



Tips and Tools for Improving GPRA!

GPRA RESOURCE GUIDE

Government Performance and Results Act
(GPRA)

CALIFORNIA AREA INDIAN HEALTH SERVICE

650 Capitol Mall, Suite 7-100
Sacramento, CA 95814

Phone: 916-930-3927

FAX: 916-930-3953

Email: caogpra@ihs.gov

The Government Performance and Results Act (GPRA) is a federal law requiring agencies to demonstrate that they are using their funds effectively. The Indian Health Service reports data for 21 annual clinical GPRA measures and one long-term GPRA measure. 19 of these measures have annual targets at the Area and site level. In FY 2011, the California Area only met the targets for 8 of the 19 clinical measures. This resource guide was developed to assist clinic staff with improving care at their clinic as well as improving performance on the clinical GPRA measures.

Included in this guide are the following resources, instructions, and informational materials to assist your program:

California Area Office Contacts:

- CAO Office of Public Health Contacts

Intro to GPRA/GPRA 101:

- Important Websites for GPRA
- GPRA 101 for Patients flyer
- GPRA for providers flyer
- GPRA numerator and denominator definitions Cheat Sheet

Data Entry:

- PCC Data Entry Cheat Sheet
- EHR Data Entry Cheat Sheet

CRS Tools:

- Instructions for Running 2012 GPRA Report in CRS 11.1
- Instructions for Running the National GPRA Dashboard
 - Example of National GPRA Dashboard
- Instructions for Running a Patient List in CRS

HIV Tools and Resources:

- Prenatal HIV Screening Package
 - Tips for Improving HIV Screening Rates
 - Prenatal HIV Screening measure logic
 - Notification of Prenatal HIV Screening form
 - HIPAA Privacy Authorization Form

CAO Trainings, Calls, & Conferences:

- Medical Providers' Best Practices Conference Save the Date flyer
- FY 2012 California GPRA Coordinators Calls flyer

Immunization Challenges:

- 2012 Immunization Challenge Package
 - Letter to Program Administrator with Challenge details

- Influenza/Pneumococcal vaccination challenge flyer
- Childhood Immunization challenge flyer
- Tips for improving immunization coverage/ Helpful Links

Behavioral Health Challenge:

- 2012 BH Challenge Information

Behavioral Health Screening Tools:

- Central Valley's Health Screening Form (Depression Screening, DV/IPV Screening, FAS Screening, and Tobacco Screening)
- Sample Behavioral Health Screening Tool (Depression Screening, Alcohol Screening, and DV/IPV Screening)

Shared Tools: (These are tools used at Central Valley Indian Health Program and Santa Barbara Urban Indian Health Program that they have allowed us to share with California programs):

- Central Valley's Diabetes/Hypertension medication form
- Central Valley's Standing Orders
- Santa Barbara's Comprehensive Assessment Form

If you have any questions about this guide or the materials within, please contact the GPRA Team at the California Area Office at caogpra@ihs.gov.



California Area Office of Public Health Contacts

	Contact	Email	Phone Number
Behavioral Health	Dawn Phillips, RN, CDE	dawn.phillips@ihs.gov	916-930-3981 ext 331
Dental	Steve Riggio, DDS	steve.riggio@ihs.gov	916-930-3981 ext 322
Diabetes	Helen Maldonado, PA-C	helen.maldonado@ihs.gov	916-930-3981 ext 332
EHR & Telemedicine	Steve Viramontes	steve.viramontes@ihs.gov	916-930-3981 ext 359
Immunizations & Public Health Nursing	Susan Ducore, BN, RN, MSN	susan.ducore@ihs.gov	916-930-3981 ext 323
IT/Data Entry	IT Help Desk	caohelp@ihs.gov	916-930-3981 ext 353
	Elaine Brinn	elaine.brinn@ihs.gov	916-930-3981 ext 320
	Amy Patterson, PhD	amy.patterson@ihs.gov	916-716-6929
National GPRA Support Team (caogpra@ihs.gov)	Christine Brennan, MPH	christine.brennan@ihs.gov	916-930-3981 ext 333
	Wendy Blocker, MSN	wendy.blocker@ihs.gov	916-930-3981 ext 308
	Rachel Pulverman	rachel.pulverman@ihs.gov	916-930-3981 ext 361
Vista Imaging & Meaningful Use	Marilyn Freeman	marilyn.freeman@ihs.gov	916-930-3981 ext 362

Important Websites

Clinical Reporting System: <http://www.ihs.gov/cio/crs/>

- Current measure logic
- CRS User Manual
- Software update information
- GPRA Reporting Instructions and Due Dates
- Performance Improvement Toolbox – contains clinical measure information, screening tools, guidelines, and other useful tools

California Area Indian Health Service: <http://www.ihs.gov/california/>

- California Area Office (CAO) contacts
- CAO Training Calendar
- Health Program listing and locations
- Important News and Announcements
- Government Performance and Results Act (GPRA) Page
 - California Area and National Results and Publications
 - Best Practices Conference Presentations and Materials
 - GPRA Bulletins
- Clinical Management Information for Dental, Behavioral Health, Information Resource Management, Nursing, Diabetes, Health Promotion and Disease Prevention, Immunizations, HIPAA, and EHR

Understanding the Government Performance and Results Act (GPRA)

What is GPRA?

GPRA is a Federal law. It shows Congress how well the Indian Health Service (IHS) is doing in providing health care services to American Indians and Alaska Natives who use IHS federal, tribal, and urban health facilities. IHS collects data and reports data to Congress on over 20 clinical GPRA measures every year.

What are GPRA measures?

GPRA measures are indicators of how well the agency has provided clinical care to its patients. Overall, they measure how well the IHS has done in the prevention and treatment of certain diseases, and the improvement of overall health.

Does GPRA mean my health information is made public?

No! Clinics never share any individual patient health data, and only national rates are reported to Congress. The point of GPRA is to assess how well IHS is providing for all of its patients.

GPRA data answers the following about the *entire population* served by the IHS:

▪ Immunizations

Are young children receiving the immunizations they need by 3 years of age?
This includes:

- 4 DTaP (Diphtheria-Tetanus-Pertussis)
- 3 IPV/OPV (injected or oral Polio)
- 1 MMR (Measles-Mumps-Rubella)
- 3 Hepatitis B
- 3 Hib (Haemophilus Influenzae type b)
- 1 Varicella (Chicken Pox)
- 4 doses of Pneumococcal

Are adults 65+ receiving an annual flu shot?
Have they received at least one pneumococcal shot?

▪ Dental Care

Do all patients have a yearly dental visit?
How many topical fluorides and dental sealants have been placed in patients in the past year?

▪ Prenatal Care

Have all pregnant women received an HIV test?

▪ Diabetes

Are patients with diabetes having their blood sugar levels and blood pressures checked and are they within normal levels?

Are patients with diabetes getting their cholesterol levels, kidney function, and eyes checked regularly?

▪ Cancer Screening

Are women ages 21-64 years old getting a Pap smear at least every 3 years and women ages 52-64 years old getting a mammogram at least every 2 years?

Are all adults ages 51-80 years old being checked for colorectal cancer?

▪ Behavioral Health

Are all adult patients being screened for depression?

Are women being screened for domestic violence and alcohol use (to prevent birth complications like Fetal Alcohol Syndrome)?

Are tobacco-using patients being offered counseling to quit?

GPRA provides information about how the IHS cares for you, your family, and your community.

What Can You Do To Help?

- Ask your health care provider if you are due for any screenings, tests, or immunizations and check to make sure appointments are scheduled for your medical needs.
- Make sure your provider takes your height and weight measurements at least once a year.
- Tell your provider about your health habits (examples: alcohol use and/or smoking).
- Tell your provider about any tests/procedures/ immunizations you had at a clinic other than where you normally receive care. For example, tell the provider about the colonoscopy you had five years ago at your prior facility.
- Make sure you arrive on time for your appointments whenever possible and call to reschedule if you cannot make it so the appointment can be used by someone else.
- Take care of yourself! Ask your providers for tips on healthy eating and healthy habits.



The Department of Health and Human Services is the principal agency for protecting the health of all Americans.

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**650 Capitol Mall
Suite 7-100
Sacramento, CA 95814
(916) 930-3927
FAX (916) 930-3952**

GPRA 101 For Patients

GPRA: Government Performance and Results Act

How does GPRA affect me,
my family, and my
community?



Understanding the Government Performance and Results Act (GPRRA) WHAT IS GPRRA AND HOW DOES IT AFFECT ME?

Introduction to GPRRA for Providers and Clinic Staff

What is GPRRA?

The Government Performance and Results Act (GPRRA) is a federal law. It requires Federal agencies to demonstrate that they are using their funds effectively toward meeting their missions. The law requires federal agencies to have a 5-year Strategic Plan and to submit Annual Performance Plans and Reports with their budget requests.

The Annual Performance Plan describes what the agency intends to accomplish with its annual budget. All federal agencies have specific annual performance *measures* with specific annual targets. For the Indian Health Service (IHS), these annual targets are set by the Office of Management and Budget (OMB) in consultation with the representatives from IHS and the Department of Health and Human Services (HHS). GPRRA is a critical part of the annual budget request for IHS.

The GPRRA “year” runs from July 1st- June 30th. Quarterly reports are run for the second quarter (ending Dec. 31st), and third quarter (ending March 31st), and a final report is run at the end of the year (ending June 30th). These reports are cumulative. Reports are sent to the California Area Office (CAO), which has the National GPRRA Support Team (NGST). This team is responsible for aggregating all data received and creating reports showing how the agency performed over the GPRRA year, including whether the annual targets are met. Only national aggregate data is reported to Congress; no individual clinic or Area-level data is reported.



What is a GPRO Clinical Measure?

A GPRO clinical measure is a specific indicator of performance on patient care. Current GPRO Clinical Measures include:

- ▣ **Diabetes**
 - Blood Sugar Control
 - Blood Pressure Control
 - Cholesterol
 - Nephropathy
 - Retinopathy
- ▣ **Dental**
 - Access
 - Topical Fluorides
 - Sealants
- ▣ **Immunizations**
 - Childhood
 - Adult Influenza
 - Adult Pneumococcal
- ▣ **Cancer Screening**
 - Mammography
 - Pap Screening
 - Colorectal Cancer Screening
- ▣ **Behavioral Health**
 - Depression Screening
 - Alcohol Screening
 - Domestic Violence Screening
 - Tobacco Cessation
- ▣ **Cardiovascular/BMI**
 - CVD Comprehensive Screening
 - Childhood Weight Control
- ▣ **HIV**
 - Prenatal HIV Screening

There are also a number of non-clinical GPRO measures that assess supporting factors such as facility accreditation, environmental and sanitation services, and health provider scholarship placements. These measures are reported directly by the programs that administer these activities.

How is GPRO data reported?

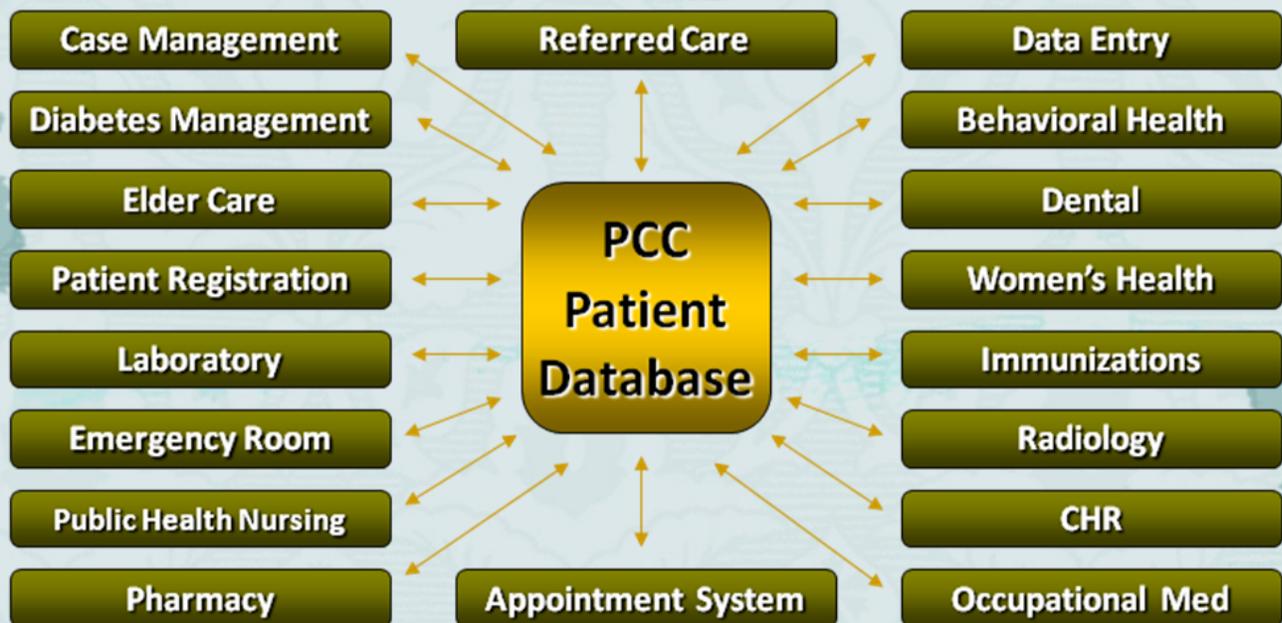
- At the end of each GPRO quarter and at the end of the GPRO year, facilities run their National GPRO report and export their data to their respective Area Offices.
- Area GPRO Coordinators load the facility reports and run an Area Aggregate report. This report shows if the overall Area GPRO measures are being met.

CRS

The Clinical Reporting System (CRS), a software application in the Resource Patient Management System (RPMS), is the tool for reporting of all GPRO clinical measures at IHS.

- Federal (IHS) facilities are required to use CRS for GPRO reporting
- Tribal and Urban facilities are not required to use CRS but are strongly encouraged to use it
- Currently, there is no way to combine data from sites that do not run RPMS into the GPRO data set
- CRS provides verified and validated data with an audit trail; this is critical for Congressional reporting
- CRS data is reported in aggregate, and does not contain any patient identifiers.

All RPMS applications have a link from the application to PCC!



“What do Meaningful Use and GPRO have in Common?”

The HITECH Act strives to improve patient care through the meaningful use (MU) of certified electronic health records (EHRs).

In order to demonstrate meaningful use, eligible providers and hospitals will report clinical performance measures that are similar, but not identical to GPRO. Both sets of measures correspond directly to quality of healthcare delivery.

CMS EHR Financial Incentives

Participants in the Medicare program must demonstrate meaningful use during their first year of participation while participants in the Medicaid program must simply adopt, implement, or upgrade a certified EHR. More information is available at: www.cms.gov/EHRIncentivePrograms/



How to generate good GPRA data and improve GPRA performance:

Providers:

- Participate in quality improvement activities at your facility.
- Review documentation standards that support GPRA performance activities.
- If your site is not using the Electronic Health Record (EHR), communicate with data entry staff on what they should look for on the encounter forms and ensure they know how to enter it into PCC.
- Ensure you and/or others are asking patients the questions that need to be asked (e.g. do you smoke, drink) and getting height, weight, and blood pressure measurements. Ensure that the information is being documented on the encounter form in the appropriate place.
- Document patient refusals, patient education, and health factors.
- Ask patients about tests/ immunizations/procedures that the patient may have received outside of your clinic and document them on the encounter form according to the policy in place at your facility.
- Review the National GPRA report for the measures that are applicable to you. For example, if you are a dentist, review the GPRA dental measures. If you are the Diabetes Coordinator, review the diabetes measures. Review throughout the GPRA year; do not wait until the last minute.

All staff:

- Monitor data input frequently.
- During a review of data, consider:
 - Do the rates look reasonable? If not, obtain a copy of the patient list(s) for the measure(s) and compare with the charts to see where problems may exist.
 - Is the data in the chart but not in PCC? Does the data entry staff need to be advised on how to enter it in PCC? Was it documented in the correct place on the encounter form?
 - Was the data in PCC but documented with an incorrect code?

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Sacramento, CA 95814
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FAX (916) 930-3952

**For additional information on the Government Performance and Results Act, please contact
National GPRA Support Team (NGST)**

caogpra@ihs.gov

GPRA Measure Numerator and Denominator Definitions		
DIABETES	Numerator	Denominator
Diabetes Dx Ever	# patients ever diagnosed w/diabetes	Active GPRA User Population
Documented HbA1c	# patients with Hemoglobin A1c documented during report period	Active Diabetic Patients
Poor Glycemic Control	# patients with A1c > 9.5	Active Diabetic Patients
Ideal Glycemic Control	# patients with A1c < 7	Active Diabetic Patients
Controlled BP <130/80	# patients with controlled BP (<130/80) documented during report period (uses mean of last three BPs documented on non-ER visits)	Active Diabetic Patients
LDL Assessed	# patients with LDL completed during report period	Active Diabetic Patients
Nephropathy Assessed	# patients with nephropathy assessment during report period or diagnosis/treatment of ESRD any time before end of report period	Active Diabetic Patients
Retinopathy Exam	# patients receiving qualified retinal exam during report period	Active Diabetic Patients
DENTAL		
Access to Services	# patients w/documented dental visit during report period	Active GPRA User Population
Sealants	total # of dental sealants during report period	No Denominator (count only)
Topical Fluoride- Patients	# of patients receiving flouride application during report period	No Denominator (count only)
IMMUNIZATIONS		
Influenza 65+	# patients with flu vaccine during report period	Active clinical population 65 +
Pneumovax 65+	# patients with pneumo vaccine during report period	Active clinical population 65 +
Childhood Izs	# patients who received the 4:3:1:3:3:1:4 combo (including contraindications and evidence of disease)	Active GPRA user pop patients age 19-35mo (who are active in the immunization package)
PREVENTION		
Pap Smear Rates	# patients with documented pap smear in past three years	Female active clinical patients age 21-64 (without a documented hysterectomy)
Mammogram Rates	# patients with documented mammogram in past two years	Female active clinical patients age 52-64 (without documented bilateral mastectomy or two unilateral mastectomies)
Colorectal Cancer Screening	# patients who have had any colorectal cancer screening	Active clinical patients age 51-80 without history of colorectal cancer or colectomy
Tobacco Cessation	# patients who received tobacco cessation counseling or an Rx for smoking cessment	Active clinical patients identified as current tobacco users prior to the report period
FAS Prevention	# patients screened for alcohol use during report period	Female active clinical patients age 15-44
IPV/DV Screening	# patients screened for or diagnosed with DV/IPV during report period	Female active clinical patients age 15-40
Depression Screening	# patients screened for depression or diagnosed with mood disorder during report period	Active clinical patients age 18+
CVD-Comprehensive Assessment	# patients who received a comprehensive CVD assessment	Active IHD patients age 22+
Prenatal HIV Screening	# patients who received HIV test during the past 20 months	All pregnant active clinical patients w/ no documented miscarriage or abortion in past 20 months and no recorded HIV diagnosis ever
Childhood Weight Control	# Patients with a BMI at or above the 95th percentile	Active clinical patients age 2-5 for whom BMI could be calculated

User Population for National GPRA Reporting

- Must have been seen at least once in the three years prior to the end of the time period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the Report Period.
- Must be 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 CHS catchment area.

Active Clinical Population for National GPRA Reporting

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the CRS 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 CHS catchment area.

Active Diabetic Patients

- All active clinical patients diagnosed with diabetes at least one year prior to the report period
- At least 2 visits in the past year
- 2 DM-related visits ever

Nephropathy Assessment

- an estimated GFR AND a quantitative urinary protein assessment during the report period OR
- evidence of diagnosis and/or treatment of End Stage Renal Disease (ESRD) at any time before the end of the report period

Colorectal Cancer Screening Definition (includes any of the following)

- Fecal occult blood test (FOBT) during the report period
- Flexible sigmoidoscopy or double contrast barium enema in the past five years
- Colonoscopy in the past 10 years
- documented refusal in the past year

Active IHD Patients

- Active clinical patients diagnosed with ischemic heart disease (IHD) prior to the report period
- At least 2 visits during the report period
- 2 IHD-related visits ever

Comprehensive CVD-Related Assessment

- Blood pressure value documented at least twice in prior two years
- LDL completed in past five years, regardless of result
- Screened for tobacco use during report period
- For whom a BMI could be calculated, including refusals in the past year
- Who have received any lifestyle adaptation counseling during the report period

KEY CLINICAL PERFORMANCE OBJECTIVES

“Cheat Sheet” for PCC Documentation and Data Entry for CRS Version 12.0

Last Updated January 2012

Recommended use for this material: Each facility should (1) Identify their three or four key clinical problem areas; (2) Review the attached information; (3) Customize the provider documentation and data entry instructions, if necessary; (4) Train staff on appropriate documentation; and (5) Post the applicable pages of the Cheat Sheet in exam rooms.

This document is to provide information to both providers and to data entry on the *most appropriate* way to document key clinical procedures in the Resource and Patient Management System (RPMS). It does not include all of the codes the Clinical Reporting System (CRS) checks for when determining if a performance measure is met. To review that information, view the CRS short version logic at:

<http://www.ihs.gov/CIO/CRS/documents/crsv12/GPRA%20PART%20Measures%20V12.pdf>

Note: GPRA measures do not include refusals.

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes Prevalence NOTE: This is not a GPRA measure; however, it is used in determining patients that have been diagnosed with diabetes.		Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC: Date received Location Results	Standard PCC data entry: Diabetes Prevalence Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: 250.00-250.93 Provider Narrative: Modifier: Cause of DX:
Diabetes: Glycemic Control	Active Clinical Patients DX with diabetes and with an A1c: <ul style="list-style-type: none"> > 9.5 (Poor Glycemic Control) < 7 (Ideal Glycemic Control) 	Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC: Date received Location Results	Standard PCC data entry: A1c Lab Test <i>Mnemonic LAB enter</i> Enter Lab Test Type: [Enter site’s defined A1c Lab Test] Results: [Enter Results] Units: Abnormal: Site: [Blood, Plasma]

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes: Glycemic Control (cont)			<p>Historical A1c Lab Test <i>Mnemonic HLAB enter</i> Date of Historical Lab Test: Type: Location Name: Enter Lab Test: [Enter site's defined A1c Lab Test] Results:</p> <p>CPT Entry <i>Mnemonic CPT enter</i> Enter CPT: 83036, 83037, 3044F-3046F Quantity: Modifier: Modifier 2:</p>
Diabetes: Blood Pressure Control	<p>Active Clinical Patients DX with diabetes and with controlled Blood Pressure:</p> <ul style="list-style-type: none"> • < 130/80 (mean systolic < 130, mean diastolic < 80) 	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received Location Results</p>	<p>Standard PCC data entry:</p> <p>Blood Pressure Data Entry <i>Mnemonic BP enter</i> Value: [Enter as Systolic/Diastolic (e.g., 130/80)] Select Qualifier: Date/Time Vitals Taken:</p>
Diabetes: LDL Assessment	<p>Active Clinical Patients DX with diabetes and a completed LDL test.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received Location Results</p>	<p>Standard PCC data entry:</p> <p>LDL (Calculated) (REF)* Lab Test *REF–Reference Lab <i>Mnemonic LAB enter</i> Enter Lab Test Type: [Enter site's defined LDL Reference Lab Test]</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes: LDL Assessment (cont)			<p>Results: [Enter Results] Units: Abnormal: Site: [Blood, Serum]</p> <p>LDL (Calculated) Lab Test <i>Mnemonic LAB enter</i> Enter Lab Test Type: [Enter site's defined LDL Lab Test] Results: [Enter Results] Units: Abnormal: Site: [Blood]</p> <p>Historical LDL Lab Test <i>Mnemonic HLAB enter</i> Date of Historical Lab Test: Type: Location Name: Enter Lab Test: [Enter site's defined LDL Reference Lab Test or LDL Lab Test] Results:</p> <p>LDL CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes: Nephropathy Assessment	Active Clinical Patients DX with diabetes with a Nephropathy assessment: <ul style="list-style-type: none"> • Estimated GFR with result during the Report Period • Quantitative Urinary Protein Assessment during the Report Period • End Stage Renal Disease diagnosis/treatment 	Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC: <p>Date received</p> <p>Location</p> <p>Results</p>	Standard PCC data entry: <p>Estimated GFR Lab Test <i>Mnemonic LAB enter</i> Enter Lab Test Type: [Enter site's defined Est GFR Lab Test] Results: [Enter Results] Units: Abnormal: Site: [Blood]</p> <p>Historical GFR Lab Test <i>Mnemonic HLAB enter</i> Date of Historical Lab Test: Type: Location Name: Enter Lab Test: [Enter site's defined Est GFR Lab Test] Results:</p> <p>Quantitative Urinary Protein Assessment CPT <i>Mnemonic CPT enter</i> Enter CPT: 82042, 82043, 84156 Quantity: Modifier: Modifier 2:</p> <p>ESRD CPT <i>Mnemonic CPT enter</i></p>

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes: Nephropathy Assessment (cont)			Enter CPT: 36145, 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, G0257, G0308-G0327, G0392, G0393, or S9339 Quantity: Modifier: Modifier 2: ESRD POV <i>Mnemonic PPV enter</i> Purpose of Visit: 585.5, 585.6, V42.0, V45.11, V45.12, or V56.* Provider Narrative: Modifier: Cause of DX: ESRD Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6* Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX (ESRD)]

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Diabetic Retinopathy</p>	<p>Patients with diabetes will have a qualified* retinal examination during the report period.</p> <p>*Qualified retinal exam: The following methods are qualifying for this measure:</p> <ul style="list-style-type: none"> • Dilated retinal evaluation by an optometrist or ophthalmologist • Seven Standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist • Any photographic method formally validated to seven standard fields (ETDRS). <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Exams:</p> <p>Diabetic Retinal Exam</p> <p>Dilated retinal eye exam</p> <p>Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist</p> <p>Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos</p> <p>Routine ophthalmological examination including refraction (new or existing patient)</p> <p>Diabetic indicator; retinal eye exam, dilated, bilateral</p> <p>Other Eye Exams</p> <p>Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or validated tele-ophthalmology retinal evaluation clinics</p> <p>non-DNKA visits to an optometrist or ophthalmologist</p>	<p>Standard PCC data entry:</p> <p>Diabetic Retinopathy Exam <i>Mnemonic EX enter</i> Select Exam: 03 Result: [Enter Results] Comments: Provider Performing Exam:</p> <p>Historical Retinopathy Exam: <i>Mnemonic HEX enter</i> Date of Historical Exam: Type: Location Name: Exam Type: 03 Result Comments Encounter Provider</p> <p>Retinal Exam CPT <i>Mnemonic CPT enter</i> Enter CPT: 2022F, 2024F, 2026F, S0620, S0621, S3000 Quantity: Modifier: Modifier 2:</p> <p>Other Eye Exam CPT <i>Mnemonic CPT enter</i> Enter CPT: 67028, 67038, 67039, 67040, 92002, 92004, 92012, 92014 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetic Retinopathy (cont)			<p>Other Eye Exam POV <i>Mnemonic PPV enter</i> Purpose of Visit: V72.0 Provider Narrative: Modifier: Cause of DX:</p> <p>Other Eye Exam Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 95.02 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>Other Eye Exam Clinic <i>Mnemonic CL enter</i> Clinic: A2, 17, 18, 64 Was this an appointment or walk in?:</p>
Access to Dental Service	<p>Patients should have annual dental exams.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <ul style="list-style-type: none"> Date received Location Results 	<p>Standard PCC data entry</p> <p>Dental Exam <i>Mnemonic EX enter</i> Select Exam: 30 Result: [Enter Results] Comments: Provider Performing Exam:</p> <p>Historical Dental Exam <i>Mnemonic HEX enter</i> Date of Historical Exam: Type: Location Name:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Access to Dental Service (cont)			Exam Type: 30 Result: Comments: Encounter Provider: Dental Exam (ADA code) <i>Mnemonic ADA enter</i> Dental Service Code: 0000, 0190 Type: No. Of Units: Operative Site: Historical Dental Exam (ADA code) <i>Mnemonic HADA enter</i> Date of Historical ADA: Type: Location Name: ADA Code: 0000, 0190 Units: Dental Exam POV <i>Mnemonic PPV enter</i> Purpose of Visit: V72.2 Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Dental Sealants</p>	<p>A maximum of two sealants per tooth are counted toward the GPRA measure.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p>	<p>Standard PCC data entry</p> <p>Dental Sealants (ADA) <i>Mnemonic ADA enter</i> Dental Service Code: 1351 Type: No. Of Units: Operative Site:</p> <p>Historical Dental Sealants <i>Mnemonic HADA enter</i> Date of Historical ADA: Type: Location Name: ADA Code: 1351 Units:</p> <p>Dental Sealants CPT <i>Mnemonic CPT enter</i> Enter CPT: D1351 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Topical Fluoride</p>	<p>A maximum of four topical fluoride application are counted toward the GPRA measure.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p>	<p>Standard PCC data entry</p> <p>Topical Fluoride (ADA code) <i>Mnemonic ADA enter</i> Dental Service Code: 1203, 1204, 1206, 5986 Type: No. Of Units: Operative Site:</p> <p>Historical Fluoride (ADA code) <i>Mnemonic HADA enter</i> Date of Historical ADA: Type: Location Name: ADA Code: 1203, 1204, 1206, 5986 Units:</p> <p>Topical Flouride CPT <i>Mnemonic CPT enter</i> Enter CPT: D1203, D1204, D1206, D5986 Quantity: Modifier: Modifier 2:</p> <p>Topical Flouride POV <i>Mnemonic PPV enter</i> Purpose of Visit: V07.31 Provider Narrative: Modifier: Cause of DX:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Adult Immunizations: Influenza</p>	<p>All adults ages 65 and older should have an annual Influenza (flu) shot.</p> <p>Adults 55-64 are strongly recommended to have annual Influenza (flu) shot.</p> <p>All adult (18 and older) diabetic patients are strongly recommended to have annual Influenza (flu) shot.</p> <p>Refusals should be documented. Note: Only NMI (Not Medically Indicated) refusals are counted toward the GPRA Measure.</p>	<p>Standard PCC documentation for immunizations performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <ul style="list-style-type: none"> IZ type Date received Location <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include:</p> <ul style="list-style-type: none"> Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal 	<p>Standard PCC data entry</p> <p>Influenza Vaccine <i>Mnemonic IM enter</i> Select Immunization Name: 140, 141 or 144 (other options are 111, 15, 16, 88) Lot: VFC Eligibility:</p> <p>Historical Influenza Vaccine <i>Mnemonic HIM enter</i> Date of Historical Immunization: Type: Location: Immunization Type: 88 (other options are 111, 15, 16) Series:</p> <p>Influenza Vaccine POV <i>Mnemonic PPV enter</i> Purpose of Visit: *V04.81, *V06.6 Provider Narrative: Modifier: Cause of DX:</p> <p>* NOT documented with 90663, 90664, 90666-90668, 90470, G9141, G9142</p> <p>Influenza Vaccine CPT <i>Mnemonic CPT enter</i> Enter CPT: 90654-90662, G0008, G8108 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Adult Immunizations: Influenza (cont)			<p>Influenza Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 99.52 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>NMI Refusal of Influenza <i>Mnemonic NMI enter</i> Patient Refusals For Service/NMI Refusal Type: Immunization Immunization Value: [See codes above] Date Refused: Provider Who Documented: Comment:</p> <p>Immunization Package Contraindication Influenza (Assumes you are in the IMM Pkg for Single Patient Record for your site) Select Action: C (Contraindications) Select Action: A (Add Contraindication) Vaccine: [See codes above] Reason: Egg Allergy, Anaphylaxis Date Noted: Command: Save Select Action: Quit</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Adult Immunizations: Pneumovax</p>	<p>All adults ages 65 and older will have a pneumovax.</p> <p>All adult (18 and older) diabetic patients are strongly recommended to have a pneumovax.</p> <p>Refusals should be documented. Note: Only NMI (Not Medically Indicated) refusals are counted toward the GPRA Measure.</p>	<p>Standard PCC documentation for immunizations performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <ul style="list-style-type: none"> IZ type Date received Location <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include:</p> <ul style="list-style-type: none"> Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal 	<p>Standard PCC data entry</p> <p>Pneumovax Vaccine <i>Mnemonic IM enter</i> Select Immunization Name: 33, 100, 109, 133 Lot: VFC Eligibility:</p> <p>Historical Pneumovax Vaccine <i>Mnemonic HIM enter</i> Date of Historical Immunization: Type: Location: Immunization Type: 33, 100, 109, 133 Series:</p> <p>Pneumovax Vaccine POV <i>Mnemonic PPV enter</i> Purpose of Visit: V06.6, V03.82 Provider Narrative: Modifier: Cause of DX:</p> <p>Pneumovax Vaccine CPT <i>Mnemonic CPT enter</i> Enter CPT: 90669, 90670, 90732, G0009, G8115 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Adult Immunizations: Pneumovax (cont)</p>			<p>Pneumovax Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 99.55 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>NMI Refusal of Pneumovax <i>Mnemonic NMI enter</i> Patient Refusals For Service/NMI Refusal Type: Immunization Immunization Value: [See codes above] Date Refused: Provider Who Documented: Comment:</p> <p>Immunization Package Contraindication Pneumovax (Assumes you are in the IMM Pkg for Single Patient Record for your site) Select Action: C (Contraindications) Select Action: A (Add Contraindication) Vaccine: [See codes above] Reason: Egg Allergy, Anaphylaxis Date Noted: Command: Save Select Action: Quit</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Immunizations	<p>Children age 19-35 months will be up-to-date for all ACIP recommended immunizations.</p> <p>This is the 4313314 combo:</p> <p>4 DTaP</p> <p>3 IPV</p> <p>1 MMR</p> <p>3 Hepatitis B</p> <p>3 Hib</p> <p>1 Varicella</p> <p>4 Pneumococcal</p> <p>Refusals should be documented.</p> <p>Note: Only NMI (Not Medically Indicated) refusals are counted toward the GPRA Measure.</p>	<p>Standard PCC documentation for immunizations performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>IZ type</p> <p>Date received</p> <p>Location</p> <p>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</p> <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include Immunization Package of "Anaphylaxis" for all childhood immunizations. The following additional contraindications are also counted:</p> <p>IPV:</p> <p>Immunization Package: "Neomycin Allergy."</p> <p>MMR:</p> <p>Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</p> <p>Varicella:</p> <p>Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</p> <p>Dosage and types of immunization definitions:</p> <p>4 doses of DTaP:</p> <p>4 DTaP/DTP/Tdap</p> <p>1 DTaP/DTP/Tdap and 3 DT/Td</p> <p>1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus</p>	<p>Standard PCC data entry</p> <p>Childhood Immunizations</p> <p><i>Mnemonic IM enter</i></p> <p>Select Immunization Name:</p> <p><i>DTaP: 20, 50, 106, 107, 110, 120, 130, 146; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113; Tetanus: 35, 112; Acellular Pertussis: 11; OPV: 2, 89; IPV: 10, 89, 110, 120, 130, 146; MMR: 3, 94; M/R: 4; R/M: 38 ; Measles: 5; Mumps: 7; Rubella: 6; Hepatitis B: 8, 42-45, 51, 102, 104, 110, 146; HIB: 17, 22, 46-49, 50, 51, 102, 120, 146; Varicella: 21, 94</i></p> <p>Lot:</p> <p>VFC Eligibility:</p> <p>Historical Childhood Immunizations</p> <p><i>Mnemonic HIM enter</i></p> <p>Date of Historical Immunization:</p> <p>Type:</p> <p>Location:</p> <p>Immunization Type: <i>DTaP: 20, 50, 106, 107, 110, 120, 130; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113; Tetanus: 35, 112; Acellular Pertussis: 11; OPV: 2, 89; IPV: 10, 89, 110, 120, 130; MMR: 3, 94; M/R: 4; R/M: 38 ; Measles: 5; Mumps: 7; Rubella: 6; Hepatitis B: 8, 42-45, 51, 102, 104, 110; HIB: 17, 22, 46-49, 50, 51, 102, 120; Varicella: 21, 94</i></p> <p>Series:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Childhood Immunizations (cont)</p>		<p>4 DT and 4 Acellular Pertussis</p> <p>4 Td and 4 Acellular Pertussis</p> <p>4 each of Diphtheria, Tetanus, and Acellular Pertussis</p> <p>3 doses of IPV:</p> <p>3 OPV</p> <p>3 IPV</p> <p>Combination of OPV & IPV totaling 3 doses</p> <p>1 dose of MMR:</p> <p>MMR</p> <p>1 M/R and 1 Mumps</p> <p>1 R/M and 1 Measles</p> <p>1 each of Measles, Mumps, and Rubella</p> <p>3 doses of Hepatitis B</p> <p>3 doses of Hep B</p> <p>3 doses of HIB</p> <p>1 dose of Varicella</p> <p>IMPORTANT NOTE:</p> <p>The GPRA denominator is all User Population patients who are active in the Immunization Package. This means you must be using the Immunization Package and maintaining the active/inactive status field in order to have patients in your denominator for this GPRA measure. Immunization package v8.4 offers a scan function that searches the RPMS Patient Database for children who are less than 36 months old and reside in GPRA communities for the facility and automatically enters them into the Register with a status of Active. Sites can run this scan at any time, and should run it upon loading 8.4. Children already in the Register or residing outside of the</p>	<p>Childhood Immunizations POV</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: <i>DTaP: V06.1; DTP: V06.1, V06.2, V06.3; DT: V06.5; Td: V06.5; Diphtheria: V03.5; Tetanus: V03.7; Acellular Pertussis: V03.6; OPV contraindication: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; IPV: V04.0, V06.3; IPV (evidence of disease): 730.70-730.79; MMR: V06.4; Measles: V04.2; Measles (evidence of disease): 055*; Mumps: V04.6; Mumps (evidence of disease): 072*; Rubella: V04.3; Rubella (evidence of disease): 056*, 771.0; Hepatitis B (evidence of disease): V02.61, 070.2, 070.3; HIB: V03.81; Varicella: V05.4; Varicella (evidence of disease): 052*, 053*; Varicella contraindication: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208</i></p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Childhood Immunizations CPT</p> <p><i>Mnemonic CPT enter</i></p> <p>Enter CPT: <i>DTaP: 90696, 90698, 90700, 90721, 90723; DTP: 90701, 90720; Tdap: 90715; DT: 90702; Td: 90714, 90718; Diphtheria: 90719; Tetanus:</i></p>

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Immunizations (cont)		GPRA communities will not be affected.	<p> 90703; OPV: 90712; IPV: 90696, 90698, 90713, 90723; MMR: 90707, 90710; M/R: 90708; Measles: 90705; Mumps: 90704; Rubella: 90706; Hepatitis B: 90636, 90723, 90740, 90743-90748, G0010; HIB: 90645-90648, 90698, 90720-90721, 90748; Varicella: 90710, 90716 Quantity: Modifier: Modifier 2: </p> <p> Childhood Immunizations Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: DTP: 99.39; Diphtheria: 99.36; Tetanus: 99.38; IPV: 99.41; MMR: 99.48; MMR contraindication: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; Measles: 99.45; Mumps: 99.46; Rubella: 99.47; Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] </p> <p> NMI Refusal of Childhood Immunizations <i>Mnemonic NMI enter</i> Patient Refusals For Service/NMI Refusal Type: Immunization Immunization Value: [See codes above] Date Refused: </p>

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Immunizations (cont)			Provider Who Documented: Comment: Immunization Package Contraindication Childhood Immunizations (Assumes you are in the IMM Pkg for Single Patient Record for your site) Select Action: C (Contraindications) Select Action: A (Add Contraindication) Vaccine: [See codes above] Reason: [See Contraindications section under the Provider Documentation column] Date Noted: Command: Save Select Action: Quit
Cancer Screening: Pap Smear Rates	Women ages 21-64 should have a Pap Smear every 3 years. Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.	Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC: Date received Location Results	Data entry through Women’s Health program or standard PCC data entry for tests performed at the facility. Pap Smear V Lab <i>Mnemonic LAB enter</i> Enter Lab Test Type: Pap Smear Results: [Enter Results] Units: Abnormal: Site: Pap Smear POV <i>Mnemonic PPV enter</i>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Cancer Screening: Pap Smear Rates (cont)</p>			<p>Purpose of Visit: V67.01, V76.2, V72.32, V72.3, V76.47, 795.0*, 795.10-16, 795.19</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Pap Smear CPT <i>Mnemonic CPT enter</i> Enter CPT: 88141-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091</p> <p>Quantity:</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>Pap Smear Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 91.46</p> <p>Provider Narrative:</p> <p>Operating Provider:</p> <p>Diagnosis: [Enter appropriate DX]</p> <p>Historical Pap Smear <i>Mnemonic HPAP enter</i> Date Historical Pap Smear:</p> <p>Type of Visit:</p> <p>Location Name:</p> <p>Enter Outside Location: [(if "Other" was entered for Location Name:)]</p> <p>Select V Lab Test: Pap Smear Results: [Enter Results]</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Cancer Screening: Mammogram Rates</p>	<p>Women ages 52-64 should have a mammogram every 2 years</p> <p>Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for Radiology performed at the facility, Ask and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Telephone visit with patient</p> <p>Verbal or written lab report</p> <p>Patient’s next visit</p>	<p>Data entry through Women’s Health program or standard PCC data entry for tests performed at the facility</p> <p>Mammogram Radiology Procedure</p> <p><i>Mnemonic RAD enter</i></p> <p>Enter Radiology Procedure: 77053-77059, G0206; G0204, G0202</p> <p>Impression: [Enter Results]</p> <p>Abnormal:</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>Historical Mammogram Radiology</p> <p><i>Mnemonic HRAD enter</i></p> <p>Date of Historical Radiology Exam:</p> <p>Type:</p> <p>Location Name:</p> <p>Enter Outside Location: [(if “Other” was entered for Location Name:)]</p> <p>Radiology Exam: 77053-77059,G0206; G0204, G0202</p> <p>Impression:</p> <p>Abnormal:</p> <p>Mammogram POV</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: V76.11, V76.12, 793.80, 793.81, 793.89</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Cancer Screening: Mammogram Rates (cont)			Provider Narrative: Modifier: Cause of DX: Mammogram CPT <i>Mnemonic CPT enter</i> Enter CPT: 77053-77059, G0206; G0204, G0202 Quantity: Modifier: Modifier 2: Mammogram Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 87.36, 87.37 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Colorectal Cancer Screening</p>	<p>Adults ages 50 -75 should be screened for CRC (USPTF).</p> <p>For GPRA, IHS counts any of the following:</p> <ul style="list-style-type: none"> • Annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT) • Flexible sigmoidoscopy or double contrast barium enema in the past 5 years • Colonoscopy every 10 years. <p>Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for procedures performed at the facility (Radiology, Lab, Provider).</p> <p>Guaiac cards returned by patients to providers should be sent to Lab for processing.</p> <p>Ask and record historical information on PCC:</p> <p style="padding-left: 20px;">Date received</p> <p style="padding-left: 20px;">Location</p> <p style="padding-left: 20px;">Results</p> <p>Telephone visit with patient</p> <p>Verbal or written lab report</p> <p>Patient’s next visit</p>	<p>Standard PCC data entry process for procedures, Lab or Radiology</p> <p>Colorectal Cancer POV <i>Mnemonic PPV enter</i> Purpose of Visit: 153.*, 154.0, 154.1, 197.5, V10.05 Provider Narrative: Modifier: Cause of DX:</p> <p>Colorectal Cancer CPT <i>Mnemonic CPT enter</i> Enter CPT: G0213-G0215, G0231 Quantity: Modifier: Modifier 2:</p> <p>Total Colectomy CPT <i>Mnemonic CPT enter</i> Enter CPT: 44150-44151, 44155-44158, 44210-44212 Quantity: Modifier: Modifier 2:</p> <p>FOBT or FIT CPT <i>Mnemonic CPT enter</i> Enter CPT: 82270, 82274, G0328 Quantity: Modifier: Modifier 2:</p> <p>Flexible Sigmoidoscopy CPT <i>Mnemonic CPT enter</i> Enter CPT: 45330-45345, G0104</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Colorectal Cancer Screening (cont)			<p>Quantity: Modifier: Modifier 2:</p> <p>Flexible Sigmoidoscopy Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 45.24 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>DBE CPT <i>Mnemonic CPT enter</i> Enter CPT: 74280, G0106, G0120 Quantity: Modifier: Modifier 2:</p> <p>DBE Radiology Procedure <i>Mnemonic RAD enter</i> Enter Radiology Procedure: 74280, G0106, G0120 Impression: [Enter Results] Abnormal: Modifier: Modifier 2:</p> <p>Colonoscopy POV <i>Mnemonic PPV enter</i> Purpose of Visit: V76.51 Provider Narrative: Modifier: Cause of DX:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Colorectal Cancer Screening (cont)			<p>Colon Screening CPT <i>Mnemonic CPT enter</i> Enter CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121 Quantity: Modifier: Modifier 2:</p> <p>Colon Screening Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 45.22, 45.23, 45.25, 45.42, 45.43 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>Historical CRC HCOL - Historical Colonoscopy HFOB - Historical FOBT (Guaiac) HSIG - Historical Sigmoidoscopy HBE - Historical Barium Enema <i>Mnemonics for [Historical CRC Mnemonic above] enter:</i> Date: Type: Location of Encounter: Quantity:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Tobacco Use and Exposure Assessment</p> <p>NOTE: This is not a GPRA measure; however, it will be used for reducing the incidence of Tobacco Use.</p>	<p>Ask all patients age five and over about tobacco use at least annually.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask and record historical information on PCC:</p> <ul style="list-style-type: none"> Date received Location Results <p>Document on designated Health Factors section of form:</p> <ul style="list-style-type: none"> HF–Current Smoker, every day HF–Current Smoker, some day HF–Current Smoker, status unknown HF–Current Smokeless HF–Previous (Former) Smoker [or -Smokeless] (quit > 6 months) HF–Cessation-Smoker [or -Smokeless] (quit or actively trying < 6 months) HF–Smoker in Home HF–Ceremonial Use Only HF–Exp to ETS (Second Hand Smoke) HF–Smoke Free Home <p>NOTE: If your site uses other expressions (e.g.,” Chew” instead of “Smokeless;” “Past” instead of “Previous”), be sure Data Entry staff knows how to “translate”</p> <p>Tobacco Patient Education Codes:</p> <ul style="list-style-type: none"> Codes will contain "TO-", "-TO", "-SHS" 	<p>Standard PCC data entry</p> <p>Tobacco Screening Health Factor</p> <p><i>Mnemonic HF enter</i></p> <p>Select V Health Factor: [Enter HF (See the Provider Documentation column)]</p> <p>Level/Severity:</p> <p>Provider:</p> <p>Quantity:</p> <p>Historical Tobacco Health Factor</p> <p><i>Mnemonic HHF enter</i></p> <p>Date Historical Health Factor:</p> <p>Type of Visit:</p> <p>Location Name:</p> <p>Enter Health Factor: : [Enter HF (See the Provider Documentation column)]</p> <p>Level/Severity:</p> <p>Provider:</p> <p>Quantity:</p> <p>Tobacco Screening PED - Topic</p> <p><i>Mnemonic PED enter</i></p> <p>Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Educ (Minutes):</p> <p>Comment</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Use and Exposure Assessment (cont)		<p>NOTE: Ensure you update the patient’s health factors as they enter a cessation program and eventually become non-tobacco users. Patients who are in a tobacco cessation program should have their health factor changed from “Smoker” or “Smokeless” to “Cessation-Smoker” or “Cessation-Smokeless” until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to “Previous Smoker” or “Previous Smokeless.”</p>	<p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Tobacco Users Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Current Smoker (every day, some day, or status unknown), Current Smokeless, Cessation-Smoker, Cessation-Smokeless Level/Severity: Provider: Quantity: Smokers Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Current Smoker (every day, some day, or status unknown), or Cessation-Smoker Level/Severity: Provider: Quantity: Smokeless Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Current Smokeless or Cessation-Smokeless Level/Severity: Provider: Quantity:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Use and Exposure Assessment (cont)			ETS Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Exp to ETS Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Tobacco Cessation</p>	<p>Active Clinical patients identified as current tobacco users prior to report period and who have received tobacco cessation counseling or a Rx for smoking cessation aid.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask and record historical information on PCC:</p> <ul style="list-style-type: none"> Date received Location Results <p>Current tobacco users are defined by having any of the following documented prior to the report period:</p> <ul style="list-style-type: none"> Last documented Tobacco Health Factor Last documented Tobacco related POV Last documented Tobacco related CPT <p>Health factors considered to be a tobacco user:</p> <ul style="list-style-type: none"> HF–Current Smoker, every day HF–Current Smoker, some day HF–Current Smoker, status unknown HF–Current Smokeless HF–Cessation-Smoker [or -Smokeless] (quit or actively trying < 6 months) <p>Tobacco Patient Education Codes:</p> <ul style="list-style-type: none"> Codes will contain "TO-", "-TO", "-SHS" 	<p>Standard PCC data entry</p> <p>Tobacco Cessation PED - Topic <i>Mnemonic PED enter</i></p> <p>Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Tobacco Cessation PED - Diagnosis <i>Mnemonic PED enter</i></p> <p>Select ICD Diagnosis Code Number: 649.00-649.04</p> <p>Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Cessation (cont)		<p>Prescribe Tobacco Cessation Aids: Predefined Site-Populated Smoking Cessation Meds</p> <p>Meds containing:</p> <ul style="list-style-type: none"> “Nicotine Patch” “Nicotine Polacrilex” “Nicotine Inhaler” “Nicotine Nasal Spray” <p>NOTE: Ensure you update the patient’s health factors as they enter a cessation program and eventually become non-tobacco users. Patients who are in a tobacco cessation program should have their health factor changed from “Smoker” or “Smokeless” to “Cessation-Smoker” or “Cessation-Smokeless” until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to “Previous Smoker” or “Previous Smokeless.”</p>	<p>Goal Comment: Provider’s Narrative:</p> <p>Tobacco Cessation Clinic <i>Mnemonic CL enter</i> Clinic: 94 Was this an appointment or walk in?:</p> <p>Tobacco Cessation Dental (ADA) <i>Mnemonic ADA enter</i> Select V Dental Service Code: 1320 No. Of Units: Operative Site:</p> <p>Tobacco Cessation CPT <i>Mnemonic CPT enter</i> Enter CPT Code: D1320, 99406, 99407, 4000F, G8402 or G8453 Quantity Modifier: Modifier 2:</p> <p>Tobacco Cessation Medication <i>Mnemonic RX enter</i> Select Medication: [Enter Tobacco Cessation Prescribed Medication] Outside Drug Name (Optional): [Enter any additional name for the drug] SIG</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Cessation (cont)			Quantity: Day Prescribed: Event Date&Time: Ordering Provider: Historical Tobacco Cessation Medication <i>Mnemonic HRX enter</i> Date of Historical Medication: Type: Location Name: Enter Medication: [Enter Tobacco Cessation Prescribed Medication] Name of Non-Table Drug: SIG: Days Prescribed: Date Discontinued: Date Dispensed (If Known): Outside Provider Name: Tobacco Cessation Prescription CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 4001F Quantity Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Alcohol Screening (FAS Prevention)</p>	<p>Pregnant women should be screened for alcohol use at least on their first visit; education and follow-up provided as appropriate.</p> <p>Women of childbearing age should be screened at least annually.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Alcohol screening may be documented with either an exam code or the CAGE health factor in PCC or BHS. BHS problem codes can also currently be used.</p> <p>Medical Providers:</p> <p>EXAM—Alcohol Screening</p> <p>Negative—Patient’s screening exam does not indicate risky alcohol use.</p> <p>Positive—Patient’s screening exam indicates potential risky alcohol use.</p> <p>Refused—Patient declined exam/screen</p> <p>Unable to screen - Provider unable to screen</p> <p>Behavioral Health Providers:</p> <p>Enter BHS problem code 29.1 or narrative “Screening for Alcoholism.”*</p> <p>Note: BHS problem code 29.1 maps to ICD-9 V79.1.</p> <p>Note: Recommended Brief Screening Tool: SASQ (below).</p> <p><i>Single Alcohol Screening Question (SASQ)</i></p> <p><i>For Women:</i></p> <p>When was the last time you had more than 4 drinks in one day?</p> <p><i>For Men:</i></p> <p>When was the last time you had more than 5 drinks in one day?</p>	<p>Standard PCC data entry</p> <p>Alcohol Screening Exam</p> <p><i>Mnemonic EX enter</i></p> <p>Select Exam: 35, ALC</p> <p>Result:</p> <p>A—Abnormal</p> <p>N—Normal/Negative</p> <p>PR—Resent</p> <p>PAP—Present and Past</p> <p>PA—Past</p> <p>PO—Positive</p> <p>Comments: SASQ</p> <p>Provider Performing Exam:</p> <p>Historical Alcohol Screen Exam</p> <p><i>Mnemonic HEX enter</i></p> <p>Date of Historical Exam:</p> <p>Type:</p> <p>Location Name:</p> <p>Exam Type: 35, ALC</p> <p>Result:</p> <p>Comments:</p> <p>Encounter Provider:</p> <p>Cage Health Factor</p> <p><i>Mnemonic HF enter</i></p> <p>Select Health Factor: CAGE</p> <p>1 CAGE 0/4 (all No answers)</p> <p>2 CAGE 1/4</p> <p>3 CAGE 2/4</p> <p>4 CAGE 3/4</p> <p>5 CAGE 4/4</p> <p>Choose 1-5: [Number from above]</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		<p>Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen:</p> <p style="padding-left: 40px;">Alcohol Screening Exam Code Result: Positive</p> <p>The patient may decline the screen or “Refuse to answer”:</p> <p style="padding-left: 40px;">Alcohol Screening Exam Code Result: Refused</p> <p>The provider is unable to conduct the screen:</p> <p style="padding-left: 40px;">Alcohol Screening Exam Code Result: Unable To Screen</p> <p>Note: Provider should note the screening tool used was the SASQ at the <i>Comment</i> Mnemonic for the Exam code.</p> <p>All Providers: Use the CAGE questionnaire:</p> <ul style="list-style-type: none"> • Have you ever felt the need to Cut down on your drinking? • Have people Annoyed you by criticizing your drinking? • Have you ever felt bad or Guilty about your drinking? • Have you ever needed an Eye opener the first thing in the morning to steady your nerves or get rid of a hangover? <p>Tolerance: How many drinks does it take you to get high?</p> <p>Based on how many YES answers were received, document Health Factor on PCC:</p> <p style="padding-left: 40px;">HF-CAGE 0/4 (all No answers)</p> <p style="padding-left: 40px;">HF-CAGE 1/4</p> <p style="padding-left: 40px;">HF-CAGE 2/4</p> <p style="padding-left: 40px;">HF-CAGE 3/4</p>	<p>Level/Severity: Provider: Quantity:</p> <p>Alcohol Screening POV <i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: V11.3, V79.1 Provider Narrative: Modifier: Cause of DX:</p> <p>Standard BHS data entry Enter BHS problem code *29.1 or narrative: “Screening for Alcoholism.”</p> <p>*Note: BHS problem code 29.1 maps to ICD-9 V79.1 (Screening for Alcoholism).</p> <p>Alcohol Screening CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 99408, 99409, G0396, G0397, H0049, H0050 Quantity: Modifier: Modifier 2:</p> <p>Alcohol-Related Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: 303.*, 305.*, 291.*, 357.5* Provider Narrative: Modifier: Cause of DX:</p> <p>Alcohol-Related Diagnosis BHS POV data entry</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		<p>HF-CAGE 4/4</p> <p>Optional values: Level/Severity: Minimal, Moderate, or Heavy/Severe</p> <p>Quantity: # of drinks daily OR T (Tolerance) -- # drinks to get high (e.g. T-4)</p> <p>Comment: used to capture other relevant clinical info e.g. "Non-drinker"</p> <p>Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-"</p> <p>AUDIT Measurements:</p> <p>Zone I: Score 0–7 Low risk drinking or abstinence</p> <p>Zone II: Score 8–15 Alcohol use in excess of low-risk guidelines</p> <p>Zone III: Score 16–19 Harmful and hazardous drinking</p> <p>Zone IV: Score 20–40 Referral to Specialist for Diagnostic Evaluation and Treatment</p> <p>AUDIT-C Measurements:</p> <p>How often do you have a drink containing alcohol?</p> <p>(0) Never (Skip to Questions 9-10)</p> <p>(1) Monthly or less</p> <p>(2) 2 to 4 times a month</p> <p>(3) 2 to 3 times a week</p> <p>(4) 4 or more times a week</p> <p>How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2</p> <p>(1) 3 or 4</p>	<p>Enter BHS problem code 10, 27, 29</p> <p>Alcohol-Related Procedure <i>Mnemonic IOP enter</i></p> <p>Operation/Procedure: 94.46, 94.53, 94.61-94.63, 94.67-94.69</p> <p>Provider Narrative:</p> <p>Operating Provider:</p> <p>Diagnosis: [Enter appropriate DX]</p> <p>Alcohol-Related PED - Topic <i>Mnemonic PED enter</i></p> <p>Enter Education Topic: [Enter Alcohol-Related Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Educ (Minutes):</p> <p>Comment:</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Alcohol-Related PED - Diagnosis <i>Mnemonic PED enter</i></p> <p>Select ICD Diagnosis Code Number: V11.3, V79.1, 303.*, 305.0*, 291.* or 357.5*</p> <p>Category:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		<p>(2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more</p> <p>How often do you have six or more drinks on one occasion?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p>The AUDIT-C (the first three AUDIT questions which focus on alcohol consumption) is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).</p> <p>In men, a score of 4 or more is considered positive In women, a score of 3 or more is considered positive.</p> <p>A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence.</p> <p>CRAFFT Measurements:</p> <p>C–Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? A–Do you ever use alcohol/drugs while you are by yourself, ALONE? F–Do you ever FORGET things you did while using alcohol or drugs? F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?</p>	<p>Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider’s Narrative:</p> <p>Alcohol Screen AUDIT Measurement <i>Mnemonic AUDT enter</i> Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken:</p> <p>Alcohol Screen AUDIT-C Measurement <i>Mnemonic AUDC enter</i> Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken:</p> <p>Alcohol Screen CRAFFT Measurement <i>Mnemonic CRFT enter</i> Value: [Enter 0-6] Select Qualifier: Date/Time Vitals Taken:</p> <p>Unable to Perform Alcohol Screen <i>Mnemonic UAS enter</i></p>

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		<p>T–Have you gotten into TROUBLE while you were using alcohol or drugs?</p> <p>Total CRAFFT score (Range: 0–6).</p> <p>Positive answers to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated.</p>	<p>Patient Refusals For Service: Exam</p> <p>Exam Value: 35, ALC</p> <p>Date Refused:</p> <p>Provider Who Documented:</p> <p>Comment:</p>
Intimate Partner (Domestic) Violence Screening (IPV/DV)	<p>Adult females should be screened for domestic violence at <i>new encounter and at least annually Prenatal once each trimester</i></p> <p>(Source: Family Violence Prevention Fund National Consensus Guidelines)</p> <p>Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask and <i>record historical information</i> on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Medical and Behavioral Health Providers:</p> <p>EXAM—IPV/DV Screening</p> <p>Negative – Denies being a current or past victim of IPV/DV</p> <p>Past – Denies being a current victim, but discloses being a past victim of IPV/DV</p> <p>Present – Discloses current IPV/DV</p> <p>Present and Past – Discloses past victimization and current IPV/DV victimization</p> <p>Refused – Patient declined exam/screen</p> <p>Unable to screen – Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.)</p> <p>IPV/DV Patient Education Codes:</p> <p>Codes will contain "DV-" or "-DV"</p>	<p>Standard PCC data entry</p> <p>IPV/DV Screening Exam</p> <p><i>Mnemonic EX enter</i></p> <p>Select Exam: 34, INT</p> <p>Result:</p> <p>A–Abnormal</p> <p>N–Normal/Negative</p> <p>PR–Resent</p> <p>PAP–Present and Past</p> <p>PA–Past</p> <p>PO–Positive</p> <p>Comments:</p> <p>Provider Performing Exam:</p> <p>Historical IPV/DV Screen Exam</p> <p><i>Mnemonic HEX enter</i></p> <p>Date of Historical Exam:</p> <p>Type:</p> <p>Location Name:</p> <p>Exam Type: 34, INT</p> <p>Result:</p> <p>Comments:</p> <p>Encounter Provider:</p> <p>Standard BHS data entry</p> <p>Enter BHS problem code</p> <p>Narrative “IPV/DV exam”</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont)			<p>IPV/DV Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: 995.80-83, 995.85, V15.41, V15.42, V15.49, V61.11 (IPV/DV Counseling) Provider Narrative: Modifier: Cause of DX:</p> <p>IPV/DV Diagnosis BHS POV data entry Enter BHS problem code 43.*, 44.*</p> <p>IPV/DV–Topic <i>Mnemonic PED enter</i> Enter Education Topic: [Enter IPV/DV Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p> <p>IPV/DV PED–Diagnosis <i>Mnemonic PED enter</i> Select ICD Diagnosis Code Number: 995.80-83, 995.85, V15.41, V15.42, V15.49</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont)			Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative: Unable to Screen for IPV/DV <i>Mnemonic UAS enter</i> Patient Refusals For Service: Exam Select Exam: 34 or INT Date Refused: Provider Who Documented: Comment:

Performance Measure	Standard	Provider Documentation	Data Entry
Depression Screening	<p>Adult patients 18 years of age and older should be screened for depression at least annually.</p> <p>(Source: United States Preventive Services Task Force)</p> <p>Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Medical Providers:</p> <p>EXAM—Depression Screening</p> <p>Normal/Negative – Denies symptoms of depression</p> <p>Abnormal/Positive – Further evaluation indicated</p> <p>Refused – Patient declined exam/screen</p> <p>Unable to screen – Provider unable to screen</p> <p>Note: Refusals are <i>not</i> counted toward the GPRA measure, but should be documented.</p> <p>Behavioral Health Providers:</p> <p>Enter BHS problem code 14.1 or narrative “Screening for Depression.”</p> <p>Note: BHS problem code 14.1 maps to ICD-9 V79.0.</p> <p>Mood Disorders:</p> <p>Two or more visits with POV related to:</p> <p>Major Depressive Disorder</p> <p>Dysthymic Disorder</p> <p>Depressive Disorder NOS</p> <p>Bipolar I or II Disorder</p> <p>Cyclothymic Disorder</p> <p>Bipolar Disorder NOS</p>	<p>Standard PCC data entry</p> <p>Depression Screening Exam</p> <p>Mnemonic <i>EX</i> enter</p> <p>Select Exam: 36, DEP</p> <p>Result:</p> <p>A–Abnormal</p> <p>N–Normal/Negative</p> <p>PR–Resent</p> <p>PAP–Present and Past</p> <p>PA–Past</p> <p>PO–Positive</p> <p>Comments: PHQ-2 Scaled, PHQ9</p> <p>Provider Performing Exam:</p> <p>Historical Depression Screen Exam</p> <p>Mnemonic <i>HEX</i> enter</p> <p>Date of Historical Exam:</p> <p>Type:</p> <p>Location Name:</p> <p>Exam Type: 36, DEP</p> <p>Result:</p> <p>Comments: PHQ-2 Scaled, PHQ9 (If Known)</p> <p>Encounter Provider:</p> <p>Depression Screen Diagnosis POV</p> <p>Mnemonic <i>PPV</i> enter</p> <p>Purpose of Visit: V79.0</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p>

Performance Measure	Standard	Provider Documentation	Data Entry																
<p>Depression Screening (cont)</p>		<p>Mood Disorder Due to a General Medical Condition Substance-induced Mood Disorder Mood Disorder NOS</p> <p>Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</p> <p><i>Patient Health Questionnaire (PHQ-2 Scaled Version)</i></p> <p>Over the past 2 weeks, how often have you been bothered by any of the following problems?</p> <p>Little interest or pleasure in doing things</p> <table border="0"> <tr> <td>a. Not at all</td> <td>Value: 0</td> </tr> <tr> <td>b. Several days</td> <td>Value: 1</td> </tr> <tr> <td>c. More than half the days</td> <td>Value: 2</td> </tr> <tr> <td>d. Nearly every day</td> <td>Value: 3</td> </tr> </table> <p>Feeling down, depressed, or hopeless</p> <table border="0"> <tr> <td>a. Not at all</td> <td>Value: 0</td> </tr> <tr> <td>b. Several days</td> <td>Value: 1</td> </tr> <tr> <td>c. More than half the days</td> <td>Value: 2</td> </tr> <tr> <td>d. Nearly every day</td> <td>Value: 3</td> </tr> </table> <p><i>PHQ-2 Scaled Version (cont'd)</i></p> <p>Total Possible PHQ-2 Score: Range: 0-6</p> <p>0-2: Negative Depression Screening Exam: Code Result: Normal or Negative</p> <p>3-6: Positive; further evaluation indicated Depression Screening Exam Code Result: Abnormal or Positive</p> <p>The patient may decline the screen or “Refuse to answer” Depression Screening Exam Code Result: Refused</p>	a. Not at all	Value: 0	b. Several days	Value: 1	c. More than half the days	Value: 2	d. Nearly every day	Value: 3	a. Not at all	Value: 0	b. Several days	Value: 1	c. More than half the days	Value: 2	d. Nearly every day	Value: 3	<p>Depression Screening CPT <i>Mnemonic CPT enter</i> Enter CPT: 1220F Quantity: Modifier: Modifier 2:</p> <p>Standard BHS POV data entry Enter BHS problem code *14.1 or narrative: “Screening for Depression.”</p> <p>*Note: BHS problem code 14.1 maps to ICD-9 V79.0 (Special Screening for Mental Disorders and Developmental Handicaps, Depression).</p> <p>Unable to Screen for Depression <i>Mnemonic UAS enter</i> Patient Refusals For Service: Exam Exam Value: 36, DEP Date Refused: Provider Who Documented: Comment:</p> <p>Mood Disorder Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311 Provider Narrative: Modifier: Cause of DX:</p>
a. Not at all	Value: 0																		
b. Several days	Value: 1																		
c. More than half the days	Value: 2																		
d. Nearly every day	Value: 3																		
a. Not at all	Value: 0																		
b. Several days	Value: 1																		
c. More than half the days	Value: 2																		
d. Nearly every day	Value: 3																		

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Depression Screening (cont)</p>		<p>The provider is unable to conduct the Screen Depression Screening Exam Code Result: Unable To Screen</p> <p>Provider should note the screening tool used was the PHQ-2 Scaled at the <i>Comment</i> Mnemonic for the Exam Code.</p> <p><i>PHQ9 Questionnaire Screening Tool</i></p> <p>Little interest or pleasure in doing things?</p> <p>a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3</p> <p>Feeling down, depressed, or hopeless?</p> <p>a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3</p> <p>Trouble falling or staying asleep, or sleeping too much?</p> <p>a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3</p> <p>Feeling tired or having little energy?</p> <p>a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3</p>	<p>Standard BHS Mood Disorder POV data entry Enter BHS problem code: 14, 15</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Depression Screening (cont)		<p>Poor appetite or overeating?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>Feeling bad about yourself—or that you are a failure or have let yourself or your family down?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>Trouble concentrating on things, such as reading the newspaper or watching television?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p>	

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Depression Screening (cont)</p>		<p>Thoughts that you would be better off dead, or of hurting yourself in some way?</p> <ul style="list-style-type: none"> a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3 <p><i>PHQ9 Questionnaire (Cont'd)</i></p> <p>Total Possible PHQ-2 Score: Range: 0-27</p> <p>0-4 Negative/None Depression Screening Exam: Code Result: None</p> <p>5-9 Mild Depression Screening Exam: Code Result: Mild depression</p> <p>10-14 Moderate Depression Screening Exam: Code Result: Moderate depression</p> <p>15-19 Moderately Severe Depression Screening Exam: Code Result: Moderately Severe depression</p> <p>20-27 Severe Depression Screening Exam: Code Result: Severe depression</p> <p>Provider should note the screening tool used was the PHQ9 Scaled at the <i>Comment</i> Mnemonic for the Exam Code.</p>	

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Obesity Assessment (Calculate BMI [Body Mass Index])</p> <p>NOTE: This is not a GPRA measure; however, it's displayed in GPRA report for reducing the incidence of obesity. The information is included here is to inform providers and data entry staff of how to collect, document, and enter the data.</p>	<p>Children (through age 18) must have both height and weight taken on the same day at least annually (at every visit is recommended).</p> <p>Adults 19-50, height and weight at least every 5 years, not required to be on same day.</p> <p>Adults over 50, height and weight taken every 2 years, not required to be on same day.</p>	<p>Standard PCC documentation Obtain Height and Weight during visit and record information on PCC:</p> <p>Height</p> <p>Weight</p> <p>Date Recorded</p> <p>BMI is calculated using NHANES II.</p> <p>Obese is defined as:</p> <p>BMI of 30 or more for adults 19 and older.</p> <p>For ages 2-18, definitions based on standard tables.</p> <p>To document Refusals on PCC:</p> <p>Use the REF Mnemonic</p> <p>Refusals include:</p> <p>REF (refused)</p> <p>NMI (not medically indicated)</p> <p>UAS (unable to screen) and must be documented during the past year.</p> <p>For ages 18 and under, both the height and weight must be refused on the same visit at any time during the past year.</p> <p>For ages 19 and older, the height and weight must be refused during the past year and are not required to be on the same visit.</p> <p>Patients whose BMI either is greater or less than the Data Check Limit range shown in the BMI Standard Reference Data Table in PCC will not be included in the report counts for Overweight or Obese.</p>	<p>Standard PCC data entry:</p> <p>Height Measurement</p> <p><i>Mnemonic HT enter</i></p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Estimated</p> <p>Date/Time Vitals Taken:</p> <p>Weight Measurement</p> <p><i>Mnemonic WT enter</i></p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Bed</p> <p>Chair</p> <p>Dry</p> <p>Estimated</p> <p>Standing</p> <p>Date/Time Vitals Taken:</p> <p>Historical Height and Weight Measurement (May be used for ages 19 and older)</p> <p><i>Mnemonic HMSR enter</i></p> <p>Enter Date Historical Measurement:</p> <p>Type:</p> <p>Location:</p> <p>Select Measurement: HT, WT</p> <p>Value:</p> <p>Refusal of Height</p> <p><i>Mnemonic REF enter</i></p> <p>Patient Refusals For Service:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Obesity Assessment (Calculate BMI [Body Mass Index]) (cont)</p>			<p>Measurements Measurement Type: HT Date Refused: Provider Who Documented: Comment:</p> <p>Refusal of Weight <i>Mnemonic REF enter</i> Patient Refusals For Service:</p> <p>Measurements Measurement Type: WT Date Refused: Provider Who Documented: Comment:</p> <p>Unable to Screen for Height <i>Mnemonic UAS enter</i> Patient Refusals For Service:</p> <p>Measurements Enter Measurement Type: HT Date Refused/Not Indicated: Provider Who Documented: Comment:</p> <p>Unable to Screen for Weight <i>Mnemonic UAS enter</i> Patient Refusals For Service:</p> <p>Measurements Enter Measurement Type: WT Date Refused/Not Indicated: Provider Who Documented: Comment:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Childhood Weight Control</p>	<p>Patients ages 2-5 at the beginning of the report period whose BMI could be calculated and have a BMI => 95%.</p> <p>Height and weight taken on the same day.</p> <p>Patients that turn 6 years old during the report period are not included in the GPRA measure.</p>	<p>Standard PCC documentation Obtain Height and Weight during visit and record information on PCC:</p> <p>Height</p> <p>Weight</p> <p>Date Recorded</p> <p>BMI is calculated using NHANES II</p> <p>Age in the age groups is calculated based on the date of the most current BMI found.</p> <p>Example, a patient may be 2 at the beginning of the time period but is 3 at the time of the most current BMI found, patient will fall into the age 3 group.</p> <p>The BMI values for this measure are reported differently than in the Obesity Assessment measure as they are Age-Dependent. The BMI values are categorized as Overweight for patients with a BMI in the 85th to 94th percentile and Obese for patients with a BMI at or above the 95th percentile (GPRA).</p> <p>Patients whose BMI either is greater or less than the Data Check Limit range shown below will not be included in the report counts for Overweight or Obese.</p>	<p>Standard PCC data entry</p> <p>Height Measurement</p> <p><i>Mnemonic HT enter</i></p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Estimated</p> <p>Date/Time Vitals Taken:</p> <p>Weight Measurement</p> <p><i>Mnemonic WT enter</i></p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Bed</p> <p>Chair</p> <p>Dry</p> <p>Estimated</p> <p>Standing</p> <p>Date/Time Vitals Taken:</p>

Performance Measure	Standard	Provider Documentation						Data Entry
Childhood Weight Control (cont)		Low-High		BMI >= 85	BMI >= 95	Data Check Limits		
		Ages	Sex	Over Weight	Obese	BMI >	BMI <	
		2-2	M	17.7	18.7	36.8	7.2	
			F	17.5	18.6	37.0	7.1	
		3-3	M	17.1	18.0	35.6	7.1	
			F	17.0	18.1	35.4	6.8	
		4-4	M	16.8	17.8	36.2	7.0	
	F	16.7	18.1	36.0	6.9			
5-5	M	16.9	18.1	36.0	6.9			
	F	16.9	18.5	39.2	6.8			
Comprehensive CVD-Related Assessment	<p>Active Clinical Patients ages 22 and older diagnosed with Ischemic Heart Disease (IHD) prior to the Report Period, AND at least 2 visits during the Report Period, AND 2 IHD-related visits ever who had the following tests documented:</p> <ul style="list-style-type: none"> • Blood Pressure • LDL Assessment • Tobacco Use Assessment • BMI Calculated • Lifestyle Counseling <p>Note: This does NOT include depression screening and does NOT include refusals of BMI.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Note: See related individual measures above for recording historical information.</p> <p>Blood Pressure Control</p> <p>LDL Assessment</p> <p>Tobacco Use and Assessment</p> <p>BMI (Obesity)</p> <p>Tobacco Use Health Factors:</p> <p>HF–Current Smoker, every day</p> <p>HF–Current Smoker, some day</p> <p>HF–Current Smoker, status unknown</p> <p>HF–Current Smokeless</p> <p>HF–Previous (Former) Smoker [or -Smokeless] (quit > 6 months)</p>						<p>Standard PCC data entry</p> <p>IHD Diagnosis POV (Prior to the report period)</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: 410.0-412.*, 414.0-414.9, 428.* 429.2</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Blood Pressure Data Entry</p> <p><i>Mnemonic BP enter</i></p> <p>Value: [Enter as Systolic/Diastolic (e.g., 130/80)]</p> <p>Select Qualifier:</p> <p>Date/Time Vitals Taken:</p> <p>LDL (Calculated) (REF)* Lab Test</p> <p><i>Mnemonic LAB enter</i></p> <p>Enter Lab Test Type: LDL</p> <p>Results:</p> <p>Units:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Comprehensive CVD-Related Assessment (cont)</p>	<p>Note: Refusals of any or all of the above are not counted toward the GPRA measure, but should still be documented.</p>	<p>HF–Cessation-Smoker [or -Smokeless] (quit or actively trying < 6 months)</p> <p>HF–Smoker in Home</p> <p>HF–Ceremonial Use Only</p> <p>HF–Exp to ETS (Second Hand Smoke)</p> <p>HF–Smoke Free HomeNOTE: If your site uses other expressions (e.g.,” Chew” instead of “Smokeless;” “Past” instead of “Previous”), be sure Data Entry staff knows how to “translate”</p> <p>Tobacco Patient Education Codes: Codes will contain "TO-", "-TO", "-SHS"</p> <p>BMI is calculated using NHANES II. Adults 19–50, height and weight at least every 5 years, not required to be on same day. Adults over 50, height and weight taken every 2 years, not required to be on same day.</p> <p>Nutrition, dietary surveillance and counseling Patient Education Codes: Codes will contain "-N" (Nutrition) or "-MNT"</p> <p>Exercise Patient Education Codes: Codes will contain “-EX”</p> <p>Lifestyle Patient Education Codes: Codes will contain “-LA”</p> <p>Other Related Nutrition and Exercise Patient Educations Codes: Codes will contain “-OBS” (Obesity)</p> <p>Lifestyle Counseling includes: Lifestyle adaptation counseling Medical nutrition therapy Nutrition counseling Exercise counseling</p>	<p>Abnormal: Site: [Blood, Serum]</p> <p>*REF – Reference Lab</p> <p>LDL (Calculated) Lab Test <i>Mnemonic LAB enter</i> Enter Lab Test Type: LDL Results: Units: Abnormal: Site: [Blood]</p> <p>LDL CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F Quantity : Modifier: Modifier 2:</p> <p>Tobacco Use Assessment <i>Mnemonic HF enter</i> Select V Health Factor: [Enter HF (See the Provider Documentation column)] Level/Severity: Provider: Quantity:</p> <p>Tobacco Use Dental (ADA) <i>Mnemonic ADA enter</i> Select V Dental Service Code: 1320 No. Of Units: Operative Site:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Comprehensive CVD-Related Assessment (cont)</p>		<p>Other lifestyle education</p>	<p>Tobacco Screening CPT <i>Mnemonic CPT enter</i> Enter CPT Code: D1320, 99406, 99407, 1034F, 1035F, 1036F, 1000, G8455, G8456, G8457, G8402, G8453 Quantity Modifier: Modifier 2:</p> <p>Tobacco Related Diagnoses POV <i>Mnemonic PPV enter</i> Purpose of Visit: 305.1, 649.00-649.04, V15.82 Provider Narrative: Modifier: Cause of DX:</p> <p>Tobacco Screening PED - Topic <i>Mnemonic PED enter</i> Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Comprehensive CVD-Related Assessment (cont)</p>			<p>Tobacco Screening PED - Diagnosis <i>Mnemonic PED enter</i> Select ICD Diagnosis Code Number: 305.1, 649.00-649.04, V15.82 Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:</p> <p>BMI Data Entry Height Measurement <i>Mnemonic HT enter</i> Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken:</p> <p>Weight Measurement <i>Mnemonic WT enter</i> Value: Select Qualifier: Actual Bed</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Comprehensive CVD-Related Assessment (cont)			Chair Dry Estimated Standing Date/Time Vitals Taken: Lifestyle Counseling Data Entry Medical Nutrition Therapy CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 97802-97804, G0270, G0271 Quantity: Modifier: Modifier 2: Medical Nutrition Therapy Clinic <i>Mnemonic CL enter</i> Clinic: 67, 36 Was this an appointment or walk in?: Nutrition Education POV <i>Mnemonic PPV enter</i> Purpose of Visit: V65.3 Provider Narrative: Modifier: Cause of DX: Nutrition/Exercise/Lifestyle Adaption PED - Topic <i>Mnemonic PED enter</i> Enter Education Topic: [Enter Nutrition/Exercise/Lifestyle Adaption Patient Education Code (See the Provider Documentation column)]

Performance Measure	Standard	Provider Documentation	Data Entry
Comprehensive CVD-Related Assessment (cont)			Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Nutrition/Exercise/Lifestyle Adaption PED - Diagnosis <i>Mnemonic PED enter</i> Select ICD Diagnosis Code Number: V65.3 (Nutrition), V65.41 (Exercise), 278.00 or 278.01 (Obesity) Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:

Performance Measure	Standard	Provider Documentation	Data Entry
<p>HIV Screening</p>	<p>Pregnant women should be tested for HIV at least on their first visit; education and follow-up provided as appropriate.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>NOTE: The timeframe for screening for the pregnant patients denominator is anytime during the past 20 months.</p> <p>Pregnant patients are any patients with at least 2 non-pharmacy only visits with a pregnancy POV code with no recorded abortion or miscarriage in this timeframe.</p>	<p>Standard PCC data entry</p> <p>HIV Screen CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 86689, 86701-86703, 87390, 87391, 87534-87539</p> <p>Quantity: Modifier: Modifier 2:</p> <p>HIV Diagnoses POV <i>Mnemonic PPV enter</i> Purpose of Visit: 042, 079.53, V08, 795.71</p> <p>Provider Narrative: Modifier: Cause of DX:</p> <p>HIV Lab Test <i>Mnemonic LAB enter</i> Enter Lab Test Type: [Enter site's defined HIV Screen Lab Test] Results: [Enter Results (e.g., Negative, Positive, Indeterminant)] Units: Abnormal: Site: [Blood, Serum]</p> <p>Historical HIV Screen <i>Mnemonic HLAB enter</i> Date of Historical Lab Test: Type: Location Name: Enter Lab Test:</p>

Performance Measure	Standard	Provider Documentation	Data Entry																																																								
HIV Screening (cont)			Results:																																																								
<p>Breastfeeding Rates</p> <p>NOTE: This is not a GPRA measure; however, it will be used in conjunction with the Childhood Weight Control measure for reducing the incidence of childhood obesity.</p> <p>The information is included here to inform providers and data entry staff of how to collect, document, and enter the data.</p>	<p><i>All providers should assess the feeding practices of all newborns through age 1 year at all well-child visits.</i></p>	<p>The following grid is designed to be used on PCC and PCC+. It was successfully field tested at Phoenix Indian Medical Center (PIMC) for pediatric clinic visits. See the next page for definitions of each feeding choice.</p> <table border="1" data-bbox="919 407 1373 950"> <tr> <td colspan="4">Feeding Choice (today) X</td> </tr> <tr> <td colspan="2">Exclusive Breastfeeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">Mostly Breastfeeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">½ Breastfeeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">½ Formula feeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">Mostly Formula feeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">Formula only feeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="4"> </td> </tr> <tr> <td colspan="4">Mom's name</td> </tr> <tr> <td colspan="4">Or chart#</td> </tr> <tr> <td>Birth order</td> <td></td> <td>Birth wt.</td> <td></td> </tr> <tr> <td colspan="2">started formula</td> <td colspan="2">___wks/mth</td> </tr> <tr> <td colspan="2">stopped breastfeeding</td> <td colspan="2">___wks/mth</td> </tr> <tr> <td colspan="2">started solids</td> <td colspan="2">___wks/mth</td> </tr> </table> <p>Exclusive Breastfeeding–Breastfed or expressed breast milk only, no formula</p> <p>Mostly Breastfeeding–Mostly breastfed or expressed breast milk, with some formula feeding (1X per week or more, but less than half the time formula feeding.)</p> <p>½ Breastfeeding, ½ Formula Feeding–Half the time breastfeeding/expressed breast milk, half formula feeding</p> <p>Mostly Formula–The baby is mostly formula fed, but breastfeeds at least once a week</p> <p>Formula Only–Baby receives only formula</p>	Feeding Choice (today) X				Exclusive Breastfeeding				Mostly Breastfeeding				½ Breastfeeding				½ Formula feeding				Mostly Formula feeding				Formula only feeding								Mom's name				Or chart#				Birth order		Birth wt.		started formula		___wks/mth		stopped breastfeeding		___wks/mth		started solids		___wks/mth		<p>Standard PCC data entry</p> <p>Infant Breastfeeding</p> <p><i>Mnemonic IF enter</i></p> <p>Enter Feeding Choice:</p> <ol style="list-style-type: none"> 1 Exclusive Breastfeeding 2 Mostly Breastfeeding 3 1/2 & 1/2 Breast and Formula 4 Mostly Formula 5 Formula Only
Feeding Choice (today) X																																																											
Exclusive Breastfeeding																																																											
Mostly Breastfeeding																																																											
½ Breastfeeding																																																											
½ Formula feeding																																																											
Mostly Formula feeding																																																											
Formula only feeding																																																											
Mom's name																																																											
Or chart#																																																											
Birth order		Birth wt.																																																									
started formula		___wks/mth																																																									
stopped breastfeeding		___wks/mth																																																									
started solids		___wks/mth																																																									

Performance Measure	Standard	Provider Documentation	Data Entry
Breastfeeding Rates (cont)		The additional one-time data fields, e.g., birth weight, formula started, and breast stopped, may also be collected and may be entered using the data entry Mnemonic PIF. However, this information is not used or counted in the CRS logic for Breastfeeding Rates.	
Patient Education Measures (Patient Education Report) NOTE: This is not a GPRA measure; however, the information is being provided because there are several GPRA measures that do include patient education as meeting the numerator (e.g. alcohol screening). Providers and data entry staff need to know they need to collect and enter ALL components of patient education.	N/A	<i>All providers should document all 5 patient education elements and elements #6-7 below if a goal was set for the patient:</i> <ol style="list-style-type: none"> 1. Education Topic/Diagnosis 2. Readiness to Learn 3. Level of Understanding (see below) 4. Initials of Who Taught 5. Time spent (in minutes) 6. Goal Not Set, Goal Set, Goal Met, Goal Not Met 7. Text relating to the goal or its status Readiness to Learn: <ul style="list-style-type: none"> Distraction Eager To Learn Intoxication Not Ready Pain Receptive Severity of Illness Unreceptive 	Standard PCC data entry Patient Education Topic <i>Mnemonic PED enter</i> Topic: [Enter Topic] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider: Length of Educ (minutes): Comment: Goal Code: GS, GM, GNM, GNS Goal Comment: Patient Education Diagnosis <i>Mnemonic PED enter</i> Select ICD Diagnosis Code Number: Category: [Enter Category] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider: Length of Educ (Minutes): Comment:

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Patient Education Measures (Patient Education Report) (cont)</p>		<p>Levels of Understanding: P–Poor F–Fair G–Good GR–Group-No Assessment R–Refused</p> <p>Goal codes: GS–Goal Set GM–Goal Met GNM–Goal Not Met GNS–Goal Not Set</p> <p>An example of how this would look on the PCC form for Topic is:</p> <p>DM-N-E-G-DU-15 MIN-GS-Patient will eat more fruits and vegetables and less sugar: DM-N = Diabetes Mellitus -Nutrition (Topic) E = Eager to Learn (Readiness to Learn) G = Good (Level of Understanding) DU = Initials of Provider 15 MIN = 15 minutes spent providing education to the patient (Time Spent) GS = A goal was set Patient will... = The goal set for the patient</p> <p>Diagnosis Categories: Anatomy and Physiology Complications Disease Process Equipment Exercise</p>	<p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Provider’s Narrative:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Patient Education Measures (Patient Education Report) (cont)</p>		<p>Follow-up Home Management Hygiene Lifestyle Adaptation Literature Medical Nutrition Therapy Medications Nutrition Prevention Procedures Safety Tests Treatment</p> <p>An example of how this would look on the PCC form for Diagnosis is:</p> <p>V65.3-N-E-G-DU-15 MIN-GS-Patient will eat more fruits and vegetables and less sugar:</p> <p>V65.3 = Dietary Surveil/Counsel (Diagnosis) N = Nutrition (Category) E = Eager to Learn (Readiness to Learn) G = Good (Level of Understanding) DU = Initials of Provider 15 MIN = 15 minutes spent providing education to the patient (Time Spent) GS = A goal was set Patient will... = The goal set for the patient</p>	

KEY CLINICAL PERFORMANCE OBJECTIVES

“Cheat Sheet” for EHR Documentation and Data Entry for CRS Version 10.0

Last Updated November 2010

Recommended use for this material: Each facility should (1) identify their three or four key clinical problem areas; (2) review the attached information; (3) customize the provider documentation and data entry instructions, if necessary; (4) train staff on appropriate documentation; and (5) post the applicable pages of the Cheat Sheet in exam rooms.

This document is to provide information to both providers and to data entry on the *most appropriate* way to document key clinical procedures in the Electronic Health Record (EHR). It does not include all of the codes the Clinical Reporting System (CRS) checks when determining if a performance measure is met. To review that information, view the CRS short version logic at:

<http://www.ihs.gov/CIO/CRS/documents/GPRA%20PART%20Measures%20V10.pdf>

See [Appendix A](#) for detailed instructions on how to enter information into EHR.

Note: Government Performance and Results Act (GPRA) measures do not include refusals.

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes Prevalence NOTE: This is not a GPRA measure; however, it is used in determining patients that have been diagnosed with diabetes.		Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR: Date received Location Results	Diabetes Prevalence Diagnosis POV Visit Diagnosis Entry Purpose of Visit: 250.00-250.93 Provider Narrative: Modifier: Cause of DX:
Diabetes: Glycemic Control	Active Clinical Patients DX with diabetes and with an A1c: <ul style="list-style-type: none"> • > 9.5 (Poor Glycemic Control) • < 7 (Ideal Glycemic Control) 	Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR: Date received Location Results	A1c Lab Test Lab Test Entry Enter Lab Test Type: [Enter site’s defined A1c Lab Test] Collect Sample/Specimen: [Blood, Plasma] Clinical Indication:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			<p>CPT Visit Services Entry (includes historical CPTs) Enter CPT: 83036, 83037, 3044F-3046F Quantity: Modifier: Modifier 2:</p>
<p>Diabetes: Blood Pressure Control</p>	<p>Active Clinical Patients DX with diabetes and with controlled blood pressure:</p> <ul style="list-style-type: none"> • < 130/80 (mean systolic < 130, mean diastolic < 80) 	<p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <p>Date received Location Results</p>	<p>Blood Pressure Data Entry Vital Measurements Entry (includes historical Vitals) Value: [Enter as Systolic/Diastolic (e.g., 130/80)] Select Qualifier: Date/Time Vitals Taken:</p>
<p>Diabetes: LDL Assessment</p>	<p>Active Clinical Patients DX with diabetes and a completed LDL test.</p>	<p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <p>Date received Location Results</p>	<p>LDL (Calculated) Lab Test Lab Test Entry Enter Lab Test Type: [Enter site’s defined LDL Lab Test] Collect Sample/Specimen: [Blood] Clinical Indication:</p> <p>LDL CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Nephropathy Assessment	Active Clinical Patients DX with diabetes with a Nephropathy assessment: <ul style="list-style-type: none"> • Estimated GFR with result during the Report Period • Quantitative Urinary Protein Assessment during the Report Period • End Stage Renal Disease diagnosis/treatment 	Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR: <p>Date received</p> <p>Location</p> <p>Results</p>	Estimated GFR Lab Test Lab Test Entry Enter Lab Test Type: [Enter site’s defined Est GFR Lab Test] Collect Sample/Specimen: [Blood] Clinical Indication: Quantitative Urinary Protein Assessment CPT Visit Services Entry (includes historical CPTs) Enter CPT: 82042, 82043, 84156 Quantity: Modifier: Modifier 2: ESRD CPT Visit Services Entry (includes historical CPTs) Enter CPT: 36145, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, G0257, G0308-G0327, G0392, G0393, or S9339 Quantity: Modifier: Modifier 2: ESRD POV Visit Diagnosis Entry

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			Purpose of Visit: 585.5, 585.6, V42.0, V45.11, V45.12, or V56.* Provider Narrative: Modifier: Cause of DX: ESRD Procedure Procedure Entry Operation/Procedure: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6* Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX (ESRD)]
Diabetic Retinopathy	<p>Patients with diabetes will have a qualified* retinal examination during the report period.</p> <p>*Qualified retinal exam: The following methods are qualifying for this measure:</p> <ul style="list-style-type: none"> Dilated retinal evaluation by an optometrist or ophthalmologist Seven standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist Any photographic method formally 	<p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Exams:</p> <p>Diabetic Retinal Exam</p> <p>Dilated retinal eye exam</p> <p>Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist</p> <p>Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos</p> <p>Routine ophthalmological examination including refraction (new or existing patient)</p> <p>Diabetic indicator; retinal eye exam, dilated,</p>	<p>Diabetic Retinopathy Exam Exam Entry (includes historical exams) Select Exam: 03 Result: [Enter Results] Comments: Provider Performing Exam:</p> <p>Retinal Exam CPT Visit Services Entry (includes historical CPTs) Enter CPT: 2022F, 2024F, 2026F, S0620, S0621, S3000 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
	<p>validated to seven standard fields (ETDRS).</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>bilateral</p> <p>Other Eye Exams</p> <p>Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or validated tele-ophthalmology retinal evaluation clinics</p> <p>Non-DNKA visits to an optometrist or ophthalmologist</p>	<p>Other Eye Exam CPT Visit Services Entry (includes historical CPTs) Enter CPT: 67028, 67038, 67039, 67040, 92002, 92004, 92012, 92014 Quantity: Modifier: Modifier 2:</p> <p>Other Eye Exam POV Visit Diagnosis Entry Purpose of Visit: V72.0 Provider Narrative: Modifier: Cause of DX:</p> <p>Other Eye Exam Procedure Procedure Entry Operation/Procedure: 95.02 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>Other Eye Exam Clinic Clinic Entry Clinic: A2, 17, 18, 64</p>
<p>Access to Dental Service</p>	<p>Patients should have annual dental exams.</p> <p>Note: Refusals are not counted toward the GPRA measure, but</p>	<p>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</p> <p>Date received</p> <p>Location</p>	<p>Dental Exam Exam Entry (includes historical exams) Select Exam: 30 Result: [Enter Results]</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
	<p>should still be documented.</p>	<p>Results</p>	<p>Comments: Provider Performing Exam:</p> <p>Dental Exam (ADA code) <i>ADA codes cannot be entered into EHR.</i></p> <p>Dental Exam CPT Visit Services Entry (includes historical CPTs) Enter CPT: D0000, D0190 Quantity: Modifier: Modifier 2:</p> <p>Dental Exam POV Visit Diagnosis Entry Purpose of Visit: V72.2 Provider Narrative: Modifier: Cause of DX:</p>
<p>Dental Sealants</p>	<p>A maximum of two sealants per tooth are counted toward the GPRA measure.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</p> <p>Date received</p> <p>Location</p> <p>Results</p>	<p>Dental Sealants (ADA) <i>ADA codes cannot be entered into EHR.</i></p> <p>Dental Sealants CPT Visit Services Entry (includes historical CPTs) Enter CPT: D1351 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Topical Fluoride</p>	<p>A maximum of four topical fluoride application are counted toward the GPRA measure.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> Date received Location Results 	<p>Topical Fluoride (ADA code) <i>ADA codes cannot be entered into EHR.</i></p> <p>Topical Flouride CPT Visit Services Entry (includes historical CPTs) Enter CPT: D1203, D1204, D1206, D5986 Quantity: Modifier: Modifier 2:</p> <p>Topical Flouride POV Visit Diagnosis Entry Purpose of Visit: V07.31 Provider Narrative: Modifier: Cause of DX:</p>
<p>Adult Immunizations: Influenza</p>	<p>All adults ages 65 and older should have an annual influenza (flu) shot.</p> <p>Adults 55-64 are strongly recommended to have annual influenza (flu) shot.</p> <p>All adult (18 and older) diabetic patients are strongly recommended to have annual influenza (flu) shot.</p>	<p>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> IZ type Date received Location <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include:</p> <ul style="list-style-type: none"> Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal 	<p>Influenza Vaccine Immunization Entry (includes historical immunizations) Select Immunization Name: 88 (other options are 111, 15, 16) Lot: VFC Eligibility:</p> <p>Influenza Vaccine POV Visit Diagnosis Entry Purpose of Visit: *V04.81, *V06.6 Provider Narrative: Modifier: Cause of DX:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
	<p>Refusals should be documented. Note: Only Not Medically Indicated (NMI) refusals are counted toward the GPRA Measure.</p>		<p>* NOT documented with 90663, 90664, 90666-90668, 90470, G9141, G9142</p> <p>Influenza Vaccine CPT Visit Services Entry (includes historical CPTs) Enter CPT: 90655-90662, G0008, G8108 Quantity: Modifier: Modifier 2:</p> <p>NMI Refusal of Influenza <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p>Contraindication Influenza Immunization Entry - Contraindications Vaccine: [See codes above] Reason: Egg Allergy, Anaphylaxis</p>
<p>Adult Immunizations: Pneumovax</p>	<p>All adults ages 65 and older will have a pneumovax.</p> <p>All adult (18 and older) diabetic patients are strongly recommended to have a pneumovax.</p> <p>Refusals should be documented. Note: Only NMI refusals are counted</p>	<p>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <p>IZ type Date received Location</p> <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include:</p>	<p>Pneumovax Vaccine Immunization Entry (includes historical immunizations) Select Immunization Name: 33, 100, 109, 133 Lot: VFC Eligibility:</p> <p>Pneumovax Vaccine POV Visit Diagnosis Entry Purpose of Visit: V06.6, V03.82</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
	<p>toward the GPRA Measure.</p>	<p>Immunization Package of "Egg Allergy" or "Anaphylaxis"</p> <p>NMI Refusal</p>	<p>Provider Narrative: Modifier: Cause of DX:</p> <p>Pneumovax Vaccine CPT Visit Services Entry (includes historical CPTs) Enter CPT: 90669, 90670, 90732, G0009, G8115 Quantity: Modifier: Modifier 2:</p> <p>Pneumovax Procedure Procedure Entry Operation/Procedure: 99.55 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>NMI Refusal of Pneumovax <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p>Contraindication Pneumovax Immunization Entry - Contraindications Vaccine: [See codes above] Reason: Egg Allergy, Anaphylaxis</p>
<p>Childhood Immunizations</p>	<p>Children age 19–35 months will be up-to-date for all ACIP recommended</p>	<p>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</p>	<p>Childhood Immunizations Immunization Entry (includes historical immunizations) Select Immunization Name: <i>DTaP:</i></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
	<p>immunizations.</p> <p>This is the 431331 combo:</p> <p>4 DTaP</p> <p>3 IPV</p> <p>1 MMR</p> <p>3 Hepatitis B</p> <p>3 Hib</p> <p>1 Varicella</p> <p>Refusals should be documented.</p> <p>Note: Only NMI refusals are counted toward the GPRa Measure.</p>	<p>IZ type</p> <p>Date received</p> <p>Location</p> <p>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</p> <p>Contraindications should be documented and are counted toward the GPRa Measure. Contraindications include Immunization Package of "Anaphylaxis" for all childhood immunizations. The following additional contraindications are also counted:</p> <p>IPV: Immunization Package: "Neomycin Allergy."</p> <p>MMR: Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</p> <p>Varicella: Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</p> <p>Dosage and types of immunization definitions:</p> <p>Four doses of DTaP:</p> <p>4 DTaP/DTP/Tdap</p> <p>1 DTaP/DTP/Tdap and 3 DT/Td</p> <p>1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus</p>	<p>20, 50, 106, 107, 110, 120, 130; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113; Tetanus: 35, 112; Acellular Pertussis: 11; OPV: 2, 89; IPV: 10, 89, 110, 120, 130; MMR: 3, 94; M/R: 4; R/M: 38; Measles: 5; Mumps: 7; Rubella: 6; Hepatitis B: 8, 42-45, 51, 102, 104, 110; HIB: 17, 22, 46-49, 50, 51, 102, 120; Varicella: 21, 94</p> <p>Lot:</p> <p>VFC Eligibility:</p> <p>Childhood Immunizations POV</p> <p>Visit Diagnosis Entry</p> <p>Purpose of Visit: DTaP: V06.1; DTP: V06.1, V06.2, V06.3; DT: V06.5; Td: V06.5; Diphtheria: V03.5; Tetanus: V03.7; Acellular Pertussis: V03.6; OPV contraindication: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; IPV: V04.0, V06.3; IPV (evidence of disease): 730.70-730.79; MMR: V06.4; Measles: V04.2; Measles (evidence of disease): 055*; Mumps: V04.6; Mumps (evidence of disease): 072*; Rubella: V04.3; Rubella (evidence of disease): 056*, 771.0; Hepatitis B (evidence of disease): V02.61, 070.2, 070.3; HIB: V03.81; Varicella: V05.4; Varicella (evidence of disease): 052*, 053*; Varicella contraindication: 279, V08, 042, 200-202, 203.0, 203.1,</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>4 DT and 4 Acellular Pertussis</p> <p>4 Td and 4 Acellular Pertussis</p> <p>4 each of Diphtheria, Tetanus, and Acellular Pertussis</p> <p>Three doses of IPV:</p> <p>3 OPV</p> <p>3 IPV</p> <p>Combination of OPV and IPV totaling three doses</p> <p>One dose of MMR:</p> <p>MMR</p> <p>1 M/R and 1 Mumps</p> <p>1 R/M and 1 Measles</p> <p>1 each of Measles, Mumps, and Rubella</p> <p>Three doses of Hepatitis B</p> <p>3 doses of Hep B</p> <p>2 doses IF documented with CPT 90743</p> <p>Three doses of HIB</p> <p>One dose of Varicella</p> <p>IMPORTANT NOTE:</p> <p>The GPRA denominator is all User Population patients who are active in the Immunization Package. This means you must be using the Immunization Package and maintaining the active/inactive status field in order to have patients in your denominator for this GPRA measure. Immunization package v8.4 offers a scan function that searches the RPMS Patient Database for children who are less than 36 months old and</p>	<p>203.8, 204-208</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Childhood Immunizations CPT Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT: <i>DTaP</i>: 90696, 90698, 90700, 90721, 90723; <i>DTP</i>: 90701, 90720; <i>Tdap</i>: 90715; <i>DT</i>: 90702; <i>Td</i>: 90714, 90718; <i>Diphtheria</i>: 90719; <i>Tetanus</i>: 90703; <i>OPV</i>: 90712; <i>IPV</i>: 90696, 90698, 90713, 90723; <i>MMR</i>: 90707, 90710; <i>M/R</i>: 90708; <i>Measles</i>: 90705; <i>Mumps</i>: 90704; <i>Rubella</i>: 90706; <i>Hepatitis B</i>: 90636, 90723, 90740, 90743-90748, G0010; <i>HIB</i>: 90645-90648, 90698, 90720-90721, 90748; <i>Varicella</i>: 90710, 90716</p> <p>Quantity:</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>Childhood Immunizations Procedure Procedure Entry</p> <p>Operation/Procedure: <i>DTP</i>: 99.39; <i>Diphtheria</i>: 99.36; <i>Tetanus</i>: 99.38; <i>IPV</i>: 99.41; <i>MMR</i>: 99.48; <i>MMR contraindication</i>: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; <i>Measles</i>: 99.45; <i>Mumps</i>: 99.46; <i>Rubella</i>: 99.47;</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>reside in GPRA communities for the facility, and automatically enters them into the Register with a status of Active. Sites can run this scan at any time, and should run it upon loading 8.4. Children already in the Register or residing outside of the GPRA communities will not be affected.</p>	<p>Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>NMI Refusal of Childhood Immunizations <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p>Contraindication Childhood Immunizations Immunization Entry - Contraindications Vaccine: [See codes above] Reason: [See Contraindications section under the Provider Documentation column]</p>
<p>Cancer Screening: Pap Smear Rates</p>	<p>Women ages 21–64 should have a Pap Smear every 3 years.</p> <p>Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <p>Date received Location Results</p>	<p>Pap Smear V Lab Lab Test Entry Enter Lab Test Type: [Enter site’s defined Pap Smear Lab Test] Clinical Indication:</p> <p>Pap Smear POV Visit Diagnosis Entry Purpose of Visit: V67.01, V76.2, V72.31, V72.32, V72.3, V76.47, 795.0*, 795.10-16, 795.19 Provider Narrative: Modifier: Cause of DX:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			<p>Pap Smear CPT Visit Services Entry (includes historical CPTs) Enter CPT: 88141-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 Quantity: Modifier: Modifier 2:</p> <p>Pap Smear Procedure Procedure Entry Operation/Procedure: 91.46 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p>
<p>Cancer Screening: Mammogram Rates</p>	<p>Women ages 52–64 should have a mammogram every 2 years</p> <p>Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard EHR documentation for Radiology performed at the facility. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> Date received Location Results <p>Telephone visit with patient Verbal or written lab report Patient’s next visit</p>	<p>Mammogram POV Visit Diagnosis Entry Purpose of Visit: V76.11, V76.12, 793.80, 793.81, 793.89 Provider Narrative: Modifier: Cause of DX:</p> <p>Mammogram CPT Visit Services Entry (includes historical CPTs) Enter CPT: 77053-77059, G0206; G0204, G0202 Quantity:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			Modifier: Modifier 2: Mammogram Procedure Procedure Entry Operation/Procedure: 87.36, 87.37 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]
Colorectal Cancer Screening	<p>Adults ages 50–75 should be screened for CRC (USPTF).</p> <p>For GPRA, IHS counts any of the following:</p> <ul style="list-style-type: none"> • Annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT) • Flexible sigmoidoscopy or double contrast barium enema in the past 5 years • Colonoscopy every 10 years. <p>Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard EHR documentation for procedures performed at the facility (Radiology, Lab, provider).</p> <p>Guaiac cards returned by patients to providers should be sent to Lab for processing.</p> <p>Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> Date received Location Results <p>Telephone visit with patient Verbal or written lab report Patient’s next visit</p>	<p>Colorectal Cancer POV Visit Diagnosis Entry Purpose of Visit: 153.*, 154.0, 154.1, 197.5, V10.05 Provider Narrative: Modifier: Cause of DX:</p> <p>Colorectal Cancer CPT Visit Services Entry (includes historical CPTs) Enter CPT: G0213-G0215, G0231 Quantity: Modifier: Modifier 2:</p> <p>Total Colectomy CPT Visit Services Entry (includes historical CPTs) Enter CPT: 44150-44151, 44155-44158, 44210-44212 Quantity: Modifier:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			<p>Modifier 2:</p> <p>FOBT or FIT CPT Visit Services Entry (includes historical CPTs) Enter CPT: 82270, 82274, G0328 Quantity: Modifier: Modifier 2:</p> <p>Flexible Sigmoidoscopy CPT Visit Services Entry (includes historical CPTs) Enter CPT: 45330–45345, G0104 Quantity: Modifier: Modifier 2:</p> <p>Flexible Sigmoidoscopy Procedure Procedure Entry Operation/Procedure: 45.24 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>DBE CPT Visit Services Entry (includes historical CPTs) Enter CPT: 74280, G0106, G0120 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			<p>Colonoscopy POV Visit Diagnosis Entry Purpose of Visit: V76.51 Provider Narrative: Modifier: Cause of DX:</p> <p>Colon Screening CPT Visit Services Entry (includes historical CPTs) Enter CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121 Quantity: Modifier: Modifier 2:</p> <p>Colon Screening Procedure Procedure Entry Operation/Procedure: 45.22, 45.23, 45.25, 45.42, 45.43 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p>
<p>Tobacco Use and Exposure Assessment</p> <p>NOTE: This is not a GPRA measure; however, it will be used for reducing</p>	<p>Ask all patients age five and over about tobacco use at least annually.</p>	<p>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</p> <ul style="list-style-type: none"> Date received Location Results 	<p>Tobacco Screening Health Factor Health Factor Entry Select V Health Factor: [Enter HF (See the Provider Documentation column)] Level/Severity: Provider:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>the incidence of Tobacco Use.</p>		<p>Document on designated Health Factors section of form:</p> <ul style="list-style-type: none"> HF–Current Smoker HF–Current Smokeless HF–Current Smoker & Smokeless HF–Previous Smoker [or -Smokeless] (quit > 6 months) HF–Cessation-Smoker [or -Smokeless] (quit or actively trying < 6 months) HF–Smoker in Home HF–Ceremonial Use Only HF–Exp to ETS (Second Hand Smoke) HF–Smoke Free Home <p>NOTE: If your site uses other expressions (e.g.,” Chew” instead of “Smokeless;” “Past” instead of “Previous”), be sure Data Entry staff knows how to “translate”</p> <p>Tobacco Patient Education Codes: Codes will contain "TO-", "-TO", "-SHS"</p> <p>NOTE: Ensure you update the patient’s health factors as they enter a cessation program and eventually become non-tobacco users. Patients who are in a tobacco cessation program should have their health factor changed from “Smoker” or “Smokeless” to “Cessation-Smoker” or “Cessation-Smokeless” until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to “Previous Smoker” or “Previous Smokeless.”</p>	<p>Quantity:</p> <p>Tobacco Screening PED–Topic Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p> <p>Tobacco Users Health Factor Health Factor Entry Select V Health Factor: Current Smoker, Current Smokeless, Current Smoker and Smokeless, Cessation-Smoker, Cessation-Smokeless Level/Severity: Provider: Quantity:</p> <p>Smokers Health Factor Health Factor Entry Select V Health Factor: Current</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			<p>Smoker, Current Smoker and Smokeless, or Cessation-Smoker Level/Severity: Provider: Quantity:</p> <p>Smokeless Health Factor Health Factor Entry Select V Health Factor: Current Smokeless, Current Smoker and Smokeless, or Cessation-Smokeless Level/Severity: Provider: Quantity:</p> <p>ETS Health Factor Health Factor Entry Select V Health Factor: Exp to ETS Level/Severity: Provider: Quantity:</p>
<p>Tobacco Cessation</p>	<p>Active clinical patients identified as current tobacco users prior to report period and who have received tobacco cessation counseling or a Rx for smoking cessation aid.</p> <p>Note: Refusals are not counted toward the</p>	<p>Standard EHR documentation for tests performed at the facility. Ask and <i>record historical information</i> in EHR:</p> <p style="padding-left: 40px;">Date received Location Results</p> <p>Current tobacco users are defined by having any of the following documented prior to the report period:</p>	<p>Tobacco Cessation PED - Topic Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
	<p>GPRA measure, but should still be documented.</p>	<p>Last documented Tobacco Health Factor Last documented Tobacco related POV Last documented Tobacco related CPT</p> <p>Health factors considered to be a tobacco user: HF–Current Smoker HF–Current Smokeless HF–Current Smoker & Smokeless HF–Cessation-Smoker [or -Smokeless] (quit or actively trying < 6 months)</p> <p>Tobacco Patient Education Codes: Codes will contain "TO-", "-TO", "-SHS"</p> <p>Prescribe Tobacco Cessation Aids: Predefined Site-Populated Smoking Cessation Meds Meds containing: “Nicotine Patch” “Nicotine Polacrilex” “Nicotine Inhaler” “Nicotine Nasal Spray”</p> <p>NOTE: Ensure you update the patient’s health factors as they enter a cessation program and eventually become nontobacco users. Patients who are in a tobacco cessation program should have their health factor changed from “Smoker” or “Smokeless” to “Cessation-Smoker” or “Cessation-Smokeless” until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to “Previous Smoker” or “Previous</p>	<p>Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p> <p>Tobacco Cessation PED–Diagnosis Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: 649.00-649.04 Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider’s Narrative:</p> <p>Tobacco Cessation Clinic Clinic Entry Clinic: 94</p> <p>Tobacco Cessation Dental (ADA) <i>ADA codes cannot be entered into EHR.</i></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		Smokeless.”	<p>Tobacco Cessation CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: D1320, 99406, 99407, 4000F, G8402 or G8453 Quantity Modifier: Modifier 2:</p> <p>Tobacco Cessation Medication Medication Entry Select Medication: [Enter Tobacco Cessation Prescribed Medication] Outside Drug Name (Optional): [Enter any additional name for the drug] SIG Quantity: Day Prescribed: Event Date&Time: Ordering Provider:</p> <p>Tobacco Cessation Prescription CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 4001F Quantity Modifier: Modifier 2:</p>
Alcohol Screening (FAS Prevention)	Pregnant women should be screened for alcohol use at least on their first	Standard EHR documentation for tests performed at the facility. Ask and <i>record</i>	Alcohol Screening Exam Exam Entry (includes historical

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
	<p>visit; education and follow-up provided as appropriate.</p> <p>Women of childbearing age should be screened at least annually.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p><i>historical information</i> in EHR:</p> <ul style="list-style-type: none"> Date received Location Results <p>Alcohol screening may be documented with either an exam code or the CAGE health factor in EHR.</p> <p>Medical Providers:</p> <p>EXAM—Alcohol Screening</p> <ul style="list-style-type: none"> Negative—Patient’s screening exam does not indicate risky alcohol use. Positive—Patient’s screening exam indicates potential risky alcohol use. Refused—Patient declined exam/screen Unable to screen - Provider unable to screen <p>Note: Recommended Brief Screening Tool: SASQ (below).</p> <p><u>Single Alcohol Screening Question (SASQ)</u></p> <p><u>For Women:</u></p> <p>When was the last time you had more than 4 drinks in one day?</p> <p><u>For Men:</u></p> <p>When was the last time you had more than 5 drinks in one day?</p> <p>Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen:</p> <p>Alcohol Screening Exam Code Result:</p>	<p>exams)</p> <p>Select Exam: 35, ALC</p> <p>Result:</p> <ul style="list-style-type: none"> A—Abnormal N—Normal/Negative PR—Resent PAP—Present and Past PA—Past PO—Positive <p>Comments: SASQ</p> <p>Provider Performing Exam:</p> <p>Cage Health Factor</p> <p>Health Factor Entry</p> <p>Select Health Factor: CAGE</p> <ol style="list-style-type: none"> 1 CAGE 0/4 (all No answers) 2 CAGE 1/4 3 CAGE 2/4 4 CAGE 3/4 5 CAGE 4/4 <p>Choose 1-5: [Number from above]</p> <p>Level/Severity:</p> <p>Provider:</p> <p>Quantity:</p> <p>Alcohol Screening POV</p> <p>Visit Diagnosis Entry</p> <p>Purpose of Visit: V11.3, V79.1</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>Positive</p> <p>The patient may decline the screen or “Refuse to answer”: Alcohol Screening Exam Code Result: Refused</p> <p>The provider is unable to conduct the screen: Alcohol Screening Exam Code Result: Unable To Screen</p> <p>Note: Provider should note the screening tool used was the SASQ at the <i>Comment</i> Mnemonic for the Exam code.</p> <p>All Providers: Use the CAGE questionnaire:</p> <p>Have you ever felt the need to Cut down on your drinking?</p> <p>Have people Annoyed you by criticizing your drinking?</p> <p>Have you ever felt bad or Guilty about your drinking?</p> <p>Have you ever needed an Eye-opener the first thing in the morning to steady your nerves or get rid of a hangover?</p> <p>Tolerance: How many drinks does it take you to get high? Based on how many YES answers were received, document Health Factor in EHR: HF-CAGE 0/4 (all No answers) HF-CAGE 1/4</p>	<p>Alcohol Screening CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 99408, 99409, G0396, G0397, H0049, H0050 Quantity Modifier: Modifier 2:</p> <p>Alcohol-Related Diagnosis POV Visit Diagnosis Entry Purpose of Visit: 303.*, 305.0*, 291.*, 357.5* Provider Narrative: Modifier: Cause of DX:</p> <p>Alcohol-Related Procedure Procedure Entry Operation/Procedure: 94.46, 94.53, 94.61-94.63, 94.67-94.69 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>Alcohol-Related PED - Topic Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter Alcohol-Related Education Code (See the Provider Documentation column)]</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>HF-CAGE 2/4 HF-CAGE 3/4 HF-CAGE 4/4</p> <p>Optional values: Level/Severity: Minimal, Moderate, or Heavy/Severe Quantity: # of drinks daily OR T (Tolerance) -- # drinks to get high (e.g. T-4) Comment: used to capture other relevant clinical info e.g. "Non-drinker"</p> <p>Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-"</p> <p>AUDIT Measurements: Zone I: Score 0–7 Low risk drinking or abstinence Zone II: Score 8–15 Alcohol use in excess of low-risk guidelines Zone III: Score 16–19 Harmful and hazardous drinking Zone IV: Score 20–40 Referral to Specialist for Diagnostic Evaluation and Treatment</p> <p>AUDIT-C Measurements: How often do you have a drink containing alcohol? (0) Never (Skip to Questions 9-10) (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week</p>	<p>Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p> <p>Alcohol-Related PED - Diagnosis Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: V11.3, V79.1, 303.*, 305.0*, 291.* or 357.5* Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider’s Narrative:</p> <p>Alcohol Screen AUDIT Measurement Vital Measurements Entry (includes historical Vitals)</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>(4) 4 or more times a week</p> <p>How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more</p> <p>How often do you have six or more drinks on one occasion?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p>The AUDIT-C (the first three AUDIT questions which focus on alcohol consumption) is scored on a scale of 0–12 (scores of 0 reflect no alcohol use).</p> <p>In men, a score of 4 or more is considered positive In women, a score of 3 or more is considered positive.</p> <p>A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence.</p> <p>CRAFFT Measurements:</p> <p>C–Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?</p>	<p>Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken:</p> <p>Alcohol Screen AUDIT-C Measurement Vital Measurements Entry (includes historical Vitals) Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken:</p> <p>Alcohol Screen CRAFFT Measurement Vital Measurements Entry (includes historical Vitals) Value: [Enter 0-6] Select Qualifier: Date/Time Vitals Taken:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?</p> <p>A–Do you ever use alcohol/drugs while you are by yourself, ALONE?</p> <p>F–Do you ever FORGET things you did while using alcohol or drugs?</p> <p>F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?</p> <p>T–Have you gotten into TROUBLE while you were using alcohol or drugs?</p> <p>Total CRAFFT score (Range: 0–6). Positive answers to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated.</p>	
<p>Intimate Partner (Domestic) Violence Screening (IPV/DV)</p>	<p>Adult females should be screened for domestic violence at new encounter and at least annually Prenatal once each trimester (Source: Family Violence Prevention Fund National Consensus Guidelines)</p> <p>Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</p>	<p>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Medical and Behavioral Health Providers: EXAM—IPV/DV Screening</p> <p>Negative–Denies being a current or past victim of IPV/DV</p> <p>Past–Denies being a current victim, but discloses being a past victim of IPV/DV</p> <p>Present–Discloses current IPV/DV</p> <p>Present and Past–Discloses past victimization and current IPV/DV victimization</p> <p>Refused–Patient declined exam/screen</p> <p>Unable to screen–Unable to screen patient</p>	<p>IPV/DV Screening Exam Exam Entry (includes historical exams) Select Exam: 34, INT Result: A–Abnormal N–Normal/Negative PR–Resent PAP–Present and Past PA–Past PO–Positive Comments: Provider Performing Exam:</p> <p>IPV/DV Diagnosis POV Visit Diagnosis Entry Purpose of Visit: 995.80-83, 995.85, V15.41, V15.42, V15.49,</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>(partner or verbal child present, unable to secure an appropriate interpreter, etc.)</p> <p>IPV/DV Patient Education Codes: Codes will contain "DV-" or "-DV"</p>	<p>V61.11 (IPV/DV Counseling) Provider Narrative: Modifier: Cause of DX:</p> <p>IPV/DV–Topic Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter IPV/DV Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p> <p>IPV/DV PED–Diagnosis Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: 995.80-83, 995.85, V15.41, V15.42, V15.49 Category: Readiness to Learn: Level of Understanding: Provider:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:
Depression Screening	<p>Adult patients 18 years of age and older should be screened for depression at least annually. (Source: United States Preventive Services Task Force)</p> <p>Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</p>	<p>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> Date received Location Results <p>Medical Providers: EXAM—Depression Screening</p> <ul style="list-style-type: none"> Normal/Negative—Denies symptoms of depression Abnormal/Positive—Further evaluation indicated Refused—Patient declined exam/screen Unable to screen—Provider unable to screen <p>Note: Refusals are not counted toward the GPRA measure, but should be documented.</p> <p>Mood Disorders: Two or more visits with POV related to:</p> <ul style="list-style-type: none"> Major Depressive Disorder Dysthymic Disorder Depressive Disorder NOS Bipolar I or II Disorder 	<p>Depression Screening Exam Exam Entry (includes historical exams) Select Exam: 36, DEP Result: A—Abnormal N—Normal/Negative PR—Resent PAP—Present and Past PA—Past PO—Positive Comments: PHQ-2 Scaled, PHQ9 Provider Performing Exam:</p> <p>Depression Screen Diagnosis POV Visit Diagnosis Entry Purpose of Visit: V79.0 Provider Narrative: Modifier: Cause of DX:</p> <p>Mood Disorder Diagnosis POV Visit Diagnosis Entry Purpose of Visit: 296.*, 291.89,</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>Cyclothymic Disorder</p> <p>Bipolar Disorder NOS</p> <p>Mood Disorder Due to a General Medical Condition</p> <p>Substance-induced Mood Disorder</p> <p>Mood Disorder NOS</p> <p>Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</p> <p><u>Patient Health Questionnaire (PHQ-2 Scaled Version)</u></p> <p>Over the past 2 weeks, how often have you been bothered by any of the following problems?</p> <p>Little interest or pleasure in doing things</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>Feeling down, depressed, or hopeless</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>PHQ-2 Scaled Version (continued)</p> <p>Total Possible PHQ-2 Score: Range: 0-6</p> <p>0-2: Negative Depression Screening Exam:</p> <p>Code Result: Normal or Negative</p>	<p>292.84, 293.83, 300.4, 301.13, 311</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>3-6: Positive; further evaluation indicated Depression Screening Exam Code Result: Abnormal or Positive</p> <p>The patient may decline the screen or “Refuse to answer” Depression Screening Exam Code Result: Refused</p> <p>The provider is unable to conduct the Screen Depression Screening Exam Code Result: Unable To Screen</p> <p>Provider should note the screening tool used was the PHQ-2 Scaled at the <i>Comment</i> Mnemonic for the Exam Code.</p> <p><u>PHQ9 Questionnaire Screening Tool</u></p> <p>Little interest or pleasure in doing things?</p> <ul style="list-style-type: none"> a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3 <p>Feeling down, depressed, or hopeless?</p> <ul style="list-style-type: none"> a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3 <p>Trouble falling or staying asleep, or sleeping too much?</p> <ul style="list-style-type: none"> a. Not at all Value: 0 b. Several days Value: 1 	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>Feeling tired or having little energy?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>Poor appetite or overeating?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>Feeling bad about yourself—or that you are a failure or have let yourself or your family down?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>Trouble concentrating on things, such as reading the newspaper or watching television?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>Moving or speaking so slowly that other people could have noticed. Or the opposite—being so</p>	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>fidgety or restless that you have been moving around a lot more than usual?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p>Thoughts that you would be better off dead, or of hurting yourself in some way?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><u>PHQ9 Questionnaire (Continued)</u></p> <p>Total Possible PHQ-2 Score: Range: 0–27</p> <p>0-4 Negative/None Depression Screening Exam: Code Result: None</p> <p>5-9 Mild Depression Screening Exam: Code Result: Mild depression</p> <p>10-14 Moderate Depression Screening Exam: Code Result: Moderate depression</p> <p>15-19 Moderately Severe Depression Screening Exam: Code Result: Moderately Severe depression</p> <p>20-27 Severe Depression Screening Exam: Code Result: Severe depression</p> <p>Provider should note the screening tool used was the PHQ9 Scaled at the <i>Comment</i></p>	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		Mnemonic for the Exam Code.	
<p>Obesity Assessment (Calculate Body Mass Index [BMI])</p> <p>NOTE: This is not a GPRA measure; however, it's displayed in GPRA report for reducing the incidence of obesity. The information is included here is to inform providers and data entry staff of how to collect, document, and enter the data.</p>	<p>Children (through age 18) must have both height and weight taken <u>on the same day</u> at least annually (at every visit is recommended).</p> <p>Adults 19-50, height and weight at least <u>every 5 years</u>, not required to be on same day.</p> <p>Adults over 50, height and weight taken <u>every 2 years</u>, not required to be on same day.</p>	<p>Standard EHR documentation. Obtain height and weight during visit and record information in EHR:</p> <p>Height</p> <p>Weight</p> <p>Date Recorded</p> <p>BMI is calculated using NHANES II.</p> <p>Obese is defined as:</p> <p>BMI of 30 or more for adults 19 and older.</p> <p>For ages 2–18, definitions based on standard tables.</p> <p>To document Refusals in EHR:</p> <p>Refusal Entry in EHR</p> <p>For ages 18 and under, both the height and weight must be refused on the same visit at any time during the past year.</p> <p>For ages 19 and older, the height and weight must be refused during the past year and are not required to be on the same visit.</p>	<p>Height Measurement</p> <p>Vital Measurements Entry (includes historical Vitals)</p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Estimated</p> <p>Date/Time Vitals Taken:</p> <p>Weight Measurement</p> <p>Vital Measurements Entry (includes historical Vitals)</p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Bed</p> <p>Chair</p> <p>Dry</p> <p>Estimated</p> <p>Standing</p> <p>Date/Time Vitals Taken:</p>
<p>Childhood Weight Control</p>	<p>Patients ages 2–5 at the beginning of the report period whose BMI could be calculated and have a BMI => 95%.</p> <p>Height and weight taken on the same day.</p> <p>Patients that turn 6 years old during the report</p>	<p>Standard EHR documentation. obtain height and weight during visit and record information in EHR:</p> <p>Height</p> <p>Weight</p> <p>Date Recorded</p> <p>BMI is calculated using NHANES II</p> <p>Age in the age groups is calculated based on the</p>	<p>Height Measurement</p> <p>Vital Measurements Entry (includes historical Vitals)</p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Estimated</p> <p>Date/Time Vitals Taken:</p>

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	<p>period are not included in the GPRA measure.</p>	<p>date of the most current BMI found.</p> <p>Example, a patient may be 2 at the beginning of the time period but is 3 at the time of the most current BMI found, patient will fall into the age 3 group.</p> <p>The BMI values for this measure are reported differently than in the Obesity Assessment measure as they are Age-Dependent. The BMI values are categorized as Overweight for patients with a BMI in the 85th to 94th percentile and Obese for patients with a BMI at or above the 95th percentile (GPRA).</p> <p>Patients whose BMI either is greater or less than the Data Check Limit range shown below will not be included in the report counts for Overweight or Obese.</p> <table border="1" data-bbox="856 824 1514 1263"> <thead> <tr> <th data-bbox="863 829 961 914">Low-High</th> <th data-bbox="966 829 1064 914"></th> <th data-bbox="1068 829 1178 914">BMI ≥ 85</th> <th data-bbox="1182 829 1291 914">BMI ≥ 95</th> <th colspan="2" data-bbox="1295 829 1507 914">Data Check Limits</th> </tr> <tr> <th data-bbox="863 917 961 987">Ages</th> <th data-bbox="966 917 1064 987">Sex</th> <th data-bbox="1068 917 1178 987">Over Weight</th> <th data-bbox="1182 917 1291 987">Obese</th> <th data-bbox="1295 917 1386 987">BMI ></th> <th data-bbox="1390 917 1507 987">BMI <</th> </tr> </thead> <tbody> <tr> <td data-bbox="863 990 961 1060">2-2</td> <td data-bbox="966 990 1064 1060">M F</td> <td data-bbox="1068 990 1178 1060">17.7 17.5</td> <td data-bbox="1182 990 1291 1060">18.7 18.6</td> <td data-bbox="1295 990 1386 1060">36.8 37.0</td> <td data-bbox="1390 990 1507 1060">7.2 7.1</td> </tr> <tr> <td data-bbox="863 1063 961 1133">3-3</td> <td data-bbox="966 1063 1064 1133">M F</td> <td data-bbox="1068 1063 1178 1133">17.1 17.0</td> <td data-bbox="1182 1063 1291 1133">18.0 18.1</td> <td data-bbox="1295 1063 1386 1133">35.6 35.4</td> <td data-bbox="1390 1063 1507 1133">7.1 6.8</td> </tr> <tr> <td data-bbox="863 1136 961 1206">4-4</td> <td data-bbox="966 1136 1064 1206">M F</td> <td data-bbox="1068 1136 1178 1206">16.8 16.7</td> <td data-bbox="1182 1136 1291 1206">17.8 18.1</td> <td data-bbox="1295 1136 1386 1206">36.2 36.0</td> <td data-bbox="1390 1136 1507 1206">7.0 6.9</td> </tr> <tr> <td data-bbox="863 1209 961 1263">5-5</td> <td data-bbox="966 1209 1064 1263">M F</td> <td data-bbox="1068 1209 1178 1263">16.9 16.9</td> <td data-bbox="1182 1209 1291 1263">18.1 18.5</td> <td data-bbox="1295 1209 1386 1263">36.0 39.2</td> <td data-bbox="1390 1209 1507 1263">6.9 6.8</td> </tr> </tbody> </table>	Low-High		BMI ≥ 85	BMI ≥ 95	Data Check Limits		Ages	Sex	Over Weight	Obese	BMI >	BMI <	2-2	M F	17.7 17.5	18.7 18.6	36.8 37.0	7.2 7.1	3-3	M F	17.1 17.0	18.0 18.1	35.6 35.4	7.1 6.8	4-4	M F	16.8 16.7	17.8 18.1	36.2 36.0	7.0 6.9	5-5	M F	16.9 16.9	18.1 18.5	36.0 39.2	6.9 6.8	<p>Weight Measurement Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Bed Chair Dry Estimated Standing Date/Time Vitals Taken:</p>
Low-High		BMI ≥ 85	BMI ≥ 95	Data Check Limits																																			
Ages	Sex	Over Weight	Obese	BMI >	BMI <																																		
2-2	M F	17.7 17.5	18.7 18.6	36.8 37.0	7.2 7.1																																		
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5-5	M F	16.9 16.9	18.1 18.5	36.0 39.2	6.9 6.8																																		
<p>Comprehensive CVD-Related Assessment</p>	<p>Active Clinical Patients ages 22 and older diagnosed with Ischemic Heart Disease (IHD) prior to the Report Period, and at least 2</p>	<p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <p>Date received</p> <p>Location</p>	<p>IHD Diagnosis POV (Prior to the report period) Visit Diagnosis Entry Purpose of Visit: 410.0-412.*, 414.0-414.9, 428.* 429.2 Provider Narrative:</p>																																				

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
	<p>visits during the Report Period, and 2 IHD-related visits ever who had the following tests documented:</p> <ul style="list-style-type: none"> • Blood Pressure • LDL Assessment • Tobacco Use Assessment • BMI Calculated • Lifestyle Counseling <p>Note: This does <i>not</i> include depression screening and does <i>not</i> include refusals of BMI.</p> <p>Note: Refusals of any or all of the above are not counted toward the GPRA measure, but should still be documented.</p>	<p>Results</p> <p>Note: See related individual measures above for recording historical information.</p> <p>Blood Pressure Control</p> <p>LDL Assessment</p> <p>Tobacco Use and Assessment</p> <p>BMI (Obesity)</p> <p>Tobacco Use Health Factors:</p> <p>HF–Current Smoker</p> <p>HF–Current Smokeless</p> <p>HF–Current Smoker & Smokeless</p> <p>HF–Previous Smoker [or -Smokeless] (quit > 6 months)</p> <p>HF–Cessation-Smoker [or -Smokeless] (quit or actively trying < 6 months)</p> <p>HF–Smoker in Home</p> <p>HF–Ceremonial Use Only</p> <p>HF–Exp to ETS (Second Hand Smoke)</p> <p>HF–Smoke Free Home</p> <p>NOTE: If your site uses other expressions (e.g.,” Chew” instead of “Smokeless;” “Past” instead of “Previous”), be sure Data Entry staff knows how to “translate”</p> <p>Tobacco Patient Education Codes:</p> <p>Codes will contain "TO-", "-TO", "-SHS"</p> <p>BMI is calculated using NHANES II.</p> <p>Adults 19–50, height and weight at least every 5 years, not required to be on same day.</p>	<p>Modifier:</p> <p>Cause of DX:</p> <p>Blood Pressure Data Entry</p> <p>Vital Measurements Entry (includes historical Vitals)</p> <p>Value: [Enter as Systolic/Diastolic (e.g., 130/80)]</p> <p>Select Qualifier:</p> <p>Date/Time Vitals Taken:</p> <p>LDL (Calculated) Lab Test</p> <p>Lab Test Entry</p> <p>Enter Lab Test Type: LDL</p> <p>Collect Sample/Specimen: [Blood]</p> <p>Clinical Indication:</p> <p>LDL CPT</p> <p>Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F</p> <p>Quantity :</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>Tobacco Use Assessment</p> <p>Health Factor Entry</p> <p>Select V Health Factor: [Enter HF (See the Provider Documentation column)]</p> <p>Level/Severity:</p> <p>Provider:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<p>Adults over 50, height and weight taken every 2 years, not required to be on same day.</p> <p>Nutrition, dietary surveillance and counseling Patient Education Codes: Codes will contain "-N" (Nutrition) or "-MNT"</p> <p>Exercise Patient Education Codes: Codes will contain "-EX"</p> <p>Lifestyle Patient Education Codes: Codes will contain "-LA"</p> <p>Other Related Nutrition and Exercise Patient Educations Codes: Codes will contain "-OBS" (Obesity)</p> <p>Lifestyle Counseling includes: Lifestyle adaptation counseling Medical nutrition therapy Nutrition counseling Exercise counseling Other lifestyle education</p>	<p>Quantity:</p> <p>Tobacco Use Dental (ADA) <i>ADA codes cannot be entered into EHR.</i></p> <p>Tobacco Screening CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: D1320, 99406, 99407, 1034F, 1035F, 1036F, 1000, G8455, G8456, G8457, G8402, G8453</p> <p>Quantity Modifier: Modifier 2:</p> <p>Tobacco Related Diagnoses POV Visit Diagnosis Entry Purpose of Visit: 305.1, 649.00-649.04, V15.82 Provider Narrative: Modifier: Cause of DX:</p> <p>Tobacco Screening PED - Topic Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			<p>Provider: Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p> <p>Tobacco Screening PED– Diagnosis Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: 305.1, 649.00-649.04, V15.82 Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider’s Narrative:</p> <p>BMI Data Entry Height Measurement Vital Measurements Entry (includes historical Vitals) Value:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			<p>Select Qualifier: Actual Estimated Date/Time Vitals Taken:</p> <p>Weight Measurement Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Bed Chair Dry Estimated Standing Date/Time Vitals Taken:</p> <p>Lifestyle Counseling Data Entry Medical Nutrition Therapy CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 97802-97804, G0270, G0271 Quantity Modifier: Modifier 2:</p> <p>Medical Nutrition Therapy Clinic Clinic Entry Clinic: 67, 36</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			<p>Nutrition Education POV Visit Diagnosis Entry Purpose of Visit: V65.3 Provider Narrative: Modifier: Cause of DX:</p> <p>Nutrition/Exercise/Lifestyle Adaption PED–Topic Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter Nutrition/Exercise/Lifestyle Adaption Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p> <p>Nutrition/Exercise/Lifestyle Adaption PED–Diagnosis Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: V65.3 (Nutrition),</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			<p>V65.41 (Exercise), 278.00 or 278.01 (Obesity)</p> <p>Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:</p>
<p>HIV Screening</p>	<p>Pregnant women should be tested for HIV at least on their first visit; education and follow-up provided as appropriate.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</p> <p style="padding-left: 40px;">Date received Location Results</p> <p>NOTE: The timeframe for screening for the pregnant patient's denominator is anytime during the past 20 months.</p> <p>Pregnant patients are any patients with at least two visits with a pregnancy POV code with no recorded abortion or miscarriage in this timeframe.</p>	<p>HIV Screen CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 86689, 86701-86703, 87390, 87391, 87534-87539 Quantity Modifier: Modifier 2:</p> <p>HIV Diagnoses POV Visit Diagnosis Entry Purpose of Visit: 042, 079.53, V08, 795.71 Provider Narrative: Modifier: Cause of DX:</p> <p>HIV Lab Test Lab Test Entry</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			Enter Lab Test Type: [Enter site's defined HIV Screen Lab Test] Collect Sample/Specimen: [Blood, Serum] Clinical Indication:
Breastfeeding Rates NOTE: This is not a GPRA measure; however, it will be used in conjunction with the Childhood Weight Control measure for reducing the incidence of childhood obesity. The information is included here to inform providers and data entry staff of how to collect, document, and enter the data.	<u>All providers should assess the feeding practices of all newborns through age 1 year at all well-child visits.</u>	Definitions for Infant Feeding Choice Options: Exclusive Breastfeeding –Breastfed or expressed breast milk only, no formula Mostly Breastfeeding –Mostly breastfed or expressed breast milk, with some formula feeding (1X per week or more, but less than half the time formula feeding.) $\frac{1}{2}$ Breastfeeding, $\frac{1}{2}$ Formula Feeding –Half the time breastfeeding/expressed breast milk, half formula feeding Mostly Formula –The baby is mostly formula fed, but breastfeeds at least once a week Formula Only –Baby receives only formula The additional one-time data fields, e.g., birth weight, formula started, and breast stopped, may also be collected and may be entered using the data entry Mnemonic PIF. However, this information is not used or counted in the CRS logic for Breastfeeding Rates.	Infant Breastfeeding Infant Feeding Choice Entry Enter Feeding Choice: Exclusive Breastfeeding Mostly Breastfeeding 1/2 & 1/2 Breast and Formula Mostly Formula Formula Only
Patient Education Measures (Patient Education Report) NOTE: This is not a GPRA measure; however, the information is being provided because there are several	N/A	<u>All providers should document all 5 patient education elements and elements #6–7 below if a goal was set for the patient:</u> 1. Education Topic/Diagnosis 2. Readiness to Learn 3. Level of Understanding (see below) 4. Initials of Who Taught	Patient Education Topic Patient Education Entry (includes historical patient education) Topic: [Enter Topic] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>GPRA measures that do include patient education as meeting the numerator (e.g. alcohol screening). Providers and data entry staff need to know they need to collect and enter <i>all</i> components of patient education.</p>		<p>5. Time spent (in minutes)</p> <p>6. Goal Not Set, Goal Set, Goal Met, Goal Not Met</p> <p>7. Text relating to the goal or its status</p> <p>Readiness to Learn:</p> <ul style="list-style-type: none"> Distraction Eager To Learn Intoxication Not Ready Pain Receptive Severity of Illness Unreceptive <p>Levels of Understanding:</p> <ul style="list-style-type: none"> P–Poor F–Fair G–Good GR–Group-No Assessment R–Refused <p>Goal Codes:</p> <ul style="list-style-type: none"> GS–Goal Set GM–Goal Met GNM–Goal Not Met GNS–Goal Not Set <p>Diagnosis Categories:</p> <ul style="list-style-type: none"> Anatomy and Physiology 	<p>Length of Educ (minutes):</p> <p>Comment:</p> <p>Goal Code: GS, GM, GNM, GNS</p> <p>Goal Comment:</p> <p>Patient Education Diagnosis</p> <p>Patient Education Entry (includes historical patient education)</p> <p>Select ICD Diagnosis Code Number:</p> <p>Category: [Enter Category]</p> <p>Readiness to Learn: D, E, I, N, P, R, S, U</p> <p>Level of Understanding: P, F, G, GR, R</p> <p>Provider:</p> <p>Length of Educ (Minutes):</p> <p>Comment:</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Provider’s Narrative:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		Complications Disease Process Equipment Exercise Follow-up Home Management Hygiene Lifestyle Adaptation Literature Medical Nutrition Therapy Medications Nutrition Prevention Procedures Safety Tests Treatment	

Appendix A

Below you will find general instructions on how to enter the following information in EHR:

- [Clinic Codes](#)
- [Purpose of Visit / Diagnosis](#)
- [CPT codes](#)
- [Procedure Codes](#)
- [Exams](#)
- [Health Factors](#)
- [Immunizations](#), including [contraindications](#)
- [Vital Measurements](#)
- [Lab Tests](#)
- [Medications](#)
- [Infant Feeding](#)
- [Patient Education](#)
- [Refusals](#) (Note: GPRA measures do *not* include refusals, though refusals should still be documented.)

For many of these actions, you will need to have a visit chosen before you can enter data.

Please note that EHR is highly configurable, so components may be found on tabs other than those listed here. Tabs may also be named differently.

Clinic Codes

Clinic codes are chosen when a visit is created.

Encounter Settings for Current Activities

17 OPHTHALMOLOGY 19-Aug-2010 12:12

Encounter Location

Appointments / Visits Hospital Admissions New Visit

Visit Location

- 17 OPHTHALMOLOGY
- 11 HOME CARE
- 12 IMMUNIZATION
- 13 INTERNAL MEDICINE
- 14 MENTAL HEALTH
- 16 OBSTETRICS
- 17 OPHTHALMOLOGY
- 18 OPTOMETRY

Date of Visit

Thursday , August 19, 2010

Time of Visit

12:12 PM

Type of Visit

Ambulatory

Create a Visit Now

Encounter Providers

All Providers

- POWERS,MEGAN
- POWERS,MEGAN
- REGA,ANN
- RICHARDS,SUSAN P
- ROBARDS,DARLENE G
- ROZSNYAI,DUANE
- SALMON,PHILLIP

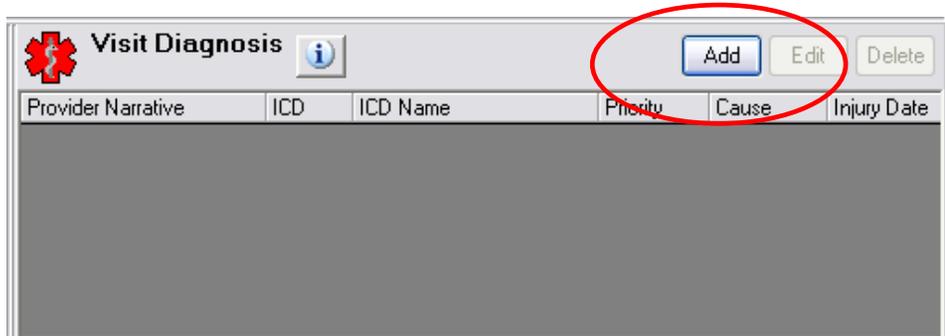
OK Cancel

Purpose of Visit/Diagnosis

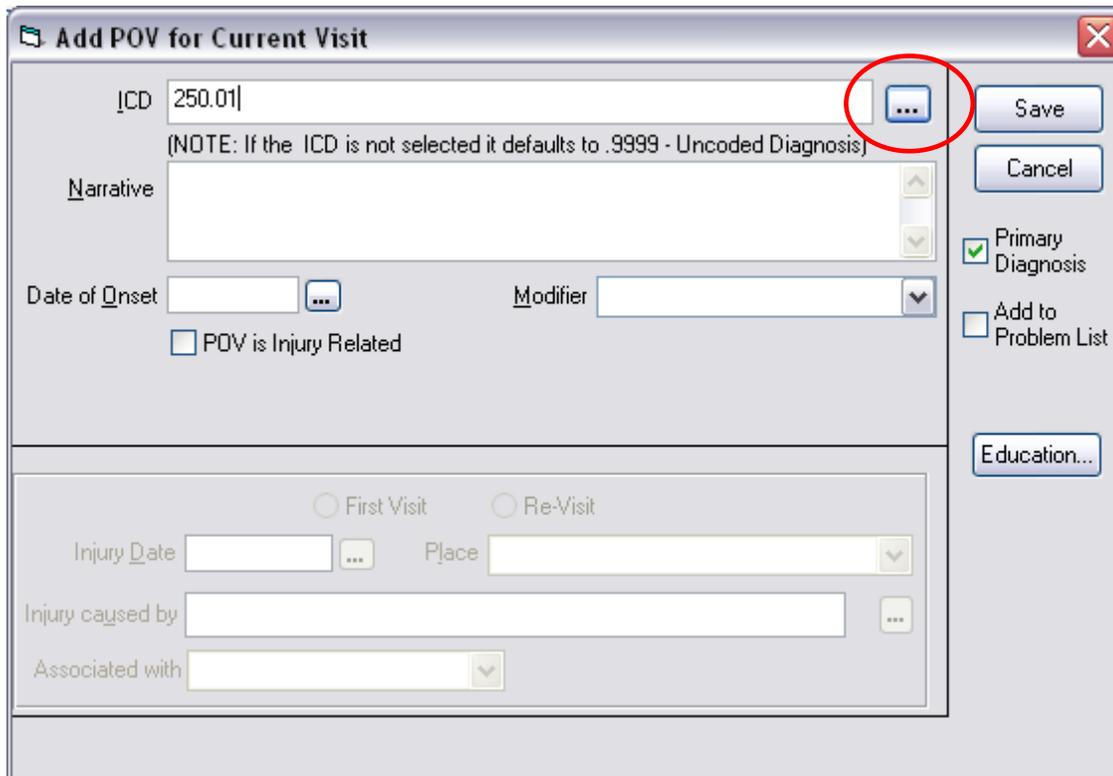
The purpose of visit is entered in the Visit Diagnosis component, which may be found on the Prob/POV tab.

The screenshot displays the IHS-EHR Tucson Development System interface. The patient information at the top includes Patient ID 900031, name POWERS, MEGAN, and date of birth 01-Jul-1958. The system shows a 'Triage Summary' section with various checkboxes for medical conditions such as 'Child Abuse And Neglect, Ot...', 'Counseling For Perpetrator O...', 'Child Abuse, Emotional/ Psy...', 'Counseling For Victim Of Chil...', 'Child Abuse, Other', 'Family Disruption', 'Child Abuse, Sexual', 'History Of Emotional Abuse', 'Child Abuse, Shaken Baby S...', 'History Of Physical Abuse', and 'Child Neglect', 'Observation For Suspected A...'. Below this is a 'Problem List' table with one entry: 'Dental Exam' (Active, Modified 06/18/2003, ICD V72.2, ICD Name DENTAL EXAMINATION, Classification). The 'Historical Diagnosis' table lists three past diagnoses: 'Dental Exam' (06/18/2003, ICD V72.2, Demo Indian Hospital), 'AMI' (06/01/2003, ICD 410.21, Demo Indian Hospital), and 'STENOSIS' (05/01/2002, ICD 395.0, Demo Indian Hospital). The 'Visit Diagnosis' component is highlighted with a red circle and is currently empty. The bottom navigation bar includes tabs for 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', and 'WCM'. The status bar at the bottom shows the user 'POWERS, MEGAN', the organization 'DEMO.OKLAHOMA.IHS.GOV', the facility 'DEMO INDIAN HOSPITAL', and the time '20-Aug-2010 15:39'.

To enter a POV, click Add in the Visit Diagnosis component.



The Add POV for Current Visit dialog box displays. Type in the ICD code and click the ellipses (...) button.



Choose the ICD that you would like to enter and click OK.

Diagnosis Lookup

Lookup Option Lexicon ICD

Search Value

Select from one of the following items

Code	Description
250.01	Diabetes Mellitus Without Mention Of Complication, Type I [juvenile Type], Not Stated As Uncontrolled

Return Search Text as Narrative

Enter in any other pertinent information and click Save.

Add POV for Current Visit

ICD: ...

(NOTE: If the ICD is not selected it defaults to .9999 - Uncoded Diagnosis)

Narrative:

Date of Onset: ... Modifier:

POV is Injury Related

Primary Diagnosis

Add to Problem List

Education...

First Visit Re-Visit

Injury Date: ... Place:

Injury caused by: ...

Associated with:

Your newly added POV should display in the Visit Diagnosis component.

Visit Diagnosis Info Add Edit Delete

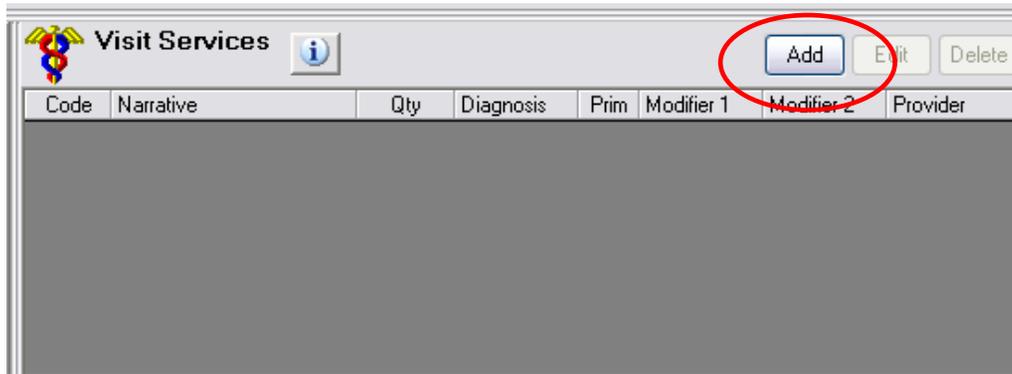
Provider Narrative	ICD	ICD Name	Priority	Cause	Injury Date	Injury Cause	Injury Place	Modifier
Diabetes Mellitus Without Mention Of Complication, Type I [juvenile Type], Not Stated As Uncontrolled	250.01	DIABETES I/JUV NOT UNCONTRL	Primary					

CPT Codes

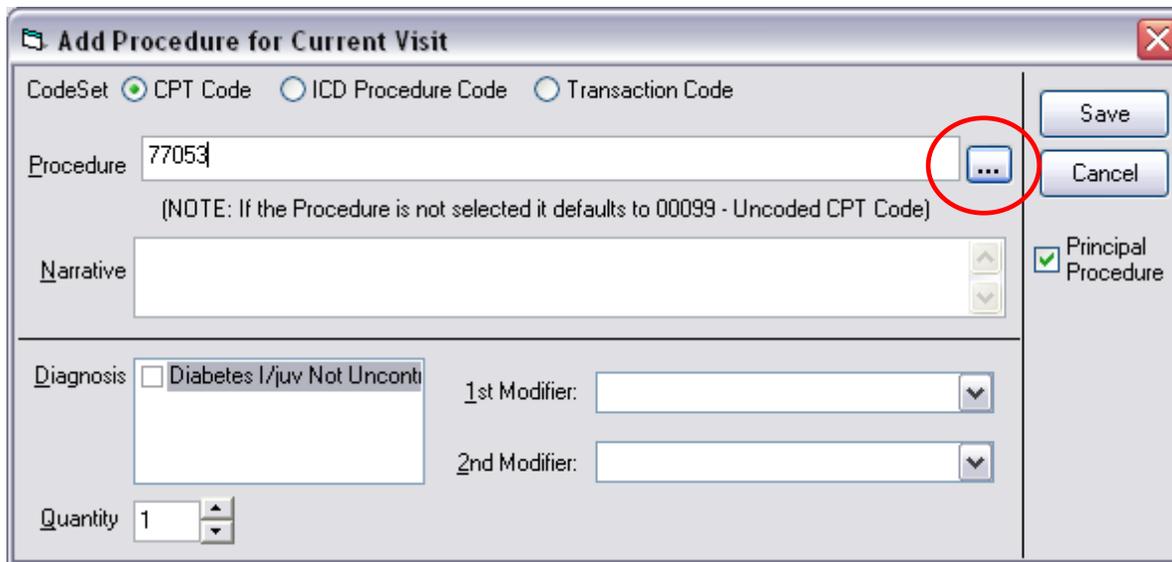
CPT codes are entered in the Visit Services component, which is located on the Services tab.

The screenshot displays the IHS-EHR Tucson Development System interface. The top navigation bar includes 'User', 'Patient', 'Tools', and 'Help'. Below this, there are tabs for 'Patient Chart', 'Communication', 'RPMS', 'CIHA Intranet', 'Micromedex', and 'E-Mail'. The patient information section shows 'Patient: Crsae', '01 GENERAL', 'POWERS, MEGAN', and '19-Aug-2010 Am'. The 'Historical Services' section is set to 'Radiology' and includes an 'Add to Current Visit' button. A table of historical services is visible, with one entry: '07/05/2010 74280 Barium Enema Cherokee Indian Hospital 1'. The 'Super-Bills' section has checkboxes for 'Display', 'Freq. Rank', 'Code', and 'Description', and a 'Cols' dropdown set to '4'. The 'Patient Education' section lists 'Pt Ed Ones', 'Diabetes', and 'Immunizations'. The 'Evaluation and Management' section has radio buttons for 'New Patient' and 'Established'. The 'Visit Services' section is highlighted with a red circle and contains a table with columns: 'Code', 'Narrative', 'Qty', 'Diagnosis', 'Prim', 'Modifier 1', 'Modifier 2', and 'Provider'. The bottom navigation bar includes tabs for 'Notifications', 'Cover Sheet', 'Triage', 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prod/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Priority', and 'WCM'. The status bar at the bottom shows 'POWERS, MEGAN', 'DEMO.OKLAHOMA.IHS.GOV', 'DEMO INDIAN HOSPITAL', and '20-Aug-2010 15:51'.

To enter a CPT code, click Add button in the Visit Services component.



The Add Procedure for Current Visit dialog box displays. Type the CPT code and click the ellipses (...) button.



Choose the CPT you would like to enter and click OK. If you cannot find the CPT code, make sure that CPT is chosen in the Lookup Option. You may also need to check off more of the Included Code Sets.

Procedure Lookup

Lookup Option Lexicon CPT

Search Value: 77053

Included Code Sets: Medical Surgical HCPCS E & M
 Radiology Laboratory Anesthesia Home Health

Select from one of the following items

Code	Narrative
77053	Mammary Ductogram Or Galactogram, Single Duct, Radiological Supervision And Interpretation

Return Search Text as Narrative

Enter any other pertinent information and click Save.

Add Procedure for Current Visit

CodeSet CPT Code ICD Procedure Code Transaction Code

Procedure: Mammary Ductogram Or Galactogram, Single Duct, Radiological Supervision And Inter ...
 (NOTE: If the Procedure is not selected it defaults to 00099 - Uncoded CPT Code)

Narrative: Mammary Ductogram Or Galactogram, Single Duct, Radiological Supervision And Interpretation

Diagnosis: Diabetes I/juv Not Uncont... 1st Modifier: [] 2nd Modifier: []

Quantity: 1

Principal Procedure

Save Cancel

Your newly added CPT code should display in the Visit Services component.

Visit Services Add Edit Delete

Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider	CPT Name	Visit Date
77053	Mammary Ductogram Or Galactogram, Single Duct, Radiological Supervision And Interpretation	1		Y			POWERS,MEGAN	X-ray Of Mammary Duct	08/19/2010

Historical CPT codes are entered in the Historical Services component, which is located on the Services tab.

The screenshot shows the IHS-EHR Tucson Development System interface. At the top, there are tabs for Patient Chart, Communication, RPMS, CIHA Intranet, Micromedex, and E-Mail. The patient information bar shows Patient Crsae 900031, 01 Jul 1959 (92) F, 01 GENERAL POWERS, MEGAN, 19-Aug-2010, and Primary Care Team Unassigned. The Historical Services component is highlighted with a red circle and contains a table with the following data:

Visit Date	CPT Code	Description	Facility	Qty	Diagnosis	Prim	Modifier 1	Modifier 2
07/05/2010	74280	Barium Enema	Cherokee Indian Hospital	1				

Below the table are sections for Super-Bills, Evaluation and Management, and Visit Services. The Visit Services component has an 'Add' button circled in red.

To enter a CPT code, click Add in the Visit Services component.

This close-up screenshot shows the Historical Services component. The 'Add' button in the Visit Services section is circled in red. The table below it contains the same data as the previous screenshot:

Visit Date	CPT Code	Description	Facility	Qty	Diagnosis	Prim	Modifier 1	Modifier 2
07/05/2010	74280	Barium Enema	Cherokee Indian Hospital	1				

The Add Historical Service dialog box displays. You can either choose an item via Pick List or Procedure code.

Pick List:

The screenshot shows the 'Add Historical Service' dialog box with the 'Pick List' tab selected. At the top, there is a dropdown menu labeled 'GPRA SERVICES'. Below it is a list of services with checkboxes: Barium Enema, Colonoscopy, Fobt (guaiac), Hiv-1, Hiv-1 And Hiv-2, Hiv-2, Mammography, Bilat, Mammography, Unilat, Pap Smear, and Sigmoidoscopy. At the bottom, there are fields for 'Date' and 'Location', and radio buttons for 'IHS/Tribal Facility' (selected) and 'Other'. On the right side, there are 'Save' and 'Cancel' buttons.

Procedure/CPT code:

The screenshot shows the 'Add Historical Service' dialog box with the 'Procedure' tab selected. At the top, there is a 'Procedure' text field with a dropdown arrow and a '...' button. Below it is a note: '(NOTE: If the Procedure is not selected it defaults to 00099 - Uncoded CPT Code)'. There is a 'Narrative' text area with up and down arrows. Below that are 'Quantity' (set to 1), '1st Modifier' (dropdown), and '2nd Modifier' (dropdown). At the bottom, there are fields for 'Date' and 'Location', and radio buttons for 'IHS/Tribal Facility' (selected) and 'Other'. On the right side, there are 'Save' and 'Cancel' buttons.

Enter the date and location of the service, and then enter the CPT in the same manner as listed above for a current CPT.

Your newly added CPT code should display in the Historical Services component.

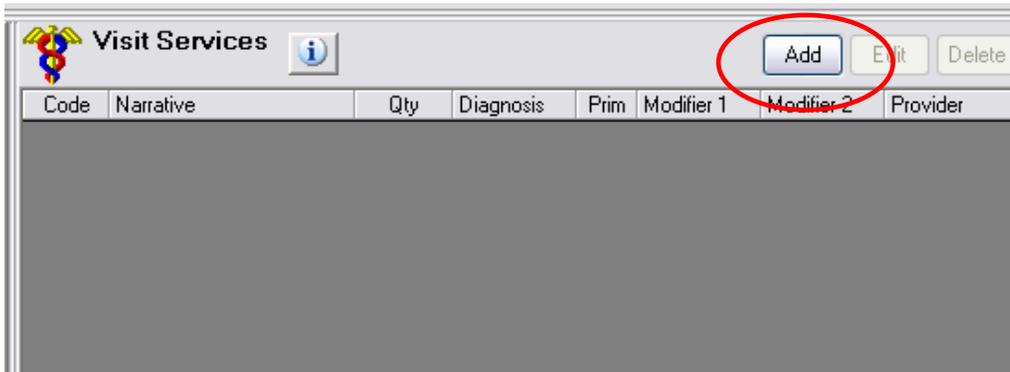
Visit Date	CPT Code	Description	Facility	Qty	Diagnosis	Prim	Modifier 1	Modifier 2
07/05/2010	74280	Barium Enema	Cherokee Indian Hospital	1				
06/08/2009	77055	Mammography: Unilateral	Cherokee Indian Hospital	1				

Procedure Codes

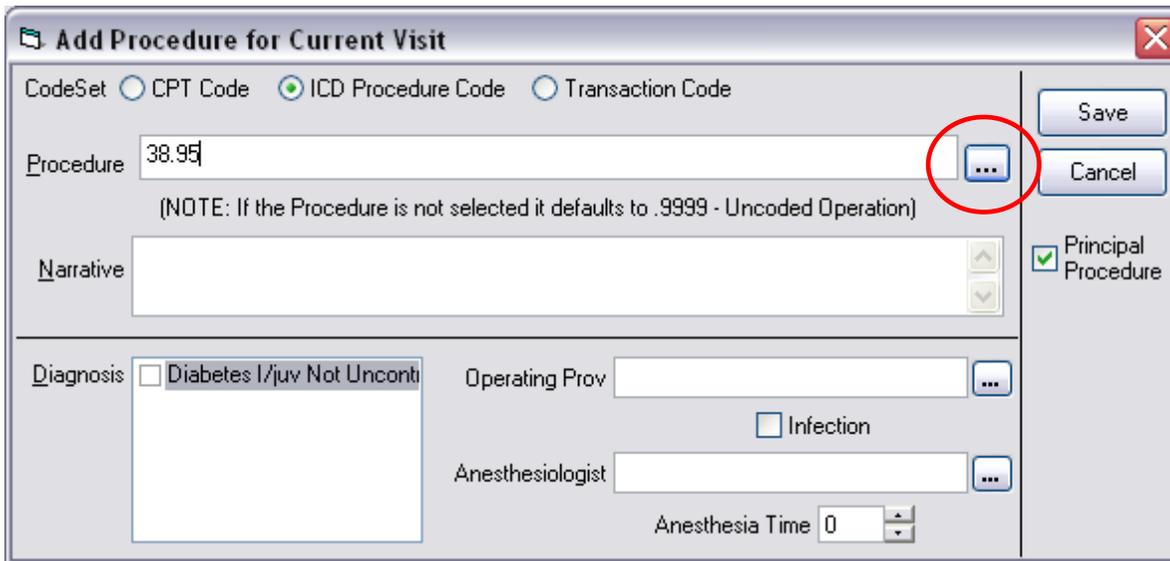
Procedure codes are entered in the Visit Services component, which is located on the Services tab.

The screenshot displays the IHS-EHR Tucson Development System interface. The top navigation bar includes 'User', 'Patient', 'Tools', and 'Help'. Below this, there are tabs for 'Patient Chart', 'Communication', 'RPMS', 'CIHA Intranet', 'Micromedex', and 'E-Mail'. The patient information section shows 'Patient, Crsae' with ID 900031, birth date 01-Jul-1958, and gender F. The visit information includes '01 GENERAL' for 'POWERS, MEGAN' on 19-Aug-2010, with a 'Primary Care Team Unassigned' status. The 'Historical Services' section shows a table with one entry: a Barium Enema procedure on 07/05/2010. The 'Super-Bills' section has checkboxes for 'Freq. Rank', 'Code', and 'Description'. The 'Evaluation and Management' section has radio buttons for 'New Patient' and 'Established'. The 'Visit Services' section is highlighted with a red circle and contains a table with columns: Code, Narrative, Qty, Diagnosis, Prim, Modifier 1, Modifier 2, and Provider. The bottom navigation bar includes 'Notifications', 'Cover Sheet', 'Triage', 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', and 'WCM'. The status bar at the bottom shows 'POWERS, MEGAN', 'DEMO.OKLAHOMA.IHS.GOV', 'DEMO INDIAN HOSPITAL', and '20-Aug-2010 15:51'.

To enter a Procedure code, click Add in the Visit Services component.



The Add Procedure for Current Visit dialog box will display. Make sure ICD Procedure Code is chosen for the CodeSet. Type in the Procedure code and click the ellipses (...) button.



Choose the Procedure that you would like to enter and click OK.

Lookup ICD Procedure

Search Value: 38.95 Search OK Cancel

Code	Procedure
38.95	VENOUS CATHETERIZATION FOR RENAL DIALYSIS

Enter in any other pertinent information and click Save.

Add Procedure for Current Visit

CodeSet: CPT Code ICD Procedure Code Transaction Code

Procedure: 38.95 - VENOUS CATHETERIZATION FOR RENAL DIALYSIS ...

(NOTE: If the Procedure is not selected it defaults to .9999 - Uncoded Operation)

Narrative: VENOUS CATHETERIZATION FOR RENAL DIALYSIS

Diagnosis: Diabetes I/juv Not Uncont

Operating Prov: ...

Infection

Anesthesiologist: ...

Anesthesia Time: 0

Save Cancel

Principal Procedure

Your newly added CPT code should appear in the Visit Services component.

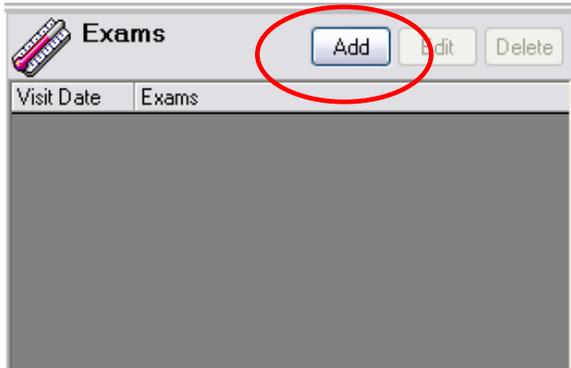
Visit Services 									
Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider	CPT Name	Visit Date
38.95	Venous Catheterization For Renal Dialysis						POWERS,MEGAN	Venous Catheterization For Dialysis	08/19/2010

Exams

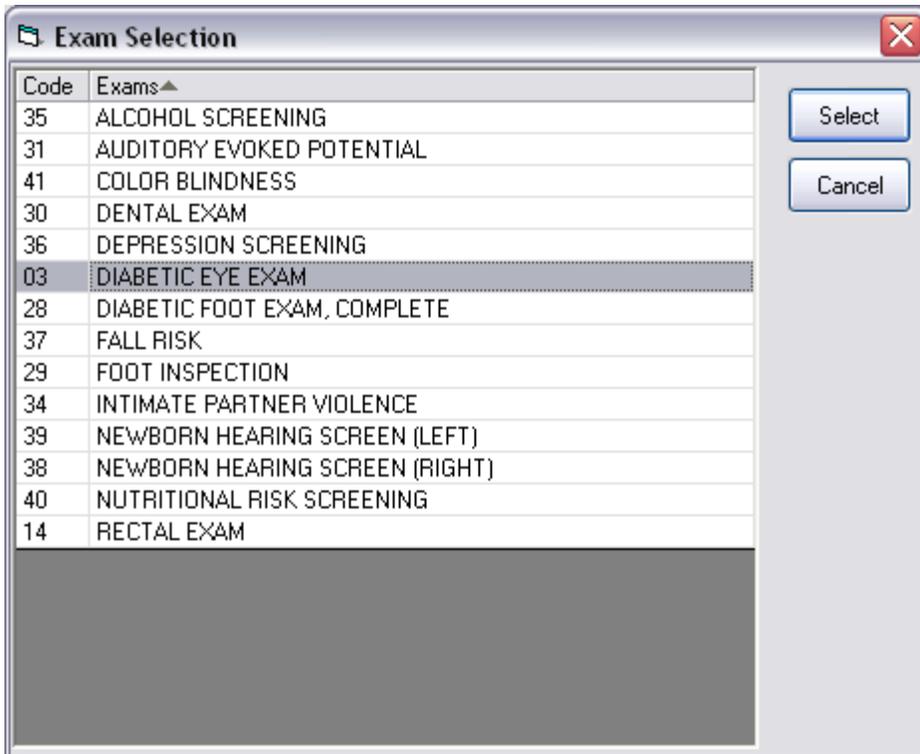
Exam codes are entered in the Exams component, which is located on the Wellness tab.

The screenshot displays the IHS-EHR Tucson Development System interface. At the top, the patient information bar shows 'Patient_Crsae' with ID 900031, birth date 01-Jul-1958, gender F, and name '01 GENERAL POWERS,MEGAN'. The date is 19-Aug-2010. Below this, the 'Education' section is visible. The main area contains three panels: 'Health Factors', 'Exams', and 'Skin Test History'. The 'Exams' panel is highlighted with a red circle. Below these panels is the 'Immunization Record' section, which includes a 'Forecast' table with one entry: 'Tdap past due'. The 'Contraindications' section lists 'PNEUMO-PS Egg Allergy' dated 19-Aug-2010. At the bottom, a navigation bar includes tabs for 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', and 'WCM'. The status bar at the very bottom shows the user 'POWERS,MEGAN', the system 'DEMO.OKLAHOMA.IHS.GOV', the location 'DEMO INDIAN HOSPITAL', and the time '20-Aug-2010 16:06'.

To enter an Exam code, click Add in the Exams component.



Select the Exam you would like to enter and click OK.



Enter in the result and any comments and click Save.

The screenshot shows a dialog box titled "Document an Exam" with a close button (X) in the top right corner. The dialog is divided into two main sections. The left section contains four input fields: "Exam" with the text "DIABETIC EYE EXAM" and a dropdown arrow; "Result" with a dropdown menu showing "NORMAL/NEGATIVE"; "Comment" with an empty text area and up/down arrows; and "Provider" with the text "POWERS,MEGAN" and a dropdown arrow. The right section contains two buttons, "Add" and "Cancel", and three radio buttons: "Current" (which is selected), "Historical", and "Refusal".

If this is a historical exam, select the Historical radio button and enter the date and location of the exam.

The screenshot shows the same "Document an Exam" dialog box, but with the "Historical" radio button selected. The "Exam" field still contains "DIABETIC EYE EXAM". The "Result" field is "NORMAL/NEGATIVE". The "Comment" field is empty. The "Provider" field contains "POWERS,MEGAN". A new "Historical" section is visible at the bottom, containing two input fields: "Event Date" with the text "06/02/2010" and a dropdown arrow, and "Location" with the text "CHEROKEE INDIAN HOSPITAL" and a dropdown arrow. Below these fields are two radio buttons: "IHS/Tribal Facility" (which is selected) and "Other".

Your newly added Exam code should appear in the Exams component.

 Exams					
Visit Date	Exams	Result	Comments	Provider	Location
08/19/2010	DIABETIC EYE EXAM	NORMAL/NEGATIVE		POWERS,MEGAN	DEMO INDIAN HOSPITAL

Health Factors

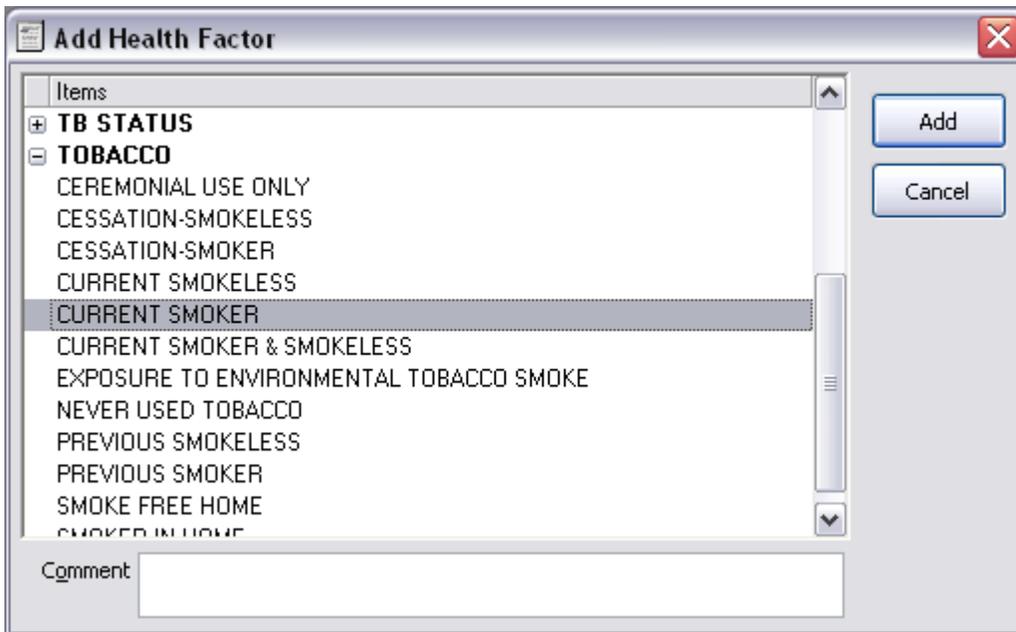
Health Factors are entered in the Health Factors component, which is located on the Wellness tab.

The screenshot displays the IHS-EHR Tucson Development System interface. At the top, the patient information bar shows 'Patient_Crsae' with ID 900031, DOB 01-Jul-1958, and gender F. The patient name is '01 GENERAL POWERS, MEGAN' with a birth date of 19-Aug-201. The primary care team is listed as 'Primary Care Team Unassigned'. Below this, the 'Education' section is visible with a 'Show Standard' button and 'Add', 'Edit', and 'Delete' options. The main content area is divided into three panels: 'Health Factors', 'Exams', and 'Skin Test History'. The 'Health Factors' panel is circled in red and has a red 'X' over its icon, indicating it is currently disabled. Below the panels, the 'Immunization Record' section is active, showing a 'Forecast' with 'Tdap past due' and 'Contraindications' including 'PNEUMO-PS Egg Allergy 19-Aug-2010'. The bottom navigation bar includes tabs for 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', and 'WCM'. The status bar at the very bottom shows the user 'POWERS, MEGAN', the system 'DEMO.OKLAHOMA.IHS.GOV', the location 'DEMO INDIAN HOSPITAL', and the time '20-Aug-2010 16:06'.

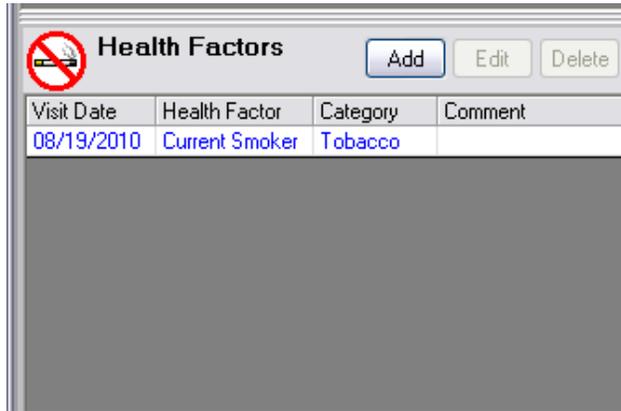
To enter a Health Factor, click Add in the Health Factors component.



Choose the Health Factor you would like to enter and click Add.



Your newly added Health Factor should appear in the Health Factors component.



The screenshot shows a window titled "Health Factors" with a "No" icon in the top-left corner. To the right of the title are three buttons: "Add", "Edit", and "Delete". Below the title bar is a table with four columns: "Visit Date", "Health Factor", "Category", and "Comment". The first row of data contains the values "08/19/2010", "Current Smoker", and "Tobacco". The "Comment" column is empty. The rest of the table area is shaded grey.

Visit Date	Health Factor	Category	Comment
08/19/2010	Current Smoker	Tobacco	

Immunizations

Immunizations are entered in the Immunization Record component, which is located on the Wellness tab.

The screenshot displays the IHS-EHR Tucson Development System interface. The patient information at the top includes Patient ID 900031, name Patient.Crsae, birth date 01-Jul-1958, gender F, and primary care team 'Primary Care Team Unassigned'. The 'Immunization Record' component is highlighted with a red circle and contains the following sections:

- Forecast:** Tdap past due
- Contraindications:** PNEUMO-PS, Egg Allergy (19-Aug-2010)
- Vaccinations:** Includes buttons for Print Record, Due Letter, Profile, Case Data, Add, Edit, and Delete.

The Vaccinations table below the buttons is empty:

Vaccine	Visit Date	Age@Visit	Location	Reaction	Volume	Inj. Site	Lot	VIS Date	Administered By	VFC Eligibility
---------	------------	-----------	----------	----------	--------	-----------	-----	----------	-----------------	-----------------

The bottom navigation bar shows the 'Wellness' tab is selected, along with other tabs like Notifications, Cover Sheet, Triage, Orders, Medications, Labs, Prob/POV, Services, Reports, D/C Summ, Consults, Privacy, and WCM. The user name POWERS,MEGAN and system information are visible at the very bottom.

To enter an Immunization, click Add in the Vaccinations section of the Immunization Record component.

The screenshot shows the 'Immunization Record' window. It has a 'Forecast' section with 'Tdap past due' and a 'Contraindications' section with one entry: 'PNEUMO-PS Egg Allergy 19-Aug-2010'. Below these is the 'Vaccinations' section, which contains buttons for 'Print Record', 'Due Letter', 'Profile', 'Case Data', 'Add', 'Edit', and 'Delete'. The 'Add' button is circled in red. Below the buttons is a table header with columns: Vaccine, Visit Date, Age@Visit, Location, Reaction, Volume, Inj. Site, Lot, VIS Date, Administered By, and VFC Eligibility.

Choose the Immunization that you would like to enter and click OK.

The screenshot shows the 'Vaccine Selection' dialog box. It has a 'Search Criteria' section with a search value of 'influ' and a 'Search' button. There are 'OK' and 'Cancel' buttons. Below the search criteria are two radio buttons: 'Show All Active Vaccines' (selected) and 'Show Only active Vaccines with a Lot Number'. Below that is the text 'Select one of the following Records'. A list of immunizations is shown with two columns: 'Immunization' and 'Description'. The row 'INFLUENZA, SPLIT (INCL. PURIFIED)' is highlighted.

Immunization	Description
INFLUENZA, H5N1	Influenza virus vaccine, H5N1, A/Vietnam/120
INFLUENZA, HIGH DOSE SEASONAL	INFLUENZA, HIGH DOSE SEASONAL, PRESI
INFLUENZA, INTRANASAL	Influenza virus vaccine, live, attenuated, for intr
INFLUENZA, NOS	Influenza virus vaccine, NOS
INFLUENZA, SPLIT (INCL. PURIFIED)	Influenza virus vaccine, split virus (incl. Purified
INFLUENZA, WHOLE	Influenza virus vaccine, whole virus
IPV	Poliovirus vaccine, inactivated
JAPANESE ENCEPHALITIS	Japanese Encephalitis virus vaccine
Japanese Encephalitis-IM	Japanese Encephalitis vaccine for intramuscul
JUNIN VIRUS	Junin virus vaccine
LEISHMANIASIS	Leishmaniasis vaccine
LEPROSY	Leprosy vaccine
LYME DISEASE	Lyme Disease Vaccine

Enter in any other pertinent information and click Save.

Add Immunization

Vaccine: INFLUENZA, SPLIT (INCL. PURIFIED)

Administered By: POWERS, MEGAN

Lot: U1293AA

Injection Site: Intranasal

Volume: .5 ml

Vac. Info. Sheet: 08/11/2009

Given: 08/20/2010 4:30 PM

Patient/Family Counseled by Provider

Current
 Historical
 Refusal

OK
Cancel

If this is a historical immunization, select the Historical radio button and enter the date and location of the immunization.

Add Historical Immunization

Vaccine: INFLUENZA, SPLIT (INCL. PURIFIED)

Documented By: POWERS, MEGAN

Event Date: 06/02/2010

Location: CHEROKEE INDIAN HOSPITAL

IHS/Tribal Facility
 Other

Current
 Historical
 Refusal

OK
Cancel

Your newly added Immunization should appear in the Immunization Record component.

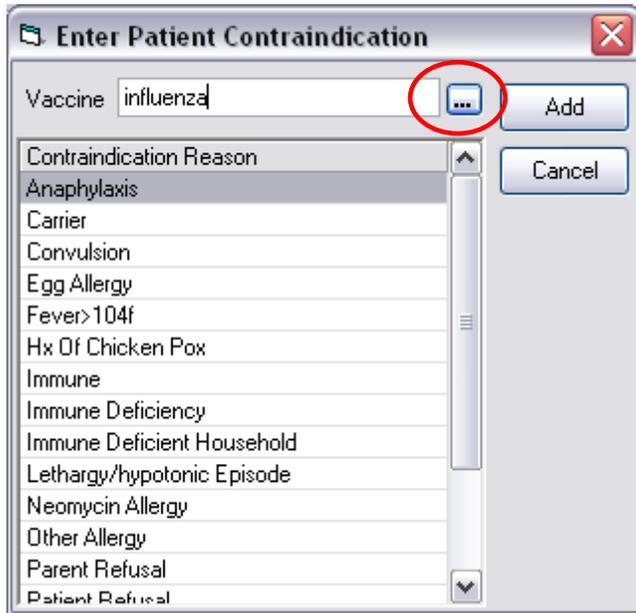
The screenshot shows the 'Immunization Record' interface. It features a 'Forecast' section with a text box containing 'Tdap past due'. The 'Contraindications' section has a table with one entry: 'PNEUMO-PS', 'Egg Allergy', and '19-Aug-2010'. Below this is a 'Vaccinations' section with buttons for 'Print Record', 'Due Letter', 'Profile', and 'Case Data'. A table below the buttons lists vaccination details.

Vaccine	Visit Date	Age@Visit	Location	Reaction	Volume	Inj. Site	Lot	VIS Date	Administered By
FLU-TIV	08/19/2010	52 yrs	DEMO INDIAN HOSPITAL		.5	Intranasal	U1293AA	08/11/2009	POWERS,MEGAN

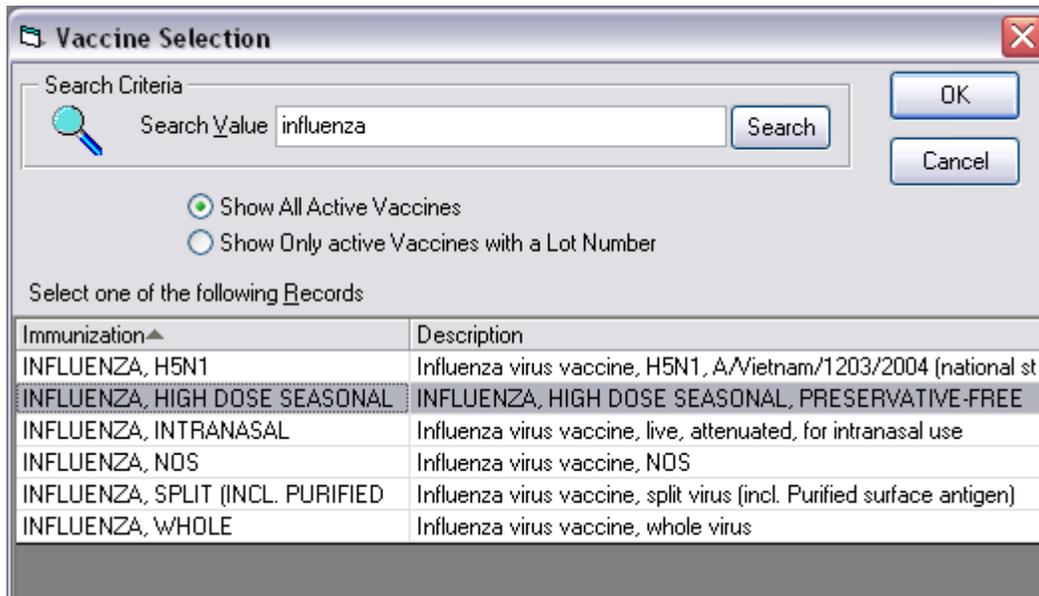
Contraindications: To enter a contraindication for an immunization, click Add in the Contraindications section of the Immunization Record component.

This screenshot is similar to the first one but highlights the 'Add' button in the 'Contraindications' section with a red circle. The 'Add' button is located to the left of the 'Delete' button in the Contraindications table.

Choose the contraindication reason, type in the vaccine, and click the ellipses (...) button.



Select the immunization and click OK.



Click Add.

Enter Patient Contraindication

Vaccine: INFLUENZA, HIGH DOSE SEAS

Contraindication Reason:

- Anaphylaxis
- Carrier
- Convulsion
- Egg Allergy
- Fever > 104f
- Hx Of Chicken Pox
- Immune
- Immune Deficiency
- Immune Deficient Household
- Lethargy/hypotonic Episode
- Neomycin Allergy
- Other Allergy
- Parent Refusal
- Patient Refusal

Buttons: Add, Cancel

Your newly added contraindication should appear in the Immunization Record component.

Immunization Record

Forecast

Tdap past due

Contraindications

PNEUMO-PS	Egg Allergy	19-Aug-2010
FLU-HIGH	Anaphylaxis	19-Aug-2010

Buttons: Add, Delete

Vital Measurements

Vital Measurements are entered in the Vitals component, which is located on the Triage tab.

The screenshot displays the IHS-EHR Tucson Development System interface. At the top, the system name and user information are visible. The main content area is divided into several sections: Patient Chart, Chief Complaint, Vitals, and Activity Time. The Vitals section is highlighted with a red circle and contains the text "No Vitals Found". The Activity Time section shows input fields for Encounter Time, Travel Time, and Total, all set to 0 minutes. The bottom of the screen features a navigation bar with various tabs and a status bar with user and system information.

IHS-EHR TUCSON DEVELOPMENT SYSTEM

User Patient Tools Help

Patient Chart Communication RPMS CIHA Intranet Micromedex E-Mail

Patient.Crsae 900031 01-Jul-1958 (52) F **01 GENERAL** POWERS.MEGAN 19-Aug-201 Am Primary Care Team Unassigned No Postings

Chief Complaint Add Edit Delete

Author Chief Complaint

Vitals No Vitals Found

Activity Time POWERS.MEGAN

Encounter Time 0 (minutes)

Travel Time 0 (minutes)

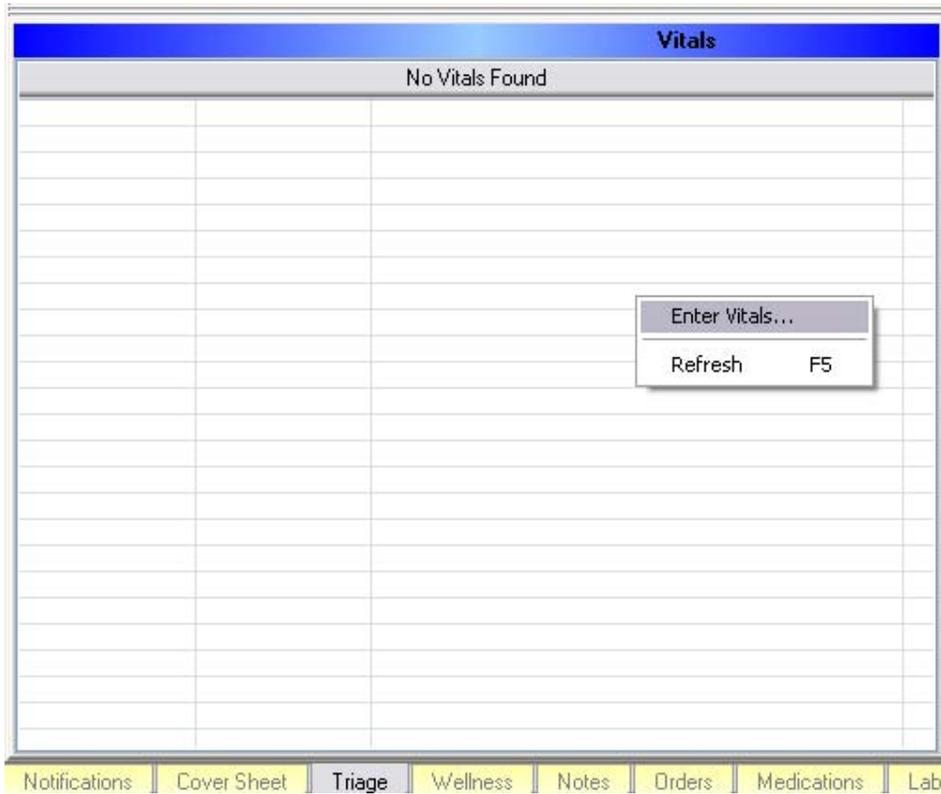
Total 0 minutes

Notifications Cover Sheet **Triage** Wellness Notes Orders Medications Labs Prob/POV Services Reports D/C Summ Consults Privacy WCM

ASU Suicide

POWERS.MEGAN DEMO.OKLAHOMA.IHS.GOV DEMO INDIAN HOSPITAL 20-Aug-2010 16:41

To enter Vital Measurements, right-click on the Vitals component and select Enter Vitals.



If you wish to enter historical vitals, click on the date and time in the column header, and then click the ellipses (...) button.

Default Units		20-Aug-2010 16:45	...	Range	Units
<input checked="" type="radio"/>	Temperature				F
	Pulse			60 - 100	/min
	Respirations				/min
	Blood Pressure			90 - 150	mmHg
	Height				in
	Weight				lb
	Pain				
	PHQ2				
	PHQ9				
	Crafft				
	Audit				
	Audiometry				
	Asq - Questionnaire (Mos)				
	Asq - Fine Motor				
	Asq - Gross Motor				
	Asq - Language				
	Asq - Problem Solving				
	Asq - Social				

New Date/Time OK Cancel

Choose the historical date and click OK.

The dialog box titled "Select Date/Time" features a calendar grid for August 2010. The date August 3, 2010, is selected. To the right of the calendar, the time is set to 10:00. Below the calendar is a "Today" button. Below the time selection is a vertical scroll bar and buttons for "Now" and "Midnight". On the right side of the dialog are "OK" and "Cancel" buttons.

Enter the Vital Measurements you would like to add and click OK.

The "Vital Measurement Entry" dialog box contains a table with the following data:

Default Units	20-Aug-2010 16:44	Range	Units
Temperature	98.8		F
Pulse	75	60 - 100	/min
Respirations			/min
Blood Pressure	128/80	90 - 150	mmHg
Height	72		in
Weight	203		lb
Pain			
<input checked="" type="radio"/> PHQ2			
PHQ9			
Crafft			
Audit			
Audiometry			
Asq - Questionnaire (Mos)			
Asq - Fine Motor			
Asq - Gross Motor			
Asq - Language			
Asq - Problem Solving			
Asq - Social			

At the bottom of the dialog are buttons for "New Date/Time", "OK", and "Cancel".

Your newly added Vital Measurements should display in the Vitals component.

Vitals		
Vital	Value	Date ▼
TMP	98.8 F (37.11 C)	20-Aug-2010 16:44
PU	75 /min	20-Aug-2010 16:44
BP	128/80 mmHg	20-Aug-2010 16:44
HT	72 in (182.88 cm)	20-Aug-2010 16:44
WT	203 lb (92.08 kg)	20-Aug-2010 16:44
BMI	27.53	20-Aug-2010 16:44

Lab Tests

Lab tests are entered in the Orders component, which is located on the Orders tab.

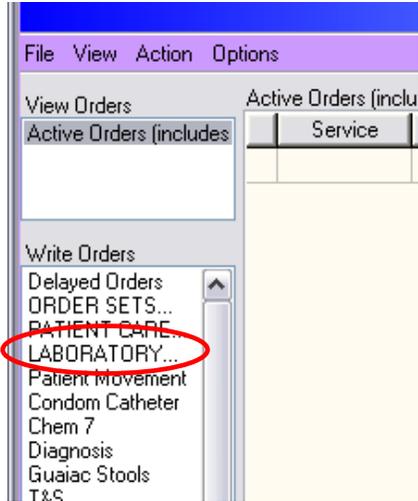
The screenshot displays the IHS EHR Tucson Development System interface. At the top, the window title is "IHS EHR TUCSON DEVELOPMENT SYSTEM". Below the title bar, there are menu options: "User", "Patient", "Tools", and "Help". A secondary menu bar includes "Patient Chart", "Communication", "RPMS", "CIHA Intranet", "Micromedex", and "E-Mail".

The main content area is titled "Orders" and features a sub-menu with "File", "View", "Action", and "Options". Below this, there is a section for "View Orders" and "Active Orders (includes Pending & Recent Activity) - ALL SERVICES". A table with the following columns is visible: "Service", "Order", "Duration", "Provider", "Nurse", "Clerk", "Chart", and "Status". The table is currently empty.

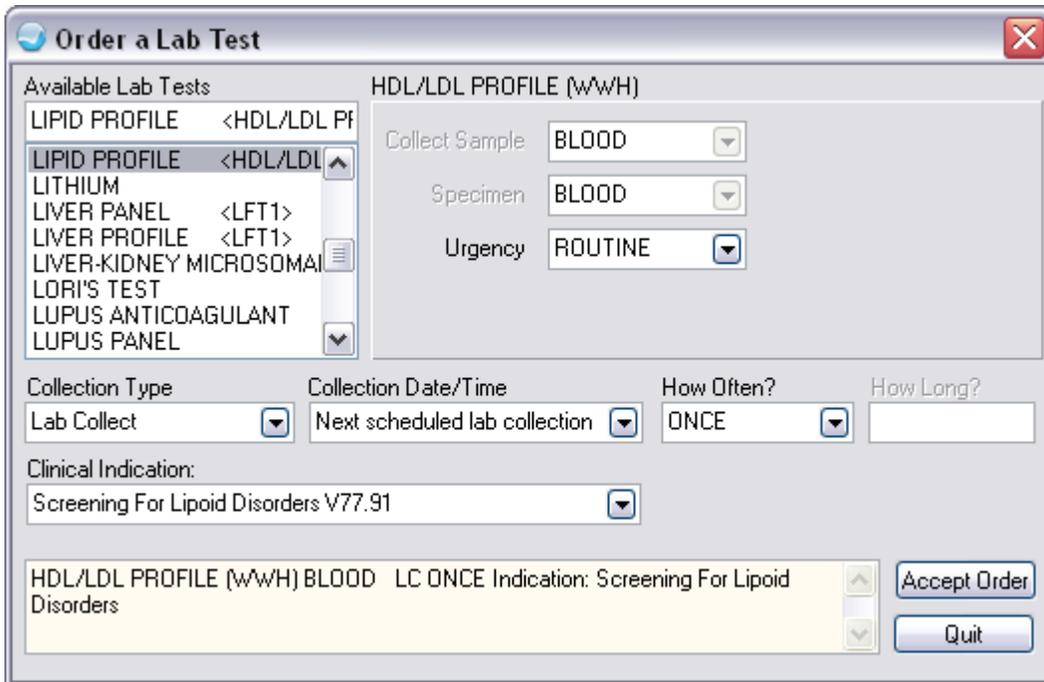
On the left side, there is a "Write Orders" section with a scrollable list of order types, including: "Delayed Orders", "ORDER SETS...", "PATIENT CARE...", "LABORATORY...", "Patient Movement", "Condom Catheter", "Chem 7", "Diagnosis", "Guaiac Stools", "T&S", "Condition", "Incentive Spiromete", "Glucose", "Allergies", "Dressing Change", "CBC w/Diff", "PT", "PARAMETERS...", "DIETETICS...", "PTT", "TPR B/P", "Regular Diet", "CPK", "Weight", "Tubefeeding", "CPK", "I & O", "NPO at Midnight", "LDH", "Call HO on", and "Urinalysis".

At the bottom of the interface, there is a navigation bar with tabs for "Notifications", "Cover Sheet", "Triage", "Wellness", "Notes", "Orders", "Medications", "Labs", "Prob/POV", "Services", "Reports", "D/C Summ", "Consults", "Privacy", and "WCM". Below this, there are three buttons: "ASU Suicide", "POWERS,MEGAN", "DEMO.OKLAHOMA.IHS.GOV", and "DEMO INDIAN HOSPITAL".

To enter a Lab test, select the Laboratory option in the Write Orders section of the Orders component. Note: this may be named differently at your site.



The Order a Lab Test dialog box displays. Select the appropriate lab test, enter any other pertinent information, and click Accept Order.



Your newly added Lab test should display in the Active Orders section of the Orders component.

Orders							
Active Orders (includes Pending & Recent Activity) - ALL SERVICES							
Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
Lab	HDL/LDL PROFILE (w/WH) BLOOD LC ONCE Indication: Screening For Lipoid Disorders *UNSIGNED*	Start: NEXT	Powers,M				unreleased

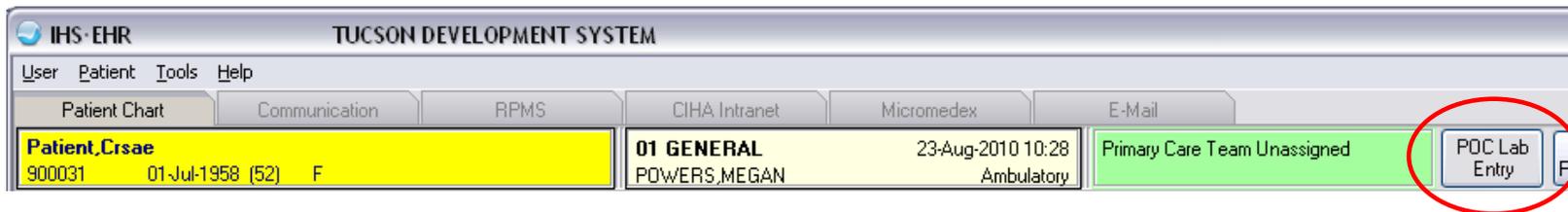
You will need to sign the order before it is released.

Once the Lab test has been completed, results can be viewed in the Laboratory Results component, which is located on the Labs tab.

The screenshot displays the IHS EHR Tucson Development System interface. At the top, the patient information is shown: Patient ID 900031, name CSRAE, and provider POWERS, MEGAN. The Laboratory Results section is currently empty, displaying "No Lab Results Collected". The interface includes a navigation menu on the left and a bottom toolbar with tabs for various clinical functions.

Please note that most laboratory results must be entered via the Lab Package or sent over electronically from a reference laboratory. These results cannot be entered through EHR. However, point of care laboratory tests and results can be entered through EHR.

To enter Point of Care Lab tests and results, click POC Lab Entry. If this button is not visible, speak with your Clinical Applications Coordinator to see if it can be added.



The Lab Point of Care Data Entry Form displays. Choose the appropriate laboratory test, enter the test results and any other pertinent information, and click Save.

The screenshot shows the 'Lab Point of Care Data Entry Form' window. The form contains the following fields and values:

- Patient: PATIENT,CRSAE
- Hospital Location: 01 GENERAL
- Ordering Provider: POWERS,MEGAN
- Nature of Order/Change: WRITTEN
- Test: GLUCOSE
- Sample Type: BLOOD
- Collection Date and Time: 08/23/2010 09:55 AM
- Sign or Symptom: 714.0 Rheumatoid Arthritis

There is a text area for 'Comment/Lab Description' and an 'Add Canned Comment' button. Below the form is a table titled 'TEST RESULTS' with the following data:

Test Name	Result	Result Range	Units
GLUCOSE	92	>70 to 105	mg/dL

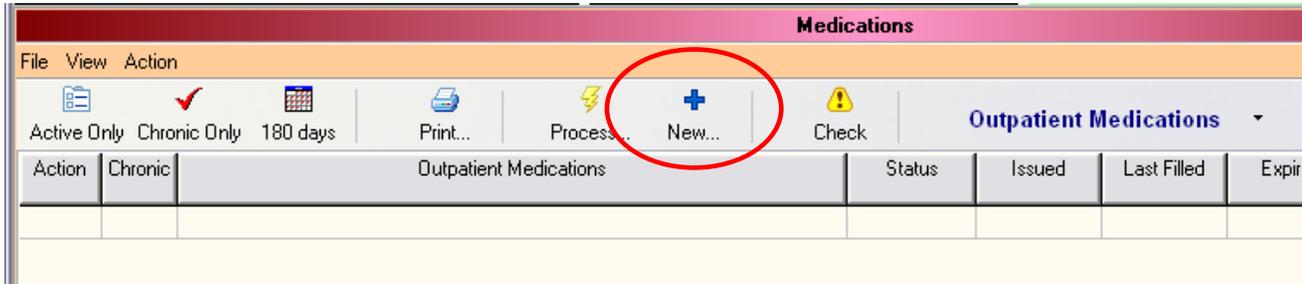
At the bottom of the form are 'Save' and 'Cancel' buttons.

Medications

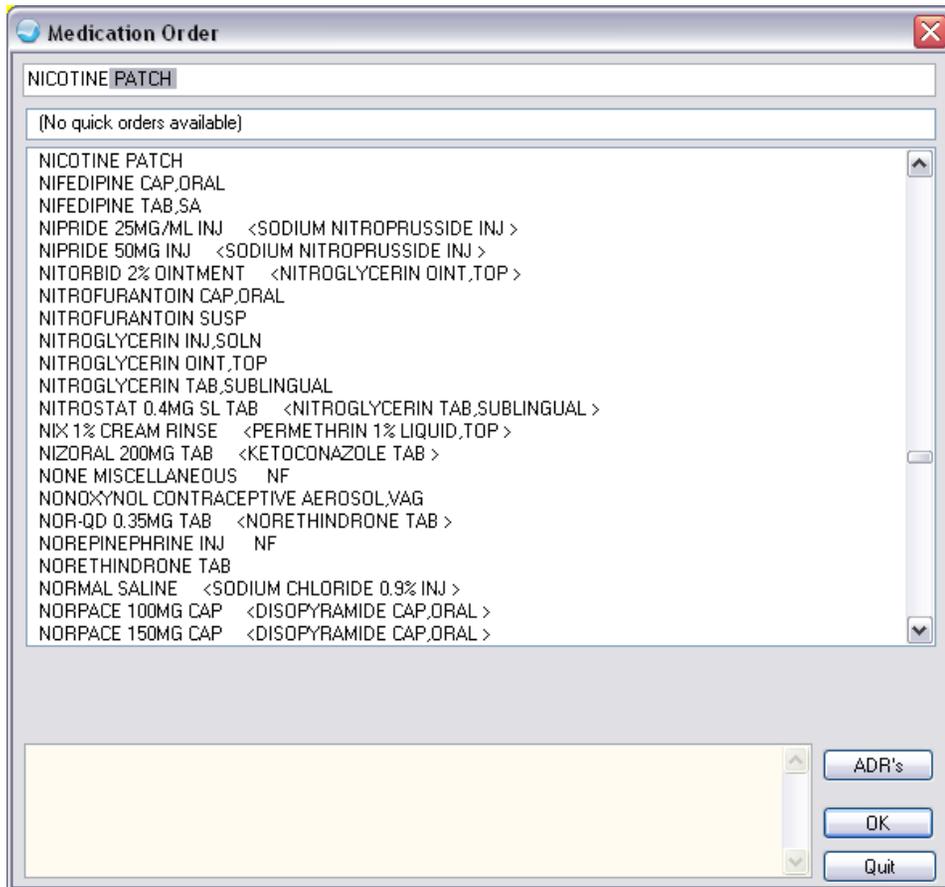
Medications are entered in the Medications component, which is located on the Medications tab.

The screenshot shows the IHS-EHR Tucson Development System interface. At the top, the patient information for MEGAN POWERS is displayed, including her ID (900031), date of birth (01-Jul-1958), and gender (F). The system is currently on the 'Medications' tab, which is highlighted in pink. Below the patient information, there is a toolbar with various icons for file operations, viewing, and actions. The main area is a table titled 'Outpatient Medications' with columns for Action, Chronic, Outpatient Medications, Status, Issued, Last Filled, Expires, Refills Remaining, Rx #, and Provider. The table is currently empty. At the bottom of the screen, there is a navigation bar with tabs for Notifications, Cover Sheet, Triage, Wellness, Notes, Orders, Medications (selected), Labs, Prob/POV, Services, Reports, D/C Summ, Consults, Privacy, and WCM. The status bar at the very bottom shows the user name POWERS, MEGAN, the system name DEMO.OKLAHOMA.IHS.GOV, the hospital name DEMO INDIAN HOSPITAL, and the current time 23-Aug-2010 12:54.

To enter a prescription for a medication, click New.....



You will then see the Medication Order dialog. Choose the appropriate medication.



You will then be able to enter more information about the prescription.

Medication Order

NICOTINE PATCH Change

Dosage Complex

Dosage	Route	Schedule
1 patch	TRANSDERMAL	DAILY <input type="checkbox"/> PRN
	TRANSDERMAL	BID (INSULIN) CONTINUOUSLY DAILY FIVE TIMES/DAY FR FR-SA US

Comments:

Days Supply: 90 Quantity: 1 Refills: 1 Clinical Indication: Personal History of Tobacco Use Chronic Med Priority: ROUTINE

Dispense as Written

Pick Up

Clinic Mail Window

NICOTINE PATCH
APPLY ONE (1) PATCH TO SKIN DAILY
Quantity: 1 Refills: 1 Chronic Med: NO Dispense as Written: NO Indication: Personal History of Tobacco Use

ADR's Accept Order Quit

Your newly added medication should display in the Medications component.

Medications										
File View Action										
Active Only Chronic Only 180 days Print... Process... New... Check Outpatient Medications										
Action	Chronic	Outpatient Medications	Status	Issued	Last Filled	Expires	Refills Remaining	Rx #	Provider	
New		NICOTINE PATCH APPLY ONE (1) PATCH TO SKIN DAILY Quantity: 1 Refills: 1 Dispense as Written: NO Indication: Personal History of Tobacco Use *UNSIGNED*								

You will need to sign the medication before it is released.

Infant Feeding

Infant Feeding choices are entered in the Infant Feeding component (new in EHR v1.1 patch 6), which is located on the Wellness tab.

The screenshot displays the IHS EHR Tucson Development System interface. The patient information at the top includes Patient, Udsbq, 519357, 12-Feb-2010 (6 months), F, 20 PEDIATRIC, POWERS, MEGAN, 23-Aug-2010 11:07, Ambulatory, and Primary Care Team Unassigned. The interface is divided into several sections: Education, Health Factors, Exams, Skin Test History, Infant Feeding, and Immunization Record. The Infant Feeding section is highlighted with a red circle. The Immunization Record section shows a list of vaccines with their due dates and a table for recording vaccinations.

Visit Date	Education Topic	Comprehensi	Readiness	Status	Objectives	Comment	Provider	Length	Type	Location
------------	-----------------	-------------	-----------	--------	------------	---------	----------	--------	------	----------

Visit Date	Health Factor	Category	Comment
------------	---------------	----------	---------

Visit Date	Exams	Result
------------	-------	--------

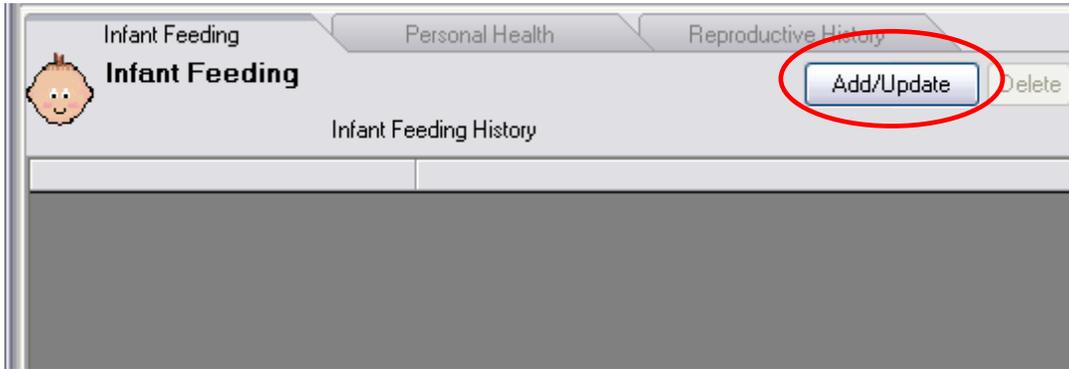
Visit Date	Skin Test	Location	Age@Visit	F
------------	-----------	----------	-----------	---

Vaccine	Visit Date	Age@Visit	Location	Reaction	Volume	Inj Site	Lot	VIS Date	Administered By
---------	------------	-----------	----------	----------	--------	----------	-----	----------	-----------------

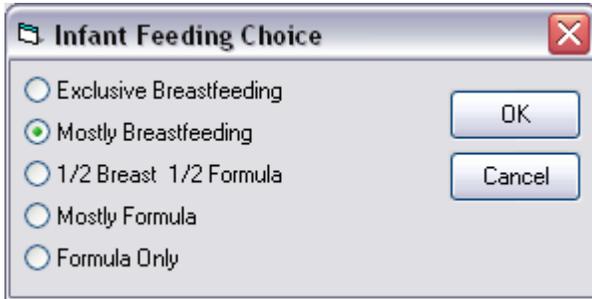
Notifications | Cover Sheet | Triage | Wellness | Alerts | Orders | Medications | Labs | Prob/POV | Services | Reports | D/C Summ | Consults | Privacy | WCM | ASQ | Suicide

POWERS, MEGAN | DEMO.OKLAHOMA.IHS.GOV | DEMO INDIAN HOSPITAL | 23-Aug-2010 11:13

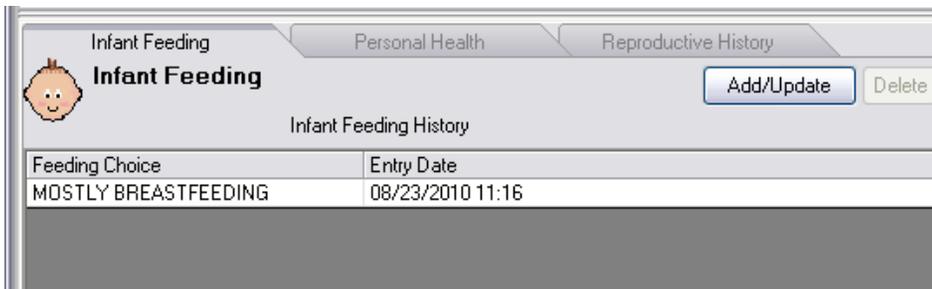
To enter Infant Feeding, click Add/Update in the Infant Feeding component.



Select the Infant Feeding choice you would like to enter and click OK.



Your newly added Infant Feeding choice should display in the Infant Feeding component.

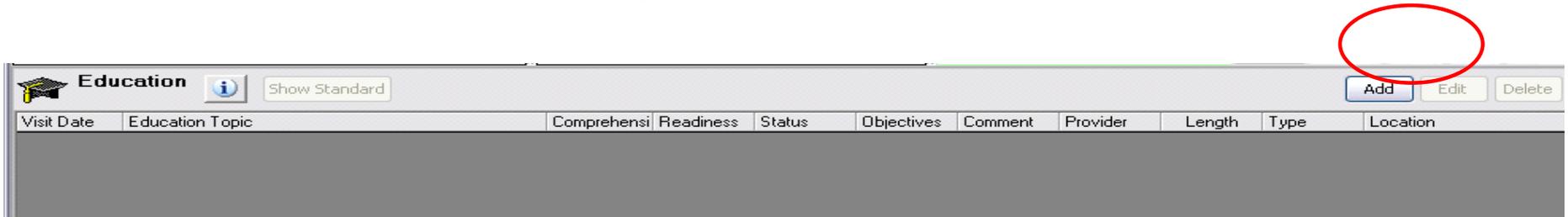


Patient Education

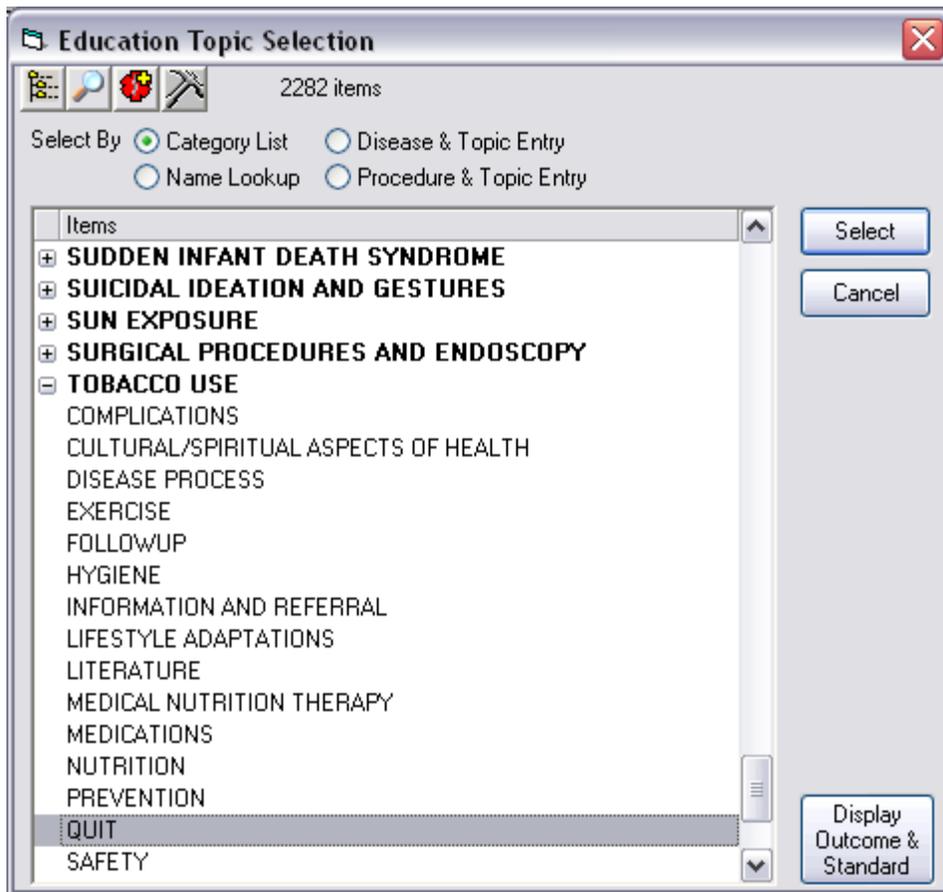
Patient Education can be entered several ways. The most common method is through the Education component, which is located on the Wellness tab.

The screenshot displays the IHS EHR Tucson Development System interface. At the top, the patient information bar shows 'Patient_Crsae' with ID 900031, DOB 01-Jul-1958, and gender F. The patient name is '01 GENERAL POWERS,MEGAN' with a birth date of 19-Aug-201 and a status of 'Primary Care Team Unassigned'. The 'Education' component is highlighted with a red circle and contains a table with the following columns: Visit Date, Education Topic, Comprehensi, Readiness, Status, Objectives, Comment, Provider, Length, Type, and Location. Below this, there are sections for 'Health Factors', 'Exams', and 'Skin Test History', each with an 'Add', 'Edit', and 'Delete' button. The 'Immunization Record' section is also visible, showing a 'Forecast' for 'Tdap past due' and 'Contraindications' for 'PNEUMO-PS Egg Allergy 19-Aug-2010'. The bottom navigation bar includes tabs for 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', and 'WCM'. The status bar at the very bottom shows the user 'POWERS,MEGAN', the system 'DEMO.OKLAHOMA.IHS.GOV', the location 'DEMO INDIAN HOSPITAL', and the time '20-Aug-2010 16:06'.

To enter Patient Education, click Add in the Education component.



Choose the Education you would like to enter and click Select. To expand a topic, click the plus sign (+) next to the topic.



To enter Patient Education by disease, select the Disease & Topic Entry radio button. (Note: Patient Education can be entered using any of the radio buttons.) Select the Disease/Illness and Topic Selection and click OK.

Education Topic Selection

Select By Category List Disease & Topic Entry Pick List
 Name Lookup Procedure & Topic Entry

Enter both the Disease/Condition/Illness and the Topic for the Education activity.

Disease/Condition/Illness Selection

Disease/Illness: Tobacco Use Disorder

POV: SCREENING FOR LIPOID DISORDERS
RHEUMATOID ARTHRITIS

Topic Selection

- ANATOMY AND PHYSIOLOGY
- COMPLICATIONS
- DISEASE PROCESS
- EQUIPMENT
- EXERCISE
- FOLLOW UP
- HOME MANAGEMENT
- HYGIENE
- LIFESTYLE ADAPTATION
- LITERATURE
- MEDICATIONS**
- NUTRITION

OK
Cancel

The Add Patient Education Event dialog box displays. Type in any pertinent information and click Add.

Add Patient Education Event

Education Topic: Tobacco Use-Quit
(Tobacco Use)

Type of Training: Individual Group

Comprehension Level: GOOD

Length: 10 (min)

Comment:

Provided By: POWERS, MEGAN

Readiness to Learn: RECEPTIVE

Status/Outcome:
 Goal Set Goal Met Goal Not Met

Buttons: Add, Cancel, Historical, Display Outcome & Standard, Patient's Learning Health Factors

If this is historical education, select the Historical check box and enter the date and location of the education.

Your newly added Patient Education should display in the Education component.

Visit Date	Education Topic	Comprehension	Readiness To Learn	Status	Objectives	Comment	Provider	Length	Type	Location
08/23/2010	Tobacco Use-Quit	GOOD	RECEPTIVE				POWERS, MEGAN	10	Individual	DEMO INDIAN HOSPITAL

Patient Education can also be entered when the Visit Diagnosis is entered. After entering the POV, click Education....

Add POV for Current Visit

ICD: ...

(NOTE: If the ICD is not selected it defaults to .9999 - Uncoded Diagnosis)

Narrative:

Date of Onset: ... Modifier:

POV is Injury Related

Primary Diagnosis

Add to Problem List

First Visit Re-Visit

Injury Date: ... Place:

Injury caused by: ...

Associated with:

The Document Patient Education dialog box displays. Type in any pertinent information and click Save.

Document Patient Education

Disease/Illness: Tobacco Use Disorder

Topic Selection:

- ANATOMY AND PHYSIOLOGY
- COMPLICATIONS
- DISEASE PROCESS
- EQUIPMENT
- EXERCISE
- FOLLOW UP

Type of Training: Individual Group

Comprehension Level: GOOD

Length: 10 (min)

Comment:

Provided By: POWERS, MEGAN

Readiness to Learn: RECEPTIVE

Status/Outcome:

Goal Set Goal Met Goal Not Met

Save

Cancel

Historical

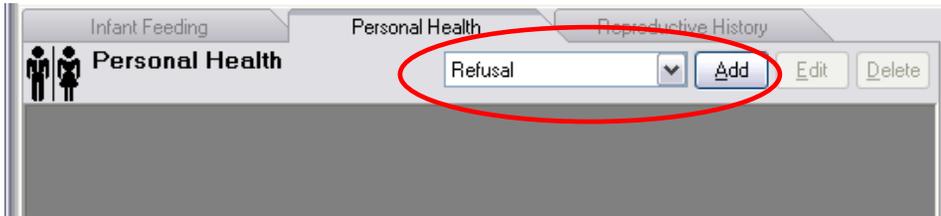
Patient's Learning Health Factors

Refusals

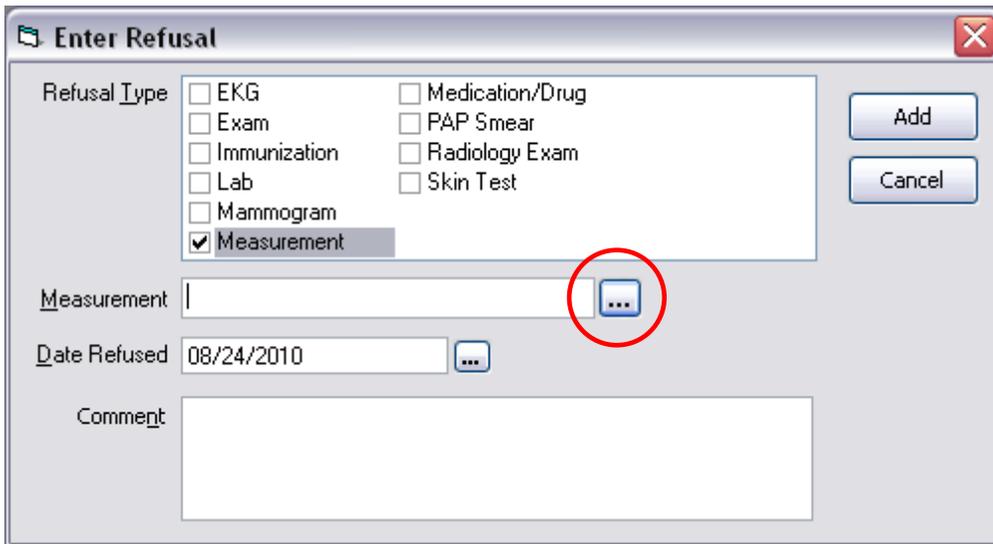
Refusals are entered in the Personal Health component, which is located on the Wellness tab. *Note: refusals are not counted toward the GPRA measure, but should still be documented.*

The screenshot displays the IHS-EHR Tucson Development System interface. The top navigation bar includes 'User', 'Patient', 'Tools', and 'Help'. Below this, there are tabs for 'Patient Chart', 'Communication', 'RPMS', 'CIHA Intranet', 'Micromedex', and 'E-Mail'. The patient information section shows 'Patient: Crsae', ID '900031', birth date '01-Jul-1958 (52)', gender 'F', and '01 GENERAL POWERS,MEGAN' with a visit date of '23-Aug-2010 10:28' at 'Ambulatory'. A green status bar indicates 'Primary Care Team Unassigned'. Below this is the 'Education' section with a table showing a record for 'Tobacco Use-Quit' on '08/23/2010' with a status of 'RECEPTIVE'. The 'Health Factors' section shows 'Current Smoker' as a tobacco factor. The 'Exams' section lists 'DIABETIC EYE EXAM' and 'ALCOHOL SCREENING'. The 'Skin Test History' section is empty. The 'Personal Health' section is highlighted with a red circle and contains a 'Refusal' dropdown menu. The 'Immunization Record' section shows a 'Forecast' of 'Tdap past due' and 'Contraindications' for 'PNEUMO-PS' and 'FLU-HIGH'. The bottom navigation bar includes 'Notifications', 'Cover Sheet', 'Triage', 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', 'WCM', 'ASQ', and 'Suicide'. The status bar at the bottom shows 'POWERS,MEGAN', 'DEMO.OKLAHOMA.IHS.GOV', 'DEMO INDIAN HOSPITAL', and '24-Aug-2010 15:41'.

To enter a Refusal, select Refusal in the drop-down box and click Add in the Personal Health component.



Select the Refusal Type you would like to enter and click the ellipses (...) button.



Search for the item you would like to add a refusal for and click OK.

Lookup Measurement

Search Value: H Search OK Cancel

Select one of the following records

Measurement ▲
HEAD CIRCUMFERENCE
HEARING
HEIGHT

Enter in a comment (if applicable) and click Add.

Enter Refusal

Refusal Type

<input type="checkbox"/> EKG	<input type="checkbox"/> Medication/Drug
<input type="checkbox"/> Exam	<input type="checkbox"/> PAP Smear
<input type="checkbox"/> Immunization	<input type="checkbox"/> Radiology Exam
<input type="checkbox"/> Lab	<input type="checkbox"/> Skin Test
<input type="checkbox"/> Mammogram	
<input checked="" type="checkbox"/> Measurement	

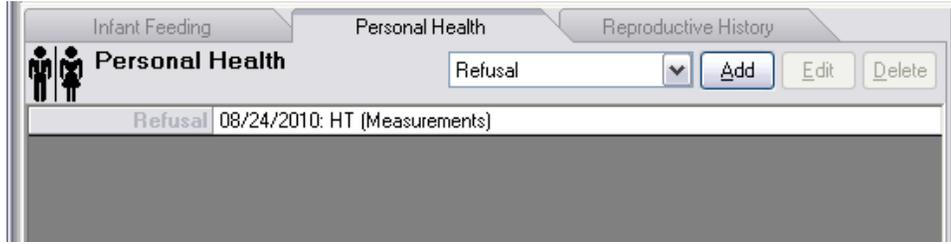
Measurement: HEIGHT ...

Date Refused: 08/24/2010 ...

Comment:

Add Cancel

Your newly added Refusal should display in the Personal Health component.



Instructions for Running a 2012 GPRA report using CRS 11.1

This guide provides detailed instructions for running a FY 2012 GPRA report using CRS version 11.1. Until CRS 12.0 is released, the GPRA and PART Performance report will need to be run to obtain 2012 results. We recommend that sites run this report on a monthly basis to monitor GPRA performance and quickly identify measures in danger of missing the national targets so improvement strategies can be implemented.

Task Summary:

Step	Action	See page:
1.	Run the 2012 GPRA & PART Performance Report	2

To run the GPRA & PART Performance Report for FY 2012

Note: Height/weight data will not be reported this quarter. Before running the National GPRA & PART Report, go into the System Setup Menu and set the 'Do you want to export Height/Weight data to the Area/National Programs?' parameter to NO.

1. At the "Select IHS Clinical Reporting System (CRS) Main Menu Option" prompt, type **CI11** and press Enter; for example,

```

*****
**      IHS/RPMS CLINICAL REPORTING SYSTEM (CRS)      **
*****
                          Version 11.1

                          DEMO INDIAN HOSPITAL

CI11  CRS 2011 ...
CI10  CRS 2010 ...
CI09  CRS 2009 ...
CI08  CRS 2008 ...
CI07  CRS 2007 ...
CI06  CRS 2006 ...
CI05  CRS 2005 ...
GP04  GPRA+ FY04 ...
GP03  GPRA+ FY03 ...
GP02  GPRA+ FY02 ...

Select IHS Clinical Reporting System (CRS) Main Menu Option:  CI11 <Enter>  CRS 2011

```

2. At the "Select CRS 2011 Option" prompt, type **RPT** and press Enter to display the Reports menu; for example,

```

*****
**      IHS/RPMS CRS 2011      **
**      Clinical Reporting System      **
*****
                          Version 11.1

                          DEMO INDIAN HOSPITAL

RPT   Reports ...
SET   System Setup ...
AO    Area Options ...

Select CRS 2011 Option:  RPT <Enter>  Reports

```

3. At the “Select Reports Option” prompt, type **OTH** and press Enter to display the Other National Reports menu; for example,

```

*****
**   IHS/RPMS CRS 2011   **
**   Reports Menu       **
*****
Version 11.1

DEMO INDIAN HOSPITAL

NTL   National GPRA & PART Reports ...
LOC   Reports for Local Use: IHS Clinical Measures ...
OTH   Other National Reports ...
TAX   Taxonomy Reports ...
MUP   Meaningful Use Performance Measure Reports ...

Select Reports Option:  OTH <Enter>  Other National Reports

```

4. At the “Other National Reports Option” prompt, type **GPU** and press Enter to run the GPRA & PART Report; for example,

```

*****
**   IHS/RPMS CRS 2011   **
**   National GPRA Reports   **
*****
Version 11.1

DEMO INDIAN HOSPITAL

GPU   GPRA & PART Performance Report
ONM   Other National Measures Report
OST   Other National Measures Report Patient List
ELD   Elder Care Report
PED   Patient Education Reports

Select Other National Reports Option:  GPU <Enter>  GPRA & PART Performance
Report

```

Information about the report is displayed; for example:

```
IHS GPRA & PART Performance Report for a User Selected Date Range

This will produce a GPRA & PART report for a year period you specify.

You will be asked to provide: 1) the reporting period, 2) the baseline
period to compare data to, 3) the Community taxonomy and 4) the patient
population (i.e. AI/AN only, non AI/AN, or both) to determine which
patients will be included.

You can choose to export this data to the Area office.  If you
answer yes at the export prompt, a report will be produced in export format
for the Area Office to use in Area aggregated data.  Depending on site specific
configuration, the export file will either be automatically transmitted
directly to the Area or the site will have to send the file manually.

Press enter to continue:
```

5. At the prompt, press Enter to continue.
6. Next, the system checks the taxonomies.
 - If the message, “All taxonomies are present. End of taxonomy check.” is displayed, press Enter, as shown in the example below.
 - If the message, “The following taxonomies are missing or have no entries” is displayed, your report results for the measure that uses the taxonomy specified are likely to be inaccurate.

Exit from the report to edit your taxonomies by typing a caret (^) at any prompt until you return to the main menu, and then follow the directions for taxonomy setup in the *Clinical Reporting System User Manual*.

```
Checking for Taxonomies to support the GPRA & PART Performance Report...

All taxonomies are present.

End of taxonomy check.  PRESS ENTER: <Enter>
```

7. If you receive the following message, you will need to update the RPMS Demo/Test Patient Search Template (DPST option located in the PCC Management Reports, Other section) if you have any demo patients in your system that you do not want included in your reports. Note: The APCLZ security key needs to be assigned to access this template.

```
Your RPMS DEMO PATIENT NAMES Search Template does not exist.
If you have 'DEMO' patients whose names begin with something
other than 'DEMO,PATIENT' they will not be excluded from this report
unless you update this template.
```

```
Do you wish to continue to generate this report? Y//
End of taxonomy check. PRESS ENTER: <Enter>
```

Type No to cease the report generation and make the Demo Patient Template updates. Otherwise, to continue, type Y and press Enter.

8. At the “Do you want to run the report on a Patient Panel” option, type N and press Enter.

```
Do you want to run the report on a Patient Panel? N//
```

9. At the “Enter the date range for your report” prompt, select **3** to choose July 1 – June 30 (the GPRA year) and press Enter.

```
Select one of the following:
```

```
1      January 1 - December 31
2      April 1 - March 31
3      July 1 - June 30
4      October 1 - September 30
5      User-Defined Report PeriodThe date ranges for this report are:
```

```
Enter the date range for your report: 3 July 1 - June 30
```

10. At the “Enter Year” prompt, type **2012** and press Enter.

```
Enter the Calendar Year for the report END date. Use a 4 digit
year, e.g. 2011
Enter Year: 2012
```

11. You will receive a warning that the end date of the report period you selected is in the future. At the “Do you want to change your Current Report Dates” prompt, type N and press Enter.

You have selected Current Report period Jul 01, 2011 through Jun 30, 2012.
The end date of this report is in the future; your data will not be complete.

Do you want to change your Current Report Dates? N//

12. At the next “Enter Year” prompt, type **2000** to select that year as the baseline year and press Enter.

Enter the Baseline Year to compare data to.
Use a 4 digit year, e.g. 1999, 2000
Enter Year (e.g. 2000): 2000

13. At the “Enter the Name of the Community Taxonomy” prompt,

- Press Enter to accept the default taxonomy if it is your official GPRA community taxonomy, as shown in the example below, or
- Type the name of your official GPRA community taxonomy and press Enter.

To display all of the available community taxonomies, type two question marks (??) and press Enter at the prompt.

Note: For GPRA reporting purposes, the community taxonomy should be the same as the site Contract Health Services Delivery Area (CHSDA), except in Oklahoma.

The date ranges for this report are:
Report Period: Jul 01, 2011 to Jun 30, 2012
Previous Year Period: Jul 01, 2010 to Jun 30, 2011
Baseline Period: Jul 01, 1999 to Jun 30, 2000

Specify the community taxonomy to determine which patients will be included in the report. You should have created this taxonomy using QMAN.

Enter the Name of the Community Taxonomy: GPRA COMMUNITIES//

14. At the “Select Beneficiary Population to include in this report” prompt, type **1** to select Indian/Alaska Native and press Enter.

Select one of the following:

- 1 Indian/Alaskan Native (Classification 01)
- 2 Not Indian Alaskan/Native (Not Classification 01)
- 3 All (both Indian/Alaskan Natives and Non 01)

Select Beneficiary Population to include in this report: 1// 1
Indian/Alaskan Native (Classification 01)

15. At the prompt to export the data to your Area office, type **Y** and press Enter. For example:

Enter the Name of the Community Taxonomy: GPRA Community// **<Enter>**

Do you wish to export this data to Area? **Y <Enter>**

A summary of the report to be generated is displayed; for example,

SUMMARY OF IHS GPRA & PART PERFORMANCE REPORT TO BE GENERATED
CRS 2011, Version 11.1

The date ranges for this report are:

Report Period: Jul 01, 2011 to Jun 30, 2012
Previous Year Period: Jul 01, 2010 to Jun 30, 2011
Baseline Period: Jul 01, 1999 to Jun 30, 2000

The COMMUNITY Taxonomy to be used is: GPRA COMMUNITIES

The Beneficiary Population is: Indian/Alaskan Native (Classification 01)

The HOME location is: NATIVE AMERICAN HEALTH CENTER 661610

1. At the “Select an Output Option” prompt, type one of the following, depending on your Area preference, and press Enter:
 - **D** (delimited output file for use in Excel), or
 - **B** (both a printed report and delimited file)

For example,

```
Please choose an output type. For an explanation of the delimited
file please see the user manual.

Select one of the following:

P          Print Report on Printer or Screen
D          Create Delimited output file (for use in Excel)
B          Both a Printed Report and Delimited File

Select an Output Option: P// B <Enter> Both a Printed Report and Delimited File
```

11. Continue to respond to the prompts, as follows:

- a. At the “Select output type” prompt, type **F** (File) and press Enter.
- b. At the prompt to enter a filename (maximum 40 characters), type a name for the file, and press Enter.

The location and name of the output file is displayed; for example,

```
You have selected to create a delimited output file. You can have this
output file created as a text file in the pub directory,
OR you can have the delimited output display on your screen so that
you can do a file capture. Keep in mind that if you choose to
do a screen capture you CANNOT Queue your report to run in the background!!

Select one of the following:

S SCREEN - delimited output will display on screen for capture
F FILE - delimited output will be written to a file in pub

Select output type: S// F <Enter> FILE - delimited output will be written to a file
in pub.
Enter a filename for the delimited output (no more than 40 characters):
DemoHospGPRA102011 <Enter>

When the report is finished your delimited output will be found in the D:\PUB
directory. The file name will be DemoHospGPRA102011.txt
```

Because you are exporting the data to your Area office, CRS creates a file that begins with “BG11” in the PUB directory (e.g. BG11505901.14), as shown in the example below. This is the file you must transmit to your Area Office for inclusion in the Area Aggregate report.

```
A file will be created called BG11505901.14 and will reside
in the q:\ directory.

Depending on your site configuration, these files may need to be manually
sent to your Area Office.
```

It is recommended that you queue the report and run it at night rather than running it during the day. To queue the report, type **Y** and press Enter at the “Won’t you queue this?” prompt.

To queue the report to run at a specified date/time, type **??** and press Enter for instructions or press Enter to start the report now.

```
Won't you queue this ? Y// YES  
Requested Start Time: NOW//
```

Note: Make sure you double check the date of the file and select the most current file before sending.

Instructions for Running National GPRA Dashboard

Beginning with CRS version 11.1, there is a new dashboard report in CRS which allows your program to easily see your GPRA results for the current GPRA year. The dashboard also shows how many more patients need to be screened/tested for each measure in order to meet the target.

NOTE: In CRS 11.1, the dashboard can only be run for the 2011 GPRA year. Once CRS 12.0 is released in December, the dashboard report can be run for the 2012 GPRA year.

To run the National GPRA Dashboard:

1. Once in CRS, type **RPT** and press Enter to display the Reports menu; for example,

```
*****  
**      IHS/RPMS CRS 2011      **  
**   Clinical Reporting System   **  
*****  
                Version 11.1  
  
                DEMO INDIAN HOSPITAL  
  
RPT   Reports ...  
SET   System Setup ...  
AO    Area Options ...  
  
Select CRS 2011 Option:  RPT <Enter>  Reports
```

2. At the “Select Reports Option” prompt, type **NTL** and press Enter to display the National GPRA & PART Reports menu; for example,

```

*****
**   IHS/RPMS CRS 2011   **
**   Reports Menu       **
*****
Version 11.1

DEMO INDIAN HOSPITAL

NTL   National GPRA & PART Reports ...
LOC   Reports for Local Use: IHS Clinical Measures ...
OTH   Other National Reports ...
TAX   Taxonomy Reports ...
MUP   Meaningful Use Performance Measure Reports ...

Select Reports Option:  NTL <Enter>  National GPRA & PART Reports

```

3. At the “National GPRA & PART Report” prompt, type **DSH** and press Enter to run the National GPRA Dashboard; for example,

```

*****
**   IHS/RPMS CRS 2011   **
**   National GPRA Reports   **
*****
Version 11.1

DEMO INDIAN HOSPITAL

GP     National GPRA & PART Report
LST    National GPRA & PART Patient List
SUM    National GPRA & PART Clinical Perf Summaries
DPRV   National GPRA & PART Report by Designated Provider
DSH    National GPRA Dashboard
HW     National GPRA Height and Weight Local Data File
NST    Create Search Template for National Patient List
FOR    GPRA & PART Forecast Patient List
FORD   GPRA & PART Forecast Denominator Definitions
CMP    Comprehensive National GPRA & PART Patient List

Select National GPRA & PART Reports Option:  DSH <Enter>  National GPRA
Dashboard

```

4. Information about the report is displayed and taxonomies are checked; for example:

- If the message, “All taxonomies are present. End of taxonomy check.” is displayed, press Enter, as shown in the example below.
- If the message, “The following taxonomies are missing or have no entries” is displayed, your report results for the measure that uses the taxonomy specified are likely to be inaccurate.

Exit from the report to edit your taxonomies by typing a caret (^) at any prompt until you return to the main menu, and then follow the directions for taxonomy setup in the *Clinical Reporting System User Manual*.

```
IHS 2011 National GPRA Dashboard

This will produce a National GPRA dashboard that will show your local
facility's current rates for GPRA measures compared to National GPRA
targets. You will be asked to provide the community taxonomy to determine
which patients will be included. This report will be run for the Report
Period July 1, 2010 through June 30, 2011 with a Baseline Year of July 1,
1999 through June 30, 2000. This report will include beneficiary
population of American Indian/Alaska Native only.

Checking for Taxonomies to support the National GPRA & PART Report...

All taxonomies are present.

End of taxonomy check. PRESS ENTER:
```

5. If you receive the following message, you will need to update the RPMS Demo/Test Patient Search Template (DPST option located in the PCC Management Reports, Other section) if you have any demo patients in your system that you do not want included in your reports. Note: The APCLZ security key needs to be assigned to access this template.

```
Your RPMS DEMO PATIENT NAMES Search Template does not exist.
If you have 'DEMO' patients whose names begin with something
other than 'DEMO,PATIENT' they will not be excluded from this report
unless you update this template.

Do you wish to continue to generate this report? Y//
End of taxonomy check. PRESS ENTER: <Enter>
```

Type No to cease the report generation and make the Demo Patient Template updates. Otherwise, to continue, type Y and press Enter.

6. At the “Enter the Name of the Community Taxonomy” prompt,
- Press Enter to accept the default taxonomy if it is your official GPRA community taxonomy, as shown in the example below, or
 - Type the name of your official GPRA community taxonomy and press Enter.
- To display all of the available community taxonomies, type two question marks (??) and press Enter at the prompt.

Note: For GPRA reporting purposes, the community taxonomy should be the same as the site Contract Health Services Delivery Area (CHSDA), except in Oklahoma.

The date ranges for this report are:
 Report Period: Jul 01, 2011 to Jun 30, 2012
 Previous Year Period: Jul 01, 2010 to Jun 30, 2011

Specify the community taxonomy to determine which patients will be included in the report. You should have created this taxonomy using QMAN.

Enter the Name of the Community Taxonomy: GPRA COMMUNITIES//

7. At the “Select an Output Option” prompt, type one of the following, depending on your Area preference, and press Enter:
- **D** (delimited output file for use in Excel), or
 - **B** (both a printed report and delimited file)

For example,

Please choose an output type. For an explanation of the delimited file please see the user manual.

Select one of the following:

P	Print Report on Printer or Screen
D	Create Delimited output file (for use in Excel)
B	Both a Printed Report and Delimited File

Select an Output Option: P// **B** <Enter> Both a Printed Report and Delimited File

8. Continue to respond to the prompts, as follows:
- At the “Select output type” prompt, type **F** (File) and press Enter.
 - At the prompt to enter a filename (maximum 40 characters), type a name for the file, and press Enter.

The location and name of the output file is displayed; for example,

```
You have selected to create a delimited output file.  You can have this
output file created as a text file in the pub directory,
OR you can have the delimited output display on your screen so that
you can do a file capture.  Keep in mind that if you choose to
do a screen capture you CANNOT Queue your report to run in the background!!
```

```
Select one of the following:
```

```
  S  SCREEN - delimited output will display on screen for capture
  F  FILE - delimited output will be written to a file in pub
```

```
Select output type: S// F <Enter>  FILE - delimited output will be written to a file
in pub.
```

```
Enter a filename for the delimited output (no more than 40 characters):
```

```
DemoHospGPRA102011 <Enter>
```

```
When the report is finished your delimited output will be found in the D:\PUB
directory.  The file name will be DemoHospGPRA102011.txt
```

9. It is recommended that you queue the report and run it at night rather than running it during the day. To queue the report, type Y and press Enter at the "Won't you queue this?" prompt.

To queue the report to run at a specified date/time, type ?? and press Enter for instructions or press Enter to start the report now.

```
Won't you queue this ? Y// YES
Requested Start Time: NOW//
```

CRS National GPRA and PART Dashboard - new feature in CRS!

Cover Page

*** IHS 2011 National GPRA & PART Report ***

CRS 2011, Version 11.1

Date Report Run: Nov 07, 2011

Site where Run: DEMO HEALTH CENTER

Report Generated by: BRENNAN,CHRISTINE

Report Period: Jul 01, 2010 to Jun 30, 2011

Previous Year Period: Jul 01, 2009 to Jun 30, 2010

Measures: GPRA Denominators and Numerators

Population: AI/AN Only (Classification 01)

RUN TIME (H.M.S): 0.4.23

This report includes clinical performance measures reported for the Government Performance and Results Act (GPRA).

Denominator Definitions used in this Report:

ACTIVE CLINICAL POPULATION:

1. Must reside in a community specified in the community taxonomy used for this report.
2. Must be alive on the last day of the Report period.
3. Indian/Alaska Natives Only - based on Classification of 01.
4. Must have 2 visits to medical clinics in the 3 years prior to the end of the Report period. At least one visit must include: 01 General, 06 Diabetic, 10 GYN, 12 Immunization, 13 Internal Med, 20 Pediatrics, 24 Well Child, 28 Family Practice, 57 EPSDT, 70 Women's Health, 80 Urgent, 89 Evening. See User Manual for complete description of medical clinics.

USER POPULATION:

1. Definitions 1-3 above.
2. Must have been seen at least once in the 3 years prior to the end of the Report period, regardless of the clinic type.

A delimited output file called GPRA Dashboard

has been placed in the d:\exports\ directory for your use in Excel or some other software package. See your site manager to access this file.

Community Taxonomy Name: GPRA COMMUNITIES

The following communities are included in this report:

BONSALL
CARDIFF-BY-THE-SEA
ENCINITAS
ESCONDIDO SOUTH
LA JOLLA RSV
MESA GRANDE RESV
OCEANSIDE
PALOMAR MOUNTAIN
RAMONA
SAN MARCOS
VALLEY CENTER

BORREGO SPRINGS	CAMP PENDLETON
CARLSBAD	COASTAL AREA
ESCONDIDO	ESCONDIDO NORTH
FALLBROOK	JULIAN AREA
LEUCADIA	LOS COYOTES RESV
MIRA MESA	NORTH COUNTY WIDE
PALA NORTH	PALA RESERV.
PAUMA VALLEY	POWAY NORTH
RINCON RESV.	SAN LUIS REY
SAN PASQUAL RESV	SANTA YSABEL RESV
VISTA	WARNER SPRINGS

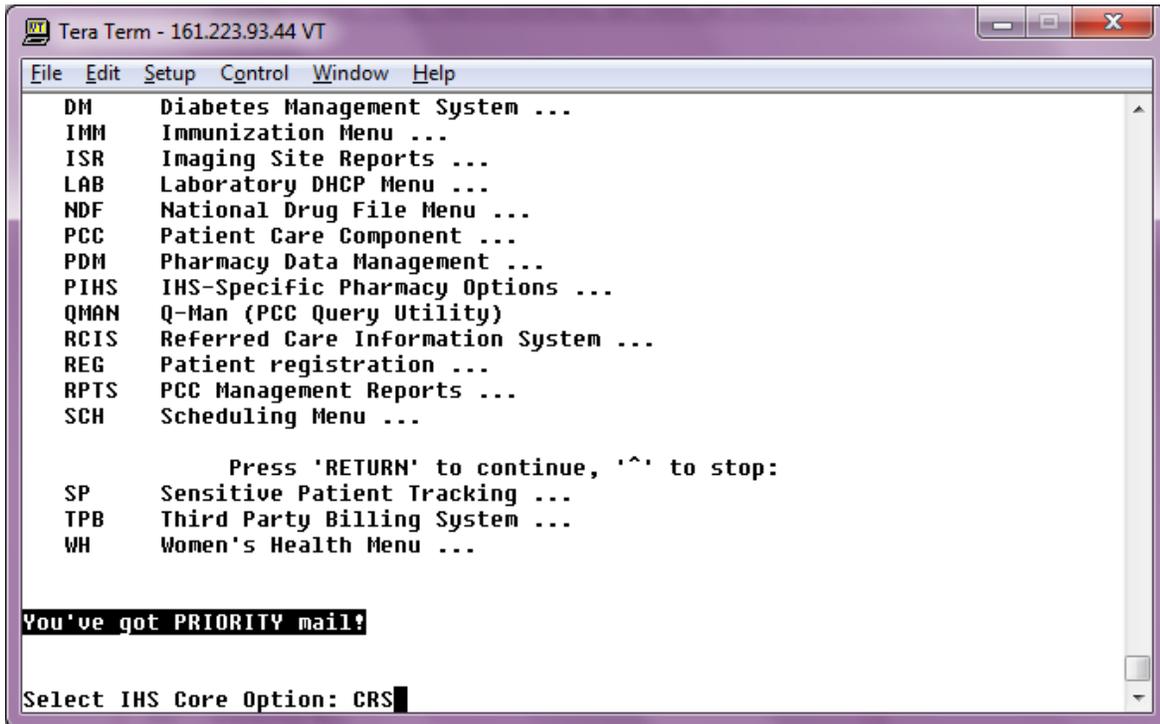
Dashboard Report -DEMO HEALTH CENTER

	National/Area 2011 Target	2010 Final	Numerator	Denominator	2011*	# Needed to Achieve Target
Poor Glycemic Control >9.5	19.4	0	0	0	0	0
Ideal Glycemic Control <7	30.2	0	0	0	0	0
Controlled BP <130/80	35.9	0	0	0	0	0
LDL Assessed	63.3	0	0	0	0	0
Nephropathy Assessed	51.9	0	0	0	0	0
Retinopathy Assessed	50.1	0	0	0	0	0
Dental Access General	23	0	3	25	12	3
# Sealants	0	0	0		0	0
Topical Fluoride-# Pts	0	0	0		0	0
Influenza 65+	58.5	0	0	0	0	0
Pneumovax Ever 65+	79.3	0	0	0	0	0
Actvie IMM 4313314	74.6	0	0	0	0	0
Pap Smear Rates 21-64	55.7	0	0	5	0	3
Mammogram Rates 52-64	46.9	0	1	4	25	1
Colorectal Cancer 51-80	36.7	0	2	5	40	0
Tobacco Cessation Counsel	23.7	0	0	0	0	0
FAS Prevention 15-44	51.7	0	0	1	0	1
IPV/DV Screen 15-40	52.8	0	0	1	0	1
Depression Screen 18+	51.9	0	1	7	14.3	3
IHD: Comp CVD Assessment	33	0	0	0	0	0
Prenatal HIV Testing	73.6	0	0	0	0	0

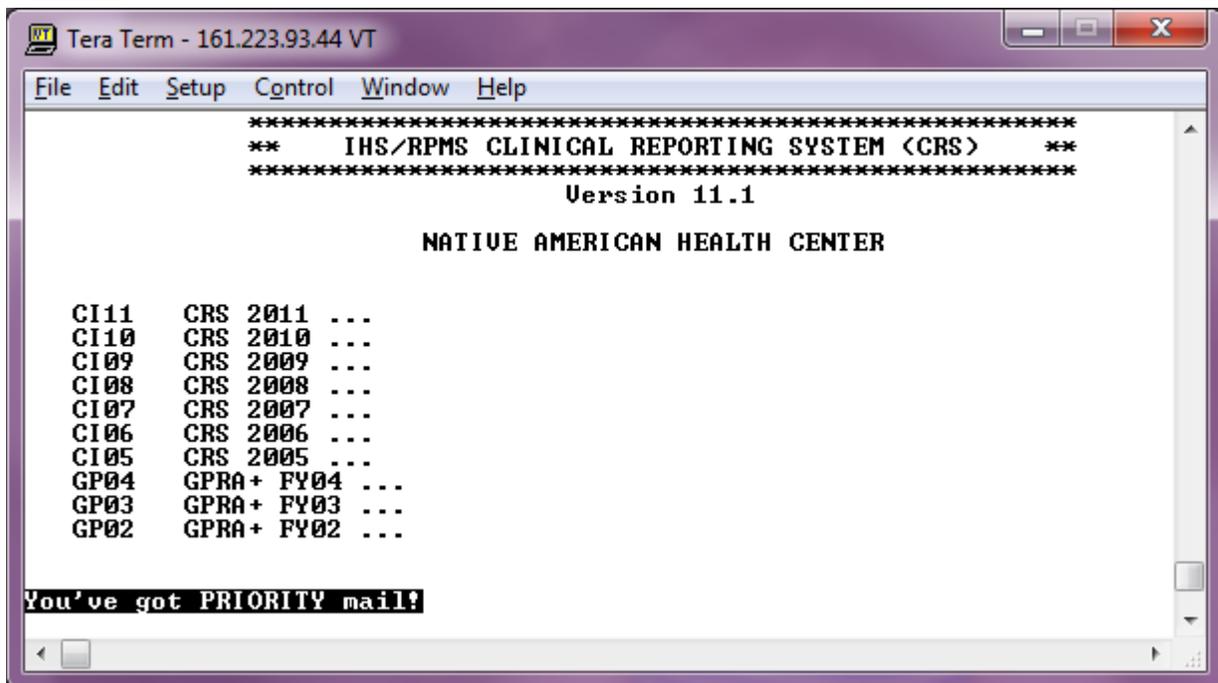
*Results reflect services provided as of the date this report was run or the report period end date, whichever is earlier

INSTRUCTIONS FOR RUNNING A PATIENT LIST IN CRS

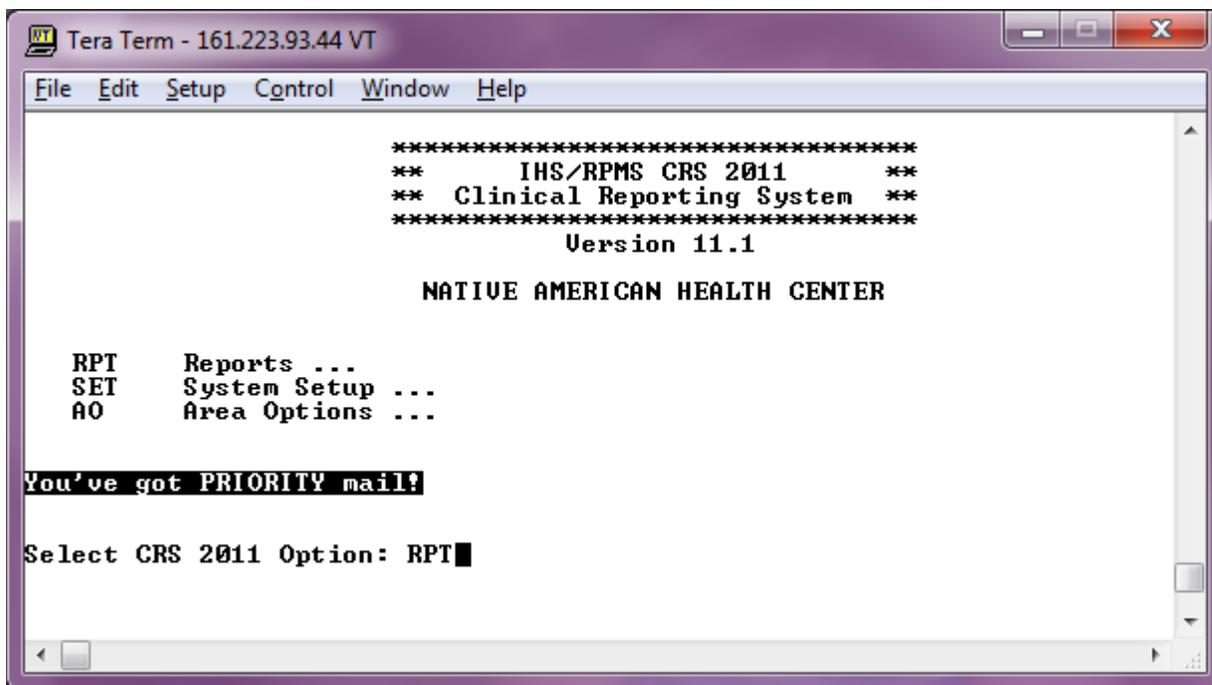
1. Select **CRS** (or GPRA) from the IHS Core Option menu:



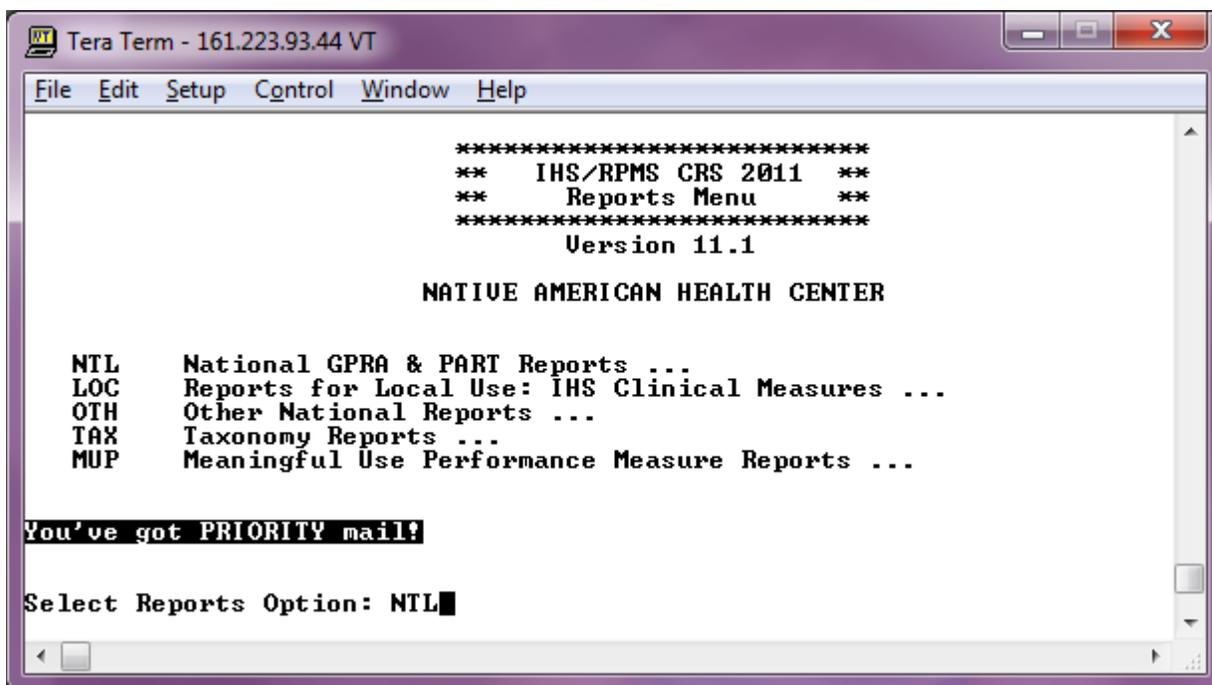
2. Select **CI11** (CRS 2011) or the most current version.



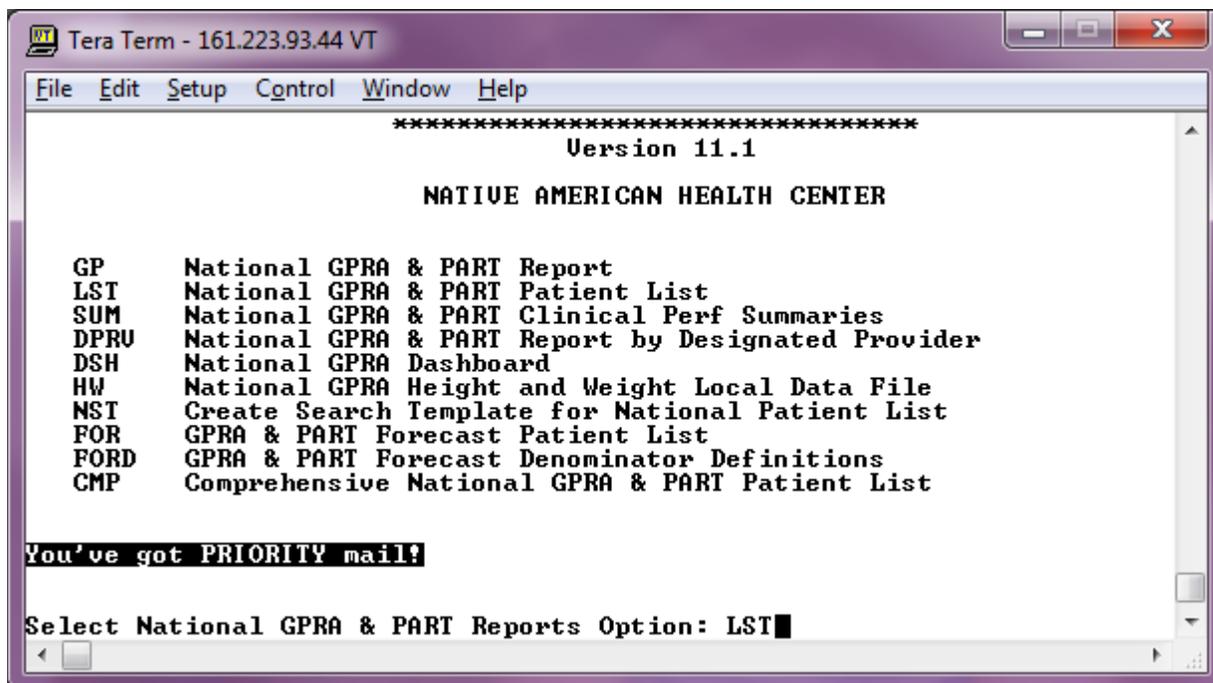
3. Select RPT (Reports)



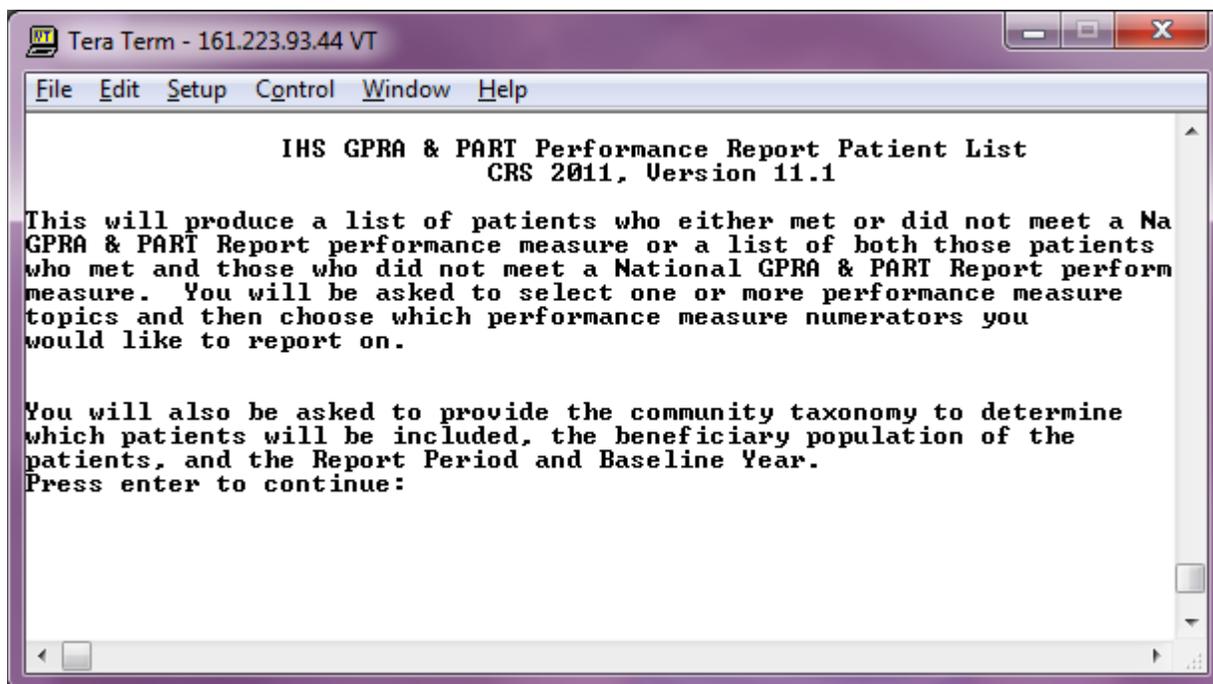
4. Select NTL (National GPRA & PART Reports)



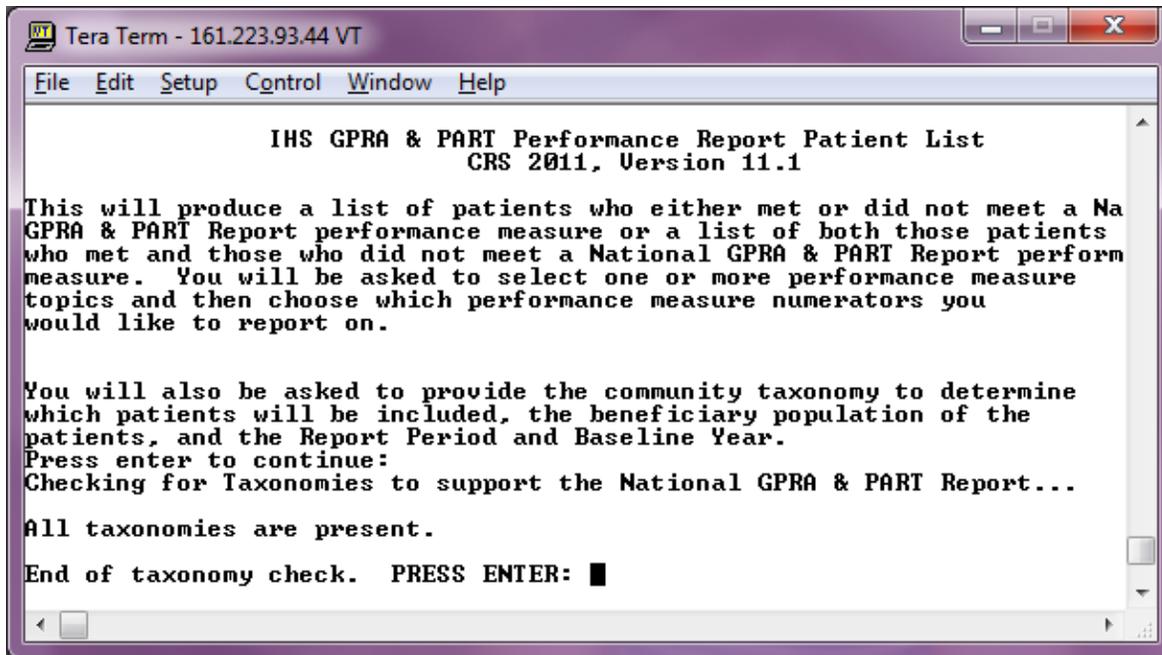
5. Select **LST** (National GPRA & PART Patient List)



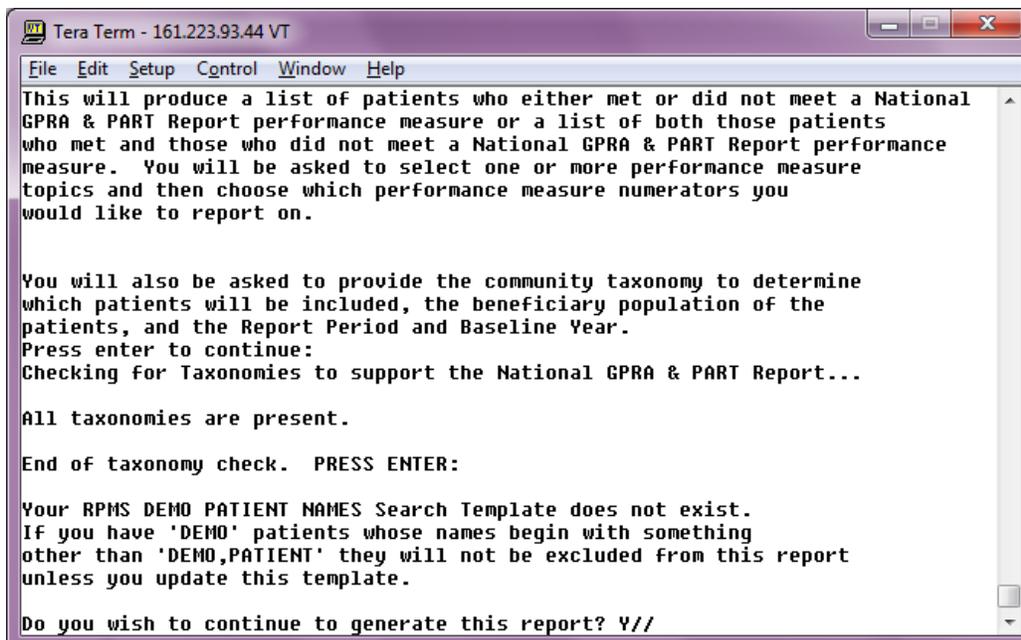
6. At the next screen, press **ENTER**



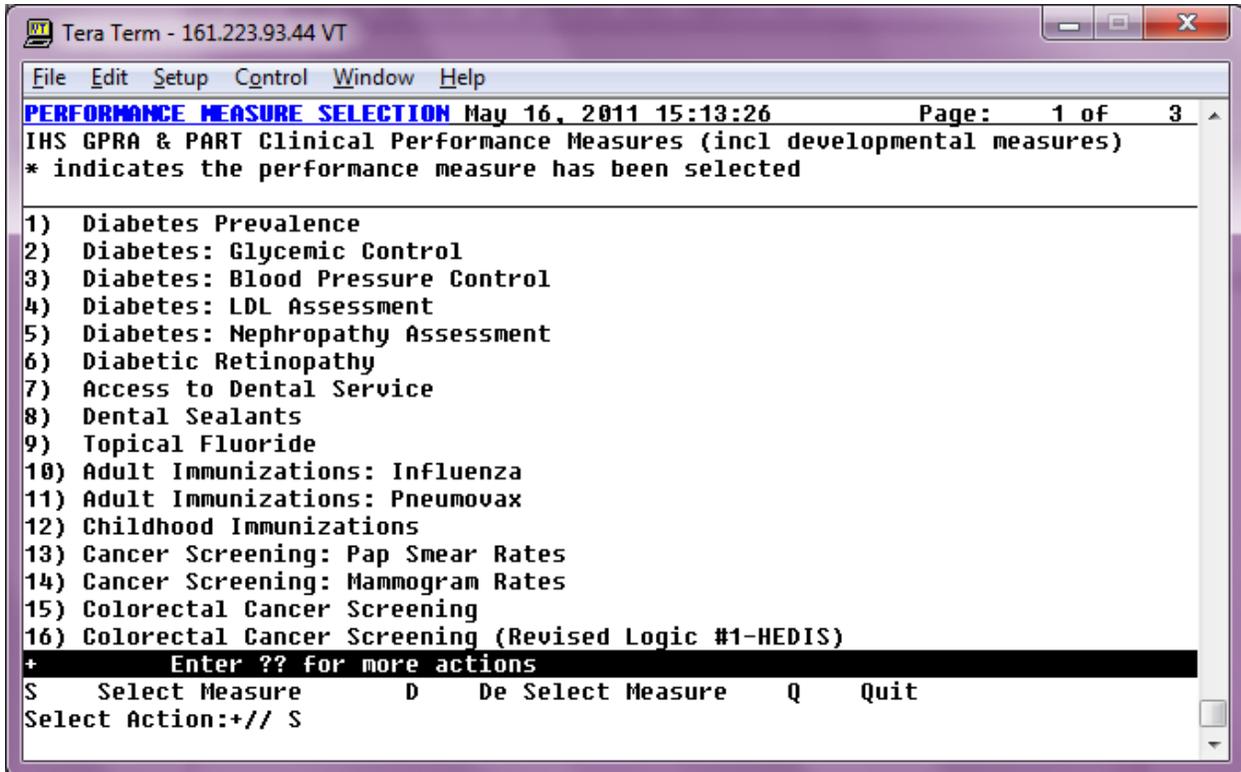
7. After the taxonomy check, press **ENTER**



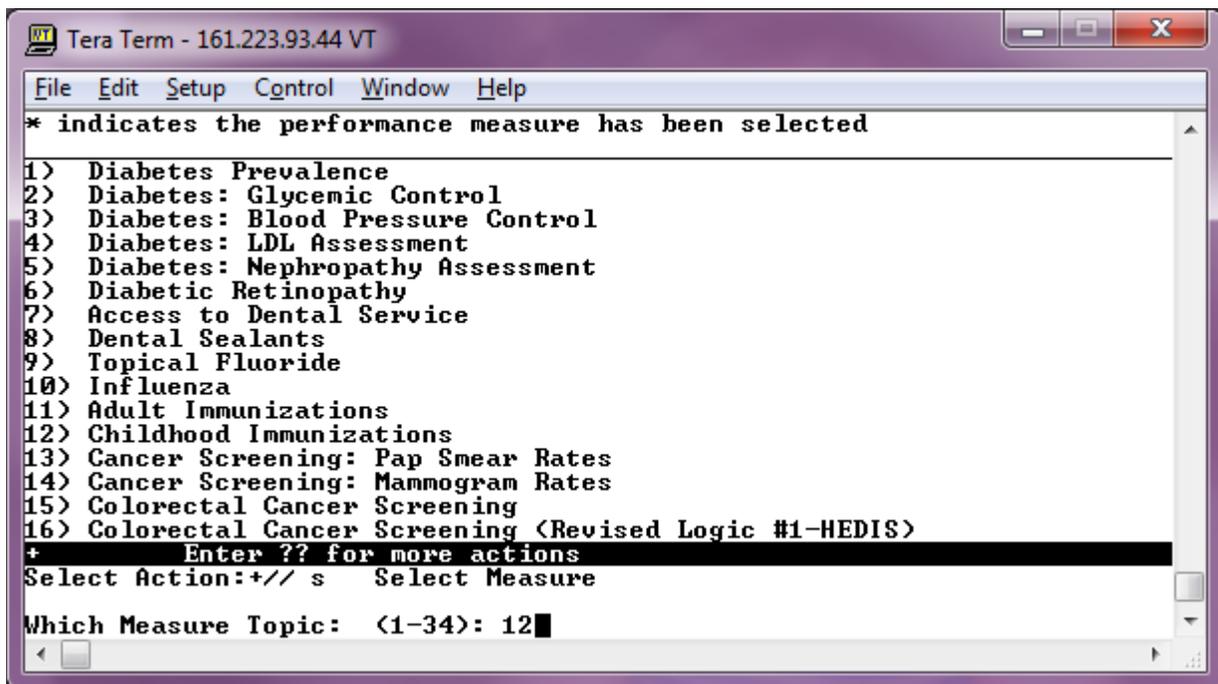
8. If you get the following message regarding the RPMS Demo Patient Names template, you will need to update the RPMS Demo/Test Patient Search Template (DPST option located in the PCC Management Reports, Other section) if you have any demo patients in your system that you do not want included in your reports. Note: The APCLZ security key needs to be assigned to access this template. Select **NO** to exit the patient list and update the search template. Otherwise, select Yes.



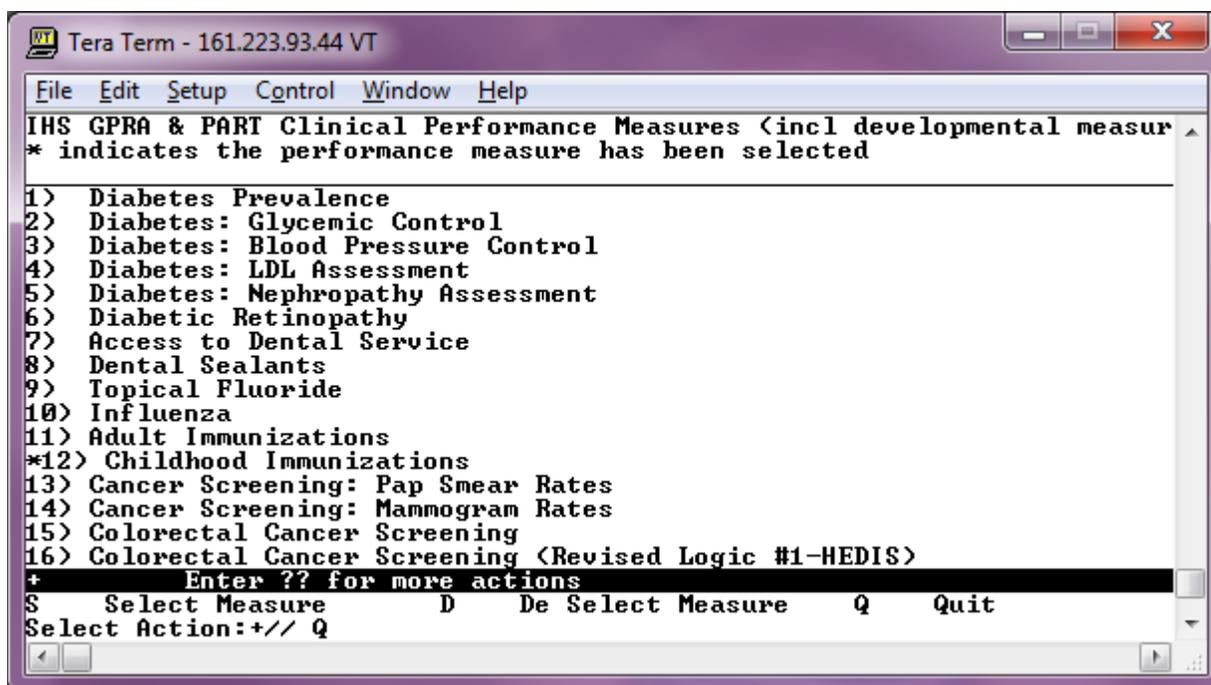
9. At the Performance Measure Selection screen, select **S** for the Select option



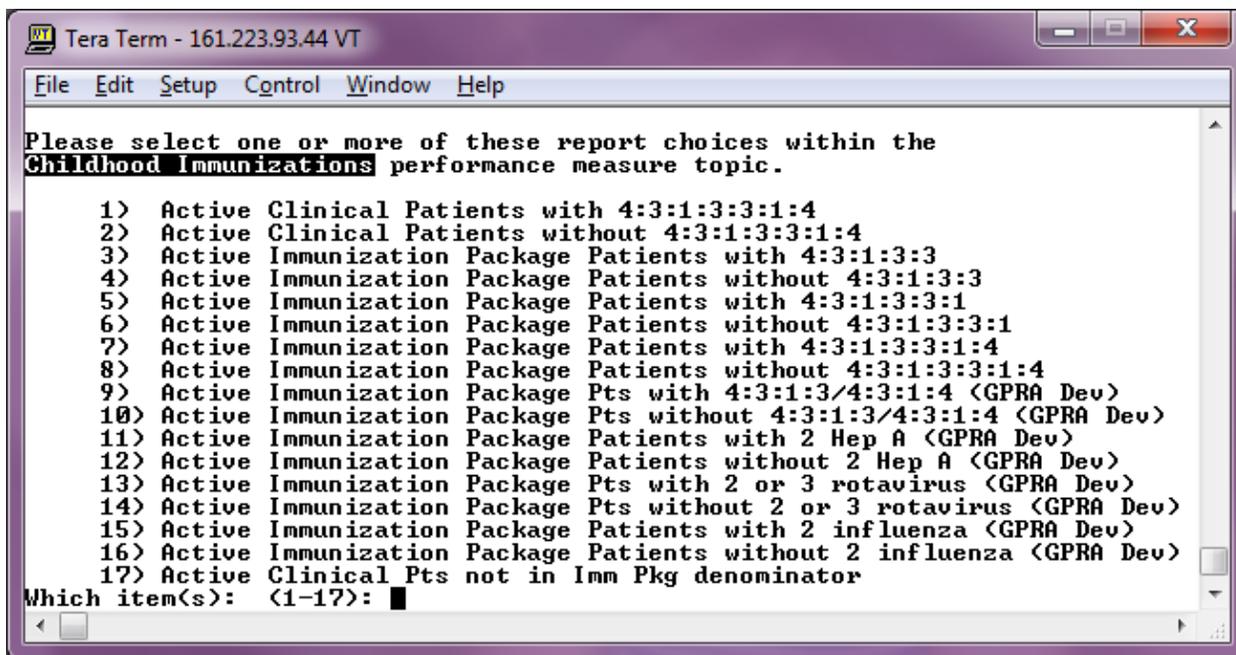
10. Enter **the number(s) for the measure(s) you want to create patient lists for**
(For example, enter 10 for Influenza, 11 for Pneumovax, or 10-11 for both)



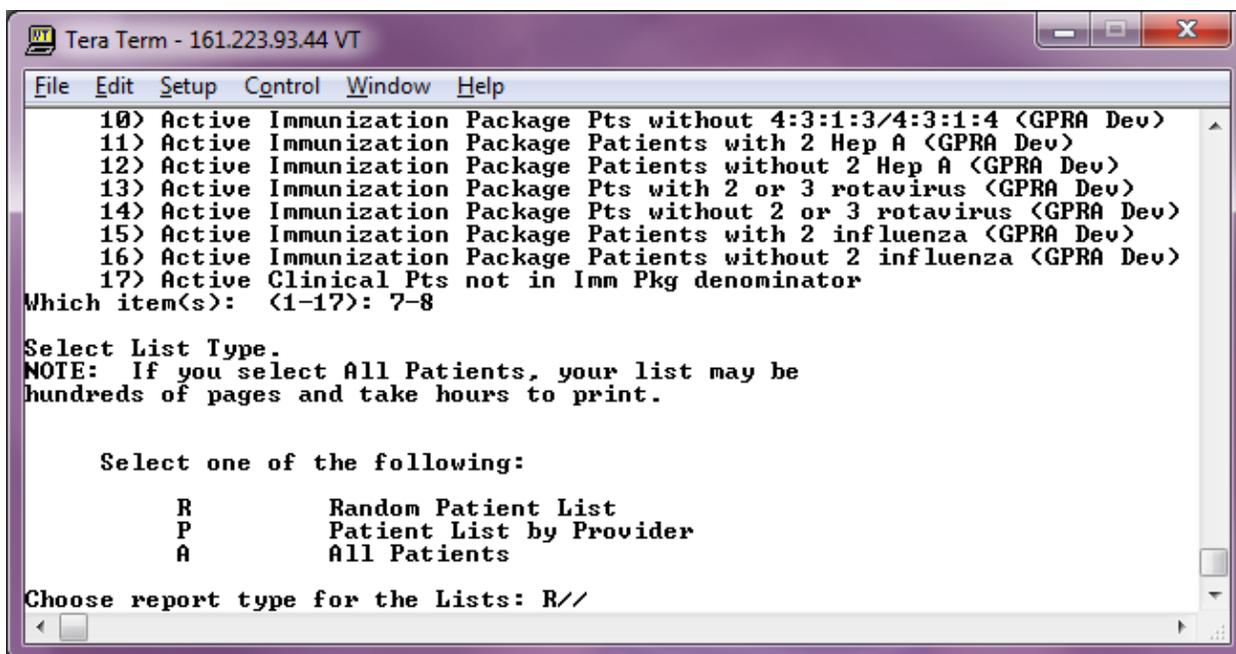
11. Select Q to Quit



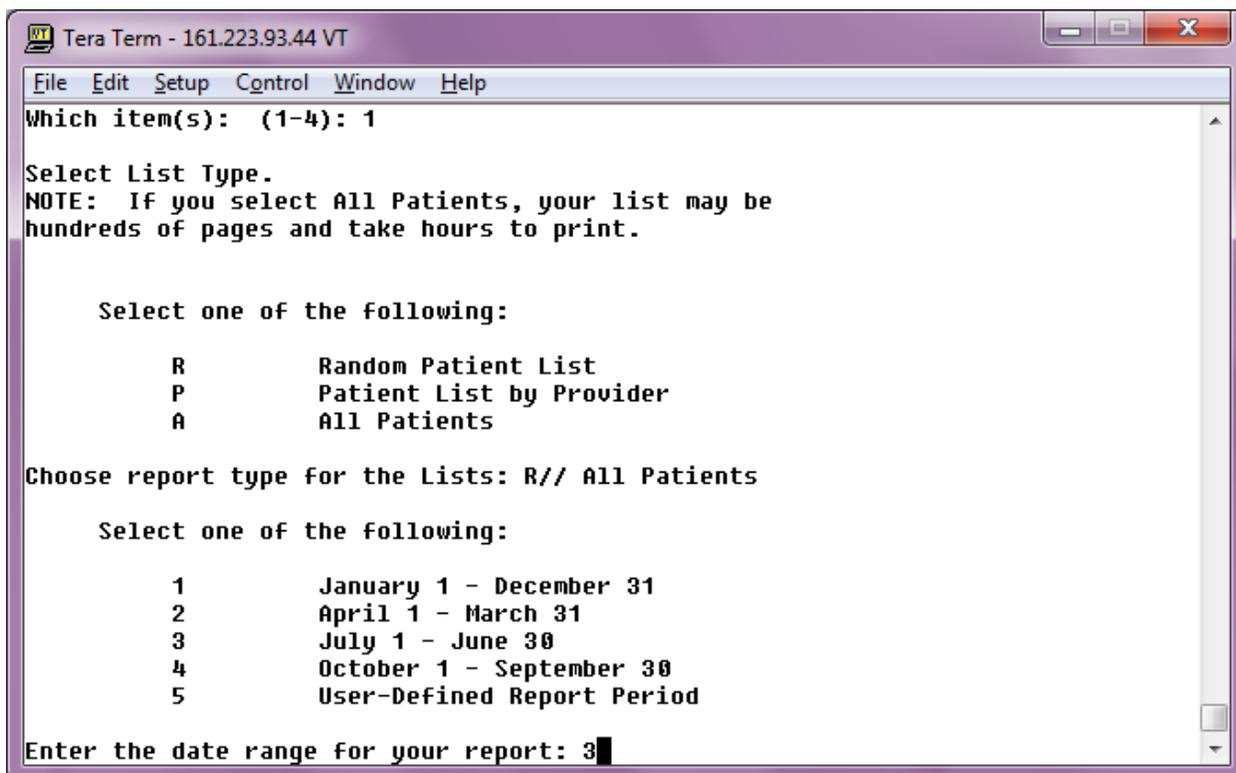
12. Select the patient list to run (for example, for childhood immunizations, select 7 to run a list of patients who HAVE met the 4:3:1:3:3:1:4 measure, select 8 to run a list of patients who HAVE NOT met the 4:3:1:3:3:1:4 measure, or select 7-8 to run both).



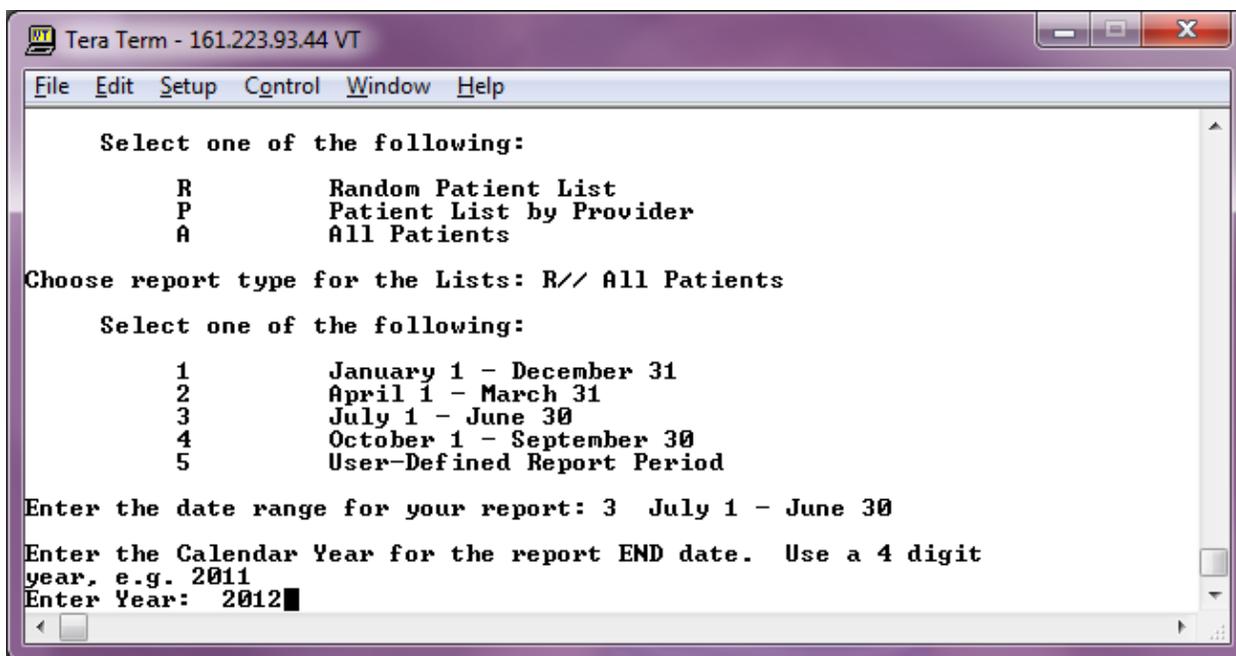
13. Select **A** to include All patients



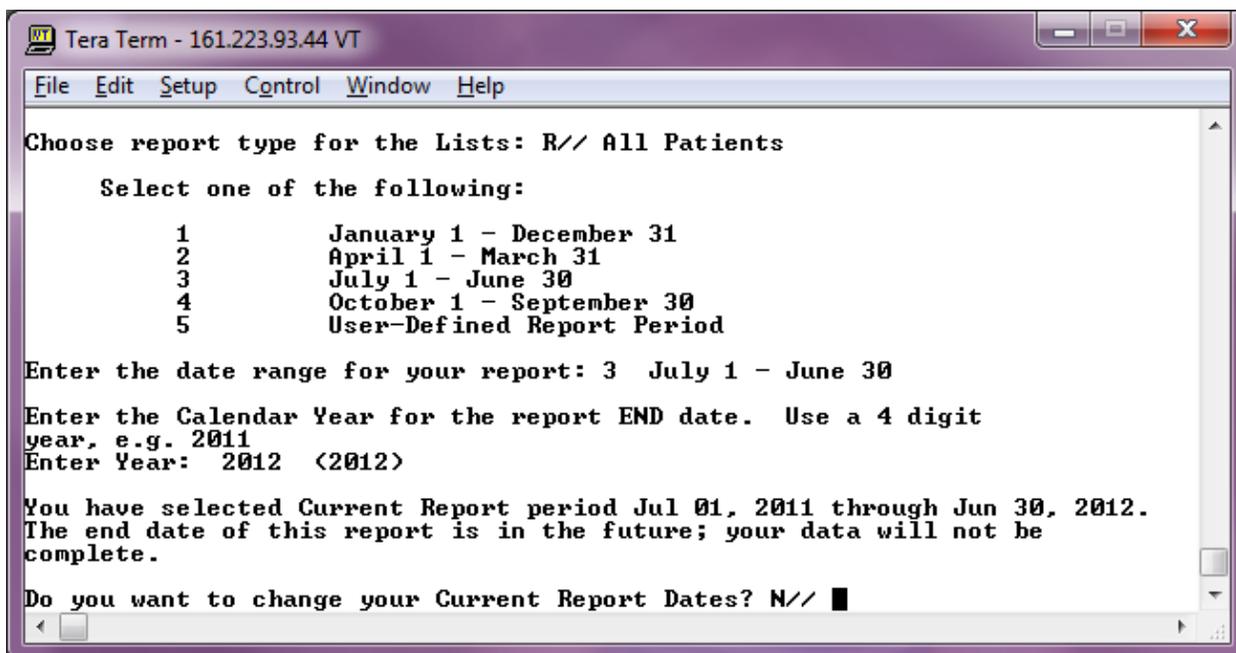
14. For the date range of the report, select **3** (July 1 – June 30)



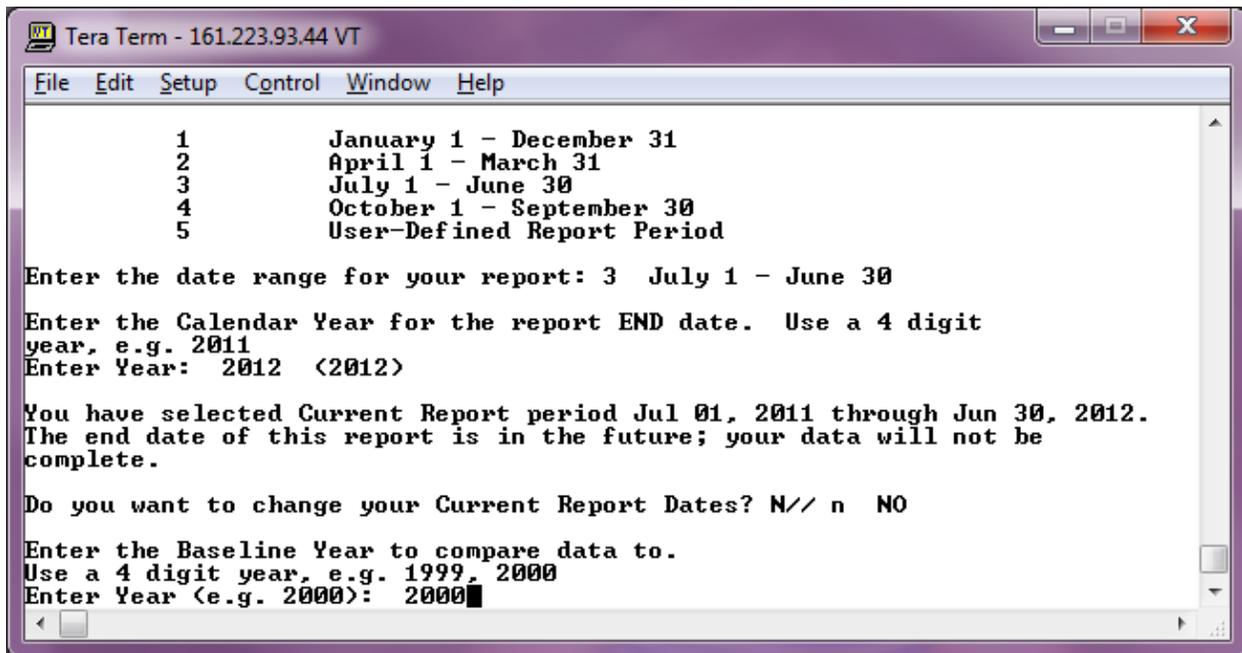
15. For the Calendar Year End Date, enter **2012**



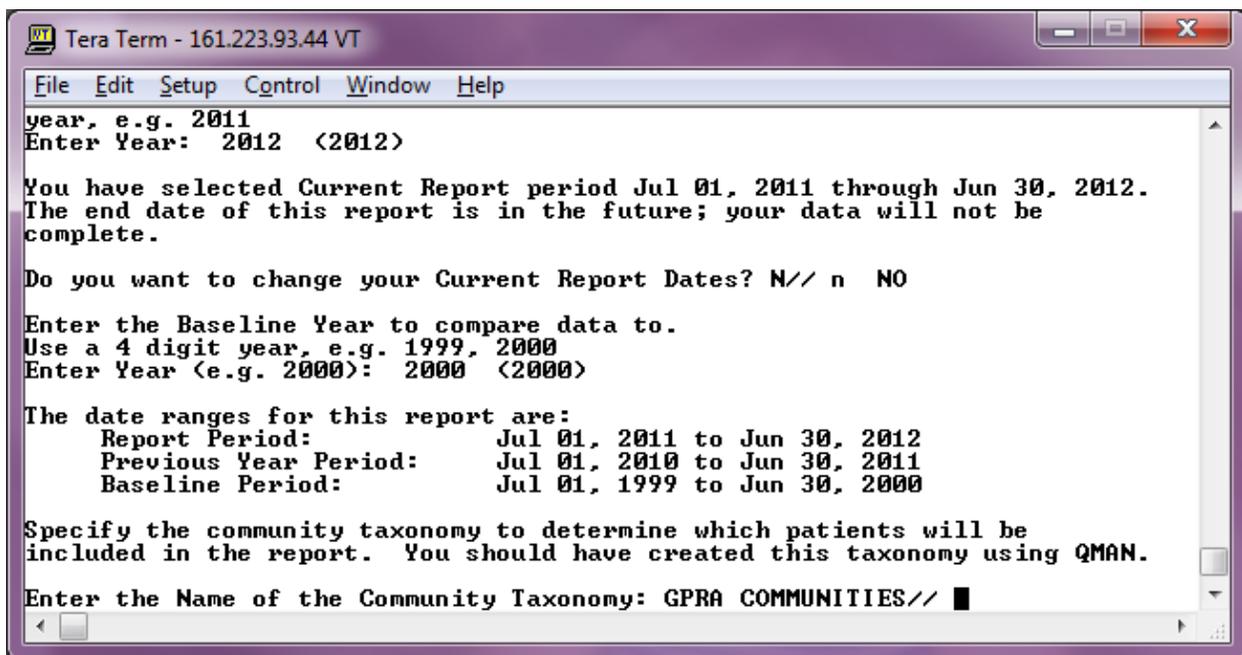
16. You will see a warning that the end date of the report is in the future, select **N** (no) at the 'Do you want to change your Current Report Date' prompt



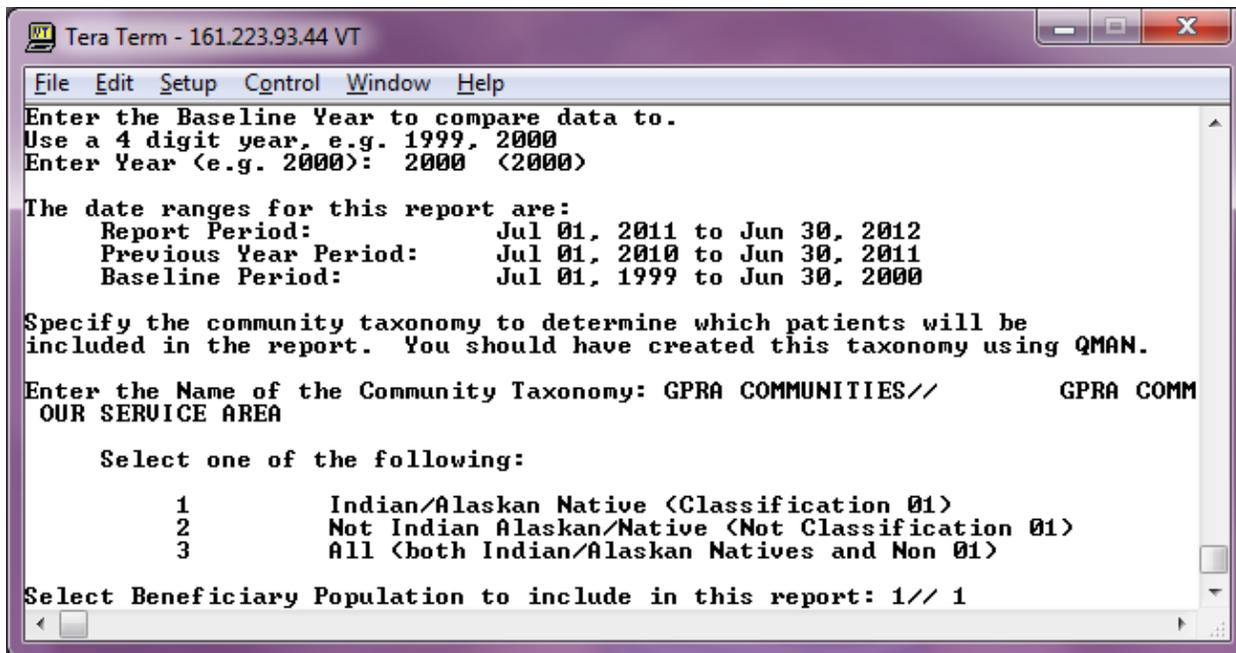
17. Enter 2000 for the Baseline Year



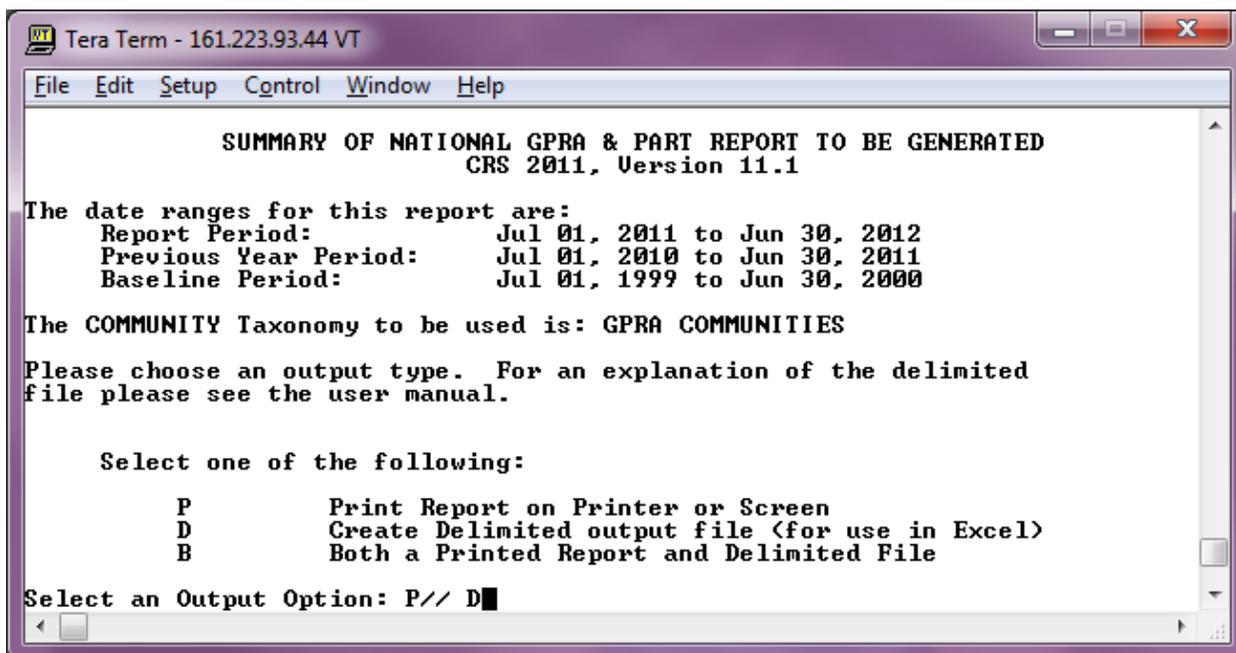
18. At the Community Taxonomy prompt, enter the GPRA Community Taxonomy used to run the quarterly GPRA report



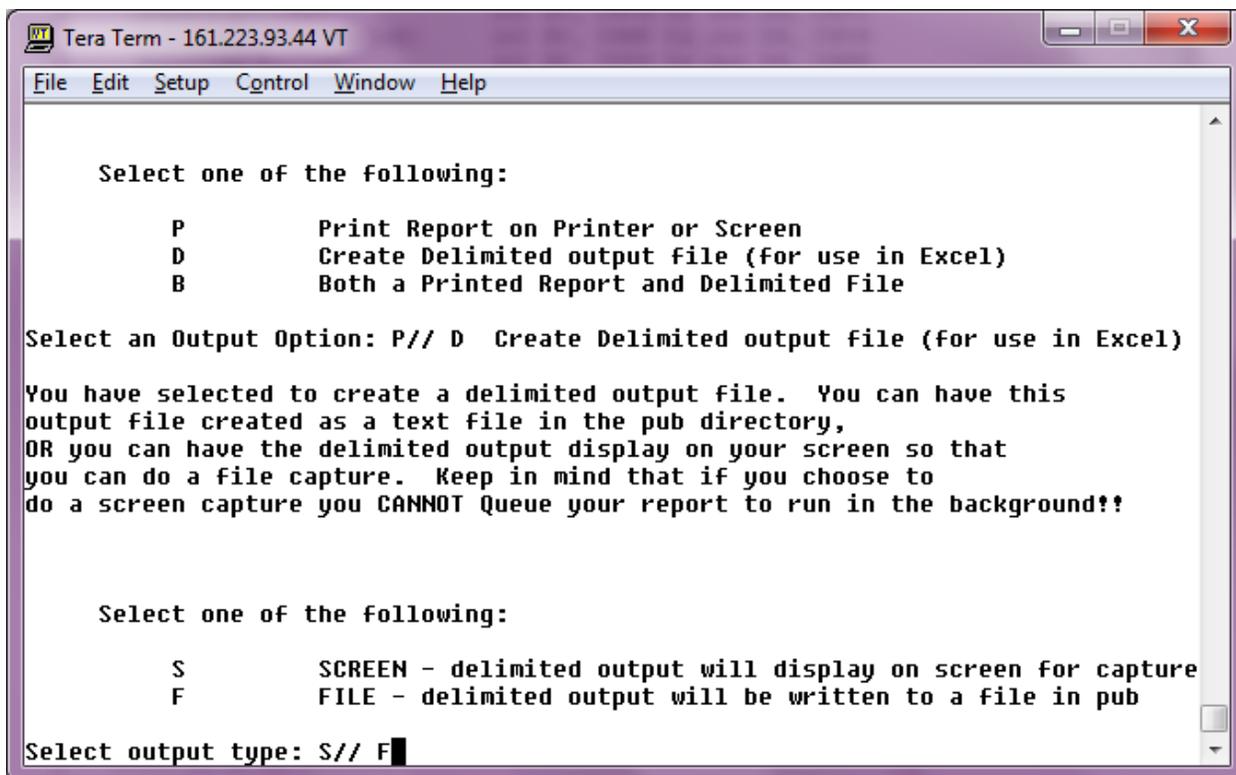
19. At the Beneficiary Population prompt, select **1** (Indian/Alaska Native)



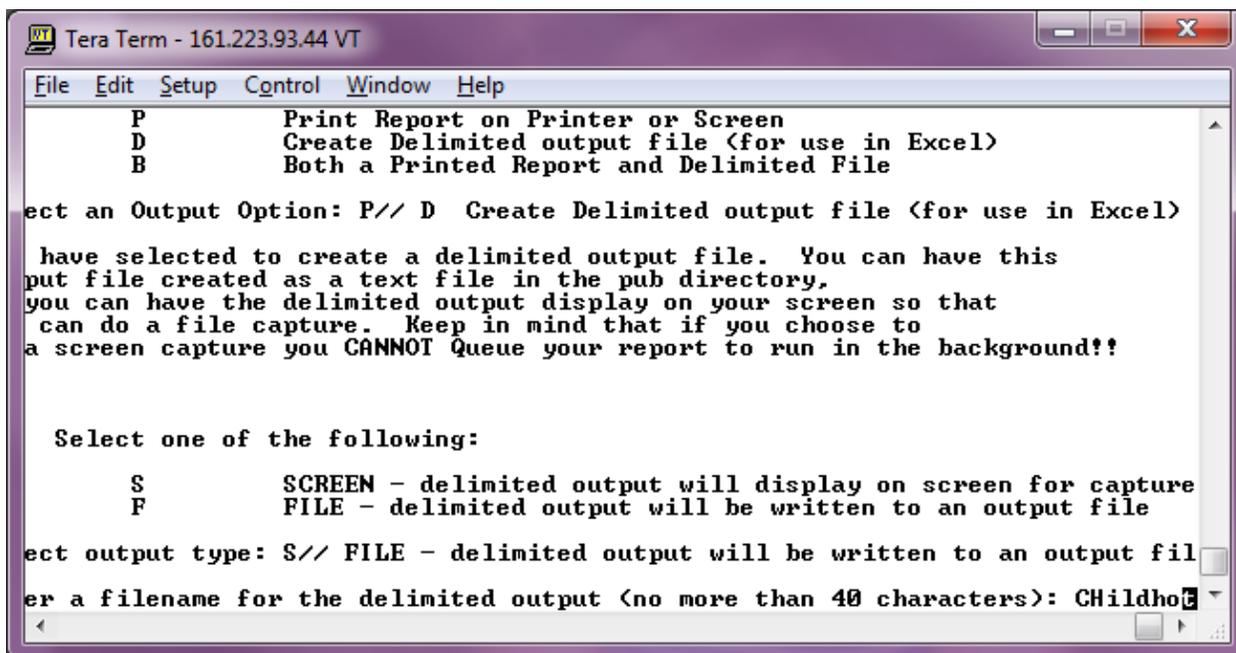
20. Select **D** (Create a Delimited output file) for Output Option



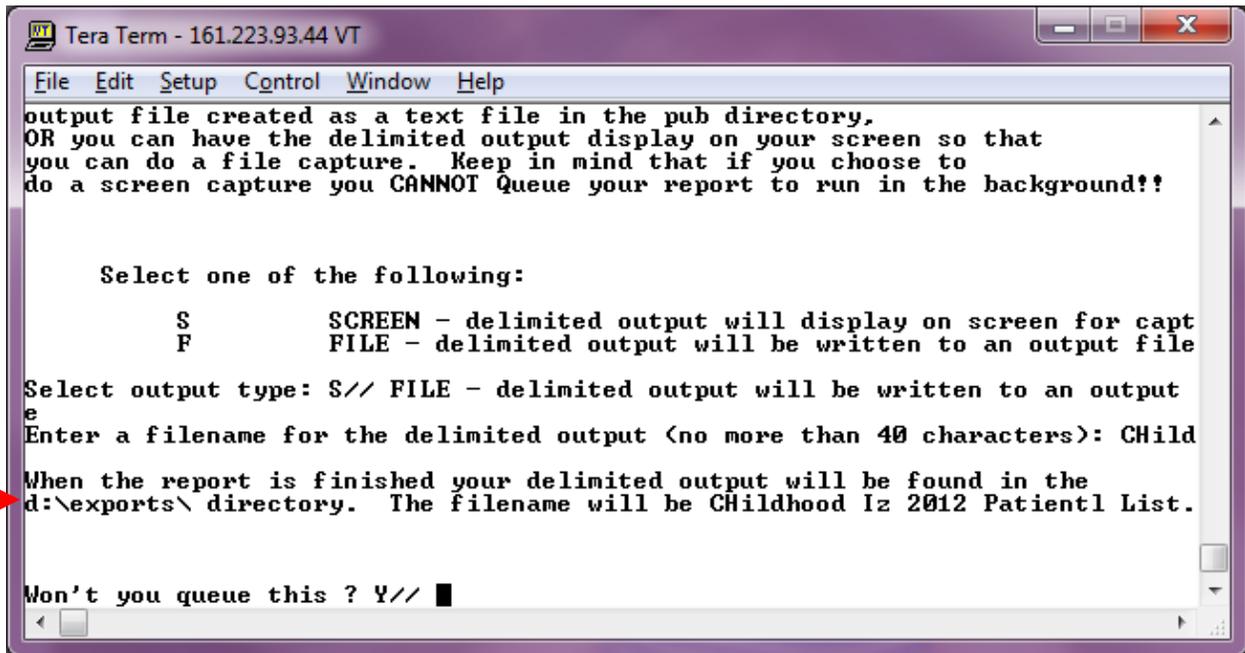
21. Select F (File) for Output Type



22. Enter a name for the output file and press Enter



23. Note the location of the file listed on the screen, this is where the file will be found once the patient list has been run. Select **Y** (yes) to queue the file



```
Tera Term - 161.223.93.44 VT
File Edit Setup Control Window Help
output file created as a text file in the pub directory.
OR you can have the delimited output display on your screen so that
you can do a file capture. Keep in mind that if you choose to
do a screen capture you CANNOT Queue your report to run in the background!!

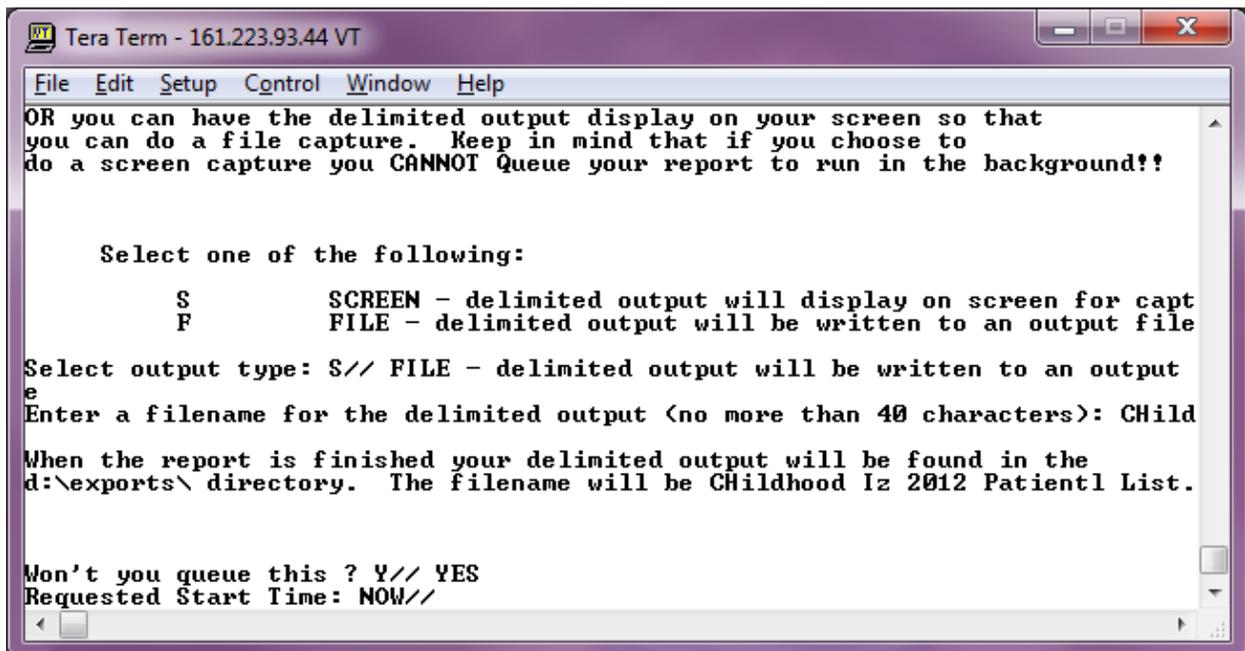
Select one of the following:

      S      SCREEN - delimited output will display on screen for capt
      F      FILE - delimited output will be written to an output file

Select output type: S// FILE - delimited output will be written to an output
e
Enter a filename for the delimited output (no more than 40 characters): Child
When the report is finished your delimited output will be found in the
d:\exports\ directory. The filename will be Childhood Iz 2012 Patient1 List.

Mon't you queue this ? Y// █
```

24. Enter a time for the file to run or press **ENTER** for the list to run immediately



```
Tera Term - 161.223.93.44 VT
File Edit Setup Control Window Help
OR you can have the delimited output display on your screen so that
you can do a file capture. Keep in mind that if you choose to
do a screen capture you CANNOT Queue your report to run in the background!!

Select one of the following:

      S      SCREEN - delimited output will display on screen for capt
      F      FILE - delimited output will be written to an output file

Select output type: S// FILE - delimited output will be written to an output
e
Enter a filename for the delimited output (no more than 40 characters): Child
When the report is finished your delimited output will be found in the
d:\exports\ directory. The filename will be Childhood Iz 2012 Patient1 List.

Mon't you queue this ? Y// YES
Requested Start Time: NOW//
```

Improving Prenatal HIV Screening

Information and Resources

For more information:
National GPRA Support Team
caogpra@ihs.gov

California Area Office, Indian Health Service
September 2011

Tips for Improving Prenatal HIV Screening Rates from Sites in California

California Area Indian health programs often refer pregnant patients to outside providers for prenatal care. As a result, documenting HIV screening can be challenging. Ideally, the HIV test should be performed onsite, prior to referral. However, if this is not possible, there are ways to improve the referral and data collection process. The following tips were shared by a few sites in California that have performed well on the prenatal HIV Screening GPRA measure.

1. Test pregnant patients for HIV before referring to outside providers. As one physician remarked, “Once the patient has been referred out, you lose control of the data and add the frustration of recall and retrieving essentially from private provider offices who don’t even begin to understand the concept of GPRA.”
2. Ensure lab taxonomies are up-to-date so that your site is receiving credit for the screenings.
3. Before referral, ask a qualified medical staff member to do one-on-one counseling with the patient to inform them of the benefits of an HIV test, to decrease the stigma associated with the screening.
4. Create a pregnancy referral “package” that includes a referral form, signed HIPPA consent form, Fax Back Form, and a letter explaining the HIPPA Regulations regarding confidential information. (Examples of a HIPPA consent form and Fax Back Form are included in this document.) The patient should bring this package to her OB/GYN appointment.
 - a. If results are not received back from outside providers, include the client’s signed consent form with another request for the information along with clients signed consent forms via certified mail.
 - b. When the results are received, enter into the RPMS system as historical data.
5. On a quarterly or annual basis, run the RPMS patient report that lists all of the patients in the measure denominator who have not received an HIV screening. Then, review the outstanding cases to determine if outside providers can send the results. Also check to make sure the patient’s pregnancy went full-term. Women with miscarriages, ectopic pregnancies, and abortions can be dropped from the denominator by putting this information in the historical section of the EHR. Medical staff should document a new diagnosis in the case of a miscarriage or ectopic pregnancy being treated medically.

Who is included in the Prenatal HIV Screening Measure?

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

Numerator: Patients who were screened for HIV during the past 20 months. Note: This numerator does *not* include refusals.

Definitions

Pregnancy At least two visits with POV or Problem diagnosis (V22.0-V23.9, V72.42, 640.*-649.*, 651.*-676.*) during the past 20 months *from the end of the Report Period*. *Pharmacy-only visits (clinic code 39) will not count toward these two visits.*

If the patient has more than two pregnancy-related visits during the past 20 months, CRS will use the first two visits in the 20-month period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit. In addition, the patient must have at least one pregnancy-related visit occurring during the reporting period. The time period is extended to include patients who were pregnant during the report period, but whose initial diagnosis (and HIV test) were documented prior to report period.

Codes:

Miscarriage

- POV 630, 631, 632, 633*, 634*
- CPT 59812, 59820, 59821, 59830

Abortion

- POV 635*, 636*, 637*
- CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260-S2267
- Procedure 69.01, 69.51, 74.91, 96.49

HIV:

Any of the following documented anytime prior to the end of the report period:

- POV or Problem List 042, 042.0-044.9 (old codes), 079.53, V08, 795.71

HIV Screening

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

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

*Please FAX Info to
[Name of Clinic]
[Fax Number]*

Notification of Prenatal HIV Screening

PATIENT NAME: _____ EXAM DATE: _____

DOB: _____ PCP: _____

HIV antibody testing performed:

- Yes (If patient has signed a release of records form, please send results of the test to the clinic.)
 - Date: _____

- Patient Opted Out of Testing (Patient Education must be provided)

Please contact our clinic at _____ if more information is needed.

Sincerely,

Please Fax or Mail To:

[Name of Facility]
[Mailing Address]
[Fax Number}

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act,
45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. _____ to _____.

OR

b. all past, present, and future periods.

3. Extent of Authorization

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. I authorize the release of my complete health record with the exception of the following information:

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment

Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

Date

Dear Program Administrator:

The purpose of this letter is to inform you of **two incentive-based immunization improvement challenges** that the IHS/CAO is offering to California Area tribal and urban Indian health programs that report GPRA through use of RPMS. The California Area Office is actively seeking ways to improve the health care status of American Indians /Alaska Natives (AI/AN). We have identified a need for improved overall immunization coverage in California and have decided to offer the following funding incentives:

- Childhood Immunization (children 19-35 months of age)
- Adult Influenza and Pneumococcal Immunization (combined challenge)

The intent of these challenges is to promote comprehensive immunization coverage and reporting for young children and elders. American Indians are known to be at greater risk for some vaccine-preventable diseases, including influenza and pneumonia. Between 2002 and 2004, the number of deaths from flu and pneumonia in AI/AN people was one and a half times higher than all other races.

The overall FY 2011 GPRA Childhood Immunizations result for California Tribal programs was 70.2% (4.4% below the 2011 national target) and 26.4% for California urban programs (34.8% below the national average for all urban programs). The overall FY 2011 GPRA Adult Influenza Immunization result for California Tribal programs was 53.3% (5.2% below the 2011 national target) and 34.4% for California urban programs (14.1% below the national average for all urban programs). The Area can meet and exceed the 2012 National Targets for each of these measures through attention to practice, patient education, documentation, and reporting.

The IHS/CAO will offer funding incentives to California Area Tribal and urban health programs that meet or exceed the targets set forth in this challenge. Funding will vary based on program size (based on active user population) and level of performance (as demonstrated by GPRA 2012 final report). Incentives will be provided once final FY 2012 GPRA reports are submitted and reviewed.

The CAO has identified the following challenge **targets**:

- Childhood Immunization (4:3:1:3:3:1:4 vaccine series) – Target: 80%
- Adult Influenza and Pneumococcal Immunization - Influenza Target: 68% and Pneumococcal Target: 90% (Incentives will be distributed to programs that meet both targets.)

The CAO will offer the following target based **financial incentives**:

- Each program that meets the identified target(s) will receive \$1,000
- The top program in each of the two challenges will receive additional funding based on program size as identified below:
 - Small - \$1,500
 - Medium - \$3,000
 - Large - \$5,000

For your use in participating in the challenge, we have attached the following:

- Immunization Challenge Flyers
- Clinical Reporting System (CRS) Instructions for running and monitoring reports through remainder of GPRA Year 2012 (July 1, 2011 through June 30, 2012)
- “Tips for Improving Immunization Coverage”

The California Area Office is committed to providing ongoing assistance to you and your staff with regard to immunization improvement. If you have any questions or want more information on improvement strategies, please contact the CAO GPRA Team caogpra@ihs.gov or the California Area Immunization Coordinator, Susan Ducore by e-mail susan.ducore@ihs.gov or by phone at (916) 930-3981 ext. 323.

Thank you for your time and consideration of this immunization improvement challenge.

Sincerely,

/Steve Riggio/

Steve Riggio, DDS
Associate Director
Office of Public Health
IHS/California Area Office



Indian Health Service
California Area Office
650 Capitol Mall, Suite 7-100
Sacramento, California 95814-4708

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Thank you for your time and consideration of this immunization improvement challenge.

Sincerely,

/Steve Riggio/

Steve Riggio, DDS
Associate Director
Office of Public Health
IHS/California Area Office



California Area GPRA Incentives



Influenza 65+/Pneumovax 65+ Measures

FACT: 36,000
people die from
flu-related causes
every year

**Earn up to \$6,000
for your health program!**

Margo Kerrigan, IHS California Area Director, receives her influenza immunization at Sacramento Native American Health Center.

Protect your family, friends, and co-workers by immunizing them against Influenza & Pneumonia

Achieve a rate of 68% or above for the Influenza 65+ GPRA measure and a rate of 90% or above for the Pneumovax 65+ GPRA measure by June 30, 2012 and receive \$1,000 for your health program. The Tribal or Urban Indian healthcare programs that achieve the highest vaccination rates for both Influenza and Pneumovax will receive an additional bonus of \$1,500, \$3,000, or \$5,000, depending on the size of the program. Bonuses will be based on the number of patients in the GPRA denominator for these measures.

For tips or more information, contact Susan Ducore, Immunization Coordinator at Susan.Ducore@ihs.gov or the National GPRA Support Team at caogpra@ihs.gov.

California Area

GPRA Incentives

Childhood Immunizations (4:3:1:3:3:1:4 vaccine series)

Achieve a rate of 80% or above for the Childhood Immunizations GPRA measure by June 30, 2012 and receive \$1,000 for your health program. The Tribal or Urban Indian healthcare programs that achieve the highest vaccination rate (of at least 80% or above) will receive an additional bonus of \$1,500, \$3,000, or \$5,000, depending on the size of the program. Bonuses will be based on the number of patients in the GPRA denominator for the measure.

Protect your children from disease

For tips or more information, contact Susan Ducore, Immunization Coordinator at [Susan .Ducore@ihs.gov](mailto:Susan.Ducore@ihs.gov) or the National GPRA Support Team at caogpra@ihs.gov.



Tips for Improving Immunization Coverage

- Establish **standing orders** for administering vaccines. Examples are available here: www.immunize.org/standingorders
- Talk to your patients about vaccinations. For tips on responding to concerns about vaccinations, visit: www.immunize.org/concerns/
- Utilize the **immunization forecasting** and **reminder recall options** located within the RPMS Immunization Package.
- Manage Inactive/Active patient lists in the RPMS Immunization Package using the **MOGE Criteria Guidelines**, available here: <http://www.ihs.gov/epi/documents/vaccine/ReportingGuidelines.pdf>

Helpful Links

- **Flu.gov** – provides comprehensive information on Influenza
<http://www.flu.gov/>
- **Centers for Disease Control and Prevention Seasonal Flu Resources:**
Free Print Materials: <http://www.cdc.gov/flu/freeresources/print.htm>
- **Centers for Disease Control and Prevention** – provides AI/AN focused information on vaccines
<http://cdc.gov/vaccines/spec-grps/ai-an.htm>
- **Immunization Action Coalition** - a 501(c)(3) non-profit organization and the nation's premier source of child, teen, and adult immunization information for health professionals and their patients
www.immunize.org/
- **California Department of Public Health Vaccines for Children (VFC) Program** - federal program that offers free vaccine to immunize eligible children, including all AI/AN children through 18 years of age
www.eziz.org/



Indian Health Service
California Area Office
650 Capitol Mall, Suite 7-100
Sacramento, California 95814-4708

Dear Executive Directors:

Each year, the California Area Office (CAO) is given specific GPRA targets for selected clinical measures. This year, particular emphasis is being placed on raising the rate of behavioral health screenings. The three behavioral health GPRA measures include: Depression Screening, Alcohol Screening (Fetal Alcohol Syndrome Prevention), and Domestic/Intimate Partner Violence Screening for all American Indians/Alaska Natives (AI/AN) within designated age groups. As most of you know, Fiscal Year (FY) 2011 annual GPRA results show that California tribal/urban programs are currently below average on all these screening measures. Among California tribal programs, FY 2010 Depression screening rate for adults over the age of 18 was 46% and the National average was 56.5%. The Alcohol Screening rate for women ages 15-44 years old was 47.5% while the National average was 57.8%. And the Domestic/Intimate Partner Violence Screening rate for women ages 15-40 was 48.1% and the National average was 55.3%. In order to improve screening rates for these three measures, the Area must focus resources and develop strategies to improve screening rates.

This letter is to invite all clinics to submit short proposals and include budget (one page) to the CAO with specific plans for improving the behavioral health GPRA measures at their facility. The Area Office will evaluate each proposal, and if accepted, the Area will reimburse the program based on performance and the criteria described under awarding conditions.

The proposal should be not more than one page and must include:

- A specific plan using best practices for how the clinic will screen more patients. Two processes that have shown to improve screening rates are “Universal Screening” and “bundling” the three measures.
- Appoint and provide the GPRA behavioral health coordinator located within the medical and/or dental clinic.
- An estimate of the costs associated with screening more patients, including staff time and instrument printing costs.
- A brief discussion of any other factors to be involved in improving screening rates, including (but not limited to) patient education materials and CRS reports.

The following conditions for awarding and reimbursement are:

- The behavioral health screenings must be performed prior to the end of the current GPRA year (June 30, 2012) and documented appropriately in RPMS.
- Final FY 2012 results must show at least a 50% improvement in screening rates over final FY 2011 results.
- The Area will reimburse the program if one of the following is achieved: the program screens at least 50% more patients for each measure in FY 2012 compared to FY 2011 (e.g. if a clinic screened 100 patients for depression in FY 2011, it would need to screen 150 patients in FY 2012, and similar increases for the other two measures); or the program achieves 80% overall rate on all three behavioral health measures.

The CAO anticipates being able to fund clinics according to size. Small ambulatory clinics, defined as a clinic with a user population up to 1,000 users would receive up to \$5,000. Clinics with a user population between 1,001 to 4,000 would receive up to \$7,500. And large clinics with a user population greater than 4,001 would receive \$10,000.

Please feel free to contact me at (916) 930-3981, extension 321 or Dawn Phillips at (916) 930-3981 extension 331, if you have any questions and/or need validated behavioral health screening tools.

/David Sprenger/

David Sprenger, MD
Chief Medical Director
California Area Indian Health Service

HEALTH SCREEN

Central Valley Indian Health, Inc. participates in a national screening program which helps to detect and respond to unrecognized health risks and problems. Please complete the following surveys to help us help you. Please circle the correct answer.

DEPRESSION SCREEN

-Have you been feeling down, depressed or hopeless in the past 2 weeks?

Yes No

-Have you been bothered by less interest or pleasure in doing things in the past 2 weeks?

Yes No

DOMESTIC VIOLENCE SCREEN

-Are you currently or have you ever been in a relationship where you were physically hurt, threatened or made to feel afraid?

Never Past Present

FETAL ALCOHOL SCREEN

-Have you ever felt you ought to cut down on your drinking or drug use? Yes No

-Do you get annoyed at criticism of your drinking or drug use? Yes No

-Do you ever feel guilty about your drinking or drug use? Yes No

-Do you ever take an early morning drink or use drugs first thing in the morning to get the day started or to stop the "shakes"? Yes No

TOBACCO SCREEN

-Have you ever smoked? Never Past Present

-Have you ever chewed tobacco? Never Past Present

-If you quit was it Less than 6 months More than 6 months

Patient counseling (provider only)

DEP-C-DP-EX-FU-IR-L-M-PSY-TX _____ _____

DVV-C-DP-FU-IR-L-LA-P-PSY-TX _____ _____

AOD-C-DP-FU-IR-L-LA-P-PSY-TX _____ _____

TO-C-DP-EX-FU-L-LA-M-QT-SHS _____ _____

NAME: _____ DOB: _____

PROVIDER: _____ DATE: _____

Screening Tool

In an effort to provide complete and comprehensive preventative care to our patients we would appreciate your assistance with completing this questionnaire. Please complete the questions as completely as you can and give to your nurse. Thank you for taking an active part in your health care.

If the health screenings are positive, would you like to be contacted by the Behavioral Health Department?

Yes / No

Are you currently a patient at the Oklahoma City Indian Clinic Behavioral Health Department?

Yes / No

Depression Screening

Chart #: _____ Date: _____

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? Read each item carefully, and mark your response.

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
i. Thinking that you would be better off dead or that you want to hurt yourself in some way	0	1	2	3
<i>(Office Use Only) Totals</i>				

Score	Chart	Action
0-14	DP -	Chart Only
≥ 15	DP +	BH Referral
I ≥ 1	DP +	BH Staff

Behavioral Health Use Only

Name: _____ Time: _____ AM / PM Phone: _____

Comments: _____

In an effort to provide complete and comprehensive preventative care to our patients we would appreciate your assistance with completing this questionnaire. Please complete the questions as completely as you can and give to your nurse. Thank you for taking an active part in your health care.

CAGE Questionnaire: Screening Test for Alcohol Dependence

Chart #: _____ Date: _____

Please check the one response to each item that best describes how you have felt and behaved over your whole life.

Do you currently drink alcohol, beer or wine?

Yes

No → Please proceed to Intimate Partner/Domestic Violence Screening

- Have you ever felt you should *cut* down on your drinking?
 - Yes
 - No
- Have people *annoyed* you by criticizing your drinking?
 - Yes
 - No
- Have you ever felt bad or *guilty* about your drinking?
 - Yes
 - No
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (*eye-opener*)?
 - Yes
 - No

CAGE Score	Chart	Action
Unable to Screen	ETOH UAS	Chart Only
0	ETOH -	Chart Only
1	ETOH -	Chart Only
2	ETOH +	BH Referral
3+	ETOH +	BH Staff

Intimate Partner/Domestic

Violence Screening (*Females only*):

- Are you in a relationship with a person who physically hurts or threatens you?
 - Yes
 - No
- Have you ever been in a relationship with a person who hurt you?
 - Yes
 - No
- Would you like to talk to someone about Intimate Partner/Domestic Violence?
 - Yes
 - No

IP/DV	Chart	Action
Unable to Screen	DV-UAS	Chart Only
1Y	DV-PR	BH Referral
2Y	DV-PA	Chart Only
1N or 2N	DV-N	Chart Only

PLEASE RETURN THE COMPLETED FORM TO YOUR NURSE

Central Valley Indian Health

Standing Orders

In an effort to decrease missed opportunities in ordering and performing GPRA health maintenance indicators the following standing orders now apply to all medical assistants, LVN's and R.N's:

1. Tdap may be given ages 11 and older if it has been 2 years since the last tetanus.
2. The 2nd and 3rd hepatitis vaccines may be given to adults and children if due.
3. Pneumovax may be given to adults 19 to 64 yrs of age with chronic conditions such as asthma, diabetes, smokers, and they are a smoker. If it has been 5 years they should receive an additional dose after 65.
4. All patients should be given a PPD if there is none recorded and they are not PPD positive.
5. Mammograms may be ordered (get provider to sign) if due:
The patient is over 40 and it has been 1 year since their last Mammogram.
6. *Opto. if due*
If the patient is due a pap smear ask the provider if you can set up to have one done. (If time allows) 15 minutes only.
7. All patients 6 months and older may be given a flu vaccination assuming our supply is adequate.
8. Second dose of varicella may be given ages 4-18years.
9. Tylenol/ibuprofen to kids with fever 101 or above per dosage chart if 4 hours since last dose.

Pediarix can be given under 6yrs old

PCV-13 under the age of 5yr.

HPV start at age 9-26yrs old with parent approval for underage

MCV4 start at age 11yr

MMR TB can be given together but if MMR is given 1st then wait 30 days for the **PPD** to be given.

Adult shots are= Tdap, Pneumo, FLU, , Twinrix, Hep A,B, PPD one screen in each chart.

Please review each chart at each visit and don't miss any shots because pt might not come back. (with parent's approval).

**2011-2012 GPRA Comprehensive Assessment Form
JULY to JUNE Annual Measures and Health Reminders**

Alcohol Screen [EX 35] Age 15-44		POSITIVE		NEGATIVE		If positive complete CAGE	
[HF] CAGE	Have you ever felt the need to cut down on drinking?	Do you ever feel guilty about your drinking?	Do people complain about your drinking?	Do you drink in the morning to relieve symptoms of a hangover?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If results are positive, ask "Would you be interested in speaking with our counselors?"</i>							
[HF] TOBACCO USE Age 5+							
Never Used Tobacco	Previous Smoker	Current Smoker	Smoke Free Home	Exposed to environmental smoke			
Ceremonial Use Only	Previous Smokeless	Current Smokeless	Smoker in Home				
Cessation Smoker (within first 6 months of quitting)		Quit? When?					
[PED] Patient Education Example: PED-TO-QT-Good-10min-HL-GS:reduce to 3 cigs/day							
Counseled to quit tobacco?		Condition	Understanding	Minutes	Initials	Goal?	Comments
		TO-QT-	Good-Fair-Poor-Group				
Depression "Spirit of Sadness" Screen [EX 36] Age 18+ POSITIVE NEGATIVE If positive complete PHQ-2							
[PHQ-2] PATIENT HEALTH QUESTIONNAIRE DEPRESSION SCREEN (ENTER SCORE)							
Over the past two weeks, how often have you been bothered by any of the following problems?							
	Not at all (0)	Several Days (1)	More than 1/2 (2)	Nearly daily (3)	0-2 = Negative 3-6 = Positive		
Little or no interest in doing things?							
Feeling down, depressed, hopeless?							
<i>If results are positive, ask "Would you be interested in speaking with our counselors?"</i>							
Suicidal/Homicidal Ideation? YES NO HCPC:3085F (positive responses Suicidal V62.84 use suicide form, Homicidal V62.85)							
[EX] TYPE OF EXAM		N Normal/Neg.	PO Positive	PR Present	PA Past	PAP Present & Past	A Abnormal
Fall Risk [37] Age 65+							
Intimate Partner Violence [34] Age 15-40							
HITS Tool Domestic Violence Screening Tool (>10=positive)			Never (1)	Rarely (2)	Sometimes (3)	Fairly Often (4)	Frequently (5)
Do you feel afraid or threatened by your partner?							
Within the past year, has anyone hit, slapped, kicked or hurt you physically?							
Within the past year, has anyone been verbally abusive, screamed or cursed towards you?							
Within the past year, has anyone coerced you to perform a sexual activity you were not comfortable with?							
Education: PED-DVV=Victim followed by.....P=Prevention IR=Information & Referral S=Safety Minutes							
Already done? Please document when and where and obtain a Release of Information consent.							
Oral Health		Age Appropriate Screenings		Immunization Status		DIABETIC?	
<input type="checkbox"/> Last Dental Exam		<input type="checkbox"/> Pap Smear, GC/CT (age 21-64)		<input type="checkbox"/> Influenza		DM <input type="checkbox"/> A1c (twice)	
<input type="checkbox"/> Sealants (age <12;12-18)		<input type="checkbox"/> Mammogram (age 40-69)		<input type="checkbox"/> Pneumovax (age 65+)		DM <input type="checkbox"/> UA Dip, Alb, Protein	
<input type="checkbox"/> Topical Fluoride		<input type="checkbox"/> Colorectal Screen FOBT (age 51-80)		<input type="checkbox"/> Child immunization		DM <input type="checkbox"/> Lipid (twice)	
<input type="checkbox"/> Oral Hygiene		<input type="checkbox"/> HIV Screening (all age 12+)		<input type="checkbox"/> Td or DTaP (10 years)		DM <input type="checkbox"/> CMP, Liver Panel	
		<input type="checkbox"/> EKG (yearly)				DM <input type="checkbox"/> Eye, Retinal, Exam	
		<input type="checkbox"/> Tuberculosis Screen (PPD) (yearly)				DM <input type="checkbox"/> Foot, Exam	
[PED] Patient Education Topics Example: PED-MNT-Good-10min-HL-GS:eat 2 vegetables/day starting today							
		Condition	Understanding	Minutes	Initials	Goal	Comments
Nutrition		HPDP-N	Good-Fair-Poor-Group				
Exercise		HPDP-EX					
How often do you exercise? (mark)		Never	<1x/week	Weekly	Daily		
Diabetic/Pre-Diabetic and CVD Additional Reminders (DM Audit Report is Jan-Dec timeframe)							
DM Exercise, Lifestyle,		DM-EX-					
DM Medical Nutrition Counseling (age 22+)		DM-MNT-					
DM Foot Care		DM-FTC-					
CVD Lifestyle adaption Counseling		CAD-LA-					
CVD Medical Nutrition Counseling		CAD-MNT-					
CVD Exercise Counseling		CAD-EX					

Date _____ Name _____ Age _____ RPMS # _____

**2011-2012 GPRA Comprehensive Assessment Form
JULY to JUNE Annual Measures and Health Reminders**

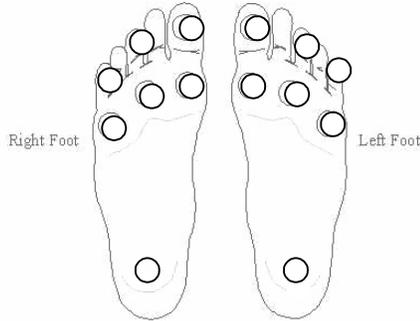
[EX]DM COMPLETE FOOT EXAM

RIGHT FOOT

Dorsalis pedis pulse Posterior tibial pulse Callus Ulcer (size if present) Bony deformity Atropic Skin

LEFT FOOT

Dorsalis pedis pulse Posterior tibial pulse Callus Ulcer (size if present) Bony deformity Atropic Skin



10gm Monofilament - 5 areas +/- of sensation

Breastfeeding Rates [IF]	Exclusive Breast	Mostly Breast	½ Breast ½ Formula	Mostly Formula	Formula Only
Active patients 45-394 days of age					
Screen for feeding choice at 45-89 days					
Screen for feeding choice at 165-209 days					
Screen for feeding choice at 255-299 days					
Screen for feeding choice at 350-394 days					

Completed referrals.....**DENTAL**.....**HUMAN SERVICES**.....**VISION**.....**OTHER**

***Does AIH&S have a current “Release of Information?”
for records from other provider(s)?***

Practitioner _____

Follow Up Appointment Needed _____

Date Name _____ Age _____ RPMS # _____