GPRA 101: Intro to GPRA & Clinical Reporting System (CRS)

Providers’ Best Practices & GPRA Measures Medical Conference

May 21, 2014
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<td>1) Intro to GPRA</td>
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<td>2) GPRA Measure Logic (all 22 GPRA measures)</td>
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<td>3) GPRA Targets</td>
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<td>4) GPRA Resources and Trainings</td>
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<td>5) Clinical Reporting System (CRS) Demo: GPRA Reports, Patient Lists &amp; Taxonomies</td>
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<td>6) GPRA Improvement Strategies  (Time Permitting)</td>
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</table>
Intro to GPRA/GPRAMA

- **GPRA**: Government Performance and Results Act
  - Federal law passed in 1993 that requires agencies to demonstrate that they are using congressional funds effectively and efficiently
  - IHS has been reporting GPRA data for over 10 years

- **GPRAMA**: Government Performance and Results Act Modernization Act of 2010
  - Update to the Government Performance and Results Act of 1993
  - Requires federal agencies to use performance data to drive decision making
  - IHS began reporting GPRAMA in FY 2013
  - Smaller set of measures than GPRA
FY 2014 GPRA/GPRAMA measures

22 Clinical GPRAMA/GPRA (Budget) Measures – GPRAMA measures in red

- Diabetes (5 measures):
  - Good Glycemic Control
  - Controlled BP <140/90
  - LDL Assessed
  - Nephropathy Assessed
  - Retinopathy Exam
- Dental (3 measures):
  - Access to Dental Services
  - Sealants
  - Fluorides
- Immunizations (3 measures):
  - Influenza 65+
  - Pneumovax 65+
  - Childhood Immunizations
- Cancer Screening (3 measures):
  - Pap Smear Rates
  - Mammogram Rates
  - Colorectal Cancer Screening
- Behavioral Health (3 measures):
  - Alcohol Screening
  - DV/IPV Screening
  - Depression Screening
- Prevention Measures (5 measures):
  - Tobacco Cessation
  - Prenatal HIV Screening
  - Comp. CVD Assessment
  - Childhood Weight Control*
  - Breastfeeding Rates
  - Controlling High Blood Pressure-Million Hearts

*Childhood Weight Control is a long term measure that was reported in FY 2013, next reported in FY 2016
Intro to GPRA/GPRAMA

Clinical GPRA/GPRAMA data

- Collected and reported three times each GPRA year via the Clinical Reporting System (CRS) package in RPMS
  - GPRA Year: July 1 – June 30
  - Data collected for Q2, Q3, and Q4
  - Data is cumulative
  - CRS data from all reporting clinics are aggregated into national result

2014 GPRA/GPRAMA Reporting Deadlines

- Q2: January 24, 2014
- Q3: April 25, 2014
- Q4: July 25, 2014
Important Definitions

0 **GPRA User Population:**
  0 Must have been seen at least once in the three years prior to the end of the time period, regardless of 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.
  0 Must be alive on the last day of the Report Period.
  0 Must be AI/AN; defined as Beneficiary 01.
  0 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.
Important Definitions

Active Clinical Population:

- Must have two face-to-face visits to medical clinics in the past three years. At least one visit must be to a core medical clinic.
- Must be alive on the last day of the Report Period.
- Must be AI/AN; defines 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.
Diabetes: Good Glycemic Control

FY 2014 Measure Logic*:

Numerator: Patients in Good Glycemic Control: A1c < 8

Denominator: Active Diabetic Patients

Active Diabetic Patient: Active Clinical patients diagnosed with diabetes (POV 250.00 through 250.93) prior to the report period, and at least two visits in the past year, and two diabetes mellitus-related visits ever.

*Prior to FY 2013, this measure was called “Ideal Glycemic Control” and reported patients with A1c < 7
## Diabetes: Blood Pressure Control

**FY 2014 Measure Logic**: 

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients with BP less than (&lt;) 140/90, i.e., the mean systolic value is less than (&lt;) 140 and the mean diastolic value is less than (&lt;) 90.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Active Diabetic Patients</td>
</tr>
</tbody>
</table>

*Prior to FY 2013, this measure reported patients with blood pressure <130/80*
**Diabetes: LDL Assessed**

**FY 2014 Measure Logic:**

<table>
<thead>
<tr>
<th><strong>Numerator:</strong></th>
<th>Patients with LDL completed during the report period, regardless of result.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong></td>
<td>Active Diabetic Patients</td>
</tr>
</tbody>
</table>
## Diabetes: Nephropathy Assessment

**FY 2014 Measure Logic:**

| Numerator:                                                                 | Patients with nephropathy assessment during report period or diagnosis/treatment of ESRD any time before the end of the report period  
|                                                                           | (Nephropathy Assessment requires an estimated GFR AND a UACR (NOT dipstick) during the report period) |
| Denominator:                                                             | Active Diabetic Patients |
Diabetes: Retinopathy Assessment

