visit, which *also* had a fracture within 60 days prior to the ADMISSION DATE.

Osteoporosis Treatment and Testing

For fractures diagnosed at an outpatient visit:

- A nondiscontinued prescription within six months (180 days) of the Index Episode Start Date (i.e., visit date) or
- A BMD test within six months of the Index Episode Start Date.

For fractures diagnosed at an inpatient visit, a BMD test performed during the inpatient stay.

- Fracture codes:
 - CPT 21800-21825, 22305-22314, 22316-22324, 22520, 22521, 22523, 22524, 23500-23515, 23570-23630, 23665-23680, 24500-24585, 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
 - POV 733.1*, 805*-806*, 807.0*-807.4, 808*-815*, 818*-825*, 827*, 828*
 - 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
- BMD Test:
 - 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
 - Procedure 88.98
 - POV V82.81

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

2.7.1.5 Patient List

List of female patients 55 and older with new fracture who had osteoporosis treatment or testing, if any.

2.7.2 Osteoporosis Screening in Women

Changes from Version 11.1, as noted.

2.7.2.1 Owner/Contact

Drs. Bruce Finke and Lisa Sumner

2.7.2.2 Denominators

1. Female Active Clinical patients ages 55 and older without a documented history of osteoporosis, broken down by age groups.

2.7.2.3 Numerators

1. Patients who had osteoporosis screening documented in the past two years.

Note: This numerator does *not* include refusals.

2. Patients with documented refusal in past year

2.7.2.4 Definitions

Patients without Osteoporosis

No osteoporosis diagnosis ever (POV 733.*)

Osteoporosis Screening

Any one of the following in the past two years:

- **Central DEXA:** *V Radiology or* CPT 77080, 76075 (old code)
- **Peripheral DEXA:** *V Radiology or* CPT 77081, 76076 (old code)
- **SEXA:** *V Radiology or* CPT G0130
- **Central CT:** *V Radiology or* CPT 77078, 76070 (old code)
- **Peripheral CT:** *V Radiology or* CPT 77079, 76071 (old code)
- **US Bone Density:** *V Radiology or* CPT 76977
- **Quantitative CT:** Procedure 88.98
- **POV V82.81** Special screening for other conditions, Osteoporosis

Refusal

Any of the following in the past year:

- *V Radiology or* CPT 77080, 76075 (old code), 77081, 76076 (old code), G0130, 77078, 76070 (old code), 77079, 76071 (old code), 76977
- Procedure 88.98

2.7.2.5 Patient List

List of female patients 55 and older with osteoporosis screening or refusal, if any.

2.7.3 Osteoarthritis Medication Monitoring

No changes from Version 11.1

2.7.3.1 Owner/Contact

Dr. Charles (Ty) Reidhead

2.7.3.2 Denominators

1. Active Clinical patients ages 55 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. Broken down by age groups.

2.7.3.3 Numerators

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

2.7.3.4 Definitions

OA

Diagnosis (POV or Problem List) 715.* prior to the report period, and at least two OA POVs during the report period.

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

- Example of Patient Not on Chronic Medication (not included in Denominator):
 - Report Period: Jan 1–Dec 31, 2011
 - Medication Period: 465 days from end of report period (Dec 31, 2011): Sep 22, 2010 – Dec 31, 2011
 - Medication Prescribed:
 - Diclofenac: 1st Rx: Oct 15, 2010, Days Supply=90; 2nd Rx: Jan 1, 2011: Days Supply=90; 3rd Rx: Mar 15, 2011: 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, 2011
 - Medication Period: 465 days from end of report period (Dec 31, 2011): Sep 22, 2010–Dec 31, 2011
 - Medication Prescribed:
 - Etodolac: 1st Rx: Sep 30, 2010: Days Supply=90; 2nd Rx: Dec 30, 2010: Days Supply=90; 3rd Rx: Mar 15, 2011: 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=11/15/2011, Discontinued Date=11/19/2011, 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

- 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, Celcoxib.
 - 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.
- All NSAID medications must have Creatinine, Liver Function Tests and CBC during the report period.
- Example of Patient Not Included in Numerator:

Medication Prescribed and Required Monitoring:

 - Diclofenac, last Rx Jun 15, 2011. Requires Creatinine, LFT, and CBC during report period
 - Only the LFT was performed during report period
 - Patient is not in numerator
- Example of Patient Included in Numerator:

Medications Prescribed and Required Monitoring:

- Diclofenac, last Rx Sep 1, 2011. Requires Creatinine, LFT, and CBC during report period
- Creatinine, LFT, and CBC performed during report period
- Patient is in the numerator

Monitoring Test Definitions

- Serum Creatinine:
 - CPT 82540, 82565-75
 - LOINC taxonomy
 - Site-populated taxonomy DM AUDIT CREATININE TAX
- CBC (Complete Blood Count):
 - CPT 85025, 85027
 - Site-populated taxonomy BGP CBC TESTS
 - LOINC taxonomy
- Liver Function Tests: Any one of the following:
 - ALT
 - CPT 84460
 - Site-populated taxonomy DM AUDIT ALT
 - LOINC taxonomy
 - AST
 - CPT 84450
 - Site-populated taxonomy DM AUDIT AST
 - LOINC taxonomy
 - Liver Function
 - CPT 80076
 - Site-populated taxonomy BGP LIVER FUNCTION
 - LOINC taxonomy

2.7.3.5 Patient List

List of OA patients 55 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:” All lab tests the patient *did* have are displayed.

2.7.4 Functional Status Assessment in Elders

No changes from Version 11.1

2.7.4.1 Owner/Contact

Dr. Bruce Finke

2.7.4.2 Denominators

1. Active Clinical patients ages 55 and older, broken down by gender and age groups.

2.7.4.3 Numerators

1. Patients screened for functional status at any time during the report period.

2.7.4.4 Definitions

Functional Status

Any non-null values in V Elder Care for the following:

- At least one of the following ADL fields: toileting, bathing, dressing, transfers, feeding, or continence
- At least one of the following IADL fields: finances, cooking, shopping, housework/chores, medications or transportation during the report period.

2.7.4.5 Patient List

List of patients 55 and older with functional status codes, if any.

The following abbreviations are used in the Numerator column:

- TLT–Toileting
- BATH–Bathing
- DRES–Dressing
- XFER–Transfers
- FEED–Feeding

- CONT–Contenance
- FIN–Finances
- COOK–Cooking
- SHOP–Shopping
- HSWK–Housework/Chores
- MEDS–Medications
- TRNS–Transportation

2.7.5 Asthma

No changes from Version 11.1

2.7.5.1 Owner/Contact

Drs. Charles (Ty) Reidhead

2.7.5.2 Denominators

1. Active Clinical patients ages 55 and older, broken out by age groups.
2. Numerator 1 (Patients who have had two asthma-related visits during the report period or with persistent asthma) broken out by age groups: <5, 5-64, 65 and older.

2.7.5.3 Numerators

1. Patients who have had two asthma-related visits during the report period or with persistent asthma.
 - A. Patients from Numerator 1 who have been hospitalized at any hospital for asthma during the report period.

2.7.5.4 Definitions

Asthma Visits

Asthma visits are defined as diagnosis (POV) 493.*.

Persistent Asthma

Any of the following:

- 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.

Hospitalizations

Hospitalizations are defined as service category H with primary POV 493.*.

2.7.5.5 Patient List

List of patients 55 and older diagnosed with asthma and any asthma-related hospitalizations.

2.7.6 Public Health Nursing

No changes from Version 11.1

2.7.6.1 Owner/Contact

Cheryl Peterson, RN

2.7.6.2 Denominators

1. Number of visits to User Population patients by Public Health Nurses (PHNs) in any setting, including Home, broken down by age groups.
 - A. Number of visits to patients ages 55–64 years
 - B. Number of visits to patients ages 65–74 years
 - C. Number of visits to patients ages 75–84 years
 - D. Number of visits to patients ages 85 and older
 - E. Number of PHN driver/interpreter (Provider code 91) visits.
2. Number of visits to User Population patients by PHNs in Home setting, broken down by age groups.
 - A. Number of Home visits to patients ages 55–64 years

- B. Number of Home visits to patients ages 65–74 years
- C. Number of Home visits to patients ages 75–84 years
- D. Number of Home visits to patients ages 85 and older
- E. Number of PHN driver/interpreter (Provider code 91) visits

2.7.6.3 Numerator

No numerator. This measure is a total count only, not a percentage.

2.7.6.4 Definitions

PHN Visit-Any Setting

Any visit with primary or secondary Provider codes 13 or 91.

PHN Visit-Home

Any visit with one of the following:

- Clinic code 11 and a primary or secondary Provider code of 13 or 91
- Location Home (as defined in Site Parameters) and a primary or secondary Provider code 13 or 91

2.7.6.5 Patient List

List of patients 55 and older with PHN visits documented.

Numerator codes in patient list:

- All PHN = Number of PHN visits in any setting
- Home = Number of PHN visits in home setting
- Driver All = Number of PHN driver/interpreter visits in any setting
- Driver Home = Number of PHN driver/interpreter visits in home setting

2.7.7 Fall Risk Assessment in Elders

No changes from Version 11.1

2.7.7.1 Owner/Contact

Dr. Bruce Finke

2.7.7.2 Denominators

1. Active Clinical patients ages 65 and older, broken down by gender.

2.7.7.3 Numerators

1. Patients who have been screened for fall risk or with a fall-related diagnosis in the past year.

Note: This numerator does *not* include 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.
2. Patients with a documented refusal of fall risk screening exam in the past year.

2.7.7.4 Definitions**Fall Risk Screen**

Any of the following:

- Fall Risk Exam defined as: V Exam code 37
- CPT 1100F, 1101F, 3288F
- History of Falling defined as: POV V15.88 (Personal History of Fall)
- Fall-related Injury Diagnosis defined as: POV (Cause codes #1–3) E880.*, E881.*, E883.*, E884.*, E885.*, E886.*, E888.*
- Abnormality of Gait/Balance or Mobility defined as: POV 781.2, 781.3, 719.7, 719.70 (old code), 719.75-719.77 (old codes), 438.84, 333.99, 443.9

Refusal

Refusal of Exam 37

2.7.7.5 Patient List

List of patients 65 years or older with fall risk assessment, if any.

2.7.8 Use of High Risk Medications in the Elderly

No changes from Version 11.1

2.7.8.1 Owner/Contact

Dr. Bruce Finke

2.7.8.2 Denominators

1. Active Clinical patients ages 65 and older, broken down by gender and age groups.

2.7.8.3 Numerators

1. Patients who received at least one high risk medication for the elderly during the report period.
 - A. Patients who received at least one prescription for a Health Plan Employer Data and Information Set- (HEDIS-) defined high-risk medication from the antianxiety medication class during the Report Period.
 - B. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the antiemetic medication class during the Report Period.
 - C. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the analgesic medication class during the Report Period.
 - D. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the antihistamine medication class during the Report Period.
 - E. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the typical antipsychotic medication class during the Report Period.
 - F. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the amphetamine medication class during the Report Period.
 - G. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the barbiturate medication class during the Report Period.

- H. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the long-acting benzodiazepine medication class during the Report Period.
 - I. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the calcium channel blocker medication class during the Report Period.
 - J. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the gastrointestinal antispasmodic medication class during the Report Period.
 - K. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the belladonna alkaloid medication class during the Report Period.
 - L. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the skeletal muscle relaxant medication class during the Report Period.
 - M. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the oral estrogen medication class during the Report Period.
 - N. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the oral hypoglycemic medication class during the Report Period.
 - O. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the narcotic medication class during the Report Period.
 - P. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the vasodilator medication class during the Report Period.
 - Q. Patients who received at least one prescription for other HEDIS-defined high-risk medications for the elderly during the Report Period.
2. Patients who received at least two different high risk medications for the elderly during the report period.

2.7.8.4 Definitions

High Risk Medications for the Elderly (i.e. potentially harmful drugs)

Defined with medication taxonomies:

- BGP HEDIS ANTIANXIETY MEDS
 - (Includes combination drugs) (Aspirin-Meprobamate, Meprobamate)

- BGP HEDIS ANTIEMETIC MEDS
 - (Scopolamine, Trimethobenzamide)
- BGP HEDIS ANALGESIC MEDS
 - (Includes combination drugs) (Acetaminophen-diphenhydramine, diphenhydramine-magnesium salicylate, Ketorolac)
- BGP HEDIS ANTIHISTAMINE MEDS
 - (Includes combination drugs) (APAP/dextromethorphan/diphenhydramine, APAP/diphenhydramine/phenylephrine, APAP/diphenhydramine/pseudoephedrine, Acetaminophen-diphenhydramine, Atropine/CPM/hyoscyamine/PE/PPA/scopolamine, Carbetapentane/diphenhydramine/phenylephrine, Codeine/phenylephrine/promethazine, Codeine-promethazine, Cyproheptadine, Dexchlorpheniramine, Dexchlorpheniramine/dextromethorphan/PSE, Dexchlorpheniramine/guaifenesin/PSE, Dexchlorpheniramine/hydrocodone/phenylephrine, Dexchlorpheniramine/methscopolamine/PSE, Dexchlorpheniramine-pseudoephedrine, Dextromethorphan-promethazine, Diphenhydramine, Diphenhydramine/hydrocodone/phenylephrine, Diphenhydramine-magnesium salicylate, Diphenhydramine-phenylephrine, Diphenhydramine-pseudoephedrine, Hydroxyzine hydrochloride, Hydroxyzine pamoate, Phenylephrine-promethazine, Promethazine, Tripeleennamine)
- BGP HEDIS ANTIPSYCHOTIC MEDS
 - (Thioridazine, Mesoridazine)
- BGP HEDIS AMPHETAMINE MEDS
 - (Aphetamine-destroamphetamine, Benzphetamine, Dexmethylphenidate, Dextroamphetamine, Diethylpropion, Methamphetamine, Methylphenidate, Pemoline, Phendimetrazine, Phenteramine)
- BGP HEDIS BARBITURATE MEDS
 - (Amobarbital, Butabarbital, Mephobarbital, Pentobarbital, Phenobarbital, Secobarbital)

- BGP HEDIS BENZODIAZEPINE MEDS
 - (Includes combination drugs) (Amitriptyline-Chlordiazepoxide, Chlordiazepoxide,, Chlordiazepoxide-clidinium, Diazepam, Flurazepam)
- IBGP HEDIS CALCIUM CHANNEL MEDS
 - (Nifedipine - short acting only)
 - BGP HEDIS GASTRO ANTISPASM MED
 - (Dicyclomine, Propantheline)
- BGP HEDIS BELLADONNA ALKA MEDS
 - (Includes combination drugs) (Atropine, Atropine/CPM/hyoscyamine/PE/scopolamine, Atropine/hyoscyamine/PB/scopolamine, Atropine-difenoxin, Atropine-diphenoxylate, Atropine-edrophonium, Belladonna, Belladonna/caffeine/ergotamine/pentobarbital, Belladonna/ergotamine/Phenobarbital, Butabarbital/hyoscyamine/phenazopyridine, Digestive enzymes/hyoscyamine/ phenyltoloxamine, Hyoscyamine, Hyoscyamine/methenam/m-blue/phenyl salicyl, Hyoscyamine-phenobarbital)
- BGP HEDIS SKL MUSCLE RELAX MED
 - (Includes combination drugs) (ASA/caffeine/orphenadrine, ASA/carisoprodol/codeine, Aspirin-carisoprodol, Aspirin-meprobamate, Aspirin-methocarbamol, Carisoprodol, Chlorzoxazone, Cyclobenzaprine, Metaxalone, Methocarbamol, Orphenadrine)
- BGP HEDIS ORAL ESTROGEN MEDS
 - (Includes combination drugs) (Conjugated estrogen, Conjugated estrogen-medroxyprogesterone, Esterified estrogen, Esterified estrogen-methyltestosterone, Estropipate)
- BGP HEDIS ORAL HYPOGLYCEMIC RX
 - (Chlorpropamide)
- BGP HEDIS NARCOTIC MEDS
 - (Includes combination drugs) (ASA/caffeine/propoxyphene, Acetaminophen-pentazocine, Acetaminophen-propoxyphene, Belladonna-opium, Meperidine, Meperidine-promethazine, Naloxone-pentazocine, Pentazocine, Propoxyphene hydrochloride, Propoxyphene napsylate)

- BGP HEDIS VASODILATOR MEDS
 - (Cyclandelate, Dipyridamole-short acting only, Ergot mesyloids, Isoxsuprine)
- BGP HEDIS OTHER MEDS AVOID ELD
 - (Includes androgens and anabolic steroids, thyroid drugs, and urinary anti-infectives) (Methyltestosterone, Nitrofurantoin, Nitrofurantoin macrocrystals, Nitrofurantoin macrocrystals-monohydrate, Thyroid desiccated)

Note: 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. Example: Rx Date=11/15/2010, Discontinued Date=11/19/2010, Recalculated # Days Prescribed=4. Medications must not have a comment of RETURNED TO STOCK.

2.7.8.5 Patient List

List of patients 65 and older with at least one prescription for a potentially harmful drug.

2.7.9 Palliative Care

No changes from Version 11.1

2.7.9.1 Owner/Contact

Dr. Bruce Finke

2.7.9.2 Denominators

1. No denominator, count only.
2. Active Clinical patients ages 55 and older with two or more types of cancer documented during the Report Period. Broken down by gender and age groups.

2.7.9.3 Numerators

1. No denominator; count only. The total number of Active Clinical patients 55 and older with at least one palliative care visit during the Report Period. Broken down by gender and age groups.
2. No denominator; count only. The total number of palliative care visits for Active Clinical patients 55 and older during the Report Period. Broken down by gender and age groups.
3. For use with Denominator #2: Patients with at least two palliative care visits during the Report Period.

2.7.9.4 Definition

Age

Age is calculated at the beginning of the report period

Palliative Care Visit

POV V66.7

Cancer Types

Cancer types defined with the following POVs:

- Melanoma: 172*
- Breast: 174*, 175*, 239.3
- Colon: 153*, 154*, 235.2
- Gyn: 180*, 182*, 183*, 184*, 236.1, 236.2
- Prostate: 185* 236.5
- Testes/Male GU: 186*, 187.3, 187.4, 187.9, 236.4, 236.6
- Head and neck: 140–149.9, 160*, 161*, 162*, 195.0
- Urinary Tract: 188*, 189*, 236.7, 236.91, 239.4, 239.5
- Non-melanomatous skin cancer: 173*, 238.2
- Non-colon GI: 150–152.9, 155–159.9, 235*, 239.0
- Lung: 162*, 235.9, 239.1
- Brain: 190–192.9, 237.5, 237.6, 239.6

- Bones/soft tissue: 170*, 171*, 238.1, 238.2
- Endocrine: 193, 194*, 237.0, 237.4, 239.7
- Pleura/mediastinum: 163*, 164*
- Non-specific site: 195*, 199*, 238.8, 238.9, 239.8, 239.9
- Lymph node spread: 196*
- Secondary cancer: 196*, 197*

2.7.9.5 Patient List

List of patients 55 and older with either two or more types of cancer or at least one palliative care visit during the Report Period.

2.7.10 Annual Wellness Visit

No changes from Version 11.1

2.7.10.1 Owner/Contact

Dr. Bruce Finke

2.7.10.2 Denominators

1. Active Clinical patients ages 65 and older. Broken down by gender and age groups.

2.7.10.3 Numerators

1. Patients with at least one Annual Wellness Exam in the past 15 months.

2.7.10.4 Definition

Age

Age is calculated at the beginning of the report period

Annual Wellnes Exam

CPT G0438, G0439, G0402

2.7.10.5 Patient List

List of patients =>65 with at least one annual wellness exam in the past 15 months.

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