Tips and Tools for Improving GPRA!

GPRA/GPRAMA RESOURCE GUIDE

VERSION 2 : UPDATED for 2013 GPRA Year

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 20 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 2012, 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 *Updated!

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 *Updated!
- Provider Article – March 2012: Intro to GPRAMA *New!
- Provider Article – Jan 2012: Strategies of Sites Meeting All GPRA Measures *New!

Data Entry:

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

CRS Tools:

- Instructions for National GPRA & PART Report *Updated!
- Instructions for Running the National GPRA Dashboard
  - Example of National GPRA Dashboard
- Instructions for Running a Patient List in CRS *New!
- Instructions for Updating Medication and Lab Taxonomies *New!

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:

- FY 2013 California GPRA Monthly Webinar flyer *updated!
- California GPRA Listserv instructions *New!********

Immunizations:

- Tips for improving immunization coverage/ Helpful Links

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)
- Northern Valley's Behavioral Health Screening Tri-fold (Depression Screening, Alcohol Use Screening, and Intimate Partner/Domestic Violence Screening) *New!

Shared Tools: (These are tools used at some of the California Area Indian health programs that they have allowed us to share with all California programs)**:**

- Central Valley's Diabetes/Hypertension medication form
- Central Valley's Standing Orders
- Santa Barbara's Comprehensive Assessment Form
- Northern Valley's Chart Audit Tool *New!
- Northern Valley Quality Improvement Calendar *New!

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, PHN	steve.viramontes@ihs.gov	916-930-3981 ext 359
Health Promotion Disease Prevention	Beverly Calderon, RD, CDE	beverly.calderon@ihs.gov	760-735-6884
IT/Data Entry	IT Help Desk	caohelp@ihs.gov	916-930-3981 ext 353
Meaningful Use & Vista Imaging	Marilyn Freeman, RHIA	marilyn.freeman@ihs.gov	916-930-3981 ext 362
Medical Records & HIPAA Compliance	CAPT Steven Lopez, RHIA	steven.lopez@ihs.gov	916-930-3981 ext 328
National GPRA Support Team (caogpra@ihs.gov)	Amy Patterson, PhD	amy.patterson@ihs.gov	916-716-6929
	Christine Brennan, MPH	christine.brennan@ihs.gov	916-930-3981 ext 333
	CDR Wendy Blocker, MSN	wendy.blocker@ihs.gov	916-930-3981 ext 308
	Rachel Pulverman	rachel.pulverman@ihs.gov	916-930-3981 ext 361
Nursing & Immunizations	Susan Ducore, RN, BSN, MSN, PHN	susan.ducore@ihs.gov	916-930-3981 ext 323

INDIAN HEALTH SERVICE
CALIFORNIA AREA OFFICE

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

Phone: 916-930-3927
Fax: 916-930-3953
E-mail: caogpra@ihs.gov

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?

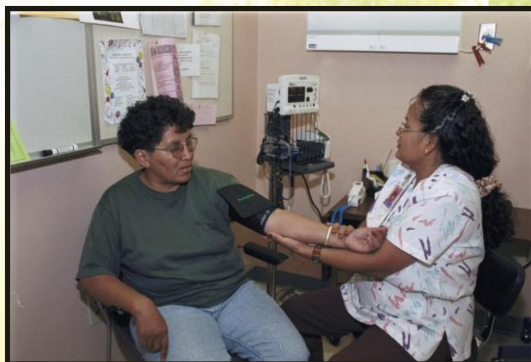
  Are women being screened for domestic violence and alcohol use (to prevent birth complications like Fetal Alcohol Syndrome)?

  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.

Distributed by the
Indian Health Service/California Area Office

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 (GPRA)
WHAT IS GPRA AND HOW DOES IT AFFECT ME?

Introduction to GPRA for Providers and Clinic Staff

What is GPRA?

The Government Performance and Results Act (GPRA) 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). GPRA is a critical part of the annual budget request for IHS.

The GPRA "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 GPRA Support Team (NGST). This team is responsible for aggregating all data received and creating reports showing how the agency performed over the GPRA 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 GPRA Clinical Measure?

A GPRA clinical measure is a specific indicator of performance on patient care. Current GPRA 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 GPRA 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 GPRA data reported?

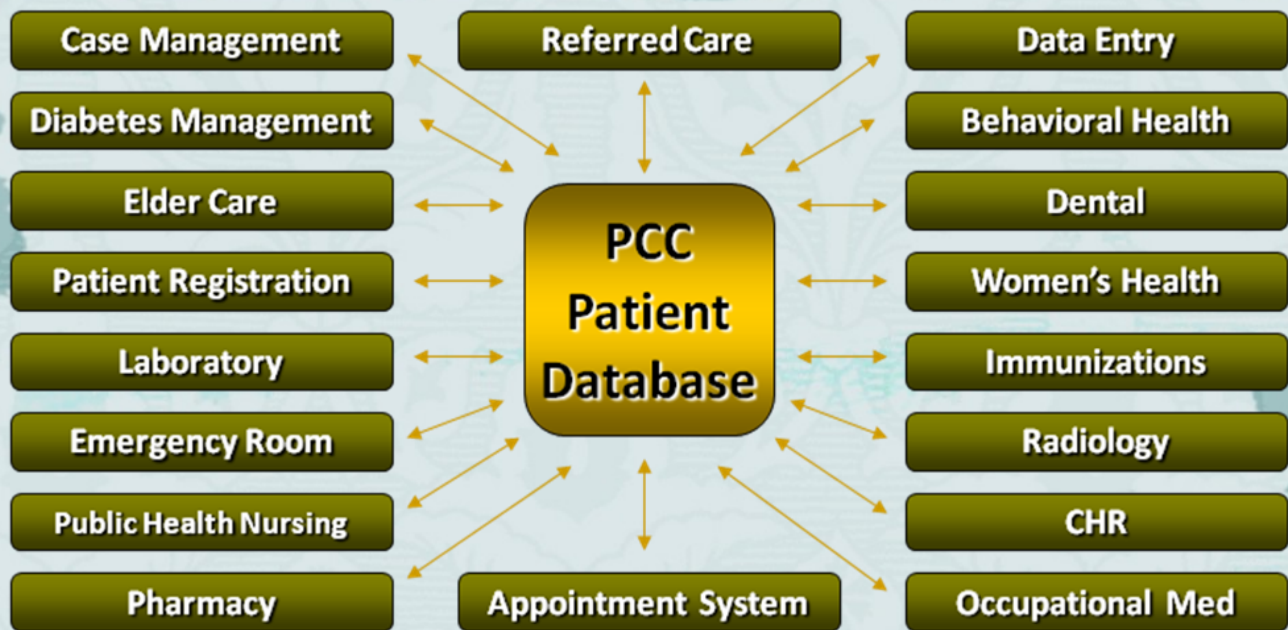
- At the end of each GPRA quarter and at the end of the GPRA year, facilities run their National GPRA report and export their data to their respective Area Offices.
- Area GPRA Coordinators load the facility reports and run an Area Aggregate report. This report shows if the overall Area GPRA measures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

- Federal (IHS) facilities are required to use CRS for GPRA 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 GPRA 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 GPRA 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 GPRA. 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?

Produced and Distributed by
Indian Health Service/
California Area Office

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

For additional information on the Government Performance and Results Act, please contact
National GPRA Support Team (NGST)
caogpra@ihs.gov

GPRAMA/CRS Budget Measure Numerator and Denominator Definitions		(GPRAMA Measures listed in red)
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
Good Glycemic Control	# patients with A1c < 8	Active Diabetic Patients
Controlled BP <140/90	# patients with controlled BP (<140/90) 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 nephopathy 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	# patients with one or more intact dental sealants	Active GPRA User Population patients ages 2-15
Topical Fluoride- Patients	# patients who received one or more topical fluoride applications during the report period	Active GPRA User Population patients ages 1-15
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 four years	Female active clinical patients age 25-64 (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 appropriate colorectal cancer screening	Active clinical patients age 50-75 without history of colorectal cancer or colectomy
Tobacco Cessation	# patients who received tobacco cessation counseling or an Rx for smoking cesssation	Active clinical patients identified as current tobacco users or tobacco users in cessation
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 CHD 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

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 sigmoidscopy
- Colonoscopy in the past 10 years

Active CHD Patients

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

Comprehensive CVD-Related Assessment

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

THE IHS PRIMARY CARE PROVIDER

A journal for health professionals working with American Indians and Alaska Natives

March 2012 **Volume 37 Number 3**

Significant Changes to GPRA Beginning in Fiscal Year 2013

Wendy Blocker, RN, MSN, Public Health Analyst, National GPRA Support Team, California Area Indian Health Service, Sacramento, California; Christine Brennan, MPH, Public Health Analyst, National GPRA Support Team, California Area Indian Health Service, Sacramento; Amy Patterson, PhD, Public Health Analyst, National GPRA Support Team, California Area Indian Health Service, Sacramento; Rachel Pulverman, BS, Editorial Assistant, National GPRA Support Team, California Area Indian Health Service, Sacramento; Carolyn Aoyama, CNM, MPH, Senior Nurse Consultant, Office of Public Health Support, Indian Health Service, Rockville, Maryland; Diane Leach, MA, Public Health Analyst, Office of Public Health Support, Indian Health Service, Rockville; and Susan Karol, MD, FACS, Chief Medical Officer, Indian Health Service, Rockville

In January 4, 2011 President Barack Obama signed into law the GPRA Modernization Act of 2010 (GPRAMA), Public Law 111-352. The GPRAMA strengthens the Government Performance and Results Act of 1993 (GPRA), Public Law 103-62 by requiring federal agencies to use performance data to drive decision making. This article describes the changes to national performance reporting for the Indian Health Service (IHS) that are required by GPRAMA beginning in fiscal year (FY) 2013.

Starting in FY 2013, the Department of Health and Human Services (HHS) will prepare the HHS annual performance plan and performance report using the GPRAMA measures reported from all the HHS operating and staff divisions (OP/DIV), including the IHS. In order to make this manageable at the department level, HHS has decreased the number of performance measures that each OP/DIV will report. As a result, as of FY 2013, the IHS will report six measures, which will be known as GPRAMA measures. These six measures are:

- Proportion of adults 18 and older who are screened for depression;
- American Indian and Alaska Native patients with diagnosed diabetes achieve ideal glycemic control (A1c less than 7.0%);
- American Indian and Alaska Native patients, 22 and older, with coronary heart disease are assessed for five cardiovascular disease (CVD) risk factors (Note: the denominator for this measure is no longer patients with ischemic heart disease);
- American Indian and Alaska Native patients, aged 19–35 months, receive childhood immunizations (4:3:1:3:3:1:4);
- 100% of hospitals and outpatient clinics operated by the Indian Health Service are accredited (excluding tribal and urban facilities);
- Implement recommendations from tribes annually to improve the tribal consultation process.

In this Issue…

46 Significant Changes to GPRA Beginning in Fiscal Year 2013

49 Help Us Save Money

49 Electronic Subscription Available

50 Colorectal Cancer Screening Activities in Indian Country: An Update

52 Colorectal Cancer Awareness Month

54 Advancements in Diabetes Seminars

55 Evaluation of Health Literacy Assessment Tools Among American Indian Patients

63 The 16th Annual Elders Issue

64 IHS Child Health Notes

66 Meetings of Interest

67 Patient Billing Coordinators: An Active Approach Yields Big Results for Winnebago

68 Position Vacancies

The remaining GPRA measures will be reclassified as "budget measures" and will continue to be reported nationally in the IHS annual budget request. The IHS will monitor our agency's performance by quarter and report final budget measure results in the annual IHS budget request, the Congressional Justification (CJ). Even though their designation has changed from GPRA measures to budget measures, they are still considered national performance measures.

Additionally, the current Performance Assessment Rating Tool (PART) measures and national program measures that are currently reported in the IHS CJ will also be reclassified as "budget measures" and will be reported in the annual budget request.

