Measure title	Colorectal Cancer Screening for Care Delivery	**Measure ID**	COL-CD
Description	The percentage of persons 45–75 years of age who had appropriate screening for colorectal cancer.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force "recommends screening for colorectal cancer in all adults aged 50 to 75 years (A recommendation) and all adults aged 45 to 49 years (B recommendation)." Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT), multitargeted stool DNA with FIT test (sDNA FIT) every 3 years, colonoscopy every 10 years, CT colonography every 5 years, flexible sigmoidoscopy every 5 years or flexible sigmoidoscopy every 10 years, with FIT every year.		
Citations	USPSTF. 2021. "Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement." *JAMA* 325(19): 1965–77. doi:10.1001/jama.2021.6238.		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Supplemental	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African.		
	• Native Hawaiian or Pacific Islander. • White. • Some Other Race. • Two or More Races. • Asked But No Answer.		

	• Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	This measure uses FHIR R4; US Core v3.1.1
Initial population	Measure item count: Person. **Patients 45-75 years of age as of the last day of the measurement period with a visit during the measurement period:** Encounter. At least one finished encounter (Office visit; Annual Wellness Visit; Preventative Care Services Established Office Visit, 18 and Up; Preventative Care Services Initial Office Visit, 18 and Up; Home Healthcare Services; Virtual Encounter; Telephone Visits) in the measurement period.
Denominator Exclusions	**Persons who died during the measurement period:** • A patient record containing a deceased date during the measurement period; OR • Professional or Institutional Claim/EOB. At least one inpatient stay (Inpatient Stay Value Set) with a service date in the measurement period and a discharge disposition (FL 17) of death (Patient Discharge Status code 20); OR • Observation. An observation indicating the person died (SNOMED-CT code 419099009) in the measurement period with a status of final, amended or corrected. **Persons who received hospice care in the measurement period:** • Professional or Institutional Claim/EOB. An indication of hospice (Hospice Encounter; Hospice Care Ambulatory) or with a discharge disposition (FL 17) to hospice (Patient Discharge Status code 50 or 51) with a service date in the measurement period; OR • Encounter. An encounter with a finished status for hospice (Hospice Encounter; Hospice Care Ambulatory) overlapping the measurement period or an inpatient encounter (Encounter Inpatient) with a discharge disposition to hospice care (SNOMED-CT code 428371000124100) or (SNOMED-CT code 428361000124107) that ends during the measurement period; OR • Procedure. A completed procedure for hospice (Hospice Encounter; Comfort Measures; Hospice Care Ambulatory) overlapping the measurement period; OR

	• Service Request. An active or completed order for hospice (Hospice Care Ambulatory) during the measurement period; OR • Observation Screening Assessment. A final, amended or corrected screening assessment for hospice (LOINC code 45755-6) with a value of 'Yes (qualifier value)' (SNOMED-CT code 373066001) with an effective date overlapping the measurement period; OR • Condition. A diagnosis of hospice (Hospice Diagnosis) with a verification status of confirmed, unconfirmed, provisional or differential overlapping the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis. **Persons who received palliative care in the measurement period:** • Professional or Institutional Claim/EOB. An indication of palliative care (Palliative Care Encounter; ICD-10-CM code Z51.5*) with a service date in the measurement period. *Do not include laboratory claims (claims with POS code 81); OR • Condition. A diagnosis of palliative care (Palliative Care Diagnosis) with a verification status of confirmed, unconfirmed, provisional or differential overlapping the measurement period as a Condition Problems Health Concerns or an Encounter Diagnosis; OR • Encounter. An encounter with a finished status for palliative care (Palliative Care Encounter) that overlaps the measurement period; OR • Observation. An Observation with a status of final, amended or corrected for palliative care assessment (Palliative Care Assessment Value Set) that overlaps the measurement period or an Observation Screening Assessment (LOINC Code 71007-9) with an effective date overlapping the measurement period; OR • Procedure. A completed procedure for palliative care (Palliative Care Encounter; Palliative Care Intervention) during the measurement period. **Persons 66 years of age or older by the last day of the measurement period had one criterion for frailty and one criterion for advanced illness:** **Frailty.** • Professional or Institutional Claim/EOB. An indication of frailty (Frailty Device Value Set; Frailty Diagnosis*; Frailty Encounter; Frailty Symptom*) with a service date in the measurement period. *Do not include laboratory claims (claims with POS code 81); OR • Condition. A diagnosis or symptom of frailty (Frailty Diagnosis; Frailty Symptom) with a verification status of confirmed, unconfirmed, provisional or differential overlapping the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis; OR • Encounter. An encounter with a finished status for frailty (Frailty Encounter) that overlaps the measurement period; OR • Observation. An observation with a final, amended, or corrected status with a symptom for frailty (Frailty Symptom) that overlaps the measurement period or an Observation Screening Assessment for medical equipment used (LOINC 98181-