**FY 2014 Measure Logic:**

<table>
<thead>
<tr>
<th><strong>Numerator:</strong></th>
<th>Patients receiving a qualified retinal evaluation during the report period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong></td>
<td>Active Diabetic Patients</td>
</tr>
</tbody>
</table>
Dental Access

- FY 2014 Measure Logic:

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients with a documented dental visit during the report period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>User Population patients</td>
</tr>
</tbody>
</table>
Dental: Sealants

0 FY 2014 Measure Logic*:

| Numerator: | Patients with at least one or more intact dental sealants |
| Denominator: | User Population patients ages 2 through 15 |

*Prior to FY 2013 this measure reported a count of the number of sealants placed during the report period
Dental: Topical Fluorides

* FY 2014 Measure Logic*:

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients who received one or more topical fluoride applications during the report period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>GPRA User Population patients age 1 through 15</td>
</tr>
</tbody>
</table>

*Prior to FY 2013 this measure reported a count of the number of patients receiving one or more topical fluoride applications during the report period*
# Influenza 65+

## FY 2014 Measure Logic:

<table>
<thead>
<tr>
<th><strong>Numerator:</strong></th>
<th>Patients with influenza vaccine documented during the report period or with a contraindication documented any time before the end of the report period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong></td>
<td>Active Clinical patients ages 65 and older</td>
</tr>
</tbody>
</table>
**Pneumovax 65+**

**FY 2014 Measure Logic:**

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients with Pneumococcal vaccine or contraindication documented ever and, if patient is older than 65 years, either a dose of pneumovax after the age of 65 or a dose of pneumovax in the past five years.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Active Clinical patients ages 65 and older</td>
</tr>
</tbody>
</table>
# Childhood Immunizations

## FY 2014 Measure Logic:

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients who have received the 4:3:1:3*:3:1:4 combination, including contraindications and evidence of disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>GPRA User Population patients active in the Immunization Package who are 19 through 35 months at end of report period</td>
</tr>
</tbody>
</table>

## 4:3:1:3*:3:1:4 Series:

- 4 DTaP
- 3 Polio
- 1 MMR
- 3 or 4 HiB (depending on brand)
- 3 Hepatitis B
- 1 Varicella
- 4 Pneumococcal
Pap (Cervical) Screening

FY 2014 Measure Logic*:

**Numerator:**
Patients with a Pap smear documented in the past three years, or if patient is 30 to 64 years of age, either a Pap Smear documented in the past three years or a Pap Smear and an HPV DNA documented in the past five years.

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

*Prior to FY 2013 this measure reported the percentage of women age 21-64 with a Pap screen in the past three years. In FY 2013 this measure reported the percentage of women 25-64 with a Pap screen in the past four years.*
FY 2014 Measure Logic:

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients who had a mammogram documented in the past two years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Female Active Clinical patients ages 52 through 64 years, without a documented bilateral mastectomy or two separate unilateral mastectomies</td>
</tr>
</tbody>
</table>
Colorectal Cancer Screening

**FY 2014 Measure Logic***:

| Numerator: | Patients who have had any Colorectal Cancer screening defined as any of the following:  
A. Fecal Occult Blood Test (FOBT) or FIT during the report period  
B. Flexible sigmoidoscopy in the past 5 years  
C. Colonoscopy in the past 10 years |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Active Clinical Patients ages 50 through 75 without a documented history of colorectal cancer or total colectomy</td>
</tr>
</tbody>
</table>

*Note: Double contrast barium enema no longer counted towards meeting this measure*
# Tobacco Cessation

*FY 2014 Measure Logic*:

<table>
<thead>
<tr>
<th><strong>Numerator:</strong></th>
<th>Patients who received tobacco cessation counseling, received a prescription for a tobacco cessation aid, or quit their tobacco use anytime during the Report Period.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong></td>
<td>Active clinical patients identified as current tobacco users or tobacco users in cessation</td>
</tr>
</tbody>
</table>
Alcohol Screening (FAS Prevention)

- FY 2014 Measure Logic:

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients screened for alcohol use, had an alcohol-related diagnosis or procedure, or received alcohol-related patient education during the report period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Female Active Clinical patients ages 15-44</td>
</tr>
</tbody>
</table>
## Intimate Partner Violence/Domestic Violence (IPV/DV) Screening

**FY 2014 Measure Logic:**

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients screened for intimate partner (domestic) violence any time during the report period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Female Active Clinical patients ages 15-40</td>
</tr>
</tbody>
</table>
Depression Screening

**FY 2014 Measure Logic:**

<table>
<thead>
<tr>
<th><strong>Numerator:</strong></th>
<th>Patients screened for depression or diagnosed with a mood disorder any time during the report period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong></td>
<td>Active Clinical patients ages 18 and older</td>
</tr>
</tbody>
</table>
Comprehensive CVD Assessment

**FY 2014 Measure Logic:**

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients with comprehensive CVD assessment, defined as having BP, LDL, and tobacco use assessed, BMI calculated, and lifestyle counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Active CHD patients* ages 22 and older</td>
</tr>
</tbody>
</table>