In summary, the IHS will report the six GPRAMA measures in the FY 2013 IHS CJ and the HHS Online Performance Appendix. The remaining 84 budget measures reported in the FY 2013 IHS CJ will be a combination of GPRA performance measures, performance or PART measures, and national program measures. The budget measures will be reported as they have been for the past few years; clinical measures will be reported via the Clinical Reporting System (CRS), and IHS headquarters programs will track their respective PART and program measures.

Frequently Asked Questions: How Does the Change from GPRA to GPRAMA Performance Measures Affect Me?

What are GPRA performance measures?

GPRA 1993 requires the integration of federal budgets and performance to demonstrate the use of appropriated federal dollars. Within the IHS, GPRA performance measures represent clinical services provided to American Indian/Alaska Native (AI/AN) patients; the GPRA measures are a marker of access to health care services. The IHS is reporting GPRA results in our annual budget documents through FY 2012.

What are GPRAMA performance measures?

Reporting on GPRAMA performance measures begins in FY 2013. Instead of reporting GPRA at the IHS level, performance reporting will be at the HHS level. HHS is including six IHS GPRAMA measures in the annual HHS performance report. These are the official performance measures for IHS; the previous GPRA measures will continue to be reported nationally and will be re-named as budget measures in 2013. The name change does not reduce the importance of these measures.

How is GPRAMA different from Meaningful Use?

GPRAMA is a federal law that requires performance be integrated into annual budget requests. The six IHS GPRAMA measures are reported at the HHS level.

Meaningful Use of a certified electronic health record (EHR) technology is part of the American Recovery and Reinvestment Act of 2009 (ARRA). The Centers of Medicare and Medicaid Services (CMS) provide incentive payment programs for eligible professionals and eligible hospitals that adopt and demonstrate meaningful use of certified EHR technology at the local level.

What will change at the local facility level?

Nothing will change at the local level in terms of what is required for performance reporting. The facility level is where most patient care is provided in the IHS, and sites will continue to enter visit information into the local RPMS server. Sites will still run their *CRS National GPRA and PART Report* at the end of the 2nd, 3rd, and 4th quarters using CRS for the existing 22 GPRA measures. Non-CRS sites will also run their quarterly reports, if they choose to report data. All quarterly CRS reports will be electronically aggregated at the Area level and manually aggregated at the national level. At the local level, improvement activities will still concentrate on the 22 GPRA measures since they are still national performance measures and reported in each annual IHS budget.

What about the CRS software?

All the CRS software and reports will continue to be supported by the IHS. CRS will continue to be updated by the IHS CRS Team and the CRS programmers. Local sites will continue to run quarterly reports that will be exported to their Area GPRA coordinator for Area aggregation. Reports from CRS version 13.1 will be used for at least the first year of the GPRAMA measures.

When does IHS begin reporting on the four CRS reported GPRAMA measures?

The FY 2013 GPRA year runs from July 1, 2012 through June 30, 2013. Many local sites will continue to run monthly reports which will provide local results for quality improvement activities.

Where can I find the budget measure national results in the IHS CJ?

The IHS Division of Budget Formulation has a web page on the IHS website. Select "Congressional Justifications" from the left column to review annual IHS CJs. Near the end of each program narrative in the CJ is a table called Outputs and Outcomes Table. The 90 total budget measure results are on these tables.

How does the GPRAMA CVD comprehensive assessment measure differ from the existing GPRA CVD measure?

The denominator for the FY 2012 CVD comprehensive assessment measure is active ischemic heart disease (IHD) patients ages 22 and older. The denominator for the GPRAMA CVD comprehensive assessment measure in FY 2013 is active

coronary heart disease (CHD) patients ages 22 and older. The denominator for CHD removes heart failure codes from the previous CVD denominator, adds angina to the GPRAMA denominator as well as a series of procedure codes added to detect coronary heart disease when the ICD codes failed to do so. Currently, the CVD comprehensive assessment measure with the new CHD denominator is a GPRA Developmental measure. Local results for this measure can be found in the GPRA Developmental section of the *CRS National GPRA and PART Report* until the measure is moved to the GPRA report section in CRS version 13.0 with an anticipated release date of December 2012.

Are there other performance (budget) measure changes?

Two of the dental measures will change. Dental Sealants and Topical Fluorides have been reported as counts; starting in FY 2013 these two measures will be reported as proportions of eligible patients who have received sealants or fluorides. FY 2013 will be the baseline year for collecting these results.

Additionally, breastfeeding rates currently are reported from federally operated sites only. Starting in FY 2013 the IHS will report breastfeeding rates as an aggregate result from federally operated sites and tribally operated sites. FY 2013 will be a baseline year for this measure.

Who should I contact if I have questions?

If your questions are about the six GPRAMA measures, contact Ms. Gayle Riddles, IHS Performance Officer at *gayle.riddles@ihs.org*.

If your questions are about the other 84 IHS budget measures, or CRS, contact either the National GPRA Support Team at *caogpra@ihs.gov*, or Ms. Diane Leach, National Budget Measures Coordinator at *diane.leach@ihs.gov*.

List of Abbreviations

GPRA	Government Performance and Results Act of 1993
GPRAMA	GPRA Modernization Act of 2010
OPA	Online Performance Appendix that includes the annual performance plan and the annual performance report
CJ	Congressional Justification is the presidential budget request for a federal agency
CRS	Clinical Reporting System, one of over 50 software applications within the Resource and Patient Management System (RPMS) used by the Indian Health Service
FY	Fiscal year
PART	Program Assessment Rating Tool established by President George W. Bush

Resources

GPRA Modernization Act of 2010, Public Law 111-352-January 4, 2011 *http://www.gpo.gov/fdsys/pkg/PLAW-111publ352/pdf/PLAW-111publ352.pdf*.

Government Performance and Results Act of 1993 (GPRA), Pub. L. No. 103-62, 107 Stat. 285 (codified as amended in scattered sections of 5 U.S.C., 31 U.S.C., and 39 U.S.C.). *http://history.nih.gov/research/downloads/PL103-62.pdf*.

THE IHS PRIMARY CARE PROVIDER

A journal for health professionals working with American Indians and Alaska Natives

January 2012 **Volume 37 Number 1**

Scoring a Perfect 19: Insights from the Facilities that Met All GPRA Targets in 2011

Erika Wolter, MBA, MPH, Improvement Programs Administrator, Alaska Native Tribal Health Consortium, Anchorage, Alaska; Kristina Rogers, MMI, Statistical Officer/GPRA Coordinator, ICD-10/Fitness Program Coordinator, Nashville Area Office, Nashville, Tennessee, and Statistical Officer/GPRA Coordinator, Albuquerque Area Office, Albuquerque, New Mexico; Tina Isham-Amos, MBA, Area Statistical Officer/Area GPRA Coordinator, Oklahoma City Area Office, Oklahoma City, Oklahoma; and Brigg Reilley, MPH, Division of Epidemiology and Disease Prevention, IHS, Albuquerque

The Government Performance and Results Act (GPRA), enacted in 1993, required federal agencies to establish standards measuring their performance and effectiveness. The Indian Health Service (HIS) reports its GPRA measures to Congress once per year, which uses the information in its budgetary decisions. GPRA is also an important indicator of the quality of care delivered by IHS sites.

In GPRA year 2011, nine sites in three Areas were “GPRA champions” and reached all 19 national GPRA targets. In the Nashville (NAS) Area, those facilities were Micmac Health Service, Passamaquoddy Indian Township, Catawba Health Service, and Oneida Nation. In the Alaska (AK) Area, the champions were Kodiak Alaska Native Association and Bristol Bay Area Health Corporation; in Oklahoma (OK) Area, the champion sites were the Wilma P Mankiller, Muskogee, and Stigler Choctaw Health Centers.

GPRA Indicators Were Prioritized as Measures of Quality of Care Provided to the Community

While it is not a requirement for tribal sites to report for GPRA, it is notable that most champion sites are, in fact, tribal. Sites indicated their facilities had an “internal” responsibility to meet GPRA targets. They viewed GPRA as a measure of how well they served their patients, not just a reporting tool. Despite any human resource shortages or turnover, the sites have adapted to optimally utilize the core set of staff, principles, methods, and policies instituted throughout the clinic to continually improve.

In addition to the local sites making GPRA a priority, Area and tribal organizations in both Nashville and Alaska provide a consistent message that GPRA is important as a minimum standard of care for the patients receiving care at the Area clinics.

Facilities Had Monthly GPRA Reports and Easy Access to Lists of Patients Whose Care Had Not Met GPRA Standards

Identification of measures and patients who need service are critical parts of meeting and improving GPRA rates. Either an in-house Clinical Applications Coordinator (CAC) or the Area GPRA coordinator, or both, ensure that staff know their progress towards meeting GPRA targets each month, as well as which patients need follow-up.

In NAS and AK, the Area- and tribally-based GPRA coordinator shares monthly GPRA numbers directly with facility leadership and relevant front-line staff, including medical practitioners at all levels (doctors, mid-levels, nurses, and health aides), Quality Improvement staff, Data Entry/Medical Records staff, Behavioral Health, and specialized staff members such as diabetes or immunization coordinators.

In this Issue…

1 Scoring a Perfect 19: Insights from the Facilities that Met All GPRA Targets in 2011

4 Advancements in Diabetes Seminars

5 Electronic Subscription Available

5 The 16th Annual Elders Issue

6 Save the Date

7 IHS Child Health Notes

9 Position Vacancies

In OK, Cherokee Nation and Choctaw Nation have SharePoint sites that allows sites to see each others' data, such as preventive screenings. This data sharing has allowed sites to contact sites that are excelling in any particular measure to learn about their policies and procedures.

Facilities Were Consistent in Sharing and Discussing GPRA Numbers Among All Staff Members.

Communication is a vital part of improving GPRA and patient care. Champion facilities had consistent interaction on indicators via a morning huddle, a weekly medical meeting, a GPRA committee, or other group meetings that helped keep staff informed about progress or patient needs. These meetings were also an important way to get input and ideas from a wide range of staff members, such as what taxonomies need to be updated for GPRA, the best way to follow up with hard-to-reach patients, targeting lagging indicators, and other practicalities.

Services Were Delegated Away from Provider Level

At many champion sites, responsibility for meeting individual GPRA measures is divided amongst the staff (medical providers and non-medical providers). This team approach helps foster an organizational goal for meeting and improving GPRA and patient care. It also enables all staff to have clear responsibilities for meeting GPRA targets, rather than creating the feeling that everyone is responsible for all measures. This helps make the targets feel more attainable and provides a sense of ownership for the staff assigned to each measure.

For example, at one site, the Chief Nursing Assistant is responsible for ensuring her staff performed screenings as indicated for depression, tobacco, alcohol use, and domestic violence. At another site, the contract health representative makes follow-up calls to patients who are overdue for certain screenings to set up appointments. Utilizing nursing staff to perform all needed screenings prior to their visit with the physician allows the patient and provider to spend more time discussing the patient's needs. This is time that can be spent building a relationship with the patient, which in turn leads to more successful counseling on issues such as nutrition, exercise, or other lifestyle choices.

Local Innovation and Special Services

Many of the champion sites have unique ways in which they approach certain GPRA measures. Creative solutions to providing services in-house or through referred care are important to ensuring patients receive the care that they need. A short list of examples includes the following.

Specialty Clinics: A diabetes clinic serves as a "one stop shop" to meet all aspects of diabetes care, and the staff ensures that all patients make their clinic appointments, including offering incentives for some patients.

Active Patient Follow-up: The contract health representative calls patients who are overdue for screening to schedule appointments.

Transport: Providing transportation support dedicated to getting patients to their contracted services appointments (such as mammograms).

Data Management: The medical records department takes the lead responsibility for prenatal HIV screening, as most tests are done outside the clinic. Medical records takes the lead on tracking down outside HIV tests, entering them in RPMS, and identifying prenatal patients who have not been tested.

Facility and Medical Team Friendly Competitions: The Area offers awards for facilities that meet certain goals and improvements. At the provider level, a site can use iCare to chart providers' and provider teams' scores for various GPRA measures. These numbers spur provider teams to increase their scores, and are a catalyst for identifying and sharing best practices. Providers are more actively involved in GPRA and provide valuable input into improvement activities.