	1) where the result is a frailty device (Frailty Device) that ends during the measurement period; OR • Device Request. A completed order for a frailty device (Frailty Device) during the measurement period. **Advanced Illness.** • Professional or Institutional Claim/EOB. At least two diagnoses of advanced illness (Advanced Illness*) on different service dates in the measurement period or the year prior to the measurement period. *Do not include laboratory claims (claims with POS code 81); OR • Pharmacy Claim/EOB. At least one dispensed dementia medication (Dementia Medications List) during the measurement period or the year prior to the measurement period; OR • Condition. A diagnosis of advanced illness (Advanced Illness) with a verification status of confirmed, unconfirmed, provisional, or differential that overlaps the measurement period or the year prior to the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis; OR • Medication Request. At least one active or completed order for a dementia medication (Dementia Medications) in the measurement period or the year prior to the measurement period; OR • Medication Dispense. At least one completed dispensed dementia medication (Dementia Medications) in the measurement period or the year prior to the measurement period. **Persons with a history of colorectal cancer or total colectomy:** • Professional or Institutional Claim/EOB. A diagnosis or procedure (Malignant Neoplasm of Colon*; Total Colectomy) anytime on or before the end of the measurement period. *Do not include laboratory claims (claims with POS code 81); OR • Condition. A diagnosis of colorectal cancer (Malignant Neoplasm of Colon) or a history of total colectomy procedure (SNOMED-CT code 119771000119101) with a verification status of confirmed, unconfirmed, provisional or differential anytime on or before the end of the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis; OR • Procedure. A completed procedure (Total Colectomy) that occurs anytime on or before the end of the measurement period.
Denominator	The initial population minus denominator exclusions.

Numerator	**Persons with evidence of colorectal cancer screening, demonstrated by any of the following:** • Professional or Institutional Claim/EOB. A claim with one of the following: o A fecal occult blood test (FOBT) (FOBT Lab Test Value Set) with a service date in the measurement period.

	○ A stool DNA (sDNA) (sDNA FIT Lab Test Value Set) with a service date in the measurement period or the 2 years prior to the measurement period. ○ A flexible sigmoidoscopy (Flexible Sigmoidoscopy) with a service date in the measurement period or the 4 years prior to the measurement period. ○ A CT colonography (CT Colonography Value Set) with a service date in the measurement period or the 4 years prior to the measurement period. ○ A colonoscopy (Colonoscopy) with a service date in the measurement period or the 9 years prior to the measurement period. • Observation. An observation with a status of final, amended, or corrected for any of the following: ○ A fecal occult blood test or test result (Fecal Occult Blood Test (FOBT); FOBT Test Result or Finding Value Set) with an effective date in the measurement period. ○ A stool DNA (sDNA) test or test result (sDNA FIT Test; SNOMED-CT code 708699002) with an effective date in the measurement period or 2 years prior to the measurement period. ○ A CT colonography (CT Colonography) diagnostic report with a status of final with an effective date in the measurement period or the 4 years prior to the measurement period. • Procedure. A completed procedure for either of the following: ○ A flexible sigmoidoscopy (Flexible Sigmoidoscopy) in the measurement period or the 4 years prior to the measurement period. ○ A colonoscopy (Colonoscopy) in the measurement period or the 9 years prior to the measurement period. • Condition. A history of either of the following: ○ Flexible sigmoidoscopy (SNOMED-CT code 841000119107) in the measurement period or the 4 years prior to the measurement period. ○ Colonoscopy (SNOMED-CT code 851000119109) in the measurement period or the 9 years prior to the measurement period.

Measure title	Appropriate Treatment for Upper Respiratory Infection for Care Delivery	**Measure ID**	URI-CD
Description	The percentage of episodes for persons 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event or order.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The common cold (or URI) is a frequent reason for patients visiting the doctor's office. Though existing clinical guidelines do not support the use of antibiotics for the common cold, physicians often prescribe them for this ailment. Clinical practice guidelines do not recommend antibiotics for a majority of URIs because of the viral etiology of these infections, including the common cold. A performance measure of antibiotic use for URI sheds light on the prevalence of inappropriate antibiotic prescribing in clinical practice and raises awareness of the importance of reducing inappropriate antibiotic use to combat antibiotic resistance in the community.		
Citations	Sur, D.K.C., & M.L. Plesa. 2022. "Antibiotic Use in Acute Upper Respiratory Tract Infections." *Am Fam Physician* 106(6):628–36. Kimberlin, D.W., R. Banerjee, E.D. Barnett, et al. 2024. "Principles of Appropriate Use of Antimicrobial Therapy for Upper Respiratory Tract Infections." In: D.W. Kimberlin, R. Banerjee, E.D. Barnett, R. Lynfield, M.H. Sawyer, eds. *Red Book: 2024–2027 Report of the Committee on Infectious Diseases*. 33rd ed. Committee on Infectious Diseases, American Academy of Pediatrics.		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Stratifications	Age as of the episode date. • 3 months–17 years. • 18–64 years. • 65 years and older.		
Risk adjustment	None.		
Improvement notation	Increased score indicates improvement.		
Guidance	This measure uses FHIR R4; US Core v3.1.1		

Definitions	
Episode date	The date of service for any outpatient, telephone or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of URI.
Initial population	*Measure item count:* Episode. **Outpatient visits, telephone visits, virtual encounter (i.e., e-visit or virtual check-in), or emergency department visits with a diagnosis of URI from January 1 to December 28 of the measurement period for patients 3 months of age and older:** Encounter and Condition. An encounter (Emergency Department Evaluation and Management Visit; Office visit; Care Services Established Office Visit, 18 and Up; Preventative Care Services Initial Office Visit, 18 and Up; Home Healthcare Services; Medical Disability Exam; Virtual Encounter; Telephone Visits; Outpatient Consultation; Preventative Care Services Group Counseling; Preventative Care Services Individual Counseling; Preventative Care, Initial Office Visit, 0 to 17; Preventative Care Established Office Visit, 0 to 17; CPT Code 99429) with a finished status and a diagnosis of Upper Respiratory Infection (Upper Respiratory Infection) with a verification status of confirmed, unconfirmed, provisional, or differential that starts before or overlaps the start of the encounter or starts on the same day of the encounter.
Denominator exclusions	**Persons who died during the measurement period:** • A patient record containing a deceased date during the measurement period; OR • Professional or Institutional Claim/EOB. At least one inpatient stay (Inpatient Stay Value Set) with a service date in the measurement period and a discharge disposition (FL 17) of death (Patient Discharge Status code 20); OR • Observation. An observation indicating the person died (SNOMED-CT code 419099009) during the measurement period with a status of final, amended or corrected. **Persons who received hospice care in the measurement period:** • Professional or Institutional Claim/EOB. An indication of hospice (Hospice Encounter; Hospice Care Ambulatory) or with a discharge disposition (FL 17) to hospice (Patient Discharge Status code 50 or 51) with a service date in the measurement period; OR • Encounter. An encounter with a finished status for hospice (Hospice Encounter; Hospice Care Ambulatory) overlapping the measurement period or an inpatient encounter (Encounter Inpatient) with a discharge disposition to hospice care (SNOMED-CT code 428371000124100) or (SNOMED-CT code 428361000124107) that ends during the measurement period; OR • Procedure. A completed procedure for hospice (Hospice Encounter; Comfort Measures; Hospice Care Ambulatory) overlapping the measurement period; OR