*Active CHD Patient*: Active Clinical patients diagnosed with CHD prior to the report period, and at least two visits during the report period, and two CHD-related visits ever

**Numerator definitions:**

- BP documented at least twice in prior two years
- LDL completed during the report period
- Tobacco use screening completed during the report period
- BMI calculated
- Received any lifestyle adaptation counseling, including medical nutrition counseling, or nutrition, exercise or other lifestyle education during the report period
Prenatal HIV Screening

FY 2014 Measure Logic:

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients who were screened for HIV during the past 20 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>All pregnant Active Clinical patients with no documented miscarriage or abortion during the past 20 months and no recorded HIV diagnosis ever</td>
</tr>
</tbody>
</table>
Breastfeeding Rates

**FY 2014 Measure Logic***:

<table>
<thead>
<tr>
<th><strong>Numerator:</strong></th>
<th>Patients who, at the age of two months (45 through 89 days), were either exclusively or mostly breastfed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong></td>
<td>Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of two months (45 through 89 days)</td>
</tr>
</tbody>
</table>

*Prior to FY 2013 this measure was reported only by federal facilities, Tribal and Urban facilities began reporting data for this measure in 2013.*
Controlling High Blood Pressure: Million Hearts

- New measure for I/T/U programs for 2014

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients with BP less than 140/90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>User Population patients ages 18 through 85 years diagnosed with hypertension and no documented history of ESRD or current diagnosis of pregnancy</td>
</tr>
</tbody>
</table>

- FY 2014 Target: Baseline
FY 2014 Targets
### FY 2014 Targets

#### FY 2014 Targets (Federal, Tribal, & Urban Programs)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Final 2014 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIABETES</strong></td>
<td></td>
</tr>
<tr>
<td>Good Glycemic Control</td>
<td>48.3%</td>
</tr>
<tr>
<td>Controlled BP &lt;140/90</td>
<td>64.6%</td>
</tr>
<tr>
<td>LDL Assessed</td>
<td>73.9%</td>
</tr>
<tr>
<td>Nephropathy Assessed</td>
<td>Baseline</td>
</tr>
<tr>
<td>Retinopathy Exam</td>
<td>58.6%</td>
</tr>
<tr>
<td><strong>DENTAL</strong></td>
<td></td>
</tr>
<tr>
<td>Dental: General Access</td>
<td>29.2%</td>
</tr>
<tr>
<td>Sealants</td>
<td>13.9%</td>
</tr>
<tr>
<td>Topical Fluoride</td>
<td>26.7%</td>
</tr>
<tr>
<td><strong>IMMUNIZATIONS</strong></td>
<td></td>
</tr>
<tr>
<td>Influenza 65+</td>
<td>69.1%</td>
</tr>
<tr>
<td>Pneumovax 65+</td>
<td>Baseline</td>
</tr>
<tr>
<td>Childhood IZ</td>
<td>74.8%</td>
</tr>
<tr>
<td><strong>PREVENTION</strong></td>
<td></td>
</tr>
<tr>
<td>Pap Screening</td>
<td>Baseline</td>
</tr>
<tr>
<td>Mammogram Screening</td>
<td>54.7%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>35.0%</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>45.7%</td>
</tr>
<tr>
<td>Alcohol Screening (FAS Prevention)</td>
<td>65.9%</td>
</tr>
<tr>
<td>DV/IPV Screening</td>
<td>64.1%</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>66.9%</td>
</tr>
<tr>
<td>Comp. CVD-Related Assessment</td>
<td>51.0%</td>
</tr>
<tr>
<td>Prenatal HIV Screening</td>
<td>89.1%</td>
</tr>
<tr>
<td>Breastfeeding Rates</td>
<td>29.0%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure – Million Hearts</td>
<td>Baseline</td>
</tr>
</tbody>
</table>
GPRA Resources/Training Opportunities
GPRA Resources/Trainings:

- CRS (Clinical Reporting System) website: http://www.ihs.gov/crs/
- California Area Indian Health Service website: http://www.ihs.gov/california
- CRS 14.0 Training Webinar (recorded): http://ihs.adobeconnect.com/p8b7xj2e1i2/
- Provider Engagement in GPRA (recorded): http://ihs.adobeconnect.com/p97h5xrxd9x/
Clinical Reporting System (CRS)

Welcome

CRS is the reporting tool used by the IHS Office of Planning and Evaluation to collect and report clinical performance results annually to HHS and to Congress. This site will serve as a central repository for information about the IHS Clinical Reporting System (BGP).

CRS is an RPMS (Resource and Patient Management System) software application designed for national reporting as well as local and area monitoring of clinical performance measures. CRS produces on demand from local RPMS databases a printed or electronic report for any or all of over 300+ clinical performance measures, representing 73 clinical topics. CRS is intended to eliminate the need for manual chart audits for evaluating and reporting clinical measures that depend on RPMS data.

Each year, an updated version of CRS software is released to reflect changes in and additions to clinical performance measure definitions. Click on any of the software versions listed in the box at the left for detailed descriptions.

Performance measure example: GPRA Measure Mammogram Rates: Report the number of female patients ages 52 through 64 without a documented history of bilateral mastectomy or two separate unilateral mastectomies who had a mammogram documented during the past two years.

Click here to view the IHS Quality of Care (QoC) site. The QoC site explains how IHS reports quality and contains important information for improving your health.

CURRENT STATUS:

CRS 2014 Version 14.0 was released nationally on December 5, 2013.

- View the performance measures and logic included in the CRS 2014 v14.0 Selected Measures (Local) Report [PDF-1MB]
- View the CRS 2014 page to view a list of key changes for CRS 2014 v14.0
- Download current software and documentation.
- View the GPRA FY12 through FY14 Performance Measures matrix [PDF-39KB]
Clinical Reporting System (CRS)

CRS 2014 (v14.0)

CRS VERSION 14.0

CRS Version 14.0 was released on December 5, 2013.

- View the CRS 2014 (v14.0) National GPRA/GPRAMA Report Performance Measure List and Definitions [PDF - 344KB]
- View the CRS 2014 (v14.0) National GPRA Developmental Report Performance Measure List and Definitions [PDF - 263KB]

Key enhancements included in CRS Version 14.0 are shown below.

- Added ICD-10 codes to numerous topics. See CRS 2014 (v14.0) Clinical Performance Measure Logic Manual for codes.
- Logic Changes to National GPRA/GPRAMA Report Measures
  - GPRA Developmental Measures:
    - Added the following new GPRA Developmental measures: Access to Dental Service (visits with general anesthesia and stainless steel crowns); Hepatitis C Screening (moved from ONM Report); Chlamydia Testing (moved from ONM Report).
    - Deleted the following GPRA Developmental measures: Adult Immunizations, Cancer Screening: Pap Smear Rates.
    - Updated codes in the following measures: Childhood Immunizations; Comprehensive Cancer Screening; HIV Screening.
  - Diabetes: Nephropathy Assessment: (1) Changed numerator and logic to look for Urine Albumin-to-Creatinine Ratio (UACR) instead of Quantitative Urine Protein Assessment. NOTE: Site populated LOINC taxonomies should be edited to reflect this change as well. (2) Removed CPT codes 92042, 84156, 3060F, 3061F, and 3062F from UACR definition. (3) Changed logic for UACR to CPT 82043 WITH 82570.
  - Diabetic Retinopathy: (1) Clarified that problem list entries for bilateral blindness must not have a status of Inactive or Deleted.
  - Influenza: (1) Added CVX codes 149, 150, 151, 153, 155, and 158 to Influenza definition. (2) Added CPT codes 90672, 90673, 90685, 90686 and 90668 to Influenza definition.
  - Adult Immunizations: (1) Moved measure from GPRA Developmental report into GPRA report and made it the new GPRA measure. (2) Added CVX code 152 to pneumovax definition.
  - Childhood Immunizations: (1) Added CVX code 152 to pneumococcal definition. (2) Added CVX codes 138 and 139 to Td definition.
  - Cancer Screening: Pap Smear Rates: (1) Moved measures from GPRA Developmental report into GPRA report and made it the new GPRA measure. (2) Changed age range from 25 through 64 to 24 through 64. (3) Changed numerator from Pap Smear in past four years to Pap Smear in past three years. (4) Changed numerator from Pap + HPV in past six years to Pap + HPV in past five years. (5) Clarified that problem list entries for hysterectomy must not have a status of Inactive or Deleted.
  - Tobacco Use and Exposure Assessment: (1) Added health factors Heavy Tobacco Smoker and Light Tobacco Smoker to report.
2.4 Cancer Screening Group

2.4.1 Cancer Screening: Pap Smear Rates

2.4.1.1 Owner and Contact
Cordyn Aycama

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

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

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

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

Note: This numerator does not include refusals.

A. Patients ages 24-29 with a Pap Smear documented in the past 3 years.
B. Patients ages 30 - 64 with a Pap Smear documented in the past 3 years.
C. Patients ages 30 - 64 with a Pap Smear documented 3 to 5 years ago and an HPV DNA documented in the past 5 years.

2.4.1.5 Definitions

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

Hysterectomy
Defined as any of the following ever:
- Procedure ICD-9: 68.4 through 68.9; ICD-10: O07.9
- CPT 51925, 56308 (old code), 58150, 57540, 57545, 57550, 57555, 57556, 58152, 58200 through 58204, 58248, 58550 through 58554, 58570 through 58573, 58591, 58593 through 58594, 58595, 59135
- Diagnosis (POV or Problem List) entry where the status is not Inactive or Deleted: ICD-9: 618.5, 732.43, V67.01, V75.47, V80.81, V80.61, V88.03, ICD-10: N99.3, Z11.72, Z90.710 through Z90.712, Q51.1
- Women’s Health procedure called Hysterectomy

Pap Smear
- Lab PAP SMEAR
- POV ICD-9: V76.2 Screen Malignancy Cervix, V73.32 Encounter for Pap Cervical Smear to Confirm Findings of Recent Normal Smear, Following Initial Abnormal Smear, 795.0; ICD-10: R87.81, R87.810, R87.820, 201.42
- Procedure ICD-9: 91.46
- CPT 58141 through 58167, 58174 through 58175, G0123, G0124, G0141, G0143 through G0145, G0147, G0148, F3000, F3001, Q0091 Screening Pap Smear
- Women’s Health procedure called Pap Smear where the result does not have “ERROR/DISREGARD”
- LOINC taxonomy
- Site-populated taxonomy BGP GPRA PAP SMEAR TAX

HPV DNA
- Lab HPV
- POV ICD-9: V73.31, U79.4, 796.75, 795.05, 795.15, 796.79, 793.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51
- CPT 57522 through 57622
Clinical Reporting System (CRS)

Performance Improvement Toolbox
To assist in improving GPRA/GPRAMA performance, below is a list of resource materials that can be adapted for use at your program.

CLINICAL GPRA MEASURE INFORMATION
- Colorectal Cancer Screening Information for Providers [PDF - 267KB]
- Comprehensive CVD Screening Information for Providers [PDF - 2MB]
- Depression Screening Information for Providers [PDF - 574KB]
- Domestic (Intimate Partner) Violence Screening Information for Providers [PDF - 360KB]
- Mammography Screening Information for Providers [PDF - 270KB]
- Prenatal HIV Screening Information for Providers [PDF - 12MB]
- Tobacco Screening and Cessation Intervention Information for Providers [PDF - 665KB]
- Improve GPRA Commercial Tobacco Treatment Interventions [PDF - 1MB]
- Achieving Meaningful Use and GPRA - Tobacco Use and Exposure [PDF - 1.1MB]

SCREENING TOOLS AND GUIDELINES FOR GPRA MEASURES
- FAQs, Clinical Performance Measurement, GPRA, and CRS [PDF - 117KB]
- Clinical Cheat Sheet [PDF - 3.0MB]
- Clinical Cheat Sheet for EHR Users [PDF - 1.4MB]
- FAQs, Infant Feeding Choice [PDF - 360KB]
- Collection of Breastfeeding Data at Pediatric Visits with the PCC Form at PIMC [PDF - 1.3MB]
- Infant Feeding Choice Screening Information for Breastfeeding Rates Measure [PDF - 191KB]
- CRS Childhood Immunizations Measure Information [PDF - 507KB]
- National Documentation of Tobacco Screening and Cessation Intervention [PDF - 144KB]
- Cherokee Indian Hospital's Documentation of Tobacco Screening and Cessation Intervention [PDF - 188KB]
- PHQ-2 Depression Screening Tool [PDF - 194KB]
- PHQ-5 Depression Screening Tool [PDF - 680KB]
- IHS Prenatal HIV Screening and Consent Procedures [PDF - 92KB]
- IHS Prenatal Health Assessment (Form 866) [PDF - 50KB]
- GPRA Handout for Patients [PDF - 78KB]
- GPRA Handout for Providers [PDF - 962KB]
<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Standard</th>
<th>Provider Documentation</th>
<th>How to Enter Data in EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Sealants</td>
<td>Patients should have one or more intact dental sealants. NOTE: Refusals are not counted toward the GFRA measure, but should still be documented.</td>
<td>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR: Date received Location Results</td>
<td>Dental Sealants (ADA) ADA codes cannot be entered into EHR. Dental Sealants CPT Visit Services Entry (includes historical CPTs) Enter CPT: D1351, D1352 Quantity: Modifier: Modifier 2:</td>
</tr>
<tr>
<td>Topical Fluoride</td>
<td>Patients should have one or more topical fluoride applications. NOTE: Refusals are not counted toward the GFRA measure, but should still be documented.</td>
<td>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR: Date received Location Results</td>
<td>Topical Fluoride (ADA code) ADA codes cannot be entered into EHR. Topical Fluoride CPT Visit Services Entry (includes historical CPTs) Enter CPT: D1206, D1208, D5986 Quantity: Modifier: Modifier 2: Topical Fluoride POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V07.31 Provider Narrative: Modifier: Cause of DX:</td>
</tr>
</tbody>
</table>
CPT codes are entered in the Visit Services component, which is located on the Services tab.
CA Member Portals

We are pleased to present this members-only portal to facilitate collaboration and communication on a level more inclusive to our clientele. Our office will soon be offering more portals for other clinical and technical disciplines in the near future. To register as a new user, click on the link below to submit your request for access to the new RPMS Site Managers portal.
Welcome to the California Area GPRA/GPRAMA Portal! This portal will allow you to access resources, connect with other healthcare programs and the GPRA Team, and learn of upcoming trainings. This portal is available to California Area healthcare program GPRA Coordinators and other interested staff.

### Training Content

**Best Practices Conference**

**GPRA 101**
This section contains an introduction to GPRA for clinic staff and patients.

**CRS Tools and Resources**
This section contains instructions for running GPRA reports and patient lists, and for updating lab and medication taxonomies in CRS. GPRA data entry cheat sheets for

### Upcoming Events

**NOV 14**
CA Monthly GPRA Collaborative Webinar - Universal BH Screening

**DEC 13**
CRS 14.0 Training

**MAY 19 - 22**
California Providers’ Best Practices & GPRA Measures Continuing Education

### Discussions

There are currently no discussions.

Welcome to the California Area GPRA/GPRAMA Portal! This portal will allow you to access resources, connect with other healthcare programs and the GPRA Team, and learn of upcoming trainings. This portal is available to California Area healthcare program GPRA Coordinators and other interested staff.
GPRA Toolkit

This section contains GPRA/GPRAMA resources for new and experienced staff. You will find information related to CRS and specific GPRA/GPRAMA measures, as well as shared resources from California Area tribal and urban Indian healthcare programs.

GPRA 101
This section contains an introduction to GPRA for clinic staff and patients.
Read More

CRS Tools and Resources
This section contains instructions for running GPRA reports and patient lists, and for updating lab and medication taxonomies in CRS. GPRA data entry cheat sheets for EHR and FCC are also included in this section.
Read More

National GPRA Webinars
Read More

GPRA Improvement Challenges
This section contains information on current GPRA improvement challenges hosted by the IHS/CAO.
Read More

Best Practices Conference
Read More

Screening Tools and Other Clinic Resources
This section contains tools for Prenatal HIV Screening, behavioral health screening, tobacco use screening, and other clinical tools shared by California Area Indian health programs.
Read More

CA Area GPRA Monthly Webinars
This section contains recorded monthly webinars hosted by the GPRA team.
Read More
2013-2014 Monthly GPRA Collaborative Webinars

2nd Thursday of each month from 12:00 – 1:00 P.M.

- September 12, 2013
- October 10, 2013 (cancelled due to shutdown)
- November 14, 2013 - Universal Screening
- December 12, 2013 (cancelled)
- January 9, 2014 – Dental Sealant and Fluorides
- February 13, 2014 – Comprehensive CVD Assessment
- March 12, 2014
- April 10, 2014 – Diabetes: Retinopathy Screening
- May 8, 2014 (cancelled due to BP Conference)
- June 12, 2014

Underlined dates are quarterly GPRA Coordinator Webinars.
All other dates are monthly GPRA Collaborative Webinars.
GPRA/GPRAMA Resource Guide

- Version 3.0 – updated for FY 2014
- Now available for download on GPRA Portal on CAO Website
- Contains new tips, tools, and resources for improving GPRA
Clinical Reporting System (CRS)
Clinical Reporting System (CRS) Reports:

0 National GPRA/GPRAMA Report
0 National GPRA/GPRAMA Patient List
0 GPRA/GPRAMA Forecast Report
0 GPRA/GPRAMA Dashboard
0 Taxonomy Reports
## National GPRA/GPRAMA Report

### Diabetes: Blood Pressure Control

<table>
<thead>
<tr>
<th>REPORT PERIOD</th>
<th>%</th>
<th>PREV YR PERIOD</th>
<th>%</th>
<th>CHG from BASE %</th>
<th>CHG from PREV YR % PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Diabetic Pts (GPRA)</td>
<td>148</td>
<td>99</td>
<td>87</td>
<td></td>
<td></td>
</tr>
<tr>
<td># w/ BPs Documented</td>
<td>118</td>
<td>79.7</td>
<td>77</td>
<td>77.8</td>
<td>2</td>
</tr>
<tr>
<td># w/Controlled BP &lt;140/90 (GPRA)</td>
<td>61</td>
<td>41.2</td>
<td>38</td>
<td>38.4</td>
<td>2.8</td>
</tr>
</tbody>
</table>
### GPRA/GPRAMA Dashboard

**CI14→RPT→NTL→DSH**

<table>
<thead>
<tr>
<th>Dashboard Report - DEMO INDIAN CLINIC</th>
<th>National 2013 Target</th>
<th>2012 Final</th>
<th>Numerator</th>
<th>Denominator</th>
<th>2013* # Needed to Achieve Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Glycemic Control &lt;8</td>
<td>Baseline</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Controlled BP &lt;140/90</td>
<td>Baseline</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>LDL Assessed</td>
<td>68</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nephropathy Assessed</td>
<td>64.2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Retinopathy Assessed</td>
<td>56.8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dental Access General</td>
<td>26.9</td>
<td>4.8</td>
<td>0</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Sealants</td>
<td>Baseline</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Topical Fluoride</td>
<td>Baseline</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Influenza 65+</td>
<td>62.3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pneumovax Ever 65+</td>
<td>84.7</td>
<td>100</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
</tbody>
</table>

*Note: All patients are demo patients from a demo database.*
# National GPRA/GPRAMA Patient List

## Diabetes: Blood Pressure Control

List of diabetic patients who had their BP assessed.

- **UP** = User Pop; **AC** = Active Clinical; **AD** = Active Diabetic; **AAD** = Active Adult Diabetic
- **PREG** = Pregnant Female; **IMM** = Active IMM Pkg Pt; **IHD** = Active Ischemic Heart Disease
- **CHD** = Active Coronary Heart Disease; **HR** = High Risk Patient

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>COMMUNITY</th>
<th>SEX</th>
<th>AGE</th>
<th>LAST MEDICAL VISIT</th>
<th>LAST VISIT</th>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOHNSON, CELIA KAY</td>
<td>105161</td>
<td>BRAGGS</td>
<td>F</td>
<td>37</td>
<td>8/1/2011</td>
<td>9/1/2011</td>
<td>UP, AD, AAD</td>
<td>131/77 UNC</td>
</tr>
<tr>
<td>BILBY, DEBORA ELLEN</td>
<td>108341</td>
<td>BRAGGS</td>
<td>F</td>
<td>45</td>
<td>12/8/2011</td>
<td>12/16/2011</td>
<td>UP, AD, AAD</td>
<td>133/82 UNC</td>
</tr>
<tr>
<td>BUNKER, EDITH</td>
<td>656723</td>
<td>BRAGGS</td>
<td>F</td>
<td>47</td>
<td>12/14/2011</td>
<td>12/14/2011</td>
<td>UP, AD, AAD</td>
<td>133/86 UNC</td>
</tr>
<tr>
<td>SHATWELL, TARA MARIE</td>
<td>111313</td>
<td>BRAGGS</td>
<td>F</td>
<td>51</td>
<td>12/30/2011</td>
<td>12/30/2011</td>
<td>UP, AD, AAD</td>
<td>201/87 UNC</td>
</tr>
<tr>
<td>JACKSON, SHERRY LADAWN</td>
<td>100939</td>
<td>BRAGGS</td>
<td>F</td>
<td>68</td>
<td>12/31/2011</td>
<td>12/31/2011</td>
<td>UP, AD, AAD</td>
<td>3074F/3080F UNC</td>
</tr>
</tbody>
</table>

Note: All patients are demo patients from a demo database.
<table>
<thead>
<tr>
<th>Appt Time</th>
<th>Patient Name</th>
<th>HRN</th>
<th>Sex</th>
<th>DOB</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:26 am</td>
<td>ERTER, RYDER KANE</td>
<td>202214</td>
<td>M</td>
<td>02/03/80</td>
<td>SALLISAW</td>
</tr>
</tbody>
</table>

**Annual Dental Exam (All Patients)**

Last Dental Exam: 06/05/12  
Overdue as of: 06/05/13  
GPRA counts visits with ADA 0000 or 0190, PCC Exam 30, POV V72.2, Z01.20, or Z01.21 or any CHS visit with any ADA code during 7/1/13-6/30/14

**Depression Screen**

Last Depression Screen: Never  
Overdue as of: 01/01/13  
GPRA counts PCC Exam 36, POV V79.0, BHS problem code 14.1, PCC or BHS V Measurement PHQ2 or PHQ9, or 2 mood disorder visits during 7/1/13-6/30/14
Taxonomy Reports

Recommend that you check medication and lab taxonomies at least once every 6 months:

- Lab taxonomies: check with lab clinic uses to get specific lab test names for each taxonomy
- Medication taxonomies: check with providers and pharmacy to get drug names for each taxonomy

To check medication and lab taxonomies:
CRS → CI14 → RPT → TAX

To edit medication and lab taxonomies:
CRS → CI14 → SET → TS
Additional Tips

- What if my results don’t look correct?
  - Run a patient list in CRS of all patients not meeting the measure in question
  - Do chart audits to make sure those patients actually did not receive test/screening
  - Check the National GPRA & PART Report Performance Measure List and Definitions document to be sure the code you are using actually counts for GPRA
  - Use Data Entry Cheat sheet to ensure data is entered into RPMS in the correct way to count for GPRA
  - Check medication and lab taxonomies for accuracy and completeness
GPRA Improvement Strategies

NGST
Prenatal HIV Screening

0 Screen for HIV as soon as patient receives positive pregnancy test, before they are referred out

0 If patient is referred out for prenatal care, contact outside provider to obtain HIV test results

0 Confirm pregnancy resulted in birth
   0 If pregnancy was ended due to abortion or miscarriage, document this in chart
Comprehensive CVD Assessment

- Run patient lists to determine which components CHD patients are missing
- Monitor each component of numerator to determine which component(s) is/are resulting in measure not being met

<table>
<thead>
<tr>
<th>Comprehensive CVD-Related Assessment</th>
<th>REPORT</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active CHD Pts 22+ (GPRAMA)</td>
<td>195</td>
<td></td>
</tr>
<tr>
<td># w/ BP documented w/in 2 yrs</td>
<td>186</td>
<td>95.3</td>
</tr>
<tr>
<td># w/ LDL done</td>
<td>104</td>
<td>53.5</td>
</tr>
<tr>
<td># w/ Tobacco Screening w/in 1 yr</td>
<td>177</td>
<td>90.7</td>
</tr>
<tr>
<td># w/BMI calculated -No Refusals</td>
<td>177</td>
<td>90.7</td>
</tr>
<tr>
<td># w/ lifestyle educ w/in 1 yr</td>
<td>82</td>
<td>41.9</td>
</tr>
<tr>
<td># w/ BP, LDL, tobacco, BMI and life counseling-No Refusals or Dep (GPRAMA)</td>
<td>54</td>
<td>27.9</td>
</tr>
</tbody>
</table>
Comprehensive CVD Assessment (cont.)

- # w/ BPs documented w/in 2 yrs: 95.3%
- # w/ LDL done: 53.5%
- # w/ Tobacco Screening w/in 1 yr: 90.7%
- # w/ BMI calculated - No Refusals: 90.7%
- # w/ lifestyle educ w/in 1 yr: 41.9%
- # w/ BP, LDL, tobacco, BMI and life counseling-No Refusals or Dep (GRPAMA): 27.9%
Retinopathy Exam

- Run patient lists to determine who needs retinopathy exam and contact patients to schedule appointment
- Utilize EHR reminders
- Utilize iCare
- Maintain extended clinic hours for ophthalmology
- Hold monthly case management meetings with DM team
- Take photos at clinic and utilize tele-health optometry services to have pictures analyzed
- Provide training to multiple staff on use of retinopathy screening cameras
BH Screening (Depression, DV/IPV, Alcohol)

- Implement Universal Behavioral Health Screening
  - Screen every patient at every visit for depression, DV/IPV, and alcohol use
  - Exception: high utilizers (some clinics screen these patients monthly)
- Utilize EHR
  - Reminders
  - Behavioral Health screening dialogues
- Provide training to staff on asking BH screening questions
### Childhood Immunizations

0 Run patient lists to determine which patients are missing vaccines, contact those patients
0 Obtain data from immunization registries for patients who received vaccines elsewhere
0 Monitor each immunization to determine which vaccine(s) is/are causing the lower rates

<table>
<thead>
<tr>
<th>Childhood Immunizations</th>
<th>REPORT PERIOD</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Imm Pkg Pts 19-35 mos (GPRAMA)</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td># w/4313*314 combo or w/ Dx/ Contraind/ NMI Refusal (GPRAMA)</td>
<td>46</td>
<td>61.5</td>
</tr>
<tr>
<td># w/ 4 doses Dtap or w/ Dx/ Contraind/ NMI Refusal</td>
<td>50</td>
<td>66.7</td>
</tr>
<tr>
<td># w/ 3 doses Polio or w/ Dx/ Contraind/ NMI Refusal</td>
<td>60</td>
<td>79.5</td>
</tr>
<tr>
<td># w/ 1 dose MMR or w/ Dx/ Contraind/ NMI Refusal</td>
<td>63</td>
<td>84.6</td>
</tr>
<tr>
<td># w/ 3-4 doses HiB or w/ Contraind/ NMI Refusal</td>
<td>56</td>
<td>74.4</td>
</tr>
<tr>
<td># w/ 3 doses Hep B or w/ Dx/Contraind/ NMI Refusal</td>
<td>62</td>
<td>82.1</td>
</tr>
<tr>
<td># w/ 1 dose Varicella or w/ Dx/Contraind/ Refusal</td>
<td>63</td>
<td>84.6</td>
</tr>
<tr>
<td># w/4 doses Pneumococcal or w/Dx/ Contraind/ NMI Refusal</td>
<td>52</td>
<td>69.2</td>
</tr>
</tbody>
</table>
Childhood Immunizations (cont.)

- #/w/4 doses DTap: 61.5
- #/w/3 doses Polio: 66.7
- #/w/1 dose MMR: 79.5
- #/w/3-4 doses Hib: 84.6
- #/w/3 doses Hep B: 74.4
- #/w/1 dose Varicella: 82.1
- #/w/4 doses Pneumococcal: 84.6
- #/w/3 doses DTaP, 3 doses Tetanus: 69.2
Influenza 65+

- Utilize EHR reminders and CRS patient lists
- Host vaccination clinics
- Utilize outreach department to conduct flu clinics in community
- Send mass mailings to educate patients on the importance of flu immunization and to remind them to get vaccinated
- Set up table outside front doors of clinic to offer flu shot as patients arrive
- Offer incentives for vaccinations
- Obtain and enter historical flu shot data for flu shots obtained outside the clinic
Colorectal Cancer Screening

0 As of FY 2013, double contrast barium enema no longer counts towards meeting measure
  0 Make sure this screening test is not being used by your clinic
0 Utilize EHR reminders and CRS patient lists to determine who needs screened
0 Obtain screening results back from outside providers for patients screened outside the clinic
Contacts:

National GPRA Support Team: caogpra@ihs.gov

- Christine Brennan: christine.brennan@ihs.gov
- Wendy Blocker: wendy.blocker@ihs.gov
- Amy Patterson: amy.patterson@ihs.gov
- Rachel Pulverman: rachel.pulverman@ihs.gov