RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System

(BGP)

National GPRA/GPRAMA Report
Performance Measure List and Definitions

Version 14.1
May 2014

Office of Information Technology
Division of Information Resource Management
Albuquerque, New Mexico

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1.0 CRS 2014 National GPRA/GPRAMA Report

1.1 Performance Measures

The following performance measures will be reported in the Clinical Reporting System (CRS) 2014 National Government Performance and Results Act of 1993 (GPRA)/GPRA Modernization Act (GPRAMA) Report.

> **Note:** Beginning FY 2010, GPRA Developmental will no longer be included in this document and will instead have its own Performance Measure Topics and Definitions document.

Notations used in this document are described in the following table.

Table 1-1: Document Notations

Notation	Location	Meaning
GPRA:	Preceding a measure	An official GPRA measure reported in the National GPRA Report submitted to Office of Management and Budget (OMB) and Congress in the annual IHS budget process.
GPRAMA:	Preceding a measure	An official GPRAMA measure reported in the National GPRA Report submitted to the Office of Management and Budget (OMB) and Congress, and included in the annual HHS Online Performance Appendix.
Plus Sign (+)	Preceding a measure	The measure is *not* an official GPRA measure but *is included* in the National GPRA Report provided to OMB and Congress to provide context to a GPRA measure(s).
Section Symbol (§)	Preceding a measure	The measure is *not* an official GPRA measure and *is not included* in the National GPRA Report provided to OMB and Congress. Included in this document to provide context to a GPRA measure(s).
Asterisk (*)	Anywhere in a code (CPT, POV, Edu.,etc.)	A 'wildcard' character indicating that the code given has one or more additional characters at this location.

DIABETES GROUP

- DIABETES PREVALENCE
  - +Diabetes Diagnosis Ever
  - §Diabetes Diagnosis during GPRA Year

- GLYCEMIC CONTROL
  - +Documented Alc
  - Poor Glycemic Control
  - §A1c equal to or greater than (=>) 7 and less than (<)8
  - GPRAMA: Good Glycemic Control
  - A1c less than (<) 7
- BLOOD PRESSURE CONTROL
  - §Blood Pressure (BP) Assessed
  - GPRA: Controlled BP (less than (<) 140/90)
- LOW DENSITY LIPOPROTEIN (LDL) ASSESSMENT
  - GPRA: LDL Assessed
  - §LDL less than (<) to 100
- NEPHROPATHY ASSESSMENT
  - GPRA: Estimated Glomerular Filtration Rate (GFR) & Urine Albumin-to-Creatinine Ratio (UACR) or History of End Stage Renal Disease (ESRD)
- RETINOPATHY ASSESSMENT
  - GPRA: Retinopathy Evaluation (No Refusals)

DENTAL GROUP

- ACCESS TO DENTAL
  - GPRA: Annual Dental Visit (No Refusals)
- DENTAL SEALANTS
  - GPRA: Dental Sealants (rate)
  - §Dental Sealants (No Refusals; count; not rate)
- TOPICAL FLUORIDE
  - GPRA: Topical Fluoride (rate)
  - §Topical Fluoride Application (No Refusals; count; not rate)

IMMUNIZATIONS

- INFLUENZA
  - GPRA: Influenza Immunization
- ADULT IMMUNIZATIONS
  - GPRA: Up to Date Pneumovax
- CHILDHOOD IMMUNIZATIONS (19 THROUGH 35 MONTHS)

  - §Active Clinical Patients with 4:3:1:3*:3:1:4 (No Refusals)
  - GPRAMA: Active IMM Patients with 4:3:1:3*:3:1:4 (No Refusals)
  - §4 DTaP
  - §3 Polio
  - §1 MMR
  - §3 or 4 HiB
  - §3 Hepatitis B
  - §1 Varicella
  - §4 Pneumococcal

CANCER SCREENING

- PAP SMEAR RATES
  - GPRA: Pap smear in past 3 years or for age 30+, Pap & HPV in past 5 years (No Refusals)
- MAMMOGRAM RATES
  - GPRA: Mammogram (No Refusals)
- COLORECTAL CANCER SCREENING
  - GPRA: Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) during report period, Flexible Sigmoidoscopy in past 5 years, or Colonoscopy in past 10 years (No Refusals)
  - §FOBT or FIT
- TOBACCO USE AND EXPOSURE ASSESSMENT
  - §Tobacco Assessment
  - §Tobacco Users
    - §Smokers
    - §Smokeless Users
  - §Exposed to Environmental Tobacco Smoke (ETS)
- TOBACCO CESSATION
  - §Tobacco Cessation Counseling or Smoking Cessation Aid (No Refusals)
  - §Quit Tobacco Use
  - GPRA: Tobacco Cessation Counseling, Smoking Cessation Aid, or Quit Tobacco Use

BEHAVIORAL HEALTH

- ALCOHOL SCREENING (FETAL ALCOHOL SYNDROME [FAS] PREVENTION)

  - GPRA: Alcohol Screening (No Refusals)
- INTIMATE PARTNER VIOLENCE/DOMESTIC VIOLENCE (IPV/DV) SCREENING
  - GPRA: IPV/DV Screening (No Refusals)
- DEPRESSION SCREENING
  - GPRAMA: Depression Screening or Mood Disorder Diagnosis (No Refusals)
  - §Depression Screening
  - §Mood Disorder Diagnosis

CARDIOVASCULAR DISEASE-RELATED

- CHILDHOOD WEIGHT CONTROL
  - GPRA: BMI 95% and Up
- CONTROLLING HIGH BLOOD PRESSURE – MILLION HEARTS
  - GPRA: BP less than (<) 140/90
- COMPREHENSIVE CVD-RELATED ASSESSMENT
  - GPRAMA: BP, LDL, and Tobacco Assessed, BMI, and Lifestyle Counseling (No Refusals)
  - §Depression Screen

STD GROUP

- HIV SCREENING
  - GPRA: Prenatal HIV Screening (No Refusals)

OTHER CLINICAL

- BREASTFEEDING RATES
  - Patients 30 through 394 days of age screened for infant feeding choice (IFC) at least once
  - Patients 30 through 394 days of age screened for IFC at the age of 2 months
  - Patients 30 through 394 days of age screened for IFC at the age of 6 months
  - Patients 30 through 394 days of age screened for IFC at the age of 9 months
  - Patients 30 through 394 days of age screened for IFC at the age of 1 year
  - GPRA: Patients 30 through 394 days of age who were exclusively or mostly breastfed at 2 months of age
  - Patients 30 through 394 days of age who were exclusively or mostly breastfed at 6 months of age
  - Patients 30 through 394 days of age who were exclusively or mostly breastfed at 9 months of age

– Patients 30 through 394 days of age who were exclusively or mostly breastfed at the age of 1 year

Note:	Definitions for all performance measure topics included in CRS begin on Section 2.0. Definitions for numerators and denominators that are preceded by "GPRA" represent measures that are reported to OMB and Congress.

1.2 CRS Denominator Definitions

1.2.1 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 Patient Care Component [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.

1.2.2 Active Clinical Population

1.2.2.1 National GPRA/GPRAMA Reporting

- Must have two visits to medical clinics in the past 3 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 FY2014 Clinical Measures User Manual* for listing of these clinics.
- Must be alive on the last day of the Report Period.
- Must be American Indian/Alaska Native (AI/AN); defined as Beneficiary 01.
- Must reside in a community specified in the site's GPRA community taxonomy, defined as all communities of residence in the defined Contract Health Service (CHS) catchment area.

1.2.2.2 Local Reports

- Must have two visits to medical clinics in the past 3 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 for FY2014 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.

1.2.3 User Population

1.2.3.1 National GPRA/GPRAMA Reporting

- Must have been seen at least once in the 3 years prior to the end of the time period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the Report Period.
- Must be AI/AN; defined as Beneficiary 01.
- Must reside in a community specified in the site's GPRA community taxonomy, defined as all communities of residence in the defined CHS catchment area.

1.2.3.2 Local Reports

- Must have been seen at least once in the 3 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.

2.0 Performance Measure Topics and Definitions

The following sections define the performance measure topics and their definitions that are included in the *CRS 2014 version 14.0 National GPRA/GPRAMA Report*.

2.1 Diabetes Group

2.1.1 Diabetes Prevalence

No changes from Version 14.0

2.1.1.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.1.2 National Reporting

NATIONAL (included in IHS Performance Report; *not* reported to OMB and Congress)

2.1.1.3 Denominators

1. User Population patients.

2.1.1.4 Numerators

1. Anyone diagnosed with diabetes ever.
2. Anyone diagnosed with diabetes during the report period.

2.1.1.5 Definitions

Diabetes Diagnosis

At least one Purpose of Visit [POV] diagnosis ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.*.

2.1.1.6 Patient Lists

Diabetic patients with most recent diagnosis.

2.1.2 Diabetes: Glycemic Control

No changes from Version 14.0

2.1.2.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.2.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.1.2.3 Denominators

1. GPRAMA: Active Diabetic patients; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits in the past year, *and* two diabetes mellitus (DM)-related visits ever. The key denominator for this and all diabetes-related topics follows.

2.1.2.4 Numerators

1. Hemoglobin A1c documented during the report period.
2. Poor control: A1c greater (>) than 9.5.
3. A1c is greater than or equal (>=) to 7 and less than (<) 8
4. GPRAMA: Good control: A1c less than (<) 8.

2.1.2.5 Definition

Diabetes

First DM POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* 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 or the same visit and one test has a result and the other does not, the test with the result will be used. If both tests have a result, the last test done on the visit 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 any of the following:
  - Current Procedural Terminology (CPT) 83036, 83037, 3044F to 3046F, 3047F (old code)
  - Logical Observations Identifiers, Names, Codes (LOINC) taxonomy
  - Site-populated taxonomy DM AUDIT HGB A1C TAX

- CPT 3044F represents A1c less than (<) 7 and will be included in the A1c less than (<) 8 numerator.

2.1.2.6 GPRA 2014 Target

Good Glycemic Control: During FY 2014, achieve the target rate of 48.3% for the proportion of patients with diagnosed diabetes who have good glycemic control (defined as A1c less than (<) 8).

2.1.2.7 Patient Lists

- List of diabetic patients with a documented Alc.
- List of diabetic patients without a documented Alc.
- List of diabetic patients with poor glycemic control (Alc greater than (>) 9.5).
- List of diabetic patients with A1c equal to or greater than (=>) 7 and less than (<) 8.
- List of diabetic patients with good glycemic control (Alc less than (<) 8).

2.1.3 Diabetes: Blood Pressure Control

No changes from Version 14.0

2.1.3.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.3.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.1.3.3 Denominators

1. GPRA: Active Diabetic patients; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits in the past year, *and* two DM-related visits ever. The key denominator for this and all diabetes-related topics follows.

2.1.3.4 Numerators

1. Patients with BP documented during the report period.
2. GPRA: Patients with BP less than (<) 140/90, i.e., the mean systolic value is less than (<) 140 and the mean diastolic value is less than (<) 90.

2.1.3.5 Definitions

Diabetes

First DM POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the report period.

Exclusions

When calculating all BPs (using vital measurements or CPT codes), the following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), or O (Observation)
- Clinic code 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), or D4 (Anesthesiology)

BP Documented

CRS uses mean of last three BPs documented during the report period. If 3 BPs are not available, uses mean of last 2 BPs. If a visit contains more than one BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last 3 (or 2) systolic values and dividing by 3 (or 2). The mean Diastolic value is calculated by adding the diastolic values from the last 3 (or 2) BPs and dividing by 3 (or 2). If the systolic and diastolic values do not *both* meet the criteria for controlled, then the value is considered not controlled.

If CRS is not able to calculate a mean BP, it will search for CPT 0001F, 2000F, 3074F through 3080F or POV ICD-9: V81.1 documented during the Report Period.

Controlled BP

CRS uses a mean, as described above where BP is less than (<) 140/90. 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 BP measurements, it will search for the most recent of any of the following codes documented during the report period:

- BP Documented: CPT 0001F or 2000F or POV ICD-9: 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 combinations represent BP less than (<) 140/90 and will be included in the Controlled BP numerator: CPT 3074F or 3075F *and* 3078F or 3079F. All other combinations will not be included in the Controlled BP numerator.

2.1.3.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 64.6% for the proportion of patients with diagnosed diabetes who have achieved BP control (defined as less than (<) 140/90).

2.1.3.7 Patient Lists

- List of diabetic patients who had their BP assessed.
- List of diabetic patients who did not have their BP assessed.
- List of diabetic patients with controlled BP, defined as below 140/90.
- List of diabetic patients with uncontrolled BP, defined as above 140/90.

2.1.4 Diabetes: LDL Assessment

Changes from CRS v14.0 are noted

2.1.4.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.4.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.1.4.3 Denominators

1. GPRA: Active Diabetic patients; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits in the past year, *and* two DM-related visits ever. The key denominator for this and all diabetes-related topics is below.

2.1.4.4 Numerators

1. GPRA: Patients with LDL completed during the report period, regardless of result.
2. LDL less than (<) 100

2.1.4.5 Definitions

Diabetes

First DM POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* 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 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 less than 100, CPT 3048F will count as meeting the measure

2.1.4.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 73.9% for the proportion of patients with diagnosed diabetes who are assessed for dyslipidemia (LDL cholesterol).

2.1.4.7 Patient Lists

- List of diabetic patients with LDL completed, regardless of result.
- List of diabetic patients without LDL completed.

2.1.5 Diabetes: Nephropathy Assessment

Changes from CRS v14.0 are noted

2.1.5.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.5.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.1.5.3 Denominators

1. GPRA: Active Diabetic patients; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits in the past year, *and* two DM-related visits ever. The key denominator for this and all diabetes-related topics is below.

2.1.5.4 Numerators

1. GPRA: Patients with nephropathy assessment, defined as an estimated Glomerular Filtration Rate (GFR) with result *and* a Urine Albumin-to-Creatinine Ratio (UACR) during the report period *or* with evidence of diagnosis or treatment of end-stage renal disease (ESRD) at any time before the end of the report period.

2.1.5.5 Definitions

Diabetes

First DM POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the report period.

Estimated GFR

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

Urine Albumin-to-Creatinine Ratio

- CPT 82043 WITH 82570
- LOINC taxonomy
- Site-populated taxonomy BGP QUANT UACR TESTS

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

ESRD

- ESRD diagnosis or treatment defined as any of the following ever:
  - CPT 36145 (old code), 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831 through 36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90951 through 90970 or old codes 90918 through 90925, 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), S2065, S9339

- POV ICD-9: 585.6, V42.0, V45.1 (old code), V45.11, V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
- Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

2.1.5.6 GPRA 2014 Target

During FY 2014, establish a baseline for the proportion of patients with diagnosed diabetes who are assessed for nephropathy.

2.1.5.7 Patient Lists

- List of diabetic patients with nephropathy assessment.
- List of diabetic patients without nephropathy assessment.

2.1.6 Diabetic Retinopathy

No changes from Version 14.0

2.1.6.1 Owner and Contact

Diabetes Program: Dr. Mark Horton

2.1.6.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.1.6.3 Denominators

1. GPRA: Active Diabetic patients; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits in the past year, *and* two DM-related visits ever, without a documented history of bilateral blindness. The key denominator for this and all diabetes-related topics is below.

2.1.6.4 Numerators

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

Note: This numerator does *not* include refusals.

   A. Patients with a JVN visit during the Report Period.

   B. Patients with an Ophthalmology visit during the Report Period.

[1] Validation study properly powered and controlled against the ETDRS gold standard.

C. Patients with an Optometry visit during the Report Period.

2.1.6.5 Definitions

Diabetes

First DM POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the report period.

Qualified Retinal Evaluation

- Diabetic retinal exam
- Other eye exam

  The following methods are qualifying for this measure:

  - Dilated retinal evaluation by an optometrist or ophthalmologist.
  - Seven standard fields stereoscopic photos (Early Treatment Diabetic Retinopathy Study [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 formally validated[2] ETDRS photographic equivalent)
- CPT 2022F Dilated retinal eye exam, 2024F Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, 2026F Eye imaging formally validated[3] 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 formally validated[4] teleophthalmology retinal evaluation clinics

[2] Validation study properly powered and controlled against the ETDRS gold standard.

[3] Ibid.

[4] Ibid.

- Non-DNKA visits to an optometrist or ophthalmologist. Searches for any of the following codes in the following order:
  - Clinic codes A2 (Diabetic Retinopathy)[5], 17, 18
  - Provider code 24, 79, 08
  - CPT 67028, 67038 (old code), 67039, 67040, 92002, 92004, 92012, 92014

JVN Visit

- Clinic code A2

Ophthalmology Visit

- Clinic code 17
- Provider code 79

Optometry Visit

- Clinic code 18
- Provider codes 08, 24

Bilateral Blindness

- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 369.01, 369.03, 369.04; ICD-10: H54.0 through H54.12

2.1.6.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 58.6% for the proportion of patients with diagnosed diabetes who receive an annual retinal examination.

2.1.6.7 Patient Lists

- List of diabetic patients who received any retinal screening.
- List of diabetic patients who did not receive any retinal screening.

2.2 Dental Group

2.2.1 Access to Dental Services

Changes from CRS v14.0 are noted

2.2.1.1 Owner and Contact

Dental Program: Dr. Patrick Blahut

[5] Validated photographic (teleophthalmology) retinal surveillance.

2.2.1.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.2.1.3 Denominators

1. GPRA: User Population patients, broken down by age groups: 0 through 5, 6 through 21, 22 through 34, 35 through 44, 45 through 54, 55 through 74, 75 and older.

2.2.1.4 Numerators

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

Note: This numerator does *not* include refusals.

2.2.1.5 Definitions

Documented Dental Visit

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

- Dental ADA code 0000, 0190, 0191
- CPT code D0190, D0191
- Exam code 30
- POV ICD-9: V72.2; ICD-10: Z01.20, Z01.21

For CHS visits, searches for any visit with an ADA code. CHS visit defined as Type code of C in Visit file.

2.2.1.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 29.2% for the proportion of patients who receive dental services.

2.2.1.7 Patient Lists

- List of patients with documented dental visit.
- List of patients without documented dental visit.

2.2.2 Dental Sealants

No changes from Version 14.0

2.2.2.1 Owner and Contact

Dental Program: Dr. Patrick Blahut

2.2.2.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.2.2.3 Denominators

1. GPRA: User Population patients ages 2 through 15. Broken down by age groups 3 through 5, 6 through 9, 10 through 12, and 13 through 15.
2. No denominator. This measure is a total count only, not a percentage. Broken down by age group 2 through 15.

2.2.2.4 Numerators

1. GPRA: Patients with at least one or more intact dental sealants.
2. Count only (no percentage comparison to denominator). For patients meeting the User Population definition, the total number of dental sealants during the report period.

Note: This numerator does *not* include refusals.

2.2.2.5 Definitions

Intact Dental Sealant

- Any of the following documented during the Report Period:
  - Dental ADA codes 1351, 1352
  - CPT D1351, D1352
- OR any of the following documented during the past 3 years from the end of the Report Period, as long as it is not documented on the same visit as any of the above codes:
  - Dental ADA code 0007

  If both ADA and CPT codes are found on the same visit, only the ADA will be counted.

  For the count measure, only two sealants per tooth will be counted during the report period. Each tooth is identified by the data element Operative Site in RPMS.

2.2.2.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 13.9% for the proportion of patients with at least one or more intact dental sealants.

2.2.2.7 Patient Lists

- List of User Pop patients ages 2 through 15 with intact dental sealant.
- List of User Pop patients ages 2 through 15 without intact dental sealant.
- Patients who received dental sealants during report period.

2.2.3 Topical Fluoride

No changes from Version 14.0

2.2.3.1 Owner and Contact

Dental Program: Dr. Patrick Blahut

2.2.3.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.2.3.3 Denominators

1. GPRA: User Population patients ages 1 through 15.
2. No denominator. This measure is a total count only, not a percentage.

2.2.3.4 Numerators

1. GPRA: Patients who received one or more topical fluoride applications during the report period.
2. Count only (no percentage comparison to denominator). For patients meeting the User Population definition, the total number of patients with at least one topical fluoride treatment during the report period. Broken down by age group 1 through 15.

Note: This numerator does *not* include refusals.

2.2.3.5 Definitions

Topical Fluoride Application

Defined as any of the following:

- Dental ADA codes 1201 (old code), 1203 (old code), 1204 (old code), 1205 (old code), 1206, 1208, 5986
- CPT D1203 (old code), D1204 (old code), D1206, D1208, D5986
- POV ICD-9: V07.31

For the count measure, a maximum of one application per patient per visit is allowed. A maximum of four topical fluoride applications are allowed per patient per year for the applications measure.

2.2.3.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 26.7% for the proportion of patients who receive at least one topical fluoride application.

2.2.3.7 Patient Lists

- List of User Pop patients ages 1 through 15 with topical fluoride application.
- List of User Pop patients ages 1 through 15 without topical fluoride application.
- Patients who received at least one topical fluoride application during report period.

2.3 Immunization Group

2.3.1 Influenza

Changes from CRS v14.0 are noted

2.3.1.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.1.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.3.1.3 Denominators

1. GPRA: Active Clinical patients ages 65 and older.

2.3.1.4 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.

> **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.

2.3.1.5 Definitions

Influenza Vaccine

Any of the following documented during the report period:

- Immunization (CVX) codes 15, 16, 88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158
- POV ICD-9: V04.8 (old code), V04.81 *not* documented with 90663, 90664, 90666 through 90668, 90470, G9141 or G9142, or V06.6 *not* documented with 90663, 90664, 90666 through 90668, 90470, G9141 or G9142
- CPT 90654 through 90662, 90672, 90673, 90685, 90686, 90688, 90724 (old code), G0008, G8108 (old code)

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

2.3.1.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 69.1% for the proportion of non-institutionalized adults aged 65 years and older who receive an influenza immunization.

2.3.1.7 Patient Lists

- List of patients 65 years or older influenza vaccination, contraindication, or NMI refusal.
- List of patients 65 years or older without influenza vaccination, contraindication, or NMI refusal.

2.3.2 Adult Immunizations

Changes from CRS v14.0 are noted

2.3.2.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.2.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.3.2.3 Denominators

1. GPRA: Active Clinical patients ages 65 or older.

2.3.2.4 Numerators

1. GPRA: Patients with Pneumococcal vaccine or contraindication documented ever and, if patient is older than 65 years, either a dose of pneumovax after the age of 65 or a dose of pneumovax in the past 5 years.

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 Pneumococcal vaccine or contraindication documented at any time before the end of the report period.

2.3.2.5 Definitions

Pneumococcal Vaccine

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

- Immunization (CVX) codes 33, 100, 109, 133, 152
- POV ICD-9: V06.6, V03.82
- CPT 90732, 90669, 90670, G0009, G8115 (old code)

Contraindication to Pneumovax Vaccine

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

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

2.3.2.6 GPRA 2014 Target

During FY 2014, establish a baseline for the proportion of adult patients age 65 years and older who receive a pneumococcal immunization.

2.3.2.7 Patient Lists

- List of patients 65 years or older with pneumovax immunization or contraindication.
- List of patients 65 years or older without pneumovax immunization or contraindication.

2.3.3 Childhood Immunizations

Changes from CRS v14.0 are noted

2.3.3.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.3.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.3.3.3 Denominators

1. Active Clinical patients ages 19 through 35 months at end of report period.
2. GPRAMA: User Population patients active in the Immunization Package who are 19 through 35 months at end of report period.

> **Note:** Sites must be running the RPMS Immunization package for this denominator. Sites not running the package will have a value of zero for this denominator.

2.3.3.4 Numerators

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

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

2. Patients who have received four doses of DTaP ever, including contraindications.

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

3. Patients who have received 3 doses of Polio ever, including contraindications and evidence of disease.

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

4. Patients who have received 1 dose of MMR ever, including contraindications, and evidence of disease.

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

5. Patients who have received 3 or 4 doses of HiB ever, including contraindications.

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

6. Patients who have received 3 doses of Hepatitis B vaccine ever, including contraindications and evidence of disease.

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

7. Patients who have received 1 dose of Varicella ever, including contraindications and evidence of disease.[6]

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

8. Patients who have received 4 doses of Pneumococcal conjugate vaccine ever, including contraindications and evidence of disease.[7]

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

[6] Included with GPRA denominator only.

[7] Ibid.

2.3.3.5 Definitions

Patient Age

Since the age of the patient is calculated at the beginning of the report period, the age range will be adjusted to 7 through 23 months at the beginning of the report period, which makes the patient between the ages of 19 through 35 months at the end of the report period.

Timing of Doses

Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization.

Active Immunization Package Patients Denominator

Same as User Population definition *except* includes only patients flagged as active in the Immunization Package.

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

Dosage and Types of Immunizations

- 4 Doses of DTaP
  - 4 DTaP or DTP or Tdap
  - 1 DTaP or DTP or Tdap and 3 DT or Td
  - 1 DTaP or DTP or Tdap and 3 each of Diphtheria and Tetanus
  - 4 DT and 4 Acellular Pertussis
  - 4 Td and 4 Acellular Pertussis, or
  - 4 each of Diphtheria, Tetanus, and Acellular Pertussis
- 3 Doses of Polio
  - 3 OPV
  - 3 IPV, or
  - Combination of OPV & IPV totaling 3 doses
- One Dose of MMR
  - MMR
  - 1 M/R and 1 Mumps
  - 1 R/M and one Measles, or
  - 1 each of Measles, Mumps, and Rubella
- 3 doses of Hep B

- 3 or 4 doses of HIB
- 1 dose of Varicella
- 4 doses of Pneumococcal

NMI refusals, Contraindication, and Evidence of Disease Information

NMI refusals, evidence of disease, and contraindications for individual immunizations will also count toward meeting the definition, as defined below.

> **Note:** NMI refusals are *not* counted as refusals; rather, they are counted as contraindications.

- For immunizations that allow a different number of doses (e.g., 3 or 4 HIB): To count toward the numerator with the smaller number of doses, all of the patient's vaccinations must be part of the smaller dose series. For example, for a patient to count toward the HIB numerator with only 3 doses, all 3 doses must be included in the 3-dose series codes listed in the HIB definition. A patient with a mix of 3-dose and 4-dose series codes will need 4 doses to count toward the numerator. An exception to this is for the HIB vaccine: if the first 2 doses are CVX code 49, then the patient only needs 3 doses (even if the third dose is included in the 4-dose series).
- Each immunization must be refused and documented separately. For example, if a patient has an NMI refusal for Rubella only, then there must be an immunization, contraindication, or separate NMI refusal for the Measles and Mumps immunizations.
- For immunizations where required number of doses is greater than one, only one NMI refusal is necessary to be counted in the numerator. For example, if there is a single NMI refusal for Hepatitis B, the patient will be included in the numerator.
- To be counted as evidence of disease or contraindication or NMI refusal, a patient must have evidence of disease, a contraindication, or an NMI refusal for any of the immunizations in the numerator. For example, if a patient was Rubella immune but had a Measles and Mumps immunization, the patient would be counted as having evidence of disease for MMR.
- For immunizations where required number of doses is greater than one, only one contraindication is necessary to be counted in the numerator. For example, if there is a single contraindication for HiB, the patient will be included in the numerator
- Evidence of disease will be checked for at any time in the child's life (prior to the end of the report period.).

NMI Refusal Definitions

PCC Refusal type NMI for any of the following codes:

- DTaP
  - Immunization (CVX) codes 20, 50, 106, 107, 110, 120, 130, 132, 146
  - CPT 90696, 90698, 90700, 90721, 90723
- DTP
  - Immunization (CVX) codes 1, 22, 102
  - CPT 90701, 90711 (old code), 90720
- Tdap
  - Immunization (CVX) code 115
  - CPT 90715
- DT
  - Immunization (CVX) code 28
  - CPT 90702
- Td
  - Immunization (CVX) codes 9, 113, 138, 139
  - CPT 90714, 90718
- Diptheria
  - CPT 90719
- Tetanus
  - Immunization (CVX) codes 35, 112
  - CPT 90703
- Acellular Pertussis
  - Immunization (CVX) code 11
- OPV
  - Immunization (CVX) codes 2, 89
  - CPT 90712
- IPV
  - Immunization (CVX) codes 10, 89, 110, 120, 130, 132, 146
  - CPT 90696, 90698, 90711 (old code), 90713, 90723
- MMR
  - Immunization (CVX) codes 3, 94
  - CPT 90707, 90710

- M/R
  - Immunization (CVX) code 4
  - CPT 90708
- R/M
  - Immunization (CVX) code 38
  - CPT 90709 (old code)
- Measles
  - Immunization (CVX) code 5
  - CPT 90705
- Mumps
  - Immunization (CVX) code 7
  - CPT 90704
- Rubella
  - Immunization (CVX) code 6
  - CPT 90706
- HiB
  - Immunization (CVX) codes 17, 22, 46 through 49, 50, 51, 102, 120, 132, 146
  - CPT 90645 through 90648, 90698, 90720 through 90721, 90737 (old code), 90748
- Hepatitis B
  - Immunization (CVX) codes 8, 42 through 45, 51, 102, 104, 110, 132, 146
  - CPT 90636, 90723, 90731 (old code), 90740, 90743 through 90748, G0010, Q3021 (old code), Q3023 (old code)
- Varicella
  - Immunization (CVX) codes 21, 94
  - CPT 90710, 90716
- Pneumococcal
  - Immunization (CVX) codes 33, 100, 109, 152
  - CPT 90669, 90670, 90732, G0009, G8115 (old code)

Immunization Definitions

- DTaP
  - Immunization (CVX) codes 20, 50, 106, 107, 110, 120, 130, 132, 146
  - POV ICD-9: V06.1

  - CPT 90696, 90698, 90700, 90721, 90723
- DTaP Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- DTP
  - Immunization (CVX) codes 1, 22, 102
  - POV ICD-9: V06.1, V06.2, V06.3
  - CPT 90701, 90711 (old code), 90720
- DTP Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Tdap
  - Immunization (CVX) code 115
  - CPT 90715
- Tdap Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- DT
  - Immunization (CVX) code 28
  - POV ICD-9: V06.5
  - CPT 90702
- DT Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Td
  - Immunization (CVX) codes 9, 113, 138, 139
  - POV ICD-9: V06.5
  - CPT 90714, 90718
- Td Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Diphtheria
  - POV ICD-9: V03.5
  - CPT 90719
- Diphtheria Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Tetanus
  - Immunization (CVX) codes 35, 112

  - POV ICD-9: V03.7
  - CPT 90703
- Tetanus Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Acellular Pertussis
  - Immunization (CVX) code 11
  - POV ICD-9: V03.6
- Acellular Pertussis Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- OPV
  - Immunization (CVX) codes 2, 89
  - CPT 90712
- OPV Contraindication Definition
  - Immunization Package contraindication of Immune Deficiency
- IPV
  - Immunization (CVX) codes 10, 89, 110, 120, 130, 132, 146
  - POV ICD-9: V04.0, V06.3
  - CPT 90696, 90698, 90711 (old code), 90713, 90723
- IPV Evidence of Disease Definitions
  - POV or PCC Problem List (active or inactive) ICD-9: 730.70 through 730.79; ICD-10: M89.6*
- IPV Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis” or “Neomycin Allergy”
- MMR
  - Immunization (CVX) codes 3, 94
  - POV ICD-9: V06.4
  - CPT 90707, 90710
- MMR Contraindication Definitions
  - Immunization Package contraindication of “Anaphylaxis,” “Immune Deficiency,” or ‘Neomycin Allergy”
- M/R
  - Immunization (CVX) code 4
  - CPT 90708

- M/R Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- R/M
  - Immunization (CVX) code 38
  - CPT 90709 (old code)
- R/M Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Measles
  - Immunization (CVX) code 5
  - POV ICD-9: V04.2
  - CPT 90705
- Measles Evidence of Disease Definition
  - POV or PCC Problem List (active or inactive) ICD-9: 055*; ICD-10: B05.*
- Measles Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Mumps
  - Immunization (CVX) code 7
  - POV ICD-9: V04.6
  - CPT 90704
- Mumps Evidence of Disease Definition
  - POV or PCC Problem List (active or inactive) ICD-9: 072*; ICD-10: B26.*
- Mumps Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Rubella
  - Immunization (CVX) code 6
  - POV ICD-9: V04.3
  - CPT 90706
- Rubella Evidence of Disease Definitions
  - POV or PCC Problem List (active or inactive) ICD-9: 056*, 771.0; ICD-10: B06.*
- Rubella Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”

- HiB
  - Three-dose series:
    - Immunization (CVX) codes 49, 51
    - CPT 90647, 90748
  - Four-dose series:
    - Immunization (CVX) codes 17, 22, 46 through 48, 50, 102, 120, 132, 146
    - POV ICD-9: V03.81
    - CPT 90645 through 90646, 90648, 90698, 90720 through 90721, 90737 (old code)
- HiB Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Hepatitis B
  - Immunization (CVX) codes 8, 42 through 45, 51, 102, 104, 110, 132, 146
  - CPT 90636, 90723, 90731 (old code), 90740, 90743 through 90748, G0010, Q3021 (old code), Q3023 (old code)
- Hepatitis B evidence of disease definition
  - POV or PCC Problem List (active or inactive) ICD-9: V02.61, 070.2*, 070.3*; ICD-10: B16.*, B19.1*, Z22.51
- Hepatitis B contraindication definition
  - Immunization Package contraindication of “Anaphylaxis”
- Varicella
  - Immunization (CVX) codes 21, 94
  - POV ICD-9: V05.4
  - CPT 90710, 90716
- Varicella Evidence of Disease Definition
  - POV or PCC Problem List (active or inactive) ICD-9: 052*, 053*; ICD-10: B01.* through B02.*
  - Immunization Package contraindication of “Hx of Chicken Pox” or “Immune”
- Varicella Contraindication Definitions
  - Immunization Package contraindication of “Anaphylaxis,” “Immune Deficiency,” or “Neomycin Allergy”
- Pneumoccocal

  - Immunization (CVX) codes 33, 100, 109, 133, 152
  - POV ICD-9: V06.6, V03.82
  - CPT 90669, 90670, 90732, G0009, G8115 (old code)
- Pneumococcal Contraindication Definition
  - Immunization Package contraindication of "Anaphylaxis"

2.3.3.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 74.8% for the proportion of AI/AN children ages 19 through 35 months who have received the recommended immunizations.

> **Notes:** In FY 2013, the GPRA measure changed to the 4:3:1:3*:3:1:4 combination, which includes 3 or 4 HiB.
>
> In FY 2011, the GPRA measure changed to the 4:3:1:3:3:1:4 combination, which includes pneumococcal.

2.3.3.7 Patient Lists

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

- List of patients Active Clinical ages 19 through 35 months who received the 4:3:1:3*:3:1:4 combination (4 DTaP, 3 Polio, 1 MMR, 3 or 4 HiB, 3 Hep B, 1 Varicella, 4 Pneumococcal).
- List of Active Clinical patients ages 19 through 35 months who have not received the 4:3:1:3*:3:1:4 combination (4 DTaP, 3 Polio, 1 MMR, 3 or 4 HiB, 3 Hep B, 1 Varicella, 4 Pneumococcal). If a patient did not have all doses in a multiple dose vaccine, the IZ will not be listed. For example, if a patient only had two DTaP, no IZ will be listed for DTaP.
- List of Active Immunization Package patients ages 19 through 35 months who received the 4:3:1:3*:3:1:4 combination (4 DTaP, 3 Polio, 1 MMR, 3 or 4 HiB, 3 Hep B, 1 Varicella, and 4 Pneumococcal).
- List of Active Immunization Package patients ages 19 through 35 months who have not received the 4:3:1:3*:3:1:4 combination (4 DTaP, 3 Polio, 1 MMR, 3 or 4 HiB, 3 Hep B, 1 Varicella, and 4 Pneumococcal). If a patient did not have all doses in a multiple dose vaccine, the IZ will not be listed. For example, if a patient only had 2 DTaP, no IZ will be listed for DTaP.

2.4 Cancer Screening Group

2.4.1 Cancer Screening: Pap Smear Rates

Changes from CRS v14.0 are noted

2.4.1.1 Owner and Contact

Carolyn Aoyama, CNM, MPH

2.4.1.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.4.1.3 Denominators

1. GPRA: Female Active Clinical patients ages 24 through 64 without a documented history of hysterectomy.

   Note: Patients must be at least 24 years of age at the beginning of the report period and less than 65 years of age as of the end of the report period.

2. Female Active Clinical patients ages 24 through 29 without documented history of Hysterectomy.

3. Female Active Clinical patients ages 30 through 64 without documented history of Hysterectomy.

2.4.1.4 Numerators

1. GPRA: Patients with a Pap smear documented in the past 3 years, or if patient is 30 to 64 years of age, either a Pap Smear documented in the past 3 years or a Pap Smear and an HPV DNA documented in the past 5 years.

   Note: This numerator does *not* include refusals.

2. Patients with a Pap Smear documented in the past 3 years.

   Note: This numerator does *not* include refusals.

3. Patients with a Pap Smear documented 3-5 years ago and an HPV DNA documented in the past 5 years.

   Note: This numerator does *not* include refusals.

2.4.1.5 Definitions

Age

Age of the patient is calculated at the beginning of the report period. Patients must be at least 24 years of age at the beginning of the report period and less than 65 years of age as of the end of the report period.

Hysterectomy

Defined as any of the following ever:

- Procedure ICD-9: 68.4 through 68.9; ICD-10: 0UT9*ZZ
- CPT 51925, 56308 (old code), 58150, 57540, 57545, 57550, 57555, 57556, 58152, 58200 through 58294, 58548, 58550 through 58554, 58570 through 58573, 58951, 58953 through 58954, 58956, 59135
- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 618.5, 752.43, V67.01, V76.47, V88.01, V88.03; ICD-10: N99.3, Z12.72, Z90.710 through Z90.712, Q51.5
- Women's Health procedure called Hysterectomy

Pap Smear

- Lab PAP SMEAR
- POV ICD-9: V76.2 Screen Mal Neop-Cervix, V72.32 Encounter for Pap Cervical Smear to Confirm Findings of Recent Normal Smear Following Initial Abnormal Smear, 795.0*; ICD-10: R87.61*, R87.810, R87.820, Z01.42
- CPT 88141 through 88154, 88160 through 88167, 88174 through 88175, G0123, G0124, G0141, G0143 through G0145, G0147, G0148, P3000, P3001, Q0091 Screening Pap Smear
- Women's Health procedure called Pap Smear and where the result does not have "ERROR/DISREGARD"
- LOINC taxonomy
- Site-populated taxonomy BGP GPRA PAP SMEAR TAX

HPV DNA

- Lab HPV
- POV ICD-9: V73.81, 079.4, 796.75, 795.05, 795.15, 796.79, 795.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51
- CPT 87620 through 87622
- LOINC taxonomy

- Site-populated taxonomy BGP HPV TAX

2.4.1.6 GPRA 2014 Target

During FY 2014, establish a baseline for the proportion of female patients ages 24 through 64 years without a documented history of hysterectomy who have had a Pap screen within the previous 3 years, or if the patient is over 30, had a Pap screen in the past 3 years or a Pap screen and HPV DNA within the previous 5 years.

2.4.1.7 Patient Lists

- List of female patients with a Pap smear documented in the past 3 years or Pap plus HPV in past 5 years.
- List of female patients without a Pap smear documented in the past 3 years or Pap plus HPV in past 5 years.

2.4.2 Cancer Screening: Mammogram Rates

No changes from Version 14.0

2.4.2.1 Owner and Contact

Carolyn Aoyama, CNM, MPH

2.4.2.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.4.2.3 Denominators

1. GPRA: Female Active Clinical patients ages 52 through 64 years, without a documented bilateral mastectomy or two separate unilateral mastectomies.

Note:	The patients must be at least 52 years of age as of the beginning of the report period and less than 65 years of age as of the end of the report period.

2.4.2.4 Numerators

1. GPRA: All patients who had a Mammogram documented in the past 2 years.

Note:	This numerator does *not* include refusals.

2.4.2.5 Definitions

Age

Age of the patient is calculated at the beginning of the report period. For all denominators, patients must be at least the minimum age as of the beginning of the report period. For the 52 through 64 denominator, the patients must be less than 65 years of age as of the end of the report period.

Bilateral Mastectomy

- CPT 19300.50 through 19307.50 OR 19300 through 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
- Procedure ICD-9: 85.42, 85.44, 85.46, 85.48; ICD-10: 0HTV0ZZ

Unilateral Mastectomy

Requires two separate occurrences for either CPT or procedure codes on either two different dates of service or on the same date of service if the codes include both a right side modifier (RT) and left side modifier (LT).

- CPT 19300 through 19307, or old codes 19180, 19200, 19220, 19240
- Procedure ICD-9: 85.41, 85.43, 85.45, 85.47; ICD-10: 07T50ZZ, 07T60ZZ, 07T70ZZ, 07T80ZZ, 07T90ZZ, 0HTT0ZZ, 0HTU0ZZ, 0KTH0ZZ, 0KTJ0ZZ

Mammogram

- Radiology or CPT 77052 through 77059, 76090 (old code), 76091 (old code), 76092 (old code), G0206, G0204, G0202
- POV ICD-9: V76.11, V76.12, 793.80 Abnormal mammogram, unspecified, 793.81 Mammographic microcalcification, 793.89, Other abnormal findings on radiological exam of breast; ICD-10: R92.0, R92.1, R92.8, Z12.31
- Procedure ICD-9: 87.36, 87.37; ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ
- Women’s Health procedure called Mammogram Screening, Mammogram Dx Bilat, Mammogram Dx Unilat and where the mammogram result does *not* have "ERROR/DISREGARD"

2.4.2.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 54.7% for the proportion of female patients ages 52 through 64 who have had mammography screening within the last 2 years.

2.4.2.7 Patient Lists

- List of female patients with a Mammogram documented in the past 2 years.
- List of female patients without a Mammogram documented in the past 2 years.

2.4.3 Colorectal Cancer Screening

No changes from Version 14.0

> **Notes:** Based on the HEDIS definition which has lowered the upper age from 80 to 75.
>
> Numerator does not include Double Contrast Barium Enema (DCBE).

2.4.3.1 Owner: Contact

Epidemiology Program: Don Haverkamp

2.4.3.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.4.3.3 Denominators

1. GPRA: Active Clinical patients ages 50 through 75 without a documented history of colorectal cancer or total colectomy.

> **Note:** Since HEDIS calculates age at the end of the report period, the patient's at the beginning of the report period must be at least 50 years of age and 51 years of age at the end of the report period.

2.4.3.4 Numerators

1. GPRA: Patients who have had any Colorectal Cancer (CRC) screening, defined as any of the following:
   A. Fecal Occult Blood Test (FOBT) or FIT during the Report Period
   B. Flexible sigmoidoscopy in the past 5 years
   C. Colonoscopy in the past 10 years
2. Patients with Fecal Occult Blood test (FOBT) or Fecal Immunochemical Test (FIT) during the Report period.

2.4.3.5 Definitions

Denominator Exclusions

Any diagnosis ever of one of the following:

- Colorectal Cancer
  - POV ICD-9: 153.*, 154.0, 154.1, 197.5, V10.05; ICD-10: C18.*, C19, C20, C78.5, Z85.030, Z85.038
  - CPT G0213 through G0215 (old codes), G0231 (old code)
- Total Colectomy
  - CPT 44150 through 44151, 44152 (old code), 44153 (old code), 44155 through 44158, 44210 through 44212
  - Procedure ICD-9: 45.8*; ICD-10: 0DTE*ZZ

Colorectal Cancer Screening

The most recent of any of the following during applicable timeframes:

- 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 ICD-9: 45.24; ICD-10: 0DJD8ZZ
  - CPT 45330 through 45345, G0104
- Colonoscopy

- Procedure ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; ICD-10: 0D5E4ZZ, 0D5E8ZZ, 0D5F4ZZ, 0D5F8ZZ, 0D5G4ZZ, 0D5G8ZZ, 0D5H4ZZ, 0D5H8ZZ, 0D5K4ZZ, 0D5K8ZZ, 0D5L4ZZ, 0D5L8ZZ, 0D5M4ZZ, 0D5M8ZZ, 0D5N4ZZ, 0D5N8ZZ, 0D9E3ZX, 0D9E4ZX, 0D9E7ZX, 0D9E8ZX, 0D9F3ZX, 0D9F4ZX, 0D9F7ZX, 0D9F8ZX, 0D9G3ZX, 0D9G4ZX, 0D9G7ZX, 0D9G8ZX, 0D9H3ZX, 0D9H4ZX, 0D9H7ZX, 0D9H8ZX, 0D9K3ZX, 0D9K4ZX, 0D9K7ZX, 0D9K8ZX, 0D9L3ZX, 0D9L4ZX, 0D9L7ZX, 0D9L8ZX, 0D9M3ZX, 0D9M4ZX, 0D9M7ZX, 0D9M8ZX, 0D9N3ZX, 0D9N4ZX, 0D9N7ZX, 0D9N8ZX, 0DBE3ZX, 0DBE4ZX, 0DBE7ZX, 0DBE8ZX, 0DBE8ZZ, 0DBF3ZX, 0DBF4ZX, 0DBF7ZX, 0DBF8ZX, 0DBF8ZZ, 0DBG3ZX, 0DBG4ZX, 0DBG7ZX, 0DBG8ZX, 0DBG8ZZ, 0DBH3ZX, 0DBH4ZX, 0DBH7ZX, 0DBH8ZX, 0DBH8ZZ, 0DBK3ZX, 0DBK4ZX, 0DBK7ZX, 0DBK8ZX, 0DBK8ZZ, 0DBL3ZX, 0DBL4ZX, 0DBL7ZX, 0DBL8ZX, 0DBL8ZZ, 0DBM3ZX, 0DBM4ZX, 0DBM7ZX, 0DBM8ZX, 0DBM8ZZ, 0DBN3ZX, 0DBN4ZX, 0DBN7ZX, 0DBN8ZX, 0DBN8ZZ, 0DJD8ZZ
- CPT 44388 through 44394, 44397, 45355, 45378 through 45387, 45391, 45392, G0105, G0121

2.4.3.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 35.0% for the proportion of clinically appropriate patients ages 50 through 75 years who have received colorectal screening.

2.4.3.7 Patient Lists

- List of patients ages 50 through 75 years with CRC screening (HEDIS definition).
- List of patients ages 50 through 75 years without CRC screening (HEDIS definition).

2.4.4 Tobacco Use and Exposure Assessment

No changes from Version 14.0

2.4.4.1 Owner and Contact

Chris Lamer, PharmD, Epidemiology Program: Dayle Knutson

2.4.4.2 National Reporting

NATIONAL (included in IHS Performance Report; *not* reported to OMB and Congress)

2.4.4.3 Denominators

1. Active Clinical patients ages 5 and older.

2.4.4.4 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 ETS during the report period.

2.4.4.5 Definitions

Tobacco Screening

At least one of the following:

- Any Health Factor for category Tobacco, TOBACCO (SMOKING), TOBACCO (SMOKELESS – CHEWING/DIP), TOBACCO (EXPOSURE)
- POV or Problem List entry where the status is not Inactive or Deleted: ICD-9: 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82 (tobacco-related diagnosis); ICD-10: F17.2*, O99.33*, Z87.891
- Dental code 1320
- Patient Education codes containing "TO-", "-TO", "-SHS," 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82, D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455 through G8457 (old codes), G8402 (old code), G8453 (old code)
- CPT D1320, 99406, 99407, G0375 (old code), G0376 (old code), G8455 through 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, Heavy Tobacco Smoker, Light Tobacco Smoker
- POV ICD-9: 305.1, 305.10 through 305.12 (old codes), 649.00 through 649.04; ICD-10: F17.2*0, F17.2*3, F17.2*8, F17.2*9, O99.33*

- 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, Heavy Tobacco Smoker, Light Tobacco Smoker
- POV ICD-9: 305.1, 305.10 through 305.12 (old codes), 649.00 through 649.04; ICD-10: F17.200, F17.203 through F17.210, F17.213 through F17.290, F17.293 through F17.299, O99.33*
- 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
- POV ICD-10: F17.220, F17.223 through F17.229
- CPT 1035F, G8456 (old code)

ETS

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

2.4.4.6 Patient Lists

- List of patients with documented tobacco screening.
- List of patients without documented tobacco screening.
- List of patients identified as current tobacco users, both smokers and smokeless users.

2.4.5 Tobacco Cessation

No changes from Version 14.0

2.4.5.1 Owner: Contact

Chris Lamer, PharmD, Epidemiology Program: Dayle Knutson

2.4.5.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.4.5.3 Denominators

1. GPRA: Active clinical patients identified as current tobacco users or tobacco users in cessation, broken down by gender and age groups: younger than 12, 12 through 17, 18 and older.

2.4.5.4 Numerators

1. Patients who have received tobacco cessation counseling or received a prescription for a smoking cessation aid anytime during the Report Period.
2. Patients identified as having quit their tobacco use anytime during the Report Period.
3. GPRA: Patients who received tobacco cessation counseling, received a prescription for a tobacco cessation aid, or quit their tobacco use anytime during the Report Period.

2.4.5.5 Definitions

Denominator

Current Tobacco Users or Tobacco Users in Cessation:

CRS will search first for all health factors documented in the Tobacco, TOBACCO (SMOKING) and TOBACCO (SMOKELESS – CHEWING/DIP) categories during the Report Period.

If health factor(s) are found and at least one of them is one of the health factors listed below, the patient is counted as a current tobacco user or tobacco user in cessation. The patient is not counted as receiving cessation counseling.

Tobacco User Health Factors (TUHFs):

- Cessation-Smoker
- Cessation-Smokeless
- Current Smoker
- Current Smokeless
- Current Smoker and Smokeless
- Current Smoker, status unknown
- Current Smoker, every day
- Current Smoker, some day
- Heavy Tobacco Smoker

- Light Tobacco Smoker

If a health factor is found and it is *not* a TUHF, CRS will then search for CPT 1034F or 1035F documented after the health factor. If one of these codes is found, the patient will be considered a tobacco user.

If no health factor was found, CRS will then search for any of the following codes documented during the Report Period:

- Tobacco-related diagnoses (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.1, 305.10 through 305.12 (old codes), 649.00 through 649.04; ICD-10: F17.2*0, F17.2*3, F17.2*8, F17.2*9, O99.33*
- CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, G8455 (old code), G8456 (old code), G8402 (old code), G8453 (old code)

If any of these codes are found, the patient will be considered a tobacco user.

If no health factor or other tobacco user-defining code listed above was found during the specified timeframe, CRS will then search for the most recent health factor documented during an *expanded* timeframe of any time prior to the report period. For example, a patient with the most recent health factor being documented 5 years prior to the report period.

Note: If multiple health factors were documented on the same date and if any of them are TUHF(s), all of the health factors will be considered as TUHF(s).

If a health factor is found during the expanded timeframe, and is a TUHF, the patient will be considered a potential tobacco user.

If a health factor is found during the expanded timeframe and it is not one of the TUHFs, CRS will then search for CPT 1034F or 1035F documented after the health factor. If one of these codes is found, the patient will be considered a potential tobacco user.

If no health factor was found, CRS will then search for any of the following codes documented through the beginning of the Report Period:

- Tobacco-related diagnoses (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.1, 305.10 through 305.12 (old codes), 649.00 through 649.04; ICD-10: F17.2*0, F17.2*3, F17.2*8, F17.2*9, O99.33*
- CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, G8455 (old code), G8456 (old code), G8402 (old code), G8453 (old code)

If any of these codes are found, the patient will be considered a potential tobacco user. If one of these codes is not found, the patient is considered a non-tobacco user and will not be included in the denominator.

If the patient is considered a potential tobacco user, CRS will then search for diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.13 Tobacco use in remission (old code) or V15.82; ICD-10: F17.2*1, Z87.891 with a date occurring after the health factor date and through the beginning of the report period. If one of these diagnoses is found, the patient will be considered as having quit their tobacco use and will not be included in the denominator. If a diagnosis is not found, the patient is included as a current tobacco user and will be included in the denominator.

Tobacco Cessation Counseling

Any of the following documented anytime during the Report Period:

- Patient education codes containing "TO-", "-TO", "-SHS", 305.1, 305.1* (old codes), 649.00 through 649.04, D1320, 99406, 99407, G0375 (old code), G0376 (old code), 4000F, G8402, G8453
- Clinic code 94 (tobacco cessation clinic)
- Dental code 1320
- CPT D1320, 99406, 99407, G0375 (old code), G0376 (old code), 4000F, G8402, G8453

Prescription for Tobacco Cessation Aid

Any of the following documented anytime during the Report Period:

- Prescription for medication in the site-populated BGP CMS SMOKING CESSATION MEDS taxonomy that does not have a comment of RETURNED TO STOCK
- Prescription for any medication with name containing “NICOTINE PATCH”, “NICOTINE POLACRILEX”, “NICOTINE INHALER”, “NICOTINE NASAL SPRAY” that does not have a comment of RETURNED TO STOCK
- CPT 4001F

Quit Tobacco Use

Any of the following documented anytime during the Report Period *and* after the date of the code found indicating the patient was a current tobacco user:

- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.13 Tobacco use in remission (old code) or V15.82; ICD-10: F17.2*1, Z87.891

- Health Factor (looks at the last documented health factor): Previous Smoker, Previous Smokeless, Previous (former) smoker, Previous (former) smokeless

2.4.5.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 45.7% for the proportion of tobacco-using patients who receive tobacco cessation intervention.

2.4.5.7 Patient Lists

- List of tobacco users with documented tobacco cessation intervention.
- List of tobacco users without documented tobacco cessation intervention.
- List of tobacco users who quit tobacco use.
- List of tobacco users who did not quit tobacco use.
- List of tobacco users with documented tobacco cessation intervention or who quit their tobacco use.
- List of tobacco users without documented tobacco cessation intervention and did not quit their tobacco use.

2.5 Behavioral Health Group

2.5.1 Alcohol Screening (FAS Prevention)

No changes from Version 14.0

2.5.1.1 Owner and Contact

Carolyn Aoyama; IHS Division of Behavioral Health (DBH)

2.5.1.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.5.1.3 Denominators

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

2.5.1.4 Numerators

1. GPRA: Patients screened for alcohol use, had an alcohol-related diagnosis or procedure, or received alcohol-related patient education during the report period.

Note: This numerator does *not* include refusals.

2.5.1.5 Definitions

Alcohol Screening

Any of the following during the report period:

- PCC Exam code 35
- Any CAGE Health Factor
- POV ICD-9: V11.3, V79.1, or Behavioral Health System (BHS) problem code 29.1
- CPT 99408, 99409, G0396, G0397, H0049, H0050, 3016F
- Measurement in PCC or Behavioral Health (BH) of AUDT, AUDC, or CRFT

Alcohol-Related Diagnosis or Procedure

Any of the following during the report period:

- Alcohol-related Diagnosis
  - POV, Current PCC or BHS Problem List ICD-9: 303.*, 305.0*, 291.*, 357.5*; ICD-10: F10.1*, F10.20, F10.220 through F10.29, F10.920 through F10.982, F10.99, G62.1
  - BHS POV 10, 27, 29
- Alcohol-related Procedure
  - Procedure ICD-9: 94.46, 94.53, 94.61 through 94.63, 94.67 through 94.69

Alcohol-Related Patient Education

Any of the following during the report period:

- All Patient Education codes containing “AOD-” or “-AOD”, “CD-” or “-CD” (old codes), or V11.3, V79.1, 303.*, 305.0*, 291.* 357.5*, 99408, 99409, G0396, G0397, H0049, H0050, 3016F.

2.5.1.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 65.9% for the proportion of female patients ages 15 through 44 years who receive screening for alcohol use.

2.5.1.7 Patient Lists

- List of female Active Clinical patients ages 15 through 44 years with documented screening.

- List of female Active Clinical patients ages 15 through 44 years without documented screening.

2.5.2 Intimate Partner (Domestic) Violence Screening

No changes from Version 14.0

2.5.2.1 Owner and Contact

IHS Division of Behavioral Health (DBH)

2.5.2.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.5.2.3 Denominators

1. GPRA: Female Active Clinical patients ages 15 through 40 years.

2.5.2.4 Numerators

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

Note: This numerator does *not* include refusals.

   A. Patients with documented IPV/DV exam.

   B. Patients with IPV/DV related diagnosis.

   C. Patients provided with education or counseling about IPV/DV.

2.5.2.5 Definitions

(Intimate Partner Violence/Domestic Violence) IPV/DV Screening

- Exam code 34
- BHS IPV/DV exam

IPV/DV Related Diagnosis

- POV, Current PCC or BHS Problem List ICD-9: 995.80 through 83, 995.85, V15.41, V15.42, V15.49; ICD-10: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, Z91.410
- BHS POV 43.*, 44.*

IPV/DV Patient Education

Patient Education codes containing "DV-" or "-DV", 995.80 through 83, 995.85, V15.41, V15.42, V15.49

IPV/DV Counseling

POV ICD-9: V61.11; ICD-10: Z69.11

2.5.2.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 64.1% for the proportion of female patients ages 15 through 40 years who receive screening for domestic violence.

2.5.2.7 Patient Lists

- List of female patients 15 through 40 years with documented IPV/DV screening.
- List of female patients 15 through 40 years without documented IPV/DV screening.

2.5.3 Depression Screening

No changes from Version 14.0

2.5.3.1 Owner and Contact

IHS Division of Behavioral Health (DBH)

2.5.3.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.5.3.3 Denominators

1. GPRAMA: Active Clinical patients ages 18 and older, broken down by gender.

2.5.3.4 Numerators

1. GPRAMA: Patients screened for depression or diagnosed with a 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.

2.5.3.5 Definitions

Depression Screening

Any of the following:

- Exam code 36
- POV ICD-9: V79.0
- CPT 1220F
- BHS problem code 14.1 (screening for depression)
- Measurement in PCC or BH of PHQ2 or PHQ9

Mood Disorders

At least two visits in PCC or BHS during the report period with POV for: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS, Bipolar I or II Disorder, Cyclothymic Disorder, Bipolar Disorder NOS, Mood Disorder Due to a General Medical Condition, Substance-induced Mood Disorder, or Mood Disorder NOS. These POV codes are:

- ICD-9: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311; ICD-10: F06.31 through F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0 through F31.71, F31.73, F31.75, F31.77, F31.81 through F31.9, F32.* through F39
- BHS POV 14, 15

2.5.3.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 66.9% for the proportion of adults ages 18 and older who receive annual screening for depression.

2.5.3.7 Patient Lists

- List of Active Clinical patients 18 or older screened for depression or diagnosed with mood disorder.
- List of Active Clinical patients 18 or older not screened for depression or diagnosed with mood disorder.

2.6 Cardiovascular Disease Related Group

2.6.1 Childhood Weight Control

No changes from Version 14.0

2.6.1.1 Owner and Contact

Nutrition Program, Lorraine Valdez, MPA, BSN, RN

2.6.1.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.6.1.3 Denominators

1. GPRA: Active Clinical Patients 2 through 5 for whom a BMI could be calculated.

2.6.1.4 Numerators

1. GPRA: Patients with a BMI at or above the 95th percentile.

2.6.1.5 Definitions

Age

All patients who are between the ages of 2 and 5 at the beginning of the report period and who do not turn age 6 during the report period are included in this measure. Age in the age groups is calculated based on the date of the most current BMI found. For example, a patient may be 2 at the beginning of the time period but is 3 at the time of the most current BMI found. That patient will fall into the Age 3 group.

BMI

CRS looks for the most recent BMI in the report period. CRS calculates BMI at the time the report is run, using NHANES II. A height and weight must be taken on the same day any time during the report period. The BMI values for this measure are reported differently than in Obesity Assessment since this age group is children ages 2 through 6, whose BMI values are age-dependent. The BMI values are categorized as Overweight for patients with a BMI in the 85th through 94th percentile and Obese for patients with a BMI at or above the 95th percentile.

Patients whose BMI either is greater or less than the Data Check Limit range, as shown in the following table, will not be included in the report counts for Overweight or Obese.

Low-High Ages	Sex	BMI (Overweight)	BMI (Obese)	Data Check Limits	
				BMI >	BMI <
2-2	Male	17.7	18.7	36.8	7.2
2-2	Female	17.5	18.6	37.0	7.1
3-3	Male	17.1	18.0	35.6	7.1
3-3	Female	17.0	18.1	35.4	6.8

Low-High Ages	Sex	BMI (Overweight)	BMI (Obese)	Data Check Limits	
				BMI >	BMI <
4-4	Male	16.8	17.8	36.2	7.0
4-4	Female	16.7	18.1	36.0	6.9
5-5	Male	16.9	18.1	36.0	6.9
5-5	Female	16.9	18.5	39.2	6.8

2.6.1.6 2014 Target

During FY 2014, achieve the target rate of 24.0% for the proportion of children with a BMI of 95% or higher.

2.6.1.7 Patient Lists

List of patients ages 2-5 with BMI at or above the 95th percentile.

2.6.2 Controlling High Blood Pressure – Million Hearts

Changes from CRS v14.0 are noted

2.6.2.1 Owner and Contact

Dr. Dena Wilson, Chris Lamer, PharmD, and Mark Veazie

2.6.2.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.6.2.3 Denominators

1. GPRA: Million Hearts (NQF 0018): User Population patients ages 18 through 85 years diagnosed with hypertension and no documented history of ESRD or current diagnosis of pregnancy.

2.6.2.4 Numerators

1. GPRA: Million Hearts (NQF 0018): Patients with BP less than (<) 140/90, i.e., the systolic value is less than (<) 140 AND the diastolic value is less than (<) 90.

2.6.2.5 Definitions

Age

Age of the patient is calculated at end of the Report period.

Hypertension

Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 401.*; ICD-10: I10 ever through the first 6 months of the Report Period, and at least one hypertension POV during the report period.

ESRD

Any of the following ever:

- CPT 36145 (old code), 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831 through 36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90918 through 90925 (old codes), 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90951 through 90970, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), S2065, S9339
- POV ICD-9: 585.6, V45.1 (old code), V45.11 V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
- Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

Pregnancy Definition

At least two visits during the Report Period with POV or Problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 674.*3, 675.*3, 676.*3, 678.*3, 679.*3, V22.0 through V23.9, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36, where the primary provider is not a CHR (Provider code 53). Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the Report Period, CRS will use the first two visits in the Report Period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit.

- Miscarriage definition:
  - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
  - CPT 59812, 59820, 59821, 59830
- Abortion definition:
  - POV ICD-9: 635*, 636* 637*; ICD-10: O00.*, O01.*, O03.1, O03.31 through O03.33, O03.6, O03.81 through O03.83, O04.6, O04.81 through O04.83, Z33.2

- CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267,
- Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

BP Values

Exclusions: When calculating all BPs, the following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), or O (Observation)
- Clinic code 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), or D4 (Anesthesiology)

CRS uses the last Blood Pressure documented during the Report Period.

2.6.2.6 GPRA 2014 Target

During FY 2014, establish a baseline for the proportion of patients with BP less than (<) 140/90.

2.6.2.7 Patient Lists

- List of hypertensive patients with BP less than (<) 140/90.
- List of hypertensive patients with BP greater than or equal to (>=) 140/90.

2.6.3 Comprehensive CVD-Related Assessment

Changes from CRS v14.0 are noted

2.6.3.1 Owner and Contact

Mark Veazie, Dr. Dena Wilson and Chris Lamer, PharmD

2.6.3.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.6.3.3 Denominators

1. GPRAMA: Active CHD patients ages 22 and older, defined as all Active Clinical patients diagnosed with CHD prior to the report period, *and* at least two visits during the report period, *and* two CHD-related visits ever.

   A. Active CHD patients 22 and older who are not Active Diabetic.

   B. Active CHD patients 22 and older who are Active Diabetic.

2.6.3.4 Numerators

1. Patients with BP value documented at least twice in prior 2 years.
2. Patients with LDL completed during the Report Period, regardless of result.
3. Patients screened for tobacco use during the report period.
4. Patients for whom a BMI could be calculated.

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

5. Patients who have received any lifestyle adaptation counseling, including medical nutrition counseling, or nutrition, exercise or other lifestyle education during the report period.
6. GPRAMA: Patients with comprehensive CVD assessment, defined as having BP, LDL, and tobacco use assessed, BMI calculated, and lifestyle counseling.

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

7. Patients screened for depression or diagnosed with a mood disorder or suicide ideation at any time during the report period.

2.6.3.5 Definitions

CHD

- POV ICD-9: 410.0 through 413.*, 414.0 through 414.9, 429.2; ICD-10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9
- One or more Coronary Artery Bypass Graft (CABG) or Percutaneous Coronary Interventions (PCI) procedures, defined as any of the following:
  - CABG Procedure
    - POV ICD-9: V45.81; ICD-10: Z95.1
    - CPT 33510 through 33514, 33516 through 33519, 33521 through 33523, 33533 through 33536, S2205 through S2209
    - Procedure ICD-9: 36.1*, 36.2*; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*
  - PCI Procedure
    - POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61

- CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, G0290
- Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06 through 36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**

BP

Having a minimum of two BPs documented in past two years. If CRS does not find two BPs, it will search for CPT 0001F, 2000F, 3074F through 3080F or POV ICD-9: V81.1 documented during the past 2 years. The following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), O (Observation)
- Clinic codes 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), D4 (Anesthesiology)

LDL

Finds the most recent test done during the Report Period, regardless of the results of the measurement.

- LDL Definition
  - CPT 80061, 83700, 83701, 83704, 83715 (old code), 83716 (old code), 83721, 3048F, 3049F, 3050F
  - LOINC taxonomy
  - Site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX

Tobacco Screening

At least one of the following:

- Any health factor for category Tobacco, TOBACCO (SMOKING), TOBACCO (SMOKELESS – CHEWING/DIP), TOBACCO (EXPOSURE) documented during current report period
- Tobacco-related diagnoses (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82; ICD-10: F17.2*, O99.33*, Z87.891
- Dental code 1320
- Any patient education code containing "TO-", "-TO", "-SHS”, 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82, D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455 through G8457 (old codes), G8402 (old code), G8453 (old code)

- CPT D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455 through G8457 (old codes), G8402 (old code), G8453 (old code)

BMI

CRS calculates BMI at the time the report is run, using NHANES II. For ages 19 through 50 years, height and weight must be recorded within the last 5 years, not required to be on the same day. For ages over 50 years, height and weight within the last 2 years, not required to be recorded on same day.

Medical Nutrition Therapy

- Any of the following:
  - CPT 97802 through 97804, G0270, G0271
  - Primary or secondary provider codes 07, 29
  - Clinic codes 67 (dietary), 36 (WIC)

Nutrition education:

- POV ICD-9: V65.3 dietary surveillance and counseling; ICD-10: Z71.3
- Patient education codes ending “-N” (Nutrition) or “-MNT” or containing V65.3 (or old code “-DT” (Diet))
- Patient Goal with Goal Type of “Nutrition” and Goal Status of "Goal Set", "Goal Met", "Maintaining Goal", or "No Change" during the Report Period

Exercise education:

- POV ICD-9: V65.41 exercise counseling
- Patient education codes ending “-EX” (Exercise) or containing V65.41
- Patient Goal with Goal Type of “Physical Activity” and Goal Status of "Goal Set", "Goal Met", "Maintaining Goal", or "No Change" during the Report Period

Related exercise and nutrition education:

- Patient education codes ending “-LA” (lifestyle adaptation) or containing “OBS-” (obesity) or 278.00 or 278.01.

Depression Screening or Mood Disorder DX or Suicide Ideation DX

Any of the following during the report period:

- Depression Screening:
  - Exam code 36
  - POV ICD-9: V79.0
  - CPT 1220F

  - BHS problem code 14.1 (screening for depression)
  - Measurement in PCC or BH of PHQ2 or PHQ9
- Mood Disorder diagnosis
  - At least two visits in PCC or BHS during the report period with POV for: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS, Bipolar I or II Disorder, Cyclothymic Disorder, Bipolar Disorder NOS, Mood Disorder Due to a General Medical Condition, Substance-induced Mood Disorder, or Mood Disorder NOS. These POV codes are:
    - ICD-9: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311; ICD-10: F06.31 through F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0 through F31.71, F31.73, F31.75, F31.77, F31.81 through F31.9, F32.* through F39
    - BHS POV 14, 15
- Suicide Ideation DX
  - POV ICD-9: V62.84; ICD-10: R45.851
  - BHS Problem code 39 during the Report Period

2.6.3.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 51.0% for the proportion of at-risk patients who have a comprehensive assessment.

2.6.3.7 Patient Lists

- List of Active CHD patients 22 and older with blood pressure documented in the past 2 years.
- List of Active CHD patients 22 and older without blood pressure documented in the past 2 years.
- List of Active CHD patients 22 and older with LDL completed during the Report Period.
- List of Active CHD patients 22 and older without LDL completed during the Report Period.
- List of Active CHD patients 22 and older with tobacco screening during the Report Period.
- List of Active CHD patients 22 and older without tobacco screening during the Report Period.
- List of Active CHD patients 22 and older with BMI calculated.

- List of Active CHD patients 22 and older without BMI calculated.
- List of Active CHD patients 22 and older with lifestyle education during the Report Period.
- List of Active CHD patients 22 and older without lifestyle education during the Report Period.
- List of Active CHD patients 22 and older with a comprehensive CVD assessment.
- List of Active CHD patients 22 and older without a comprehensive CVD assessment.
- List of Active CHD patients 22 and older with depression screening during the Report Period.
- List of Active CHD patients 22 and older without depression screening during the Report Period.

2.7 STD-Related Group

2.7.1 HIV Screening

No changes from Version 14.0

2.7.1.1 Owner and Contact

Lisa Neel, MPH and Dr. Marie Russell

2.7.1.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.7.1.3 Denominators

1. GPRA: All pregnant Active Clinical patients with no documented miscarriage or abortion during the past 20 months and *no* recorded HIV diagnosis ever.

2.7.1.4 Numerators

1. GPRA: Patients who were screened for HIV during the past 20 months.

Note: This numerator does *not* include refusals.

2.7.1.5 Definitions

HIV

Any of the following documented any time prior to the end of the report period:

- POV or Problem List entry where the status is not Inactive or Deleted: ICD-9: 042, 042.0 through 044.9 (old codes), 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711 through O98.73

Pregnancy

At least two visits with POV or Problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 674.*3, 675.*3, 676.*3, 678.*3, 679.*3, V22.0 through V23.9, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36 during the past 20 months from the end of the Report Period, where the primary provider is not a Community Health Representative (CHR) (Provider code 53). Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the past 20 months, CRS will use the first two visits in the 20-month period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit. In addition, the patient must have at least one pregnancy-related visit occurring during the reporting period. The time period is extended to include patients who were pregnant during the

report period, but whose initial diagnosis (and HIV test) were documented prior to report period.

Miscarriage

- POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
- CPT 59812, 59820, 59821, 59830

Abortion

- POV ICD-9: 635*, 636* 637*; ICD-10: O00.*, O01.*, O03.1, O03.31 through O03.33, O03.6, O03.81 through O03.83, O04.6, O04.81 through O04.83, Z33.2
- CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267
- Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

HIV Screening

- CPT 86689, 86701 through 86703, 87390, 87391, 87534 through 87539
- LOINC taxonomy
- Site-populated taxonomy BGP HIV TESTS

Note: The timeframe for screening for the pregnant patient's denominator is anytime during the past 20 months.

2.7.1.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 89.1% for the proportion of pregnant patients who are screened for HIV.

2.7.1.7 Patient Lists

- List of pregnant patients with documented HIV test in past 20 months.
- List of pregnant patients without documented HIV test in past 20 months.

2.8 Other Clinical Group

2.8.1 Breastfeeding Rates

No changes from Version 14.0

> **Note:** This measure is used in conjunction with the Childhood Weight Control GPRA long-term measure to support the reduction of the incidence of childhood obesity.

2.8.1.1 Owner and Contact

Tina Tah, RN, BSN, MBA

2.8.1.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.8.1.3 Denominators

1. Active Clinical patients who are 30 through 394 days old.
2. GPRA: Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 2 months (45 through 89 days).
3. Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 6 months (165 through 209 days).
4. Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 9 months (255 through 299 days).
5. Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 1 year (350 through 394 days)

2.8.1.4 Numerators

1. Patients who were screened for infant feeding choice at least once.
2. Patients who were screened for infant feeding choice at the age of 2 months (45 through 89 days).
3. Patients were screened for infant feeding choice at the age of 6 months (165 through 209 days).
4. Patients who were screened for infant feeding choice at the age of 9 months (255 through 299 days).
5. Patients who were screened for infant feeding choice at the age of 1 year (350 through 394 days).
6. GPRA: Patients who, at the age of 2 months (45 through 89 days), were either exclusively or mostly breastfed.

7. Patients who, at the age of 6 months (165 through 209 days), were either exclusively or mostly breastfed.
8. Patients who, at the age of 9 months (255 through 299 days), were either exclusively or mostly breastfed.
9. Patients who, at the age of 1 year (350 through 394 days), were either exclusively or mostly breastfed.

2.8.1.5 Definitions

Patient Age

Since the age of the patient is calculated at the beginning of the Report period, this measure may include patients up to 25 months old if they were within the eligible age range on the first day of the report period, and will not include any patients that were born after the first day of the report period. Patients born after the first day of the report period will be included in the following report period.

Infant Feeding Choice

The documented feeding choice from the file V Infant Feeding Choice that is closest to the exact age that is being assessed will be used. For example, if a patient was assessed at 45 days old as half breastfed and half formula and assessed again at 65 days old as mostly breastfed, the mostly breastfed value will be used since it is closer to the exact age of 2 months (i.e., 60 days). Another example is a patient who was assessed at 67 days as mostly breastfed and again at 80 days as mostly formula. In this case, the 67 days value of mostly breastfed will be used. The other exact ages are 180 days for 6 months, 270 days for 9 months, and 365 days for one year.

In order to be included in the age-specific screening numerators, the patient must have been screened at the specific age range. For example, if a patient was screened at 6 months and was exclusively breastfeeding but was not screened at 2 months, then the patient will only be counted in the 6 months numerator.

2.8.1.6 GPRA 2014 Target

During FY 2014, achieve the target rate of 29.0% for the proportion of two-month olds who are mostly or exclusively breastfeeding.

2.8.1.7 Patient Lists

- List of Active Clinical patients ages 30 through 394 days who were screened for Infant Feeding Choice at least once.

- List of Active Clinical patients ages 30 through 394 days who were not screened for Infant Feeding Choice at least once.
- List of Active Clinical patients screened at the age of 2 months (ages 45 through 89 days) and were either exclusively or mostly breastfed.
- List of Active Clinical patients screened at the age of 2 months (ages 45 through 89 days) and were not exclusively or mostly breastfed.

Acronym List

AI/AN	American Indian/Alaska Native
BH	Behavioral Health
BHS	Behavioral Health System
BMI	Body Mass Index
BP	Blood Pressure
CHD	Coronary Heart Disease
CHR	Community Health Representative
CHS	Contract Health Service
CPT	Current Procedural Terminology
CRC	Colorectal Cancer
CRS	Clinical Reporting System
CVD	Cardiovascular Disease
CVX	Vaccine Code
DM	Diabetes Mellitus
DNKA	Did Not Keep Appointment
DPST	Demo/Test Patient Search Template
ER	Emergency Room
ESRD	End Stage Renal Disease
ETDRS	Early Treatment Diabetic Retinopathy Study

ETS	Environmental Tobacco Smoke
FAS	Fetal Alcohol Syndrome
FIT	Fecal Immunochemical Test
FOBT	Fecal Occult Blood Test
FY	Fiscal Year
GFR	Glomerular Filtration Rate
GPRA	Government Performance and Results Act of 1993
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
IFC	Infant Feeding Choice
IHS	Indian Health Service
IMM	Immunization
IPV/DV	Intimate Partner Violence/Domestic Violence
LDL	Low-Density Lipoprotein
LOINC	Logical Observations Identifiers, Names, Codes
NMI	Not Medically Indicated
OMB	Office of Management and Budget
PCC	Patient Care Component
POV	Purpose of Visit
RPMS	Resource and Patient Management System

Contact Information

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