RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System

(BGP)

National GPRA Developmental Report Performance Measure List and Definitions

Version 15.0
November 2014

Office of Information Technology
Division of Information Technology
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1.0 CRS 2015 National GPRA Developmental Report

The following performance measures will be reported in the Clinical Reporting System (CRS) 2015 National Government Performance and Results Act of 1993 (GPRA)/GPRA Modernization Act (GPRAMA) Report.

> **Note:** Beginning FY 2010, GPRA Developmental Measures are reported in its own separate section within the National GPRA/GPRAMA report but are not submitted to the Office of Management and Budget (OMB) and Congress. This document contains only the GPRA Developmental performance measure lists and definitions.

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

Table 1-1: Document Notations

Notation	Location	Meaning
Section Symbol (§)	Preceding a measure	A GPRA Developmental measure. GPRA Developmental measures have the potential to become GPRA measures in the future.
Plus Symbol (+)	Preceding a measure	The measure is a new GPRA Developmental Measure for 2015.
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

- BLOOD PRESSURE CONTROL
  - §Controlled BP (less than (<) 140/90 or less than (<) 150/90 if patient is age 60 or older)

DENTAL GROUP

- ACCESS TO DENTAL SERVICE
  - §All Treatment Completed
  - Pre-natal or Nursing Mother Dental Visit
  - Visits with General Anesthesia
  - Visits with General Anesthesia and Stainless Steel Crowns

IMMUNIZATIONS

- CHILDHOOD IMMUNIZATIONS (19 THROUGH 35 MONTHS)

- 1 Hepatitis A
- 2 to 3 Rotavirus
- 2 Influenza
- §Active Clinical Patients with 4:3:1:3*:3:1:3 (No Refusals)
- 3 Pneumococcal

CANCER SCREENING

- MAMMOGRAM RATES (52 THROUGH 74 YEARS OF AGE)
  - §Mammogram (no refusals)
- CANCER SCREENING (50 THROUGH 75 YEARS OF AGE)
  - §Fecal Occult Blood Test or Fecal Immunochemical Test during Report Period, Flexible Sigmoidoscopy in past 5 years and FOB or Fecal Immunochemical Test (FIT) in the past 3 years, or Colonoscopy in past 10 years
- COMPREHENSIVE CANCER SCREENING
  - §Cervical cancer, breast cancer, or colorectal cancer screening

BEHAVIORAL HEALTH

- ALCOHOL SCREENING
  - §Alcohol Screening, alcohol-related diagnosis or procedure (no refusals)
  - Alcohol-related patient education
  - §Positive alcohol screen
- INTIMATE PARTNER VIOLENCE/DOMESTIC VIOLENCE (IPV/DV) SCREENING
  - §IPV/DV Screening (no refusals or patient education)
  - IPV/DV-related patient education
- DEPRESSION SCREENING
  - §Depression Screening, Mood Disorder Diagnosis or Suicide Ideation (no refusals)

CARDIOVASCULAR DISEASE-RELATED

- CONTROLLING HIGH BLOOD PRESSURE
  - §BP (less than (<) 140/90 or less than (<) 150/90 if patient is age 60 or older)

STD GROUP

- HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING
  - §HIV Screening (no refusals)
  - Refusal of HIV Screening
  - HIV Screening in past 5 years (no refusals)

  - HIV Screening ever (no refusals)
  - §HIV Screens for User Population with no prior HIV diagnosis
  - HIV+ with CD4 count
- HEPATITIS C SCREENING
  - Hepatitis C Screening
  - +Hepatitis C Confirmation Test
- CHLAMYDIA TESTING
  - Chlamydia Testing
- SEXUALLY TRANSMITTED INFECTION (STI) SCREENING
  - §Needed HIV Screen

OTHER CLINICAL MEASURES

- OPTOMETRY
  - +§Optic Nerve Head Evaluation
- VISIT STATISTICS
  - Active Clinical patients with no qualifying visit during the Report Period
  - Active Clinical patients with Urgent Care as their only core clinic

Note:	Definitions for all GPRA Developmental performance measures topics included in CRS begin in Section 2.0.

1.1 CRS Denominator Definitions

1.1.1 For All Denominators

- All patients with name "DEMO,PATIENT" or who are included in the RPMS Demo/Test Patient Search Template (DPST option located in the 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.

1.1.2 For All Numerators

- For all measures, except as noted, GPRA Developmental Numerators do *not* include refusals or contraindications.

1.1.3 Active Clinical Population

1.1.3.1 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 FY2015 Clinical Measures User Manual* for listing of these clinics.
- Must be alive on the last day of the Report Period.
- Must be American Indian/Alaska Native (AI/AN); defined as Beneficiary 01.
- Must reside in a community specified in the site's GPRA community taxonomy, defined as all communities of residence in the defined Contract Health Service (CHS) catchment area.

1.1.3.2 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 (CRS) for FY2015 Clinical Measures User Manual* for listing of these clinics.
- Must be alive on the last day of the Report Period.
- User defines population type: AI/AN patients only, non AI/AN, or both.
- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

1.1.4 User Population

1.1.4.1 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.

1.1.4.2 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.

1.1.5 Active Clinical Plus BH Population

1.1.5.1 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 FY2015 Clinical Measures User Manual* for listing of these clinics.
- 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 Contract Health Service (CHS) catchment area.

1.1.5.2 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 (CRS) for FY2015 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.

2.0 Performance Measure Topics and Definitions

The following sections define the performance measure topics and their definitions that are included in the CRS 2015 version 15.0 National GPRA Developmental Report.

2.1 Diabetes Group

2.1.1 Diabetes: Blood Pressure Control

2.1.1.1 Owner: Contact

Diabetes Program: Dr. Ann Bullock

2.1.1.2 National Reporting

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

2.1.1.3 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 during the report period, *and* two DM-related visits ever.
2. Active Diabetic patients under age 60.
3. Active Diabetic patients ages 60 and older.

2.1.1.4 Numerators

1. GPRA Developmental**:** Patients with controlled BP, defined as less than 140/90, i.e., the mean systolic value is less than (<) 140 *and* the mean diastolic value is less than (<) 90 or, if patient is 60 and over, with BP less than 150/90, i.e., the mean systolic value is less than (<) 150 *and* the mean diastolic value is less than (<) 90
2. 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
3. Patients with BP less than (<) 150/90, i.e., the mean systolic value is less than (<) 150 *and* the mean diastolic value is less than (<) 90

2.1.1.5 Definitions

Diabetes

First DM Purpose of Visit 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 Values

CRS uses mean of last 3 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 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 previously where BP is less than (<) 140/90 or less than (<) 150/90 for patients ages 60 and older. If *both* the mean systolic and diastolic values do not meet the criteria for controlled, then the value is considered not controlled.

BP Documented and Controlled BP

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

- CPT G9273; 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, OR G9273. All other combinations will *not* be included in the Controlled BP numerator.

2.1.1.6 Patient Lists

- List of diabetic patients with BP less than (<) 140/90, or less than (<) 150/90 for patients age 60 and older.
- List of diabetic patients with BP greater than or equal to (>=) 140/90, or greater than or equal to (>=) 150/90 for patients age 60 and older.

2.2 Dental Group

2.2.1 Access to Dental Service

2.2.1.1 Owner: Contact

Dental Program: Timothy L. Lozon, D.D.S.

2.2.1.2 National Reporting

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

2.2.1.3 Denominators

1. GPRA Developmental: User Population patients with dental exam during the Report Period.
2. All pregnant or breastfeeding female User Population patients with no documented miscarriage or abortion.
3. No denominator. This measure is a total count only, not a percentage.

2.2.1.4 Numerators

1. GPRA Developmental: Patients with all treatment completed.
2. Patients with documented pre-natal or nursing mother dental visit during the Report Period.

Note: This numerator does not include refusals.

3. For patients under age 6 meeting the User Population definition, the total number of encounters with general anesthesia during the Report Period.

    A. For patients under age 6 meeting the User Population definition, the total number of encounters with general anesthesia and stainless steel crowns (SSCs) documented on the same visit during the Report Period.

2.2.1.5 Definitions

Dental Exam

- Dental ADA codes 0120, 0150, 0145, 9990
- CPT D0120, D0150, D0145

All Treatment Completed

- Dental ADA code 9990

Pre-natal or Nursing Mother Dental Visit

- IHS Dental codes 9340, 9341

Pregnancy

At least two visits with POV 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, 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 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.

Miscarriage

- Occurring after the second pregnancy POV and during the past 20 months
  - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
  - CPT 59812, 59820, 59821, 59830

Abortion

- Occurring after the second pregnancy POV and during the past 20 months

- POV ICD-9: 635*, 636*, 637*; ICD-10: O00.* through O03.89, O04.*, 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

Breastfeeding

- Any of the following during the Report Period:
  - POV ICD-9: V24.1; ICD-10: Z39.1
  - Breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N

General Anesthesia

- Dental ADA code 9220
- CPT D9220

Stainless Steel Crowns

- Dental ADA codes 2930 or 2931
- CPT D2930 or D2931

2.2.1.6 Patient Lists

- List of User Pop patients with dental exam and all treatment completed.
- List of User Pop patients with dental exam and not all treatment completed.
- List of pregnant or breastfeeding female patients with treatment.
- List of pregnant or breastfeeding female patients without treatment.
- List of User Pop patients less than 6 years with general anesthesia.
- List of User Pop patients less than 6 years with general anesthesia and stainless steel crowns.

2.3 Immunization Group

2.3.1 Adult Immunizations

2.3.1.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.1.2 National Reporting

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

2.3.1.3 Denominators

1. Active Clinical patients ages 19-59.
2. Active Clinical patients ages 60-64.
3. GPRA**:** Active Clinical patients ages 65 or older.

2.3.1.4 Numerators

1. Patients who have received 1 dose of Tdap or Td in the past 10 years, including contraindications and evidence of disease.

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

2. Patients who have received 1 dose of Tdap ever, including contraindications and evidence of disease.

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

3. 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 NMI refusals.

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

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

5. 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 NMI refusals.

6. Patients who have received the 1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 influenza during the Report Period), including contraindications and evidence of disease.

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

7. Patients who have received the 1:1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 influenza during the Report Period, 1 Zoster ever), including contraindications and evidence of disease.

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

8. Patients who have received the 1:1:1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 influenza during the Report Period, 1 Zoster ever, 1 up-to-date Pneumovax), including contraindications and evidence of disease.

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

2.3.1.5 Definitions

Pneumococcal Vaccine

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

- Immunization (CVX) codes 33, 109
- POV ICD-9: V03.82
- CPT 90732, G0009, G8115 (old code), G9279

Pneumococcal Contraindication

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

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

Tdap Immunization:

Any of the following documented during the applicable time frame:

- Immunization (CVX) code: 115
- CPT 90715

Tdap Contraindication

Any of the following documented any time before the end of the Report Period:

- Immunization Package contraindication of "Anaphylaxis"
- PCC NMI Refusal

Td Immunization

Any of the following documented in the past 10 years:

- Immunization (CVX) code 9, 113, 138, 139
- POV ICD-9: V06.5
- CPT 90714, 90718

Td Contraindication

Any of the following documented any time before the end of the Report Period:

- Immunization Package contraindication of "Anaphylaxis"
- PCC NMI Refusal

Influenza Vaccine

Any of the following during the report period:

- Immunization (CVX) codes 15, 16, 88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158, 161
- 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 through 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

Zoster Vaccine

Any of the following documented ever:

- Immunization (CVX) codes 121
- CPT 90736

Contraindication to Zoster Vaccine

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

- Contraindication in the Immunization Package of Immune Deficiency or Anaphylaxis
- PCC NMI Refusal

2.3.1.6 Patient Lists

- List of Active Clinical patients 19 through 59 with 1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, and 1 influenza during the Report Period).
- List of Active Clinical patients 19 through 59 without 1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, and 1 influenza during the Report Period).
- List of Active Clinical patients 60 through 64 with 1:1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 influenza during the Report Period, and 1 Zoster ever).
- List of Active Clinical patients 60 through 64 without 1:1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 influenza during the Report Period, and 1 Zoster ever).
- List of Active Clinical patients 65 years and older with 1:1:1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, one Tdap ever, 1 influenza during the Report Period, 1 Zoster ever, and 1 up-to-date Pneumovax).
- List of Active Clinical patients 65 years and older without 1:1:1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 influenza during the Report Period, 1 Zoster ever, and one up-to-date Pneumovax).

2.3.2 Childhood Immunizations

2.3.2.1 Owner: Contact

Epidemiology Program: Amy Groom, MPH

2.3.2.2 National Reporting

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

2.3.2.3 Denominators

1. Active Clinical patients ages 19 through 35 months at end of report period.

2. GPRA: User Population patients active in the Immunization Package who are age 19 through 35 months at end of report period.

> **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.

2.3.2.4 Numerators

1. Patients who have received 1 dose of Hepatitis A vaccine ever, including contraindications and evidence of disease.

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

2. Patients who have received 2 or 3 doses of Rotavirus vaccine ever, including contraindications and evidence of disease.

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

3. Patients who have received 2 doses of Influenza ever, including contraindications.

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

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

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

5. Patients who have received 3 doses of Pneumococcal conjugate vaccine ever, including contraindications and evidence of disease.

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

2.3.2.5 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

- Four 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
  - 4 each of Diphtheria, Tetanus, and Acellular Pertussis
- 3 Doses of Polio
  - 3 OPV
  - 3 IPV
  - Combination of OPV and IPV totaling 3 doses
- 1 Dose of MMR
  - MMR
  - 1 M/R and 1 Mumps
  - 1 R/M and 1 Measles
  - 1 each of Measles, Mumps, and Rubella
- 3 doses of Hep B

- 3 or 4 doses of HIB, depending on the vaccine administered
- 1 dose of Varicella
- 3 doses of Pneumococcal
- 1 dose of Hep A
- 2 or 3 doses of Rotavirus, depending on the vaccine administered
- 2 doses of Influenza

Refusal, Contraindication, and Evidence of Disease Information

Except for the Immunization Program Numerators, NMI refusals, evidence of disease and contraindications for individual immunizations will also count toward meeting the definition, as defined below. Refusals will count toward meeting the definition for refusal numerators only.

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. 2 or 3 Rotavirus): 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 Rotavirus numerator with only 2 doses, all 2 doses must be included in the 2-dose series codes listed in the Rotavirus definition. A patient with a mix of 2-dose and three-dose series codes will need 3 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 more 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.
- For immunizations where required number of doses is more 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).

- 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.

NMI Refusal Definitions

Parent or Patient Refusal in Immunization package or PCC Refusal type REF or NMI for any of the following codes:

- DTaP
  - Immunization (CVX) codes 20, 50, 102, 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), G9279
- Hepatitis A
  - Immunization (CVX) codes 31, 52, 83, 84, 85, 104
  - CPT 90632 through 90634, 90636, 90730 (old code)
- Rotavirus
  - Immunization (CVX) codes 74, 116, 119, 122
  - CPT 90680
- Influenza
  - Immunization (CVX) codes 15, 16, 88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158, 161
  - CPT 90654 through 90658, 90659 (old code), 90660 through 90662, 90672, 90673, 90685 through 90688, 90724 (old code), G0008, G8108 (old code)

Immunization Definitions

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

- DTaP IZ Definitions
  - Immunization (CVX) codes 20, 50, 102, 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 IZ Definitions
  - 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 IZ Definitions
  - Immunization (CVX) code 115
  - CPT 90715
- Tdap contraindication definition
  - Immunization Package contraindication of “Anaphylaxis”

- DT IZ Definitions
  - Immunization (CVX) code 28
  - POV ICD-9: V06.5
  - CPT 90702
- DT Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Td IZ Definitions
  - Immunization (CVX) codes 9, 113, 138, 139
  - POV ICD-9: V06.5
  - CPT 90714, 90718
- Td Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Diphtheria IZ Definitions
  - POV ICD-9: V03.5
  - CPT 90719
- Diphtheria Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Tetanus Definitions
  - Immunization (CVX) codes 35, 112
  - POV ICD-9: V03.7
  - CPT 90703
- Tetanus Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- Acellular Pertussis Definitions
  - Immunization (CVX) code 11
  - POV ICD-9: V03.6
- Acellular Pertussis Contraindication Definition
  - Immunization Package contraindication of “Anaphylaxis”
- OPV Definitions
  - Immunization (CVX) codes 2, 89
  - CPT 90712
- OPV Contraindication Definition
  - Immunization Package contraindication of Immune Deficiency

- IPV Definitions
  - 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 Definitions
  - 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 Definitions
  - Immunization (CVX) code 4
  - CPT 90708
- M/R Contraindication Definition
  - Immunization Package contraindication of "Anaphylaxis"
- R/M Definitions
  - Immunization (CVX) code 38
  - CPT 90709 (old code)
- R/M Contraindication Definition
  - Immunization Package contraindication of "Anaphylaxis"
- Measles Definitions
  - 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 Definitions
  - 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 Definitions
  - 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 Definitions
  - 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 Definitions

  - 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 Definitions
  - 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 Definitions
  - Immunization (CVX) codes 21, 94
  - POV ICD-9: V05.4
  - CPT 90710, 90716
- Varicella Evidence of Disease Definitions
  - 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"
- Pneumococcal Definitions
  - Immunization (CVX) codes 33, 100, 109, 133, 152
  - POV ICD-9: V06.6, V03.82
  - CPT 90669, 90670, 90732, G0009, G8115 (old code), G9279
- Pneumococcal Contraindication Definition
  - Immunization Package contraindication of Anaphylaxis
- Hepatitis A Definitions
  - Immunization (CVX) codes 31, 52, 83, 84, 85, 104
  - CPT 90632 through 90634, 90636, 90730 (old code)
- Hepatitis A Evidence of Disease Definitions
  - POV or PCC Problem List (active or inactive) ICD-9: 070.0, 070.1; ICD-10: B15.*
- Hepatitis A Contraindication Definition
  - Immunization Package contraindication of "Anaphylaxis"
- Rotavirus Definitions

  - 2 dose series
    - Immunization (CVX) codes 119
    - CPT 90681
  - 3 dose series
    - Immunization (CVX) codes 74, 116, 122
    - POV ICD-9: V05.8
    - CPT 90680
- Rotavirus Contraindication Definition
  - Immunization Package contraindication of "Anaphylaxis" or "Immune Deficiency"
- Influenza Definitions
  - Immunizations (CVX) codes 15, 16, 88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158, 161
  - POV ICD-9: V04.8 (old code), V04.81, V06.6
  - CPT 90654 through 90658, 90659 (old code), 90660 through 90662, 90672, 90673, 90685 through 90688, 90724 (old code), G0008, G8108 (old code)
- Influenza Contraindication Definition
  - Immunization Package contraindication of "Egg Allergy" or "Anaphylaxis"

2.3.2.6 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 Active Immunization Package patients ages 19 through 35 months who received 1 dose of the Hep A vaccine.
- List of Active Immunization Package patients ages 19 through 35 months who have not received 1 dose of the Hep A vaccine.
- List of Active Immunization Package patients ages 19 through 35 months who received 2 or 3 doses of the rotavirus vaccine.
- List of Active Immunization Package patients ages 19 through 35 months who have not received 2 or 3 doses of the rotavirus vaccine.
- List of Active Immunization Package patients ages 19 through 35 months who received 2 doses of the influenza vaccine.

- List of Active Immunization Package patients ages 19 through 35 months who have not received 2 doses of the influenza vaccine.
- List of Active Immunization Package patients ages 19 through 35 months who received the 4:3:1:3*:3:1:3 combination (4 DTaP, 3 Polio, 1 MMR, 3 or 4 HiB, 3 Hep B, 1 Varicella, and 3 Pneumococcal).
- List of Active Immunization Package patients ages 19 through 35 months who have not received the 4:3:1:3*:3:1:3 combination (4 DTaP, 3 Polio, 1 MMR, 3 or 4 HiB, 3 Hep B, 1 Varicella, and 3 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: Mammogram Rates

2.4.1.1 Owner: Contact

Carolyn Aoyama

2.4.1.2 National Reporting

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

2.4.1.3 Denominators

1. GPRA Developmental: Female Active Clinical patients ages 52 through 74 without a documented history of 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.

2.4.1.4 Numerators

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

2.4.1.5 Definitions

Age

Age of the patient is calculated at the beginning of the report period. Patients must be at least 52 years of age as of the beginning 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
- 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, Z12.3
- 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"

2.4.1.6 Patient Lists

- List of female patients 52 through 74 with a Mammogram documented in the past 2 years.
- List of female patients 52 through 74 without a Mammogram documented in the past 2 years.

2.4.2 USPSTF Colorectal Cancer Screening

> **Note:** Based on the United States Preventive Services Task Force (USPSTF) 2008 recommendations and which uses the HEDIS codes for the different types of screening. This definition is different from the GPRA definition for both the denominator and numerator.
> Denominator does *not* include exclusions for patients with a diagnosis of colorectal cancer or total colectomy and the numerator does not include DCBE.

2.4.2.1 Owner: Contact

Epidemiology Program: Don Haverkamp

2.4.2.2 National Reporting

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

2.4.2.3 Denominators

1. GPRA Developmental: Active Clinical patients ages 50 through 75 years, broken out by gender.

2.4.2.4 Numerators

1. GPRA Developmental: Patients who have had any CRC screening, defined as any of the following:

   A. FOBT or FIT during the Report Period

   B. Flexible sigmoidoscopy in the past 5 years and FOB or FIT in the past three years

   C. Colonoscopy in the past 10 years

2.4.2.5 Definitions

Colorectal Cancer Screening

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

- FOBT or FIT
  - POV ICD-9: V76.51 Colon screening; ICD-10: Z12.11
  - 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, G9252, G9253

2.4.2.6 Patient Lists

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

2.4.3 Comprehensive Cancer Screening

2.4.3.1 Owner: Contact

Epidemiology Program: Don Haverkamp, Carolyn Aoyama

2.4.3.2 National Reporting

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

2.4.3.3 Denominators

1. GPRA Developmental: Active Clinical patients ages 24 through 75 years who are eligible for cervical cancer, breast cancer, or colorectal cancer screening.

   A. Active Clinical female patients ages 24 through 75 years.

   B. Active Clinical male patients ages 50 through 75 years.

2.4.3.4 Numerators

1. GPRA Developmental: Patients who have had all screenings for which they are eligible.

2. Female patients with cervical cancer, breast cancer, or colorectal cancer screening.

3. Male patients with colorectal cancer screening.

2.4.3.5 Definitions

Cervical Cancer Screening

To be eligible for this screening:

- Patients must be female Active Clinical ages 24 through 64 years and not have a documented history of hysterectomy.
- 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.
- To be counted as having the screening, the patient must have had a Pap Smear documented in the past 3 years, or if the 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.

Hysterectomy

Any of the following ever:

- Procedure ICD-9: 68.4 through 68.9; ICD-10: 0UT9*ZZ
- CPT 51925, 56308 (old code), 57540, 57545, 57550, 57555, 57556, 58150, 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
- Women's Health procedure called Pap Smear and where the result does not have "ERROR/DISREGARD"
- LOINC taxonomy
- Site-populated taxonomy BGP 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

Breast Cancer Screening

To be eligible for this screening:

- Patients must be female Active Clinical ages 52 through 64 years and not have a documented history ever of bilateral mastectomy or two separate unilateral mastectomies.
- Patients must be at least age 52 years as of the beginning of the Report Period and must be less than 65 years of age as of the end of the Report Period.
- To be counted as having the screening, the patient must have had a Mammogram documented in the past 2 years

Bilateral mastectomy

Any of the following ever:

- 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
- Procedure ICD-9: 85.42, 85.44, 85.46, 85.48; ICD-10: 0HTV0ZZ

Unilateral Mastectomy

Must have 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

Screening Mammogram

- Radiology or CPT 77052 through 77059, 76090 (old code), 76091 (old code), 76092 (old code), G0206, G0204, G0202
- POV ICD-9: V76.11 screening mammogram for high risk patient, V76.12 other screening mammogram, 793.80 Abnormal mammogram, unspecified, 793.81 Mammographic microcalcification, 793.89 Other abnormal findings on radiological exam of breast; ICD-10: R92.0, R92.1, R92.8, Z12.31
- Procedure ICD-9: 87.36 Xerography of breast, 87.37 Other Mammography; 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"

Colorectal Cancer Screening

To be eligible for this screening:

- Patients must be Active Clinical ages 50 through 75 years and not have a documented history ever of colorectal cancer or total colectomy

To be counted as having the screening, patients must have had any of the following:

- FOBT or FIT during the Report Period
- Flexible sigmoidoscopy in the past 5 years
- Colonoscopy in the past 10 years

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

- Procedure ICD-9: 45.8*; ICD-10: 0DTE*ZZ
- CPT 44150 through 44151, 44152 (old code), 44153 (old code), 44155 through 44158, 44210 through 44212

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, G9252, G9253

2.4.3.6 Patient Lists

- List of patients 24 through 75 years of age with comprehensive cancer screening.
- List of patients 24 through 75 years of age without comprehensive cancer screening.

2.5 Behavioral Health Group

2.5.1 Alcohol Screening

2.5.1.1 Owner: Contact

Marcy Ronyak, IHS Division of Behavioral Health (DBH)

2.5.1.2 National Reporting

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

2.5.1.3 Denominators

1. GPRA: Female Active Clinical Plus Behavioral Health (BH) patients 15 through 44 years of age.
2. GPRA Developmental: Active Clinical Plus BH patients ages 12 through 75 years, broken down by age groups: 12 through 19 years, 20 through 24 years, 25 through 34 years, 35 through 44 years, 45 through 54 years, and 55 through 75 years

2.5.1.4 Numerators

1. GPRA Developmental: Patients screened for alcohol use or had an alcohol-related diagnosis or procedure during the Report Period.

> **Note:** This numerator does *not* include alcohol-related patient education.

2. Patients with alcohol-related patient education during the Report Period.
3. GPRA Developmental: Patients who were screened positive for alcohol use.

2.5.1.5 Definitions

Alcohol Screening

Any of the following during the Report Period:

- 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 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
  - BHS Problem codes 10, 12.1, 14.2, 17.1, 18.1, 20.1, 22.1
- 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:

- 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

Positive Screen for Alcohol Use

Any of the following for patients with alcohol screening:

- Exam code 35 Alcohol Screening result of “Positive”
- Health factor of CAGE result of 1/4, 2/4, 3/4 or 4/4
- CPT G0396, G0397, 99408, 99409
- AUDT result of greater than or equal (>=) to 8, AUDC result of greater than or equal to (>=) 4 for men and greater than or equal to (>=) 3 for women, CRFT result of 2 to 6

2.5.1.6 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.
- List of female Active Clinical patients ages 15 through 44 years with a positive alcohol screen.
- List of female Active Clinical patients ages 15 through 44 years with a negative alcohol screen.
- List of Active Clinical patients ages 12 through 75 years with documented alcohol screening.
- List of Active Clinical patients ages 12 through 75 years without documented alcohol screening.
- List of Active Clinical patients ages 12 through 75 years with a positive alcohol screen.
- List of Active Clinical patients ages 12 through 75 years with a negative alcohol screen.

2.5.2 Intimate Partner (Domestic) Violence Screening

2.5.2.1 Owner: Contact

Beverly Cotton, IHS Division of Behavioral Health (DBH)

2.5.2.2 National Reporting

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

2.5.2.3 Denominators

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

2.5.2.4 Numerators

1. GPRA Developmental: Patients with an IPV/DV exam or IPV/DV-related diagnosis, procedure, or counseling any time during the Report Period.

> **Note:** This numerator does *not* include IPV/DV-related patient education.

2. Patients with IPV/DV-related education during the Report Period

2.5.2.5 Definitions

IPV/DV Exam

- 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 (adult maltreatment), V15.41, V15.42, V15.49 (history of abuse); 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 Patient Lists

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

2.5.3 Depression Screening

2.5.3.1 Owner: Contact

Beverly Cotton, IHS Division of Behavioral Health (DBH)

2.5.3.2 National Reporting

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

2.5.3.3 Denominators

1. GPRA Developmental: Active Clinical Plus BH patients ages 18 and older.

2. GPRA Developmental: Active Clinical Plus BH patients ages 12 through 18 years.

2.5.3.4 Numerators

1. GPRA Developmental: Patients screened for depression or diagnosed with a mood disorder or suicide ideation at any time 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, PHQ9 or PHQT

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

Suicide Ideation

- POV ICD-9: V62.84; ICD-10: R45.851
- BHS Problem code 39 during the Report Period

2.5.3.6 Patient Lists

- List of Active Clinical patients ages 18 years and older screened for depression or diagnosed with mood disorder or suicide ideation.

- List of Active Clinical patients ages 18 years and older not screened for depression or diagnosed with mood disorder or suicide ideation.
- List of Active Clinical patients ages 12 through 18 years screened for depression or diagnosed with mood disorder or suicide ideation.
- List of Active Clinical patients ages 12 through 18 years not screened for depression or diagnosed with mood disorder or suicide ideation.

2.6 Cardiovascular Disease Related Group

2.6.1 Weight Assessment and Counseling for Nutrition and Physical Activity

2.6.1.1 Owner: Contact

Alberta Becenti and Samantha Interpreter, RD

2.6.1.2 National Reporting

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

2.6.1.3 Denominators

1. Active Clinical patients ages 3 through 17, broken down by gender and age groups.

2.6.1.4 Numerators

1. Patients with comprehensive assessment, defined as having BMI documented, counseling for nutrition, and counseling for physical activity during the Report Period.
2. Patients with BMI documented during the Report Period.
3. Patients with counseling for nutrition during the Report Period.
4. Patients with counseling for physical activity during the Report Period.

2.6.1.5 Definitions

Age

Age is calculated at the end of the report period.

BMI

Any of the following during the Report Period:

- CRS calculates BMI at the time the report is run, using NHANES II. For 18 and under, a height and weight must be taken on the same day any time during the report period. For ages 19 through 50 years, height and weight must be recorded within last five years, not required to be on the same day. For over 50 years of age, height and weight within last 2 years, not required to be recorded on same day.
- POV ICD-9: V85*; ICD-10: Z68.20-Z68.54

Counseling for nutrition

- CPT 97802-97804, G0270, G0271, G0447, S9449, S9452, S9470
- POV ICD-9: V65.3; ICD-10: Z71.3
- Patient Education codes ending “-N” or "-MNT" (or old code “-DT” (Diet)) or containing V65.3, 97802 through 97804, G0270, G0271, G0447, S9449, S9452, S9470

Counseling for physical activity

- CPT G0447, S9451
- POV ICD-9: V65.41
- Patient education codes ending “-EX” (Exercise) or containing V65.41, G0447, or S9451

2.6.1.6 Patient Lists

- List of Active Clinical patients 3 through 17 with comprehensive assessment.
- List of Active Clinical patients 3 through 17 without comprehensive assessment.

2.6.2 Controlling High Blood Pressure

2.6.2.1 Owner: Contact

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

2.6.2.2 National Reporting

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

2.6.2.3 Denominators

1. Active Clinical patients diagnosed with hypertension.
2. Active Clinical patients under age 60 diagnosed with hypertension.
3. Active Clinical patients ages 60 and older diagnosed with hypertension.

2.6.2.4 Numerators

1. Patients with controlled BP, defined as less than 140/90, i.e., the mean systolic value is less than (<) 140 *and* the mean diastolic value is less than (<) 90 or, if patient is 60 and over, with BP less than 150/90, i.e., the mean systolic value is less than (<) 150 *and* the mean diastolic value is less than (<) 90.
2. 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
3. Patients with BP less than (<) 150/90, i.e., the mean systolic value is less than (<) 150 *and* the mean diastolic value is less than (<) 90

2.6.2.5 Definitions

Hypertension

- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 401.*; ICD-10: I10 prior to the report period, and at least one hypertension POV during 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 Values

- 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 1 BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last 3 (or 2) systolic values and dividing by 3 (or 2). The mean Diastolic value is calculated by adding the diastolic values from the last 3 (or 2) blood pressures and dividing by 3 (or 2). If the systolic and diastolic values do not *both* meet the current category, then the value that is least controlled determines the category.

2.6.2.6 Patient Lists

- List of patients with HTN with BP less than (<) 140/90, or less than (<) 150/90 for patients age 60 and older.
- List of patients with HTN with BP greater than or equal to (>=) 140/90, or greater than or equal to (>=) 150/90 for patients age 60 and older.

2.7 STD-Related Group

2.7.1 HIV Screening

2.7.1.1 Owner: Contact

Lisa Neel, MPH and Dr. Marie Russell

2.7.1.2 National Reporting

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

2.7.1.3 Denominators

1. GPRA Developmental: User Population patients ages 13 through 64 years with no recorded HIV diagnosis prior to the Report Period, broken down by gender and age groups: less than 13 years, 13 through 14 years, 15 through 19 years, 20 through 24 years, 25 through 29 years, 30 through 34 years, 35 through 39 years, 40 through 44 years, 45 through 49 years, 50 through 54 years, 55 through 59 years, 60 through 64 years, 65 years and older.
2. User Population patients ages 13 through 64 years with first recorded HIV diagnosis during the Report Period.

2.7.1.4 Numerators

1. GPRA Developmental: Patients who were screened for HIV during the Report Period.

   Note: This numerator does *not* include refusals.

   A. Patients with a positive result.

   B. Patients with a negative result.

   C. Patients with no result.

2. Patients with documented HIV screening refusal during the Report Period.

3. Patients who were screened for HIV in the past 5 years.

   Note: This numerator does *not* include refusals.

4. Patients who were screened for HIV at any time before the end of the Report Period.

   Note: This numerator does *not* include refusals.

5. GPRA Developmental: Number of HIV screens provided to User Population patients during the Report Period, where the patient was not diagnosed with HIV any time prior to the screen.

   Note: This numerator does *not* have a denominator. This measure is a total count only, not a percentage.

6. Patients with CD4 count within 90 days of initial HIV diagnosis.

   A. Patients with CD4 less than 200.

   B. Patients with CD4 greater than or equal to 200 and less than or equal to 350.

   C. Patients with CD4 greater than 350 and less than or equal to 500.

   D. Patients with CD4 greater than 500.

   E. Patients with no CD4 result.

2.7.1.5 Definitions

HIV

Any of the following documented any time prior to the beginning 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

HIV Screening

- CPT 86689, 86701 through 86703, 87390, 87391, 87534 through 87539
- LOINC taxonomy
- Site-populated taxonomy BGP HIV TEST TAX
- Refusal of any laboratory test in site-populated taxonomy BGP HIV TEST TAX. For the number of HIV screens provided to User Population patients numerator (count only), a maximum of one HIV screen per patient per day will be counted.

Note: Refusal is only included in the second numerator.

Positive HIV Result

- Positive result for HIV Screening test, defined as "Positive," "P," "Pos," "R," "Reactive," "Repeatedly Reactive," "+," or containing ">"
- HIV diagnosis defined as any of the following documented any time after the HIV screening:
  - POV or Problem List codes ICD-9: 042, 042.0–044.9 (old codes), 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711 through O98.73

If patient has a positive result for either an HIV-1 or HIV-2 test (regardless of any other results), it will be considered a positive result.

Negative HIV Result

Negative result for HIV Screening test, defined as "Negative," "N," "Neg," "NR," "Non Reactive," "Non-Reactive," or "-"

No Result

Any screening that does not have a positive or negative result.

CD4 Count

Searches for most recent CD4 test with a result during the Report Period. If none found, CRS searches for the most recent CD4 test without a result.

CD4 Test defined as:

- CPT 86359, 86360, 86361, G9214
- LOINC taxonomy
- Site-populated taxonomy BGP CD4 TAX

2.7.1.6 Patient Lists

- List of User Population patients ages 13 through 64 years with documented HIV test.
- List of User Population patients ages 13 through 64 years without documented HIV test.
- List of User Population patients ages 13 through 64 years with documented HIV test and positive result.
- List of User Population patients ages 13 through 64 years with documented HIV test and negative result.

- List of User Population patients ages 13 through 64 years with documented HIV test and no result.
- List of User Population patients with documented HIV test.

2.7.2 Hepatitis C Screening

2.7.2.1 Owner: Contact

Brigg Reilley

2.7.2.2 National Reporting

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

2.7.2.3 Denominators

1. User Population patients born between 1945 and 1965 with no recorded Hepatitis C diagnosis. Broken down by gender.
2. User Population patients born between 1945-1965 with documented Hep C diagnosis ever. Broken down by gender.

2.7.2.4 Numerators

1. Patients screened for Hepatitis C ever.
2. Patients who were given a Hepatitis C confirmation test.
   A. Patients with a positive result.
   B. Patients with a negative result.
   C. Patients with no result.

2.7.2.5 Definitions

Hepatitis C Diagnosis

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: 070.41, 070.44, 070.51, 070.54, 070.70 through 070.71; ICD-10: B17.10, B17.11, B18.2, B19.20, B19.21

Hepatitis C Screening

- CPT 86803

- LOINC taxonomy
- Site-populated taxonomy BGP HEP C TEST TAX

Hepatitis C Confirmation Test

Any of the following documented any time prior to the end of the Report Period:

- CPT 86804, 87520, 87521, 87522, G9203, G9207, G9209
- LOINC taxonomy
- Site-populated taxonomy BGP HEP C CONF TEST TAX

If patient has more than one confirmatory test, CRS will use the first test that has a result recorded, if any. If there is no test with a result, CRS will use the first test documented.

Positive Result

Positive confirmation test result defined as a number greater than zero.

Negative Result

Negative confirmation test result defined as result containing "<15 IU/mL" or "<1.18 LogIU/mL" or comment containing "Not Detected".

No Result

Any confirmation test that does not have a positive or negative result.

2.7.2.6 Patient Lists

- List of patients born between 1945 and 1965 with no prior Hepatitis C diagnosis who were ever screened for Hepatitis C.
- List of patients born between 1945 and 1965 with no prior Hepatitis C diagnosis or screening who were ever screened for Hepatitis C.
- List of patients born between 1945-1965 with Hep C diagnosis who were given Hep C confirmatory test.
- List of patients born between 1945-1965 with Hep C diagnosis who were not given Hep C confirmatory test.
- List of patients born between 1945-1965 with Hep C confirmatory test and positive result.
- List of patients born between 1945-1965 with Hep C confirmatory test and negative result.
- List of patients born between 1945-1965 with Hep C confirmatory test and no result.

2.7.3 Chlamydia Testing

2.7.3.1 Owner: Contact

Epidemiology Program: Scott Tulloch

2.7.3.2 National Reporting

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

2.7.3.3 Denominators

1. Female Active Clinical patients ages 16 through 25 years, broken down into age groups 16 through 20 years and 21 through 25 years.
2. Female User Population patients ages 16 through 25 years, broken down into age groups 16 through 20 years and 21 through 25 years.

2.7.3.4 Numerators

1. Patients tested for Chlamydia trachomatis during the report period.

2.7.3.5 Definitions

Chlamydia

- POV ICD-9: V73.88, V73.98
- CPT 86631, 86632, 87110, 87270, 87320, 87490 through 87492, 87810, 3511F, G9228
- Site-populated taxonomy BGP GPRA CHLAMYDIA TESTS
- LOINC taxonomy

2.7.3.6 Patient Lists

- List of Active Clinical patients with documented Chlamydia screening.
- List of Active Clinical patients without documented Chlamydia screening.

2.7.4 STI Screening

2.7.4.1 Owner: Contact

Scott Tulloch

2.7.4.2 Denominators

1. GPRA Developmental: HIV/AIDS screenings needed for key STI incidents for Active Clinical patients that occurred during the defined period.

2.7.4.3 Numerators

1. GPRA Developmental: Number of needed HIV/AIDS screenings performed from 1 month prior to the date of first STI diagnosis of each incident through 2 months after.

Note: This numerator does not include refusals.

2.7.4.4 Definitions

Key STIs

Chlamydia, gonorrhea, HIV/AIDS, and syphilis. Key STIs defined with the following POVS:

- Chlamydia: ICD-9: 079.88, 079.98, 099.41, 099.50 through 099.59; ICD-10: A56.*, A74.81 through A74.9
- Gonorrhea: ICD-9: 098.0 through 098.89; ICD-10: A54.*, O98.2*
- HIV/AIDS: ICD-9: 042, 042.0 through 044.9, 079.53, 795.71, V08; ICD-10: B20, B97.35, R75, Z21, O98.711 through O98.73
- Syphilis: ICD-9: 090.0 through 093.9, 094.1 through 097.9; ICD-10: A51.* through A53.*

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

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

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

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

Table 2-1 contains an example of a patient with multiple incidents of single STI.

Table 2-1: Example of patient with multiple incidents of single STI

Date	Visit	Total Incidents
August 1, 2014	Patient screened for Chlamydia	0
August 8, 2014	Patient diagnosed with Chlamydia	1
October 15, 2014	Patient diagnosed with Chlamydia	2
October 25, 2014	Follow-up for Chlamydia	2
November 15, 2014	Patient diagnosed with Chlamydia	2
March 1, 2015	Patient diagnosed with Chlamydia	3

Denominator Logic for Needed Screenings

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

To be included in the needed HIV screening tests denominator, the count will be derived from the number of separate non-HIV STI incidents. HIV screening tests are recommended for the following key STIs: Chlamydia, Gonorrhea, Syphilis.

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

- Only one screening for HIV is needed during the relevant time period, regardless of the number of different STI incidents identified. For example, if a patient is diagnosed with Chlamydia and Gonorrhea on the same visit, only one screening is needed for HIV/AIDS.
- A patient with HIV/AIDS diagnosis prior to any STI diagnosis that triggers a recommended HIV/AIDS screening does not need the screening ever.

Numerator Logic

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

HIV/AIDS Screening

Any of the following during the specified time period:

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

2.7.4.5 Patient Lists

- List of Active Clinical patients diagnosed with an STI who were screened for HIV.
- List of Active Clinical patients diagnosed with an STI who were not screened for HIV or who had a prior HIV diagnosis.

2.8 Other Clinical Measures Group

2.8.1 Optometry

2.8.1.1 Owner: Contact

Michael Candreva, OD

2.8.1.2 National Reporting

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

2.8.1.3 Denominators

1. GPRA Developmental (NQF 0086): Active Clinical patients ages 18 and older with a diagnosis of primary open-angle glaucoma during the Report Period.

2.8.1.4 Numerators

1. GPRA Developmental (NQF 0086): Patients with an optic nerve head evaluation during the Report Period.

2.8.1.5 Definitions

Primary open-angle glaucoma

- POV ICD-9: 365.10-365.12, 365.15; ICD-10: H40.10* - H40.12*, H40.15*

Optic nerve head evaluation

- CPT: 2027F

2.8.1.6 Patient Lists

- List of Active Clinical patients >=18 with primary open-angle glaucoma and optic nerve head evaluation.

- List of Active Clinical patients >=18 with primary open-angle glaucoma and no optic nerve head evaluation.

2.8.2 Visit Statistics

2.8.2.1 Owner: Contact

National GPRA Steering Committee

2.8.2.2 National Reporting

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

2.8.2.3 Denominators

1. All Active Clinical patients.
2. Active Clinical patients ages 2 through 18 years.
3. Active Clinical patients ages 5 years and older.
4. Active Clinical patients ages 12 through 18 years.
5. Active Clinical patients ages 12 through 75 years.
6. Female Active Clinical patients ages 15 through 40 years.
7. Female Active Clinical patients ages 15 through 44 years.
8. Active Clinical patients ages 18 years and older.
9. Active Clinical patients ages 65 years and older.
10. Active Clinical patients identified as current tobacco users prior to the Report Period.

2.8.2.4 Numerators

1. Patients who do not have a qualifying visit during the Report Period.
2. Patients who qualify as Active Clinical patients with Urgent Care as their only core clinic.

2.8.2.5 Definitions

Qualifying Visits

- Service Category A, H, O, R, S; and
- Not Clinic code 42 (Mail), 51 (Telephone Call), 52 (Chart Review), 53 (Follow-up Letter).

Current Tobacco Users

Any of the following documented prior to the report period:

- Health Factors (looks at the last documented in the Tobacco, TOBACCO (SMOKING) and TOBACCO (SMOKELESS–CHEWING/DIP) categories): Current Smoker, Current Smokeless, Current Smoker and Smokeless, Cessation-Smoker, Cessation-Smokeless, Current Smoker, status unknown, Current smoker, every day, Current smoker, someday, Heavy Tobacco Smoker, Light Tobacco Smoker
- Last documented Tobacco-related Diagnosis (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*
- Last documented CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1035F, G8455 (old code), G8456 (old code), G8402 (old code), G8453 (old code), G9276

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

Urgent Care Visits

Clinic code 80

2.8.2.6 Patient Lists

- List of Active Clinical patients with no qualifying visit during the Report Period.
- List of Active Clinical patients with Urgent Care as their only core clinic.

List of Acronyms

Acronym	Term Meaning
AI/AN	American Indian/Alaska Native
BH	Behavioral Health
BHS	Behavioral Health System
BMI	Body Mass Index
BP	Blood Pressure
CABG	Coronary Artery Bypass Graft
CPT	Current Procedural Terminology
CRC	Colorectal Cancer
CRS	Clinical Reporting System
CVD	Cardiovascular Disease
CVX	Vaccine Code
DCBE	Double Contrast Barium Enema
DM	Diabetes Mellitus
DNKA	Did Not Keep Appointment
DPST	Demo/Test Patient Search Template
ER	Emergency Room
ETDRS	Early Treatment Diabetic Retinopathy Study
FIT	Fecal Immunochemical Test
FOBT	Fecal Occult Blood Test
FY	Fiscal Year
GPRA	Government Performance and Results Act of 1993
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
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
PCI	Percutaneous Coronary Interventions

Acronym	Term Meaning
POV	Purpose of Visit
RPMS	Resource and Patient Management System
STI	Sexually Transmitted Infection

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (888) 830-7280 (toll free)

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/

Email: support@ihs.gov