	• Service Request. An active or completed order for hospice (Hospice Care Ambulatory) during the measurement period; OR • Observation Screening Assessment. A final, amended or corrected screening assessment for hospice (LOINC code 45755-6) with a value of 'Yes (qualifier value)' (SNOMED-CT Code 373066001) and an effective date overlapping the measurement period; OR • Condition. A diagnosis of hospice (Hospice Diagnosis) with a verification status of confirmed, unconfirmed, provisional or differential overlapping the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis. **Persons with a history of a comorbid condition during the 12 months prior to the episode date:** • Professional or Institutional Claim/EOB. A diagnosis for a comorbid condition (Comorbid Conditions for Respiratory Conditions*) with a service date. *Do not include laboratory claims (claims with POS code 81); OR • Condition. A diagnosis of a comorbid condition (Comorbid Conditions for Respiratory Conditions;) with a verification status of confirmed, unconfirmed, provisional, or differential as a Condition Problem Health Concern or an Encounter Diagnosis. **Persons with at least one competing diagnosis that starts 3 days or less on or after the start of the episode date**: • Professional or Institutional Claim/EOB. An indication for a competing diagnosis (Acute Pharyngitis*; Acute Tonsillitis; Competing Diagnosis for Respiratory Conditions*) with a service date. *Do not include laboratory claims (claims with POS code 81) OR; • Condition. A competing diagnosis (Competing Conditions for Respiratory Conditions; Acute Pharyngitis; Acute Tonsillitis) with a verification status of confirmed, unconfirmed, provisional, or differential as a Condition Problem Health Concern or an Encounter Diagnosis. **Persons taking antibiotics in the 30 days prior to the episode date:** • Pharmacy Claim/EOB. At least one completed dispensed antibiotic medication (AAB Antibiotic Medications List) OR; • Medication Request. At least one active or completed order for an antibiotic medication (Antibiotic Medications for Upper Respiratory Infection) OR; • Medication Dispense. At least one completed dispensed antibiotic medication (Antibiotic Medications for Upper Respiratory Infection).
Denominator	The initial population minus denominator exclusions.
Numerator	**URI episodes without a dispensing event or order for an antibiotic medication on or three days after the episode date:** • Pharmacy Claim/EOB. At least one dispensed antibiotic medication (AAB Antibiotic Medications List) OR; • Medication Request. At least one active or completed order for an antibiotic medication (Antibiotic Medications for Upper Respiratory Infection) OR;

	• Medication Dispense. At least one completed dispensed antibiotic medication (Antibiotic Medications for Upper Respiratory Infection).

Measure title	Blood Pressure Control for Patients With Hypertension For Care Delivery	**Measure ID**	BPC-CD
Description	The percentage of persons 18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The American Academy of Family Physicians (AAFP) strongly recommends clinicians treat adults who have hypertension to a standard blood pressure target (<140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality. The Joint National Committee recommends that pharmacologic treatment be initiated in the general population <60 years, to lower systolic BP ≥140 mm Hg (and treat to a goal of systolic BP <140 mm Hg) and to lower diastolic BP ≥90 mm Hg (and treat to a goal of diastolic BP <90 mm Hg). The American College of Cardiology (ACC) and American Heart Association (AHA) recommend a target BP of less than 130/80 mm Hg for adults with confirmed hypertension and known cardiovascular disease (CVD) or 10-year atherosclerotic CVD event risk of 10% or higher. In addition, they have determined that a reasonable target BP for adults with confirmed hypertension, without additional markers of increased CVD risk, is less than 130/80 mm Hg.		
Citations	Coles, S., L. Fisher, K. Lin, C. Lyon, A. Vosooney, and M. Bird. November 14, 2022. *Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP.* James, P.A., S. Oparil, B.L. Carter, W.C. Cushman, C. Dennison-Himmelfarb, J. Handler, D.T. Lackland, et al. February 5, 2014. "2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)." *JAMA* 311, no. 5: 507–20. https://doi.org/10.1001/jama.2013.284427 Whelton, P.K., R.M. Carey, W.S. Aronow, D.E. Casey, K.J. Collins, C. Dennison Himmelfarb, S.M. DePalma, et al. June 2018. "2017 ACC/AHA/ AAPA/ABC/ ACPM/AGS/ APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines." *Hypertension* 71, no. 6: e13–115. https://doi.org/10.1161/HYP.0000000000000065		
Characteristics			
Scoring	Proportion.		
Type	Outcome.		

Supplemental	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Some Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	This measure uses FHIR R4; US Core v3.1.1 In reference to the numerator element, only blood pressure readings performed by a clinician or an automated blood pressure monitor or device are acceptable for numerator compliance with this measure. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by an automated blood pressure monitor or device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the automated blood pressure monitor or device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record. Do not include BP readings taken during an acute inpatient stay or an emergency department (ED) visit. If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled". If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance.

Initial population	*Measure item count:* Person. **Patients 18-85 years of age by the last day of the measurement period who had a visit during the measurement period and diagnosis of essential hypertension that starts before or during the first six months of the measurement period.** Encounter and Condition. An encounter (Office Visit Value Set; Annual Wellness Visit ; Preventative Care Services Established Office Visit, 18 and Up; Preventative Care Services Initial Office Visit, 18 and Up; Home Healthcare Services; Virtual Encounter; Telephone Visits) with a finished status during the measurement period and a diagnosis of essential hypertension (Essential Hypertension) with a verification status of confirmed, unconfirmed, provisional or differential overlapping the start before or during the first six months of the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis.
Denominator exclusions	**Persons who died during the measurement period:** • A patient record containing a deceased date in the measurement period; OR • Professional or Institutional Claim/EOB. At least one inpatient stay (Inpatient Stay Value Set) with a service date in the measurement period and a discharge disposition (FL 17) of death (Patient Discharge Status code 20); OR • Observation. An observation indicating the person died (SNOMED-CT code 419099009) during the measurement period with a status of final, amended or corrected. **Persons who received hospice care in the measurement period:** • Professional or Institutional Claim/EOB. An indication of hospice (Hospice Encounter; Hospice Care Ambulatory) or with a discharge disposition (FL 17) to hospice (Patient Discharge Status code 50 or 51) with a service date in the measurement period; OR • Encounter. An encounter with a finished status for hospice (Hospice Encounter; Hospice Care Ambulatory) overlapping the measurement period or an inpatient encounter (Encounter Inpatient) with a discharge disposition to hospice care (SNOMED-CT code 428371000124100) or (SNOMED-CT code 428361000124107) that ends during the measurement period; OR • Procedure. A completed procedure for hospice (Hospice Encounter; Comfort Measures; Hospice Care Ambulatory) overlapping the measurement period; OR • Service Request. An active or completed order for hospice (Hospice Care Ambulatory) during the measurement period; OR • Observation Screening Assessment. A final, amended or corrected screening assessment for hospice (LOINC code 45755-6) with a value of 'Yes (qualifier value)' (SNOMED-CT code 373066001) and an effective date overlapping the measurement period; OR • Condition. A diagnosis of hospice (Hospice Diagnosis) with a verification status of confirmed, unconfirmed, provisional or differential overlapping the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis. **Persons who received palliative care in the measurement period:**

- Professional or Institutional Claim/EOB. An indication of palliative care (Palliative Care Encounter; ICD-10-CM code Z51.5*) with a service date in the measurement period. *Do not include laboratory claims (claims with POS code 81); OR
- Condition. A diagnosis of palliative care (Palliative Care Diagnosis) with a verification status of confirmed, unconfirmed, provisional or differential overlapping the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis; OR
- Encounter. An encounter with a finished status for palliative care (Palliative Care Encounter) that overlaps the measurement period; OR
- Observation. An Observation with a status of final, amended or corrected for palliative care assessment (Palliative Care Assessment Value Set) that overlaps the measurement period or an Observation Screening Assessment (LOINC code 71007-9) with an effective date overlapping the measurement period; OR
- Procedure. A completed procedure for palliative care (Palliative Care Encounter; Palliative Care Intervention) during the measurement period.

Persons 66-80 years of age by the last day of the measurement period who had one criterion for frailty and one criterion for advanced illness:

Frailty.

- Professional or Institutional Claim/EOB. An indication of frailty (Frailty Device Value Set; Frailty Diagnosis*; Frailty Encounter; Frailty Symptom*) with a service date in the measurement period. *Do not include laboratory claims (claims with POS code 81); OR
- Condition. A diagnosis or symptom of frailty (Frailty Symptom; Frailty Diagnosis) with a verification status of confirmed, unconfirmed, provisional, or differential overlapping the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis; OR
- Encounter. An encounter with a finished status for frailty (Frailty Encounter) that overlaps the measurement period; OR
- Observation. An observation with a final, amended, or corrected status with a symptom for frailty (Frailty Symptom) that overlaps the measurement period or an Observation Screening Assessment for medical equipment used (LOINC 98181-1) where the result is a frailty device (Frailty Device) that ends during the measurement period; OR
- Device Request. A completed order for a frailty device (Frailty Device) during the measurement period.

Advanced Illness.

- Professional or Institutional Claim/EOB. At least two diagnoses of advanced illness (Advanced Illness*) on different service dates in the measurement period or the year prior to the measurement period. *Do not include laboratory claims (claims with POS code 81); OR
- Pharmacy Claim/EOB. At least one dispensed dementia medication (Dementia Medications List) during the measurement period or the year prior to the measurement period; OR
- Condition. A diagnosis of advanced illness (Advanced Illness) with a verification status of confirmed, unconfirmed, provisional or differential that overlaps the measurement period

	or the year prior to the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis; OR • Medication Request. At least one active or completed order for a dementia medication (Dementia Medications) during the measurement period or the year prior to the measurement period; OR • Medication Dispense. At least one completed dispensed dementia medication (Dementia Medications) during the measurement period or the year prior to the measurement period. **Persons 81 years of age or older by the last day of the measurement period who had one criterion for frailty:** **Frailty.** • Professional or Institutional Claim/EOB. An indication of frailty (Frailty Device Value Set; Frailty Diagnosis*; Frailty Encounter; Frailty Symptom*) with a service date in the measurement period. *Do not include laboratory claims (claims with POS code 81); OR • Condition. A diagnosis or symptom of frailty (Frailty Diagnosis; Frailty Symptom) with a verification status of confirmed, unconfirmed, provisional or differential overlapping the measurement period as a Condition Problem Health Concern or an Encounter Diagnosis; OR • Encounter. An encounter with a finished status for frailty (Frailty Encounter) that overlaps the measurement period; OR • Observation. An observation with a final, amended, or corrected observation with a symptom for frailty (Frailty Symptom) that overlaps the measurement period or an Observation Screening Assessment for medical equipment used (LOINC 98181-1); where the result is a frailty device (Frailty Device) that ends during the measurement period; OR • Device Request. A completed order for a frailty device (Frailty Device) during the measurement period. **Persons with end-stage renal disease (ESRD):** • Professional or Institutional Claim/EOB. A diagnosis for ESRD (End Stage Renal Disease*; Chronic Kidney Disease, Stage 5; Kidney Transplant Recipient*) with a service date anytime on before the end of the measurement period. *Do not include laboratory claims (claims with POS code 81); OR • Procedure. A completed procedure for ESRD (Kidney Transplant; Dialysis Services) anytime on or before the end of the measurement period; OR • Condition. A diagnosis of ESRD (History of Nephrectomy or Kidney Transplant Value Set; End Stage Renal Disease; Kidney Transplant Recipient; Chronic Kidney Disease, Stage 5) with a verification status of confirmed, unconfirmed, provisional or differential overlapping the measurement period as a Condition Problem Heath Concern or an Encounter Diagnosis; OR • Encounter. An encounter with a finished status for ESRD outpatient services (ESRD Monthly Outpatient Services) that overlaps the measurement period. **Persons with a diagnosis of pregnancy:**

	• Professional or Institutional Claim/EOB. At least one indication of pregnancy (Pregnancy*) with a service date in the measurement period**. ***Do not include laboratory claims (claims with POS code 81); OR • Condition. A diagnosis of pregnancy with a verification status of confirmed, unconfirmed, provisional or differential (Pregnancy) overlapping the measurement period as a Condition Problem Heath Concern or an Encounter Diagnosis; OR • Observation. An observation with a status of final, amended, or corrected of pregnancy (Pregnancy) that overlaps the measurement period.
Denominator	The initial population minus denominator exclusions.
Numerator	**Persons whose most recent blood pressure reading is less than 140/90 mm Hg during the measurement period:** • Observation. An Observation with a status of final, amended or corrected for a systolic blood pressure (Systolic Blood Pressure) result and a diastolic blood pressure (Diastolic Blood Pressure) result, excluding those taken in an acute inpatient setting (Encounter Inpatient) or during an ED visit (Emergency Department Evaluation and Management Visit) during the measurement period.