Innovative Use of Information Technology

- Use of electronic clinic reminders to identify patients who are overdue for preventive care. In Alaska, reminders have proven highly effective both in improving patient care by ensuring needed care isn't overlooked, while also improving the efficiency of data entry
- Use of iCare for a comprehensive check of community members who are overdue for preventive care
- To - capture services done by contract health services/external sites for its patients in GPRA, one site uses the RCIS package to better track services provided by referral sites. Other sites used more basic measures for contract health data such as faxing of lab panels or other records on an as-needed basis
- Monitor patient lists pulled from the Clinical Reporting System and correcting data entry errors (for example, patients who reside in a community outside of the facility's catchment area)
- Monitor -the state's immunization registries (VacTrak system in Alaska) to identify patients who may have received vaccinations at other facilities or pharmacies
- Gather -historical information by using the Provider Portal system to monitor procedures/tests that may have occurred while the patient was visiting. While entering historical information can certainly improve the GPRA numbers, the real value is in ensuring the patient record in their home community is as accurate as possible. This improves care quality while also reducing costs associated with duplicative vaccinations, tests, procedures, etc.

For Further Action and Information

Different sites will have different challenges to reach all GPRA measures. The ability to use these best practices may depend on facility size, mobility of their patient population, human resources turnover in provider staff and CACs, and other factors. However, many of the GPRA champions' ideas can be applied successfully in the Indian Country setting.

The concept of a 'medical home' for patients, as used in the IPC initiative, has also shown success, and many (but not all) of the GPRA champions are IPC sites.

For more information about any of the above programs, including sharing ideas about how to improve any individual GPRA measure, contact Erika Wolter in AK (*ewolter@anthc.org*); Kristina Rogers in NAS (*kristina.rogers@ihs.gov*); or Tina Isham-Amos in OK (*tina.isham-amos@ihs.gov*).

Acknowledgements

The authors would like to recognize and thank the many Area, tribal, and facility providers and staff members whose hard work and contributions to this discussion made this article possible.

Area-Level Initiatives in AK, NAS, and OK

The Nashville Area instituted program award incentives and other tools in 2008 to encourage sites to meet GPRA targets. Those tools included teaching/coaching about the utilization of the Model for Improvement and Plan-Do-Study-Act (PDSA) cycles, customizable GPRA report cards, and the use of stretch goals. Since that time, the incentives have tapered down, and now the drive to meet all targets is part of their facility culture.

OK uses extensive information sharing within tribal nations. The Area has GPRA awards, and provides frequent trainings for sites about how to generate and use their local data using CRS and iCare so sites have many persons who can create patient lists to identify who is overdue for what preventive care measures.

In 2010, the Alaska Area added GPRA-based awards to help facilities better understand and be better motivated to reach targets. This has created a friendly, but rather competitive, atmosphere where tribal health organizations each want to be the next one to reach the 100% target and/or where they want to be the best on a certain measure or measure set that is of particular importance to their community.

The Alaska Area has implemented a number of tools/programs to assist and encourage improved patient care. Those tools include a virtual helpdesk and the "Measure of the Month" program. The virtual helpdesk (*https://anthc.adobeconnect.com/ipc*) allows for sharing of files, best practice ideas, and other information, while expanding capacity to provide technical assistance to sites without having to actually be at the site. This helpdesk also serves as a way for staff from the participating tribal health organizations to connect frequently for support, sharing, or simply networking. Given Alaska's vast geographic area, this tool has proved invaluable. The "Measure of the Month" program focuses on one measure or set of measures. The goal is to see how much improvement can take place over the specified time period by providing a focused effort to improve the particular measure(s). As much as possible, these measure(s) are tied to the National Health Observance months or seasonal needs. For example, the August Measure of the Month is immunizations, as August is the time when children are getting immunizations updated for school or day care and when the start of influenza and pneumonia season is on its way.

Both Alaska and Nashville Areas are also in the process of developing a website that integrates support and training for a variety of improvement programs including GPRA, the IHS Improving Patient Care initiative, and Meaningful Use. A major component of this website is the easy viewing of video vignettes that provides information and training "on demand."

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** *Mnemonic **PPV** enter* 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:** • **> 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** *Mnemonic **LAB** enter* 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)			**Historical A1c Lab Test** *Mnemonic **HLAB** enter* Date of Historical Lab Test: Type: Location Name: Enter Lab Test: **[Enter site's defined A1c Lab Test]** Results: **CPT Entry** *Mnemonic* **CPT** *enter* Enter CPT: **83036, 83037, 3044F-3046F** Quantity: Modifier: **Modifier 2:**
Diabetes: Blood Pressure Control	**Active Clinical Patients DX with diabetes and with controlled Blood Pressure:** • **< 130/80 (mean systolic < 130, mean diastolic < 80)**	**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:** **Blood Pressure Data Entry** *Mnemonic **BP** enter* Value: **[Enter as Systolic/Diastolic (e.g., 130/80)]** Select Qualifier: Date/Time Vitals Taken:
Diabetes: LDL Assessment	**Active Clinical Patients DX with diabetes and a completed LDL test.**	**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:** **LDL (Calculated) (REF)* Lab Test** ***REF–Reference Lab** *Mnemonic **LAB** enter* Enter Lab Test Type: **[Enter site's defined LDL Reference Lab Test]**

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

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes: Nephropathy Assessment	**Active Clinical Patients DX with diabetes with a Nephropathy assessment:** • **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: Date received Location Results	**Standard PCC data entry:** **Estimated GFR Lab Test** *Mnemonic **LAB** enter* Enter Lab Test Type: **[Enter site's defined Est GFR Lab Test]** Results: **[Enter Results]** Units: Abnormal: Site: **[Blood]** **Historical GFR Lab Test** *Mnemonic **HLAB** enter* Date of Historical Lab Test: Type: Location Name: Enter Lab Test: **[Enter site's defined Est GFR Lab Test]** Results: **Quantitative Urinary Protein Assessment CPT** *Mnemonic **CPT** enter* Enter CPT: **82042, 82043, 84156** Quantity: Modifier: Modifier 2: **ESRD CPT** *Mnemonic **CPT** enter*

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** *Mnemonic **PPV** enter* Purpose of Visit: **585.5, 585.6, V42.0, V45.11, V45.12, or V56.*** Provider Narrative: Modifier: Cause of DX: **ESRD Procedure** *Mnemonic **IOP** enter* 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
Diabetic Retinopathy	**Patients with diabetes will have a qualified* retinal examination during the report period.** ***Qualified retinal exam: The following methods are qualifying for this measure:** • **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).** **Note: Refusals 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 **Exams:** Diabetic Retinal Exam Dilated retinal eye exam Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos Routine ophthalmological examination including refraction (new or existing patient) Diabetic indicator; retinal eye exam, dilated, bilateral Other Eye Exams Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or validated tele-ophthalmology retinal evaluation clinics non-DNKA visits to an optometrist or ophthalmologist	**Standard PCC data entry:** **Diabetic Retinopathy Exam** *Mnemonic **EX** enter* Select Exam: **03** Result: **[Enter Results]** Comments: Provider Performing Exam: **Historical Retinopathy Exam:** *Mnemonic **HEX** enter* Date of Historical Exam: Type: Location Name: Exam Type: **03** Result Comments Encounter Provider **Retinal Exam CPT** *Mnemonic **CPT** enter* Enter CPT: **2022F, 2024F, 2026F, S0620, S0621, S3000** Quantity: Modifier: Modifier 2: **Other Eye Exam CPT** *Mnemonic **CPT** enter* Enter CPT: **67028, 67038, 67039, 67040, 92002, 92004, 92012, 92014** Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetic Retinopathy (cont)			**Other Eye Exam POV** *Mnemonic **PPV** enter* Purpose of Visit: **V72.0** Provider Narrative: Modifier: Cause of DX: **Other Eye Exam Procedure** *Mnemonic **IOP** enter* Operation/Procedure: **95.02** Provider Narrative: Operating Provider: Diagnosis: **[Enter appropriate DX]** **Other Eye Exam Clinic** *Mnemonic **CL** enter* Clinic: **A2, 17, 18, 64** Was this an appointment or walk in?:
Access to Dental Service	**Patients should have annual dental exams.** **Note: Refusals 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	**Standard PCC data entry** **Dental Exam** *Mnemonic **EX** enter* Select Exam: **30** Result: **[Enter Results]** Comments: Provider Performing Exam: **Historical Dental Exam** *Mnemonic **HEX** enter* Date of Historical Exam: Type: Location Name:

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

Performance Measure	Standard	Provider Documentation	Data Entry
Dental Sealants	**A maximum of two sealants per tooth are counted toward the GPRA measure.** **Note: Refusals 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	**Standard PCC data entry** **Dental Sealants (ADA)** *Mnemonic **ADA** enter* Dental Service Code: **1351** Type: No. Of Units: Operative Site: **Historical Dental Sealants** *Mnemonic **HADA** enter* Date of Historical ADA: Type: Location Name: ADA Code: **1351** Units: **Dental Sealants CPT** *Mnemonic **CPT** enter* Enter CPT: **D1351** Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	Data Entry
Topical Fluoride	**A maximum of four topical fluoride application are counted toward the GPRA measure.** **Note: Refusals 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	**Standard PCC data entry** **Topical Fluoride (ADA code)** *Mnemonic **ADA** enter* Dental Service Code: **1203, 1204, 1206, 5986** Type: No. Of Units: Operative Site: **Historical Fluoride (ADA code)** *Mnemonic **HADA** enter* Date of Historical ADA: Type: Location Name: ADA Code: **1203, 1204, 1206, 5986** Units: **Topical Flouride CPT** *Mnemonic **CPT** enter* Enter CPT: **D1203, D1204, D1206, D5986** Quantity: Modifier: Modifier 2: **Topical Flouride POV** *Mnemonic **PPV** enter* Purpose of Visit: **V07.31** Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	Data Entry
Adult Immunizations: Influenza	**All adults ages 65 and older should have an annual Influenza (flu) shot.** **Adults 55-64 are strongly recommended to have annual Influenza (flu) shot.** **All adult (18 and older) diabetic patients are strongly recommended to have annual Influenza (flu) shot.** **Refusals should be documented. Note: Only NMI (Not Medically Indicated) refusals are counted toward the GPRA Measure.**	**Standard PCC documentation for immunizations performed at the facility, Ask about off-site** tests and record historical information on PCC: IZ type Date received Location **Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include:** Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal	**Standard PCC data entry** **Influenza Vaccine** *Mnemonic **IM** enter* Select Immunization Name: **140, 141 or 144 (other options are 111, 15, 16, 88)** Lot: VFC Eligibility: **Historical Influenza Vaccine** *Mnemonic **HIM** enter* Date of Historical Immunization: Type: Location: Immunization Type: **88 (other options are 111, 15, 16)** Series: **Influenza Vaccine POV** *Mnemonic **PPV** enter* Purpose of Visit: ***V04.81, *V06.6** Provider Narrative: Modifier: Cause of DX: *** NOT documented with 90663, 90664, 90666-90668, 90470, G9141, G9142** **Influenza Vaccine CPT** *Mnemonic **CPT** enter* Enter CPT: **90654-90662, G0008, G8108** Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	Data Entry
Adult Immunizations: Influenza (cont)			**Influenza Procedure** *Mnemonic **IOP** enter* Operation/Procedure: **99.52** Provider Narrative: Operating Provider: Diagnosis: **[Enter appropriate DX]** **NMI Refusal of Influenza** *Mnemonic **NMI** enter* Patient Refusals For Service/NMI Refusal Type: **Immunization** Immunization Value: **[See codes above]** Date Refused: Provider Who Documented: Comment: **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**

Performance Measure	Standard	Provider Documentation	Data Entry
Adult Immunizations: Pneumovax	**All adults ages 65 and older will have a pneumovax.** **All adult (18 and older) diabetic patients are strongly recommended to have a pneumovax.** **Refusals should be documented. Note: Only NMI (Not Medically Indicated) refusals are counted toward the GPRA Measure.**	**Standard PCC documentation for immunizations performed at the facility, Ask about off-site** *tests and record historical information* on PCC: IZ type Date received Location **Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include:** Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal	**Standard PCC data entry** **Pneumovax Vaccine** *Mnemonic **IM** enter* Select Immunization Name: **33, 100, 109, 133** Lot: VFC Eligibility: **Historical Pneumovax Vaccine** *Mnemonic **HIM** enter* Date of Historical Immunization: Type: Location: Immunization Type: **33, 100, 109, 133** Series: **Pneumovax Vaccine POV** *Mnemonic **PPV** enter* Purpose of Visit: **V06.6, V03.82** Provider Narrative: Modifier: Cause of DX: **Pneumovax Vaccine CPT** *Mnemonic **CPT** enter* Enter CPT: **90669, 90670, 90732, G0009, G8115** Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	Data Entry
Adult Immunizations: Pneumovax (cont)			**Pneumovax Procedure** *Mnemonic* ***IOP*** *enter* Operation/Procedure: **99.55** Provider Narrative: Operating Provider: Diagnosis: **[Enter appropriate DX]** **NMI Refusal of Pneumovax** *Mnemonic* ***NMI*** *enter* Patient Refusals For Service/NMI Refusal Type: **Immunization** Immunization Value: **[See codes above]** Date Refused: Provider Who Documented: Comment: **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**

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Immunizations	**Children age 19-35 months will be up-to-date for all ACIP recommended immunizations.** **This is the 4313314 combo:** **4 DTaP** **3 IPV** **1 MMR** **3 Hepatitis B** **3 Hib** **1 Varicella** **4 Pneumococcal** **Refusals should be documented.** **Note: Only NMI (Not Medically Indicated) refusals are counted toward the GPRA Measure.**	**Standard PCC documentation for immunizations performed at the facility, Ask about off-site** tests and record historical information on PCC: IZ type Date received Location 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 **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:** **IPV:** Immunization Package: "Neomycin Allergy." **MMR:** Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy." **Varicella:** Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy." **Dosage and types of immunization definitions:** **4 doses of DTaP:** 4 DTaP/DTP/Tdap 1 DTaP/DTP/Tdap and 3 DT/Td 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus	**Standard PCC data entry** **Childhood Immunizations** *Mnemonic **IM** enter* Select Immunization Name: *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** Lot: VFC Eligibility: **Historical Childhood Immunizations** *Mnemonic **HIM** enter* Date of Historical Immunization: Type: Location: Immunization Type: *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** Series:

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Immunizations (cont)		4 DT and 4 Acellular Pertussis 4 Td and 4 Acellular Pertussis 4 each of Diphtheria, Tetanus, and Acellular Pertussis **3 doses of IPV:** 3 OPV 3 IPV Combination of OPV & IPV totaling 3 doses **1 dose of MMR:** MMR 1 M/R and 1 Mumps 1 R/M and 1 Measles 1 each of Measles, Mumps, and Rubella **3 doses of Hepatitis B** 3 doses of Hep B **3 doses of HIB** **1 dose of Varicella** **IMPORTANT NOTE:** 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	**Childhood Immunizations POV** *Mnemonic* ***PPV*** *enter* 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, 203.8, 204-208** Provider Narrative: Modifier: Cause of DX: **Childhood Immunizations CPT** *Mnemonic* ***CPT*** *enter* Enter CPT: *DTaP:* **90696, 90698, 90700, 90721, 90723;** *DTP:* **90701, 90720;** *Tdap:* **90715;** *DT:* **90702;** *Td:* **90714, 90718;** *Diphtheria:* **90719;** *Tetanus:*

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Immunizations (cont)		GPRA communities will not be affected.	**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: **Childhood Immunizations Procedure** *Mnemonic **IOP** enter* 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]** **NMI Refusal of Childhood Immunizations** *Mnemonic **NMI** enter* Patient Refusals For Service/NMI Refusal Type: **Immunization** Immunization Value: **[See codes above]** **Date Refused:**

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** *Mnemonic **LAB** enter* Enter Lab Test Type: **Pap Smear** Results: **[Enter Results]** Units: Abnormal: Site: **Pap Smear POV** *Mnemonic **PPV** enter*

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

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

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

Performance Measure	Standard	Provider Documentation	Data Entry
Colorectal Cancer Screening	**Adults ages 50 -75 should be screened for CRC (USPTF).** **For GPRA, IHS counts any of the following:** • **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.** **Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.**	**Standard PCC documentation for procedures performed at the facility (Radiology, Lab, Provider).** **Guaiac cards returned by patients to providers should be sent to Lab for processing.** **Ask and** *record historical information* **on PCC:** Date received Location Results **Telephone visit with patient** **Verbal or written lab report** **Patient's next visit**	**Standard PCC data entry process for procedures, Lab or Radiology** **Colorectal Cancer POV** *Mnemonic **PPV** enter* Purpose of Visit: **153.*, 154.0, 154.1, 197.5, V10.05** Provider Narrative: Modifier: Cause of DX: **Colorectal Cancer CPT** *Mnemonic **CPT** enter* Enter CPT: **G0213-G0215, G0231** Quantity: Modifier: Modifier 2: **Total Colectomy CPT** *Mnemonic **CPT** enter* Enter CPT: **44150-44151, 44155-44158, 44210-44212** Quantity: Modifier: Modifier 2: **FOBT or FIT CPT** *Mnemonic **CPT** enter* Enter CPT: **82270, 82274, G0328** Quantity: Modifier: Modifier 2: **Flexible Sigmoidoscopy CPT** *Mnemonic **CPT** enter* Enter CPT: **45330-45345, G0104**

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

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

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Use and Exposure Assessment **NOTE: This is not a GPRA measure; however, it will be used for reducing the incidence of Tobacco Use.**	**Ask all patients age five and over about tobacco use** ***at least annually*****.**	**Standard PCC documentation for tests performed at the facility, Ask and** *record historical information* on PCC: Date received Location Results **Document on designated Health Factors section of form:** 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 **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"** **Tobacco Patient Education Codes:** Codes will contain "TO-", "-TO", "-SHS"	**Standard PCC data entry** **Tobacco Screening Health Factor** *Mnemonic **HF** enter* Select V Health Factor: **[Enter HF (See the Provider Documentation column)]** Level/Severity: Provider: Quantity: **Historical Tobacco Health Factor** *Mnemonic **HHF** enter* Date Historical Health Factor: Type of Visit: Location Name: Enter Health Factor: : **[Enter HF (See the Provider Documentation column)]** Level/Severity: Provider: Quantity: **Tobacco Screening PED - Topic** *Mnemonic **PED** enter* 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

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Use and Exposure Assessment (cont)		**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."	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** *Mnemonic **HF** enter* 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** *Mnemonic **HF** enter* Select V Health Factor: **Current Smoker (every day, some day, or status unknown), or Cessation-Smoker** Level/Severity: Provider: Quantity: **Smokeless Health Factor** *Mnemonic **HF** enter* Select V Health Factor: **Current Smokeless or Cessation-Smokeless** Level/Severity: Provider: Quantity:

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

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Cessation	**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.** **Note: Refusals are not counted toward the GPRA measure, but should still be documented.**	**Standard PCC documentation for tests performed at the facility, Ask and** *record historical information* on PCC: Date received Location Results **Current tobacco users are defined by having any of the following documented prior to the report period:** Last documented Tobacco Health Factor Last documented Tobacco related POV Last documented Tobacco related CPT **Health factors considered to be a tobacco user:** 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) **Tobacco Patient Education Codes:** Codes will contain "TO-", "-TO", "-SHS"	**Standard PCC data entry** **Tobacco Cessation PED - Topic** *Mnemonic **PED** enter* 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: **Tobacco Cessation PED - Diagnosis** *Mnemonic **PED** enter* 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)]**

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Cessation (cont)		**Prescribe Tobacco Cessation Aids:** Predefined Site-Populated Smoking Cessation Meds Meds containing: "Nicotine Patch" "Nicotine Polacrilex" "Nicotine Inhaler" "Nicotine Nasal Spray" **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."	Goal Comment: Provider's Narrative: **Tobacco Cessation Clinic** *Mnemonic **CL** enter* Clinic: **94** Was this an appointment or walk in?: **Tobacco Cessation Dental (ADA)** *Mnemonic **ADA** enter* Select V Dental Service Code: **1320** No. Of Units: Operative Site: **Tobacco Cessation CPT** *Mnemonic **CPT** enter* Enter CPT Code: **D1320, 99406, 99407, 4000F, G8402 or G8453** Quantity Modifier: Modifier 2: **Tobacco Cessation Medication** *Mnemonic **RX** enter* Select Medication: **[Enter Tobacco Cessation Prescribed Medication]** Outside Drug Name (Optional): **[Enter any additional name for the drug]** SIG

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Cessation (cont)			Quantity: Day Prescribed: Event Date&Time: Ordering Provider: **Historical Tobacco Cessation Medication** *Mnemonic **HRX** enter* 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** *Mnemonic **CPT** enter* Enter CPT Code: **4001F** Quantity Modifier: Modifier 2:

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

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		**Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen:** **Alcohol Screening Exam Code Result:** Positive **The patient may decline the screen or "Refuse to answer":** **Alcohol Screening Exam Code Result:** Refused **The provider is unable to conduct the screen:** **Alcohol Screening Exam Code Result:** Unable To Screen **Note: Provider should note the screening tool used was the SASQ at the** *Comment* **Mnemonic for the Exam code.** **All Providers: Use the CAGE questionnaire:** • **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?** **Tolerance: How many drinks does it take you to get high?** **Based on how many** *YES* **answers were received, document Health Factor on PCC:** HF–CAGE 0/4 (all No answers) HF–CAGE 1/4 HF–CAGE 2/4 HF–CAGE 3/4	Level/Severity: Provider: Quantity: **Alcohol Screening POV** *Mnemonic **PPV** enter* Purpose of Visit: **V11.3, V79.1** Provider Narrative: Modifier: Cause of DX: **Standard BHS data entry** Enter BHS problem code ***29.1 or narrative: "Screening for Alcoholism."** ***Note: BHS problem code 29.1 maps to ICD-9 V79.1 (Screening for Alcoholism).** **Alcohol Screening CPT** *Mnemonic **CPT** enter* Enter CPT Code: **99408, 99409, G0396, G0397, H0049, H0050** Quantity: Modifier: Modifier 2: **Alcohol-Related Diagnosis POV** *Mnemonic **PPV** enter* Purpose of Visit: **303.*, 305.0*, 291.*, 357.5*** Provider Narrative: Modifier: Cause of DX: **Alcohol-Related Diagnosis BHS POV data entry**

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		HF–CAGE 4/4 **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" **Alcohol-Related Patient Education Codes:** Codes will contain "AOD-", "-AOD", "CD-" **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 **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 (4) 4 or more times a week **How many drinks containing alcohol do you have on a typical day when you are drinking?** (0) 1 or 2 (1) 3 or 4	Enter BHS problem code **10, 27, 29** **Alcohol-Related Procedure** *Mnemonic **IOP** enter* Operation/Procedure: **94.46, 94.53, 94.61-94.63, 94.67-94.69** Provider Narrative: Operating Provider: Diagnosis: **[Enter appropriate DX]** **Alcohol-Related PED - Topic** *Mnemonic **PED** enter* Enter Education Topic: **[Enter Alcohol-Related 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: **Alcohol-Related PED - Diagnosis** *Mnemonic **PED** enter* Select ICD Diagnosis Code Number: **V11.3, V79.1, 303.*, 305.0*, 291.* or 357.5*** Category:

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		(2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more **How often do you have six or more drinks on one occasion?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily **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).** In men, a score of 4 or more is considered positive In women, a score of 3 or more is considered positive. **A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence.** **CRAFFT Measurements:** 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?	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: **Alcohol Screen AUDIT Measurement** *Mnemonic **AUDT** enter* Value: **[Enter 0-40]** Select Qualifier: Date/Time Vitals Taken: **Alcohol Screen AUDIT-C Measurement** *Mnemonic **AUDC** enter* Value: **[Enter 0-40]** Select Qualifier: Date/Time Vitals Taken: **Alcohol Screen CRAFFT Measurement** *Mnemonic **CRFT** enter* Value: **[Enter 0-6]** Select Qualifier: Date/Time Vitals Taken: **Unable to Perform Alcohol Screen** *Mnemonic **UAS** enter*

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		T–Have you gotten into TROUBLE while you were using alcohol or drugs? 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.	Patient Refusals For Service: **Exam** Exam Value: **35, ALC** Date Refused: Provider Who Documented: Comment:
Intimate Partner (Domestic) Violence Screening (IPV/DV)	**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)** **Note: Refusals are NOT counted toward the GPRA measure, but should be documented.**	**Standard PCC documentation for tests performed at the facility, Ask and** *record historical information* on PCC: Date received Location Results **Medical and Behavioral Health Providers:** **EXAM—IPV/DV Screening** **Negative** – Denies being a current or past victim of IPV/DV **Past** – Denies being a current victim, but discloses being a past victim of IPV/DV **Present** – Discloses current IPV/DV **Present and Past** – Discloses past victimization and current IPV/DV victimization **Refused** – Patient declined exam/screen **Unable to screen** – Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.) **IPV/DV Patient Education Codes:** Codes will contain "DV-" or "-DV"	**Standard PCC data entry** **IPV/DV Screening Exam** *Mnemonic* ***EX*** *enter* Select Exam: **34, INT** Result: A–Abnormal N–Normal/Negative PR–Resent PAP–Present and Past PA–Past PO–Positive Comments: Provider Performing Exam: **Historical IPV/DV Screen Exam** *Mnemonic* ***HEX*** *enter* Date of Historical Exam: Type: Location Name: Exam Type: **34, INT** Result: Comments: Encounter Provider: **Standard BHS data entry** Enter BHS problem code **Narrative “IPV/DV exam”**

Performance Measure	Standard	Provider Documentation	Data Entry
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont)			**IPV/DV Diagnosis POV** *Mnemonic **PPV** enter* 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: **IPV/DV Diagnosis BHS POV data entry** Enter BHS problem code **43.*, 44.*** **IPV/DV–Topic** *Mnemonic **PED** enter* 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: **IPV/DV PED–Diagnosis** *Mnemonic **PED** enter* Select ICD Diagnosis Code Number: **995.80-83, 995.85, V15.41, V15.42, V15.49**

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

Performance Measure	Standard	Provider Documentation	Data Entry
Depression Screening (cont)		Mood Disorder Due to a General Medical Condition Substance-induced Mood Disorder Mood Disorder NOS **Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).** ***Patient Health Questionnaire (PHQ-2 Scaled Version)*** **Over the past 2 weeks, how often have you been bothered by any of the following problems?** **Little interest or pleasure in doing things** 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 **Feeling down, depressed, or hopeless** 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 *PHQ-2 Scaled Version (cont'd)* **Total Possible PHQ-2 Score: Range: 0-6** **0-2: Negative Depression Screening Exam:** **Code Result:** Normal or Negative **3-6: Positive; further evaluation indicated Depression Screening Exam** **Code Result:** Abnormal or Positive **The patient may decline the screen or "Refuse to answer" Depression Screening Exam** **Code Result:** Refused	**Depression Screening CPT** *Mnemonic **CPT** enter* Enter CPT: **1220F** Quantity: Modifier: Modifier 2: **Standard BHS POV data entry** Enter BHS problem code ***14.1 or narrative: "Screening for Depression."** ***Note: BHS problem code 14.1 maps to ICD-9 V79.0 (Special Screening for Mental Disorders and Developmental Handicaps, Depression).** **Unable to Screen for Depression** *Mnemonic **UAS** enter* Patient Refusals For Service: **Exam** Exam Value: **36, DEP** Date Refused: Provider Who Documented: Comment: **Mood Disorder Diagnosis POV** *Mnemonic **PPV** enter* Purpose of Visit: **296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311** Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	Data Entry
Depression Screening (cont)		**The provider is unable to conduct the Screen Depression Screening Exam** **Code Result:** Unable To Screen **Provider should note the screening tool used was the PHQ-2 Scaled at the** *Comment* **Mnemonic for the Exam Code.** ***PHQ9 Questionnaire Screening Tool*** **Little interest or pleasure in doing things?** 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 **Feeling down, depressed, or hopeless?** 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 **Trouble falling or staying asleep, or sleeping too much?** 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 **Feeling tired or having little energy?** 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	**Standard BHS Mood Disorder POV data entry** **Enter BHS problem code: 14, 15**

Performance Measure	Standard	Provider Documentation	Data Entry
Depression Screening (cont)		**Poor appetite or overeating?** 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 **Feeling bad about yourself—or that you are a failure or have let yourself or your family down?** 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 **Trouble concentrating on things, such as reading the newspaper or watching television?** 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 **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?** 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
Depression Screening (cont)		**Thoughts that you would be better off dead, or of hurting yourself in some way?** 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 ***PHQ9 Questionnaire (Cont'd)*** **Total Possible PHQ-2 Score: Range: 0-27** **0-4 Negative/None Depression Screening Exam:** **Code Result:** None **5-9 Mild Depression Screening Exam:** **Code Result:** Mild depression **10-14 Moderate Depression Screening Exam:** **Code Result:** Moderate depression **15-19 Moderately Severe Depression Screening Exam:** **Code Result:** Moderately Severe depression **20-27 Severe Depression Screening Exam:** **Code Result:** Severe depression **Provider should note the screening tool used was the PHQ9 Scaled at the** *Comment* **Mnemonic for the Exam Code.**	

Performance Measure	Standard	Provider Documentation	Data Entry
Obesity Assessment (Calculate BMI [Body Mass Index]) **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.**	**Children (through age 18) must have both height and weight taken *on the same day* at least annually (at every visit is recommended).** **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.**	**Standard PCC documentation Obtain Height and Weight during visit** *and record information* on PCC: Height Weight Date Recorded **BMI is calculated using NHANES II.** **Obese is defined as:** BMI of 30 or more for adults 19 and older. For ages 2-18, definitions based on standard tables. **To document Refusals on PCC:** Use the ***REF*** Mnemonic Refusals include: REF (refused) NMI (not medically indicated) UAS (unable to screen) and must be documented during the past year. **For ages 18 and under, both the height and weight must be refused on the same visit at any time during the past year.** **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.** 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.	**Standard PCC data entry:** **Height Measurement** *Mnemonic **HT** enter* Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken: **Weight Measurement** *Mnemonic **WT** enter* Value: Select Qualifier: Actual Bed Chair Dry Estimated Standing Date/Time Vitals Taken: **Historical Height and Weight Measurement (May be used for ages 19 and older)** *Mnemonic **HMSR** enter* Enter Date Historical Measurement: Type: Location: Select Measurement: **HT, WT** Value: **Refusal of Height** *Mnemonic **REF** enter* **Patient Refusals For Service:**

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

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Weight Control	**Patients ages 2-5 at the beginning of the report period whose BMI could be calculated and have a BMI => 95%.** **Height and weight taken on the same day.** **Patients that turn 6 years old during the report period are not included in the GPRA measure.**	**Standard PCC documentation Obtain Height and Weight during visit** *and record information* on PCC: Height Weight Date Recorded **BMI is calculated using NHANES II** **Age in the age groups is calculated based on the date of the most current BMI found.** 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. 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). 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.	**Standard PCC data entry** **Height Measurement** *Mnemonic **HT** enter* Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken: **Weight Measurement** *Mnemonic **WT** enter* Value: Select Qualifier: Actual Bed Chair Dry Estimated Standing Date/Time Vitals Taken:

<table>
<tr><th>Performance Measure</th><th>Standard</th><th>Provider Documentation</th><th>Data Entry</th></tr>
<tr><td>Childhood Weight Control (cont)</td><td></td><td>
<table>
<tr><th>Low-High</th><th></th><th>BMI >= 85</th><th>BMI >= 95</th><th colspan="2">Data Check Limits</th></tr>
<tr><td>Ages</td><td>Sex</td><td>Over Weight</td><td>Obese</td><td>BMI ></td><td>BMI <</td></tr>
<tr><td>2-2</td><td>M
F</td><td>17.7
17.5</td><td>18.7
18.6</td><td>36.8
37.0</td><td>7.2
7.1</td></tr>
<tr><td>3-3</td><td>M
F</td><td>17.1
17.0</td><td>18.0
18.1</td><td>35.6
35.4</td><td>7.1
6.8</td></tr>
<tr><td>4-4</td><td>M
F</td><td>16.8
16.7</td><td>17.8
18.1</td><td>36.2
36.0</td><td>7.0
6.9</td></tr>
<tr><td>5-5</td><td>M
F</td><td>16.9
16.9</td><td>18.1
18.5</td><td>36.0
39.2</td><td>6.9
6.8</td></tr>
</table>
</td><td></td></tr>
<tr><td>Comprehensive CVD-Related Assessment</td><td>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:
• Blood Pressure
• LDL Assessment
• Tobacco Use Assessment
• BMI Calculated
• Lifestyle Counseling
Note: This does NOT include depression screening and does NOT include refusals of BMI.</td><td>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:
Date received
Location
Results
Note: See related individual measures above for recording historical information.
Blood Pressure Control
LDL Assessment
Tobacco Use and Assessment
BMI (Obesity)
Tobacco Use Health Factors:
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)</td><td>Standard PCC data entry
IHD Diagnosis POV (Prior to the report period)
Mnemonic PPV enter
Purpose of Visit: 410.0-412.*, 414.0-414.9, 428.* 429.2
Provider Narrative:
Modifier:
Cause of DX:
Blood Pressure Data Entry
Mnemonic BP enter
Value: [Enter as Systolic/Diastolic (e.g., 130/80)]
Select Qualifier:
Date/Time Vitals Taken:
LDL (Calculated) (REF)* Lab Test
Mnemonic LAB enter
Enter Lab Test Type: LDL
Results:
Units:</td></tr>
</table>

Performance Measure	Standard	Provider Documentation	Data Entry
Comprehensive CVD-Related Assessment (cont)	**Note: Refusals of any or all of the above are not counted toward the GPRA measure, but should still be documented.**	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 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"** **Tobacco Patient Education Codes:** Codes will contain "TO-", "-TO", "-SHS" **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. **Nutrition, dietary surveillance and counseling Patient Education Codes:** Codes will contain "-N" (Nutrition) or "-MNT" **Exercise Patient Education Codes:** Codes will contain "-EX" **Lifestyle Patient Education Codes:** Codes will contain "-LA" **Other Related Nutrition and Exercise Patient Educations Codes:** Codes will contain "-OBS" (Obesity) **Lifestyle Counseling includes:** Lifestyle adaptation counseling Medical nutrition therapy Nutrition counseling Exercise counseling	Abnormal: **Site: [Blood, Serum]** ***REF – Reference Lab** **LDL (Calculated) Lab Test** *Mnemonic **LAB** enter* Enter Lab Test Type: **LDL** Results: Units: Abnormal: Site: **[Blood]** **LDL CPT** *Mnemonic **CPT** enter* Enter CPT Code: **80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F** Quantity : Modifier: Modifier 2: **Tobacco Use Assessment** *Mnemonic **HF** enter* Select V Health Factor: **[Enter HF (See the Provider Documentation column)]** Level/Severity: Provider: Quantity: **Tobacco Use Dental (ADA)** *Mnemonic **ADA** enter* Select V Dental Service Code: **1320** No. Of Units: Operative Site:

Performance Measure	Standard	Provider Documentation	Data Entry
Comprehensive CVD-Related Assessment (cont)		Other lifestyle education	**Tobacco Screening CPT** *Mnemonic* **CPT** *enter* Enter CPT Code: **D1320, 99406, 99407, 1034F, 1035F, 1036F, 1000, G8455, G8456, G8457, G8402, G8453** Quantity Modifier: Modifier 2: **Tobacco Related Diagnoses POV** *Mnemonic **PPV** enter* Purpose of Visit: **305.1, 649.00-649.04, V15.82** Provider Narrative: Modifier: Cause of DX: **Tobacco Screening PED - Topic** *Mnemonic **PED** enter* 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:

Performance Measure	Standard	Provider Documentation	Data Entry
Comprehensive CVD-Related Assessment (cont)			**Tobacco Screening PED - Diagnosis** *Mnemonic **PED** enter* 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: **BMI Data Entry** **Height Measurement** *Mnemonic **HT** enter* Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken: **Weight Measurement** *Mnemonic **WT** enter* Value: Select Qualifier: Actual Bed

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** *Mnemonic **CPT** enter* Enter CPT Code: **97802-97804, G0270, G0271** Quantity: Modifier: Modifier 2: **Medical Nutrition Therapy Clinic** *Mnemonic **CL** enter* Clinic: **67, 36** Was this an appointment or walk in?: **Nutrition Education POV** *Mnemonic **PPV** enter* Purpose of Visit: **V65.3** Provider Narrative: Modifier: Cause of DX: **Nutrition/Exercise/Lifestyle Adaption PED - Topic** *Mnemonic **PED** enter* 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** *Mnemonic **PED** enter* 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
HIV Screening	**Pregnant women should be tested for HIV at least on their first visit; education and follow-up provided as appropriate.** **Note: Refusals are not counted toward the GPRA measure, but should still be documented.**	**Standard PCC documentation for tests performed at the facility, Ask and** *record historical information* on PCC: Date received Location Results **NOTE: The timeframe for screening for the pregnant patients denominator is anytime during the past 20 months.** **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.**	**Standard PCC data entry** **HIV Screen CPT** *Mnemonic **CPT** enter* Enter CPT Code: **86689, 86701-86703, 87390, 87391, 87534-87539** Quantity: Modifier: Modifier 2: **HIV Diagnoses POV** *Mnemonic **PPV** enter* Purpose of Visit: **042, 079.53, V08, 795.71** Provider Narrative: Modifier: Cause of DX: **HIV Lab Test** *Mnemonic **LAB** enter* 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]** **Historical HIV Screen** *Mnemonic **HLAB** enter* Date of Historical Lab Test: Type: Location Name: Enter Lab Test:

<table>
<tr><th>Performance Measure</th><th>Standard</th><th>Provider Documentation</th><th>Data Entry</th></tr>
<tr><td>HIV Screening (cont)</td><td></td><td></td><td>Results:</td></tr>
<tr><td>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.</td><td>All providers should assess the feeding practices of all newborns through age 1 year at all well-child visits.</td><td>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.

<table>
<tr><th colspan="4">Feeding Choice (today) X</th></tr>
<tr><td colspan="3">Exclusive Breastfeeding</td><td></td></tr>
<tr><td colspan="3">Mostly Breastfeeding</td><td></td></tr>
<tr><td colspan="3">½ Breastfeeding
½ Formula feeding</td><td></td></tr>
<tr><td colspan="3">Mostly Formula feeding</td><td></td></tr>
<tr><td colspan="3">Formula only feeding</td><td></td></tr>
<tr><th colspan="4">One time data fields</th></tr>
<tr><td colspan="4">Mom’s name
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>

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.)
½ Breastfeeding, ½ 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</td><td>Standard PCC data entry

Infant Breastfeeding
Mnemonic IF enter
Enter Feeding Choice:
1 Exclusive Breastfeeding
2 Mostly Breastfeeding
3 1/2 & 1/2 Breast and Formula
4 Mostly Formula
5 Formula Only</td></tr>
</table>

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**	*All providers should document all 5 patient education elements and elements #6-7 below if a goal was set for the patient:* 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:** Distraction Eager To Learn Intoxication Not Ready Pain Receptive Severity of Illness Unreceptive	**Standard PCC data entry** **Patient Education Topic** *Mnemonic **PED** enter* 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** *Mnemonic **PED** enter* 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
Patient Education Measures (Patient Education Report) (cont)		**Levels of Understanding:** P–Poor F–Fair G–Good GR–Group-No Assessment R–Refused **Goal codes:** GS–Goal Set GM–Goal Met GNM–Goal Not Met GNS–Goal Not Set **An example of how this would look on the PCC form for Topic is:** **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 **Diagnosis Categories:** Anatomy and Physiology Complications Disease Process Equipment Exercise	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
Patient Education Measures (Patient Education Report) (cont)		Follow-up Home Management Hygiene Lifestyle Adaptation Literature Medical Nutrition Therapy Medications Nutrition Prevention Procedures Safety Tests Treatment **An example of how this would look on the PCC form for Diagnosis is:** **V65.3-N-E-G-DU-15 MIN-GS-Patient will eat more fruits and vegetables and less sugar:** 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	

KEY CLINICAL PERFORMANCE OBJECTIVES

“Cheat Sheet” for EHR 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 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/crsv12/GPRA%20PART%20Measures%20V12.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: • **> 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
Diabetes: Glycemic Control (cont)			CPT Visit Services Entry **(includes historical CPTs)** **Enter CPT: 83036, 83037, 3044F-3046F** **Quantity:** **Modifier:** Modifier 2:
Diabetes: Blood Pressure Control	Active Clinical Patients DX with diabetes and with controlled blood pressure: • **< 130/80 (mean systolic < 130, mean diastolic < 80)**	**Standard EHR documentation for tests performed at the facility. Ask about off-site tests and *record historical information* in EHR:** Date received Location Results	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:**
Diabetes: LDL Assessment	Active Clinical Patients DX with diabetes and a completed LDL test.	**Standard EHR documentation for tests performed at the facility. Ask about off-site tests *and record historical information* in EHR:** Date received Location Results	LDL (Calculated) Lab Test **Lab Test Entry** **Enter Lab Test Type:** [Enter site's defined LDL Lab Test] **Collect Sample/Specimen:** [Blood] **Clinical Indication:** LDL CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F** **Quantity:** **Modifier:** **Modifier 2:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Nephropathy Assessment	Active Clinical Patients DX with diabetes with a Nephropathy assessment: • **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:** Date received Location Results	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, 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:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Nephropathy Assessment (cont)			ESRD POV **Visit Diagnosis Entry** **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)]**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetic Retinopathy	Patients with diabetes will have a qualified* retinal examination during the report period. *Qualified retinal exam: The following methods are qualifying for this measure: • **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).** Note: Refusals are not counted toward the GPRA measure, but should still be documented.	**Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:** Date received Location Results Exams: Diabetic Retinal Exam Dilated retinal eye exam Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos Routine ophthalmological examination including refraction (new or existing patient) Diabetic indicator; retinal eye exam, dilated, bilateral Other Eye Exams Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or validated tele-ophthalmology retinal evaluation clinics Non-DNKA visits to an optometrist or ophthalmologist	Diabetic Retinopathy Exam Exam Entry **(includes historical exams)** **Select Exam: 03** **Result: [Enter Results]** **Comments:** **Provider Performing Exam:** Retinal Exam CPT Visit Services Entry **(includes historical CPTs)** **Enter CPT: 2022F, 2024F, 2026F, S0620, S0621, S3000** **Quantity:** **Modifier:** **Modifier 2:** Other Eye Exam CPT Visit Services Entry **(includes historical CPTs)** **Enter CPT: 67028, 67038, 67039, 67040, 92002, 92004, 92012, 92014** **Quantity:** **Modifier:** **Modifier 2:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetic Retinopathy (cont)			Other Eye Exam POV **Visit Diagnosis Entry** **Purpose of Visit: V72.0** **Provider Narrative:** **Modifier:** **Cause of DX:** Other Eye Exam Procedure **Procedure Entry** **Operation/Procedure: 95.02** **Provider Narrative:** **Operating Provider:** **Diagnosis: [Enter appropriate DX]** Other Eye Exam Clinic **Clinic Entry** Clinic: **A2, 17, 18, 64**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Access to Dental Service	Patients should have annual dental exams. Note: Refusals are not counted toward the GPRA measure, but should still be documented.	**Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:** Date received Location Results	Dental Exam **Exam Entry (includes historical exams)** **Select Exam: 30** **Result: [Enter Results]** **Comments:** **Provider Performing Exam:** Dental Exam (ADA code) *ADA codes cannot be entered into EHR.* Dental Exam POV **Visit Diagnosis Entry** **Purpose of Visit: V72.2** **Provider Narrative:** **Modifier:** **Cause of DX:**
Dental Sealants	A maximum of two sealants per tooth are counted toward the GPRA measure. Note: Refusals are not counted toward the GPRA measure, but should still be documented.	**Standard EHR documentation for tests performed at the facility, ask about off-site *tests and record historical information* in EHR:** Date received Location Results	Dental Sealants (ADA) *ADA codes cannot be entered into EHR.* Dental Sealants CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT: D1351** **Quantity:** **Modifier:** **Modifier 2:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Topical Fluoride	A maximum of four topical fluoride application are counted toward the GPRA measure. Note: Refusals are not counted toward the GPRA measure, but should still be documented.	**Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:** Date received Location Results	Topical Fluoride (ADA code) *ADA codes cannot be entered into EHR.* Topical Flouride CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT: D1203, D1204, D1206, D5986** **Quantity:** **Modifier:** **Modifier 2:** Topical Flouride POV **Visit Diagnosis Entry** **Purpose of Visit: V07.31** **Provider Narrative:** **Modifier:** **Cause of DX:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Adult Immunizations: Influenza	All adults ages 65 and older should have an annual influenza (flu) shot. Adults 55-64 are strongly recommended to have annual influenza (flu) shot. All adult (18 and older) diabetic patients are strongly recommended to have annual influenza (flu) shot. Refusals should be documented. Note: Only Not Medically Indicated (NMI) refusals are counted toward the GPRA Measure.	**Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:** IZ type Date received Location Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include: Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal	Influenza Vaccine **Immunization Entry (includes historical immunizations)** **Select Immunization Name: 140, 141 or 144 (other options are 111, 15, 16, 88)** **Lot:** **VFC Eligibility:** Influenza Vaccine POV **Visit Diagnosis Entry** **Purpose of Visit: *V04.81, *V06.6** **Provider Narrative:** **Modifier:** **Cause of DX:** *** NOT documented with 90663, 90664, 90666-90668, 90470, G9141, G9142** Influenza Vaccine CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT: 90654-90662, G0008, G8108** **Quantity:** **Modifier:** **Modifier 2:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Adult Immunizations: Influenza (cont)			Influenza Procedure **Procedure Entry** **Operation/Procedure: 99.52** **Provider Narrative:** **Operating Provider:** **Diagnosis: [Enter appropriate DX]** NMI Refusal of Influenza *NMI Refusals can only be entered in EHR via Reminder Dialogs.* Contraindication Influenza **Immunization Entry - Contraindications** **Vaccine:** [See codes above] Reason: **Egg Allergy, Anaphylaxis**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Adult Immunizations: Pneumovax	All adults ages 65 and older will have a pneumovax. All adult (18 and older) diabetic patients are strongly recommended to have a pneumovax. Refusals should be documented. Note: Only NMI refusals are counted toward the GPRA Measure.	**Standard EHR documentation for immunizations performed at the facility. Ask about off-site *tests and record historical information* in EHR:** IZ type Date received Location Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include: Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal	Pneumovax Vaccine **Immunization Entry (includes historical immunizations)** **Select Immunization Name:** 33, 100, 109, 133 **Lot:** **VFC Eligibility:** Pneumovax Vaccine POV **Visit Diagnosis Entry** **Purpose of Visit: V06.6, V03.82** **Provider Narrative:** **Modifier:** **Cause of DX:** Pneumovax Vaccine CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT: 90669, 90670, 90732, G0009, G8115** **Quantity:** **Modifier:** **Modifier 2:** Pneumovax Procedure **Procedure Entry** **Operation/Procedure: 99.55** **Provider Narrative:** **Operating Provider:** **Diagnosis: [Enter appropriate DX]**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Adult Immunizations: Pneumovax			NMI Refusal of Pneumovax *NMI Refusals can only be entered in EHR via Reminder Dialogs.* Contraindication Pneumovax **Immunization Entry - Contraindications** **Vaccine:** [See codes above] Reason: **Egg Allergy, Anaphylaxis**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations	Children age 19–35 months will be up-to-date for all ACIP recommended immunizations. This is the 4313314 combo: 4 DTaP 3 IPV 1 MMR 3 Hepatitis B 3 Hib 1 Varicella 4 Pneumococcal Refusals should be documented. Note: Only NMI refusals are counted toward the GPRA Measure.	**Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:** IZ type Date received Location **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** 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: IPV: Immunization Package: "Neomycin Allergy." MMR: Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy." Varicella: Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."	Childhood Immunizations **Immunization Entry (includes historical immunizations)** **Select Immunization Name:** ***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** **Lot:** **VFC Eligibility:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations (cont)		Dosage and types of immunization definitions: Four doses of DTaP: 4 DTaP/DTP/Tdap 1 DTaP/DTP/Tdap and 3 DT/Td 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus 4 DT and 4 Acellular Pertussis 4 Td and 4 Acellular Pertussis 4 each of Diphtheria, Tetanus, and Acellular Pertussis Three doses of IPV: 3 OPV 3 IPV Combination of OPV and IPV totaling three doses One dose of MMR: MMR 1 M/R and 1 Mumps 1 R/M and 1 Measles 1 each of Measles, Mumps, and Rubella Three doses of Hepatitis B 3 doses of Hep B Three doses of HIB One dose of Varicella	Childhood Immunizations POV Visit Diagnosis Entry **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, 203.8, 204-208** **Provider Narrative:** **Modifier:** **Cause of DX:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations (cont)		**IMPORTANT NOTE:** **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 GPRA communities will not be affected.**	Childhood Immunizations CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT: *DTaP:* 90696, 90698, 90700, 90721, 90723; *DTP:* 90701, 90720; *Tdap:* 90715; *DT:* 90702; *Td:* 90714, 90718; *Diphtheria:* 90719; *Tetanus:* 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:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations (cont)			Childhood Immunizations Procedure **Procedure Entry** **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]** NMI Refusal of Childhood Immunizations *NMI Refusals can only be entered in EHR via Reminder Dialogs.* Contraindication Childhood Immunizations **Immunization Entry - Contraindications** **Vaccine:** [See codes above] Reason: **[See Contraindications section under the Provider Documentation column]**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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 EHR documentation for tests performed at the facility. Ask about off-site tests and *record historical information* in EHR:** Date received Location Results	Pap Smear V Lab **Lab Test Entry** **Enter Lab Test Type:** [Enter site's defined Pap Smear Lab Test] **Clinical Indication:** Pap Smear POV **Visit Diagnosis Entry** **Purpose of Visit: V67.01, V76.2, V72.32, V72.3, V76.47, 795.0*, 795.10-16, 795.19** **Provider Narrative:** **Modifier:** **Cause of DX:** 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:** Pap Smear Procedure **Procedure Entry** **Operation/Procedure: 91.46** **Provider Narrative:** **Operating Provider:** **Diagnosis: [Enter appropriate DX]**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Cancer Screening: Mammogram Rates	Women ages 52–64 should have a mammogram every 2 years Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.	**Standard EHR documentation for Radiology performed at the facility. Ask and *record historical information* in EHR:** Date received Location Results Telephone visit with patient Verbal or written lab report Patient's next visit	Mammogram POV **Visit Diagnosis Entry** **Purpose of Visit: V76.11, V76.12, 793.80, 793.81, 793.89** **Provider Narrative:** **Modifier:** **Cause of DX:** Mammogram CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT: 77053-77059, G0206; G0204, G0202** **Quantity:** **Modifier:** **Modifier 2:** Mammogram Procedure **Procedure Entry** **Operation/Procedure: 87.36, 87.37** **Provider Narrative:** **Operating Provider:** **Diagnosis: [Enter appropriate DX]**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening	Adults ages 50–75 should be screened for CRC (USPTF). For GPRA, IHS counts any of the following: • **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.** Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.	Standard EHR documentation for procedures performed at the facility (Radiology, Lab, provider). Guaiac cards returned by patients to providers should be sent to Lab for processing. Ask and *record historical information* in EHR: Date received Location Results Telephone visit with patient Verbal or written lab report Patient's next visit	Colorectal Cancer POV **Visit Diagnosis Entry** **Purpose of Visit: 153.*, 154.0, 154.1, 197.5, V10.05** **Provider Narrative:** **Modifier:** **Cause of DX:** Colorectal Cancer CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT: G0213-G0215, G0231** **Quantity:** **Modifier:** **Modifier 2:** Total Colectomy CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT: 44150-44151, 44155-44158, 44210-44212** **Quantity:** **Modifier:** **Modifier 2:**

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

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening (cont)			DBE CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT: 74280, G0106, G0120** **Quantity:** **Modifier:** **Modifier 2:** Colonoscopy POV **Visit Diagnosis Entry** **Purpose of Visit: V76.51** **Provider Narrative:** **Modifier:** **Cause of DX:** 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:** 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]**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Use and Exposure Assessment NOTE: This is not a GPRA measure; however, it will be used for reducing the incidence of Tobacco Use.	**Ask all patients age five and over about tobacco use *at least annually*.**	**Standard EHR documentation for tests performed at the facility, ask and *record historical information* in EHR:** Date received Location Results Document on designated Health Factors section of form: 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 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" Tobacco Patient Education Codes: Codes will contain "TO-", "-TO", "-SHS"	Tobacco Screening Health Factor **Health Factor Entry** **Select V Health Factor: [Enter HF (See the Provider Documentation column)]** **Level/Severity:** **Provider:** **Quantity:** 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:** **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:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Use and Exposure Assessment (cont)		**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."	Tobacco Users Health Factor **Health Factor Entry** **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 **Health Factor Entry** **Select V Health Factor: Current Smoker (every day, some day, or status unknown), or Cessation-Smoker** **Level/Severity:** **Provider:** **Quantity:** Smokeless Health Factor **Health Factor Entry** **Select V Health Factor: Current Smokeless or Cessation-Smokeless** **Level/Severity:** **Provider:** **Quantity:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Use and Exposure Assessment (cont)			ETS Health Factor **Health Factor Entry** **Select V Health Factor: Exp to ETS** **Level/Severity:** **Provider:** **Quantity:**
Tobacco Cessation	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. Note: Refusals are not counted toward the GPRA measure, but should still be documented.	**Standard EHR documentation for tests performed at the facility. Ask and *record historical information* in EHR:** Date received Location Results Current tobacco users are defined by having any of the following documented prior to the report period: Last documented Tobacco Health Factor Last documented Tobacco related POV Last documented Tobacco related CPT Health factors considered to be a tobacco user: 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) Tobacco Patient Education Codes: Codes will contain "TO-", "-TO", "-SHS"	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:** **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:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Cessation (cont)		Prescribe Tobacco Cessation Aids: Predefined Site-Populated Smoking Cessation Meds Meds containing: "Nicotine Patch" "Nicotine Polacrilex" "Nicotine Inhaler" "Nicotine Nasal Spray" 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 Smokeless."	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:** Tobacco Cessation PED - CPT ***Mnemonic PED enter*** **Select CPT Code Number: D1320, 99406, 99407, G0375 (old code), G0376 (old code), 4000F, G8402 or G8453** **Category:** **Readiness to Learn:** **Level of Understanding:** **Provider:** **Length of Educ (Minutes):** **Comment**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Cessation (cont)			**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:** Tobacco Cessation Clinic **Clinic Entry** **Clinic: 94** Tobacco Cessation Dental (ADA) *ADA codes cannot be entered into EHR.* Tobacco Cessation CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT Code: D1320, 99406, 99407, 4000F, G8402 or G8453** **Quantity** **Modifier:** **Modifier 2:** 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:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Cessation (cont)			Tobacco Cessation Prescription CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT Code: 4001F** **Quantity** **Modifier:** **Modifier 2:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (FAS Prevention)	Pregnant women should be screened for alcohol use at least on their first visit; education and follow-up provided as appropriate. Women of childbearing age should be screened at least annually. Note: Refusals are not counted toward the GPRA measure, but should still be documented.	**Standard EHR documentation for tests performed at the facility. Ask and *record historical information* in EHR:** Date received Location Results Alcohol screening may be documented with either an exam code or the CAGE health factor in EHR. Medical Providers: EXAM—Alcohol Screening **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 Note: Recommended Brief Screening Tool: SASQ (below). Single Alcohol Screening Question (SASQ) For Women: When was the last time you had more than 4 drinks in one day? For Men: When was the last time you had more than 5 drinks in one day?	Alcohol Screening Exam **Exam Entry (includes historical exams)** **Select Exam: 35, ALC** **Result:** **A–Abnormal** **N–Normal/Negative** **PR–Resent** **PAP–Present and Past** **PA–Past** **PO–Positive** **Comments: SASQ** **Provider Performing Exam:** Cage Health Factor **Health Factor Entry** **Select Health Factor: CAGE** **1 CAGE 0/4 (all No answers)** **2 CAGE 1/4** **3 CAGE 2/4** **4 CAGE 3/4** **5 CAGE 4/4** **Choose 1-5: [Number from above]** **Level/Severity:** **Provider:** **Quantity:** Alcohol Screening POV **Visit Diagnosis Entry** **Purpose of Visit: V11.3, V79.1** **Provider Narrative:** **Modifier:** **Cause of DX:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (FAS Prevention) (cont)		Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen: **Alcohol Screening Exam Code Result: Positive** The patient may decline the screen or "Refuse to answer": **Alcohol Screening Exam Code Result:** Refused The provider is unable to conduct the screen: **Alcohol Screening Exam Code Result:** Unable To Screen **Note: Provider should note the screening tool used was the SASQ at the** *Comment* **Mnemonic for the Exam code.** All Providers: Use the CAGE questionnaire: 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? Tolerance: How many drinks does it take you to get high?	Alcohol Screening CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT Code: 99408, 99409, G0396, G0397, H0049, H0050** **Quantity** **Modifier:** **Modifier 2:** Alcohol-Related Diagnosis POV **Visit Diagnosis Entry** **Purpose of Visit: 303.*, 305.0*, 291.*, 357.5*** **Provider Narrative:** **Modifier:** **Cause of DX:** 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]** Alcohol-Related PED - Topic **Patient Education Entry (includes historical patient education)** **Enter Education Topic: [Enter Alcohol-Related Education Code (See the Provider Documentation column)]**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (FAS Prevention) (cont)		**Based on how many *YES* answers were received, document Health Factor in EHR:** HF–CAGE 0/4 (all No answers) HF–CAGE 1/4 HF–CAGE 2/4 HF–CAGE 3/4 HF–CAGE 4/4 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" Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-" 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	**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:** 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:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (FAS Prevention) (cont)		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 (4) 4 or more times a week How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	Alcohol-Related PED - CPT **Patient Education Entry** **(includes historical patient education)** **Select CPT Code Number: 99408, 99409, G0396, G0397, H0049, or H0050** **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:** Alcohol Screen AUDIT Measurement **Vital Measurements Entry** **(includes historical Vitals)** **Value: [Enter 0-40]** **Select Qualifier:** **Date/Time Vitals Taken:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (FAS Prevention) (cont)		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). In men, a score of 4 or more is considered positive In women, a score of 3 or more is considered positive. A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence. CRAFFT Measurements: 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? T–Have you gotten into TROUBLE while you were using alcohol or drugs? **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.**	Alcohol Screen AUDIT-C Measurement **Vital Measurements Entry** **(includes historical Vitals)** **Value: [Enter 0-40]** **Select Qualifier:** **Date/Time Vitals Taken:** Alcohol Screen CRAFFT Measurement **Vital Measurements Entry** **(includes historical Vitals)** **Value: [Enter 0-6]** **Select Qualifier:** **Date/Time Vitals Taken:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Intimate Partner (Domestic) Violence Screening (IPV/DV)	**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) Note: Refusals are NOT counted toward the GPRA measure, but should be documented.	**Standard EHR documentation for tests performed at the facility, ask and *record historical information* in EHR:** Date received Location Results Medical and Behavioral Health Providers: EXAM—IPV/DV Screening **Negative**–Denies being a current or past victim of IPV/DV **Past**–Denies being a current victim, but discloses being a past victim of IPV/DV **Present**–Discloses current IPV/DV **Present and Past**–Discloses past victimization and current IPV/DV victimization **Refused**–Patient declined exam/screen **Unable to screen**–Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.) IPV/DV Patient Education Codes: Codes will contain "DV-" or "-DV"	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:** IPV/DV Diagnosis POV **Visit Diagnosis Entry** **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:** 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:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont)			**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:** 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:** **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	How to Enter Data in EHR
Depression Screening	**Adult patients 18 years of age and older should be screened for depression *at least annually.*** (Source: United States Preventive Services Task Force) Note: Refusals are NOT counted toward the GPRA measure, but should be documented.	**Standard EHR documentation for tests performed at the facility.Aask and *record historical information* in EHR:** Date received Location Results Medical Providers: EXAM—Depression Screening **Normal/Negative**–Denies symptoms of depression Abnormal/Positive–Further evaluation indicated **Refused**–Patient declined exam/screen Unable to screen–Provider unable to screen Note: Refusals are ***not*** counted toward the GPRA measure, but should be documented. Mood Disorders: Two or more visits with POV related to: Major Depressive Disorder Dysthymic Disorder Depressive Disorder NOS Bipolar I or II Disorder Cyclothymic Disorder Bipolar Disorder NOS Mood Disorder Due to a General Medical Condition Substance-induced Mood Disorder Mood Disorder NOS Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).	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:** Depression Screen Diagnosis POV **Visit Diagnosis Entry** **Purpose of Visit: V79.0** **Provider Narrative:** **Modifier:** **Cause of DX:** Depression Screening CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT Code: 1220F** **Quantity** **Modifier:** **Modifier 2:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont)		Patient Health Questionnaire (PHQ-2 Scaled Version) Over the past 2 weeks, how often have you been bothered by any of the following problems? Little interest or pleasure in doing things 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 Feeling down, depressed, or hopeless 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 PHQ-2 Scaled Version (continued) Total Possible PHQ-2 Score: Range: 0-6 0-2: Negative **Depression Screening Exam:** Code Result: Normal or Negative 3-6: Positive; further evaluation indicated Depression Screening Exam Code Result: Abnormal or Positive The patient may decline the screen or "Refuse to answer" Depression Screening Exam Code Result: Refused The provider is unable to conduct the Screen Depression Screening Exam **Code Result:** Unable To Screen	Mood Disorder Diagnosis POV **Visit Diagnosis Entry** **Purpose of Visit: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311** **Provider Narrative:** **Modifier:** **Cause of DX:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont)		**Provider should note the screening tool used was the PHQ-2 Scaled at the *Comment* Mnemonic for the Exam Code.** PHQ9 Questionnaire Screening Tool Little interest or pleasure in doing things? 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 Feeling down, depressed, or hopeless? 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 Trouble falling or staying asleep, or sleeping too much? 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 Feeling tired or having little energy? 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	How to Enter Data in EHR
Depression Screening (cont)		Poor appetite or overeating? 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 Feeling bad about yourself—or that you are a failure or have let yourself or your family down? 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 Trouble concentrating on things, such as reading the newspaper or watching television? 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 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? 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	How to Enter Data in EHR
Depression Screening (cont)		Thoughts that you would be better off dead, or of hurting yourself in some way? 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 <u>PHQ9 Questionnaire (Continued)</u> Total Possible PHQ-2 Score: Range: 0–27 0-4 Negative/None Depression Screening Exam: **Code Result:** None 5-9 Mild Depression Screening Exam: **Code Result:** Mild depression 10-14 Moderate Depression Screening Exam: **Code Result:** Moderate depression 15-19 Moderately Severe Depression Screening Exam: **Code Result:** Moderately Severe depression 20-27 Severe Depression Screening Exam: **Code Result:** Severe depression **Provider should note the screening tool used was the PHQ9 Scaled at the *Comment* Mnemonic for the Exam Code.**	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Obesity Assessment (Calculate Body Mass Index [BMI]) 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.	Children (through age 18) must have both height and weight taken **on the same day** at least annually (at every visit is recommended). 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.	**Standard EHR documentation. Obtain height and weight during visit** *and record information* **in EHR:** Height Weight Date Recorded BMI is calculated using NHANES II. Obese is defined as: BMI of 30 or more for adults 19 and older. For ages 2–18, definitions based on standard tables. To document Refusals in EHR: **Refusal Entry in EHR** For ages 18 and under, both the height and weight must be refused on the same visit at any time during the past year. 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. 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.	Height Measurement **Vital Measurements Entry** **(includes historical Vitals)** **Value:** **Select Qualifier:** **Actual** **Estimated** **Date/Time Vitals Taken:** Weight Measurement **Vital Measurements Entry** **(includes historical Vitals)** **Value:** **Select Qualifier:** **Actual** **Bed** **Chair** **Dry** **Estimated** **Standing** **Date/Time Vitals Taken:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Weight Control	Patients ages 2–5 at the beginning of the report period whose BMI could be calculated and have a BMI => 95%. Height and weight taken on the same day. Patients that turn 6 years old during the report period are not included in the GPRA measure.	**Standard EHR documentation. obtain height and weight during visit** *and record information* **in EHR:** Height Weight Date Recorded BMI is calculated using NHANES II Age in the age groups is calculated based on the date of the most current BMI found. **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.** **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).**	Height Measurement **Vital Measurements Entry** **(includes historical Vitals)** **Value:** **Select Qualifier:** **Actual** **Estimated** **Date/Time Vitals Taken:** Weight Measurement **Vital Measurements Entry** **(includes historical Vitals)** **Value:** **Select Qualifier:** **Actual** **Bed** **Chair** **Dry** **Estimated** **Standing** **Date/Time Vitals Taken:**

<table>
<tr><th>Performance Measure</th><th>Standard</th><th>Provider Documentation</th><th>How to Enter Data in EHR</th></tr>
<tr><td>Childhood Weight Control (cont)</td><td></td><td>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.
<table>
<tr><th>Low-High</th><th></th><th>BMI >= 85</th><th>BMI >= 95</th><th colspan="2">Data Check Limits</th></tr>
<tr><td>Ages</td><td>Sex</td><td>Over Weight</td><td>Obese</td><td>BMI ></td><td>BMI <</td></tr>
<tr><td>2-2</td><td>M
F</td><td>17.7
17.5</td><td>18.7
18.6</td><td>36.8
37.0</td><td>7.2
7.1</td></tr>
<tr><td>3-3</td><td>M
F</td><td>17.1
17.0</td><td>18.0
18.1</td><td>35.6
35.4</td><td>7.1
6.8</td></tr>
<tr><td>4-4</td><td>M
F</td><td>16.8
16.7</td><td>17.8
18.1</td><td>36.2
36.0</td><td>7.0
6.9</td></tr>
<tr><td>5-5</td><td>M
F</td><td>16.9
16.9</td><td>18.1
18.5</td><td>36.0
39.2</td><td>6.9
6.8</td></tr>
</table></td><td></td></tr>
</table>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment	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: • **Blood Pressure** • **LDL Assessment** • **Tobacco Use Assessment** • **BMI Calculated** • **Lifestyle Counseling** Note: This does *not* include depression screening and does *not* include refusals of BMI. Note: Refusals of any or all of the above are not counted toward the GPRA measure, but should still be documented.	**Standard EHR documentation for tests performed at the facility. Ask about off-site tests and *record historical information* in EHR:** Date received Location Results Note: See related individual measures above for recording historical information. Blood Pressure Control LDL Assessment Tobacco Use and Assessment BMI (Obesity) Tobacco Use Health Factors: 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 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" Tobacco Patient Education Codes: Codes will contain "TO-", "-TO", "-SHS"	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:** **Modifier:** **Cause of DX:** 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:** LDL (Calculated) Lab Test **Lab Test Entry** **Enter Lab Test Type:** LDL **Collect Sample/Specimen:** [Blood] **Clinical Indication:** LDL CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F** **Quantity :** **Modifier:** Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)		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. Nutrition, dietary surveillance and counseling Patient Education Codes: Codes will contain "-N" (Nutrition) or "-MNT" Exercise Patient Education Codes: Codes will contain “-EX" Lifestyle Patient Education Codes: Codes will contain “-LA" Other Related Nutrition and Exercise Patient Educations Codes: Codes will contain “-OBS" (Obesity) Lifestyle Counseling includes: Lifestyle adaptation counseling Medical nutrition therapy Nutrition counseling Exercise counseling Other lifestyle education	Tobacco Use Assessment **Health Factor Entry** **Select V Health Factor: [Enter HF (See the Provider Documentation column)]** **Level/Severity:** **Provider:** **Quantity:** Tobacco Use Dental (ADA) *ADA codes cannot be entered into EHR.* Tobacco Screening CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT Code: D1320, 99406, 99407, 1034F, 1035F, 1036F, 1000, G8455, G8456, G8457, G8402, G8453** **Quantity** **Modifier:** **Modifier 2:** Tobacco Related Diagnoses POV **Visit Diagnosis Entry** **Purpose of Visit: 305.1, 649.00-649.04, V15.82** **Provider Narrative:** **Modifier:** **Cause of DX:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)			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:** **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:** 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**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)			**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:** Tobacco Screening PED–CPT **Patient Education Entry (includes historical patient education)** **Select CPT Code Number: D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455, G8456, G8457, G8402 or G8453** **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	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)			BMI Data Entry Height Measurement **Vital Measurements Entry (includes historical Vitals)** **Value:** **Select Qualifier:** **Actual** **Estimated** **Date/Time Vitals Taken:** Weight Measurement **Vital Measurements Entry (includes historical Vitals)** **Value:** **Select Qualifier:** **Actual** **Bed** **Chair** **Dry** **Estimated** **Standing** **Date/Time Vitals Taken:** 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:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)			Medical Nutrition Therapy Clinic **Clinic Entry** **Clinic: 67, 36** Nutrition Education POV **Visit Diagnosis Entry** **Purpose of Visit: V65.3** **Provider Narrative:** **Modifier:** **Cause of DX:** 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:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)			Nutrition/Exercise/Lifestyle Adaption PED–Diagnosis **Patient Education Entry** **(includes historical patient education)** **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	How to Enter Data in EHR
HIV Screening	Pregnant women should be tested for HIV at least on their first visit; education and follow-up provided as appropriate. Note: Refusals are not counted toward the GPRA measure, but should still be documented.	**Standard EHR documentation for tests performed at the facility, ask and *record historical information* in EHR:** Date received Location Results NOTE: The timeframe for screening for the pregnant patient's denominator is anytime during the past 20 months. Pregnant patients are any patients with at least two non-pharmacy only visits with a pregnancy POV code with no recorded abortion or miscarriage in this timeframe.	HIV Screen CPT **Visit Services Entry (includes historical CPTs)** **Enter CPT Code: 86689, 86701-86703, 87390, 87391, 87534-87539** **Quantity** **Modifier:** **Modifier 2:** HIV Diagnoses POV **Visit Diagnosis Entry** **Purpose of Visit: 042, 079.53, V08, 795.71** **Provider Narrative:** **Modifier:** **Cause of DX:** HIV Lab Test **Lab Test Entry** **Enter Lab Test Type:** [Enter site's defined HIV Screen Lab Test] **Collect Sample/Specimen: [Blood, Serum]** **Clinical Indication:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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.	**All providers** should assess the feeding practices of all newborns through age 1 year at all well-child visits.	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.)** **½ Breastfeeding, ½ 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**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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	All providers should document all 5 patient education elements and elements #6–7 below if a goal was set for the patient: 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: Distraction Eager To Learn Intoxication Not Ready Pain Receptive Severity of Illness Unreceptive Levels of Understanding: P–Poor F–Fair G–Good GR–Group-No Assessment R–Refused	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:** **Length of Educ (minutes):** **Comment:** **Goal Code: GS, GM, GNM, GNS** **Goal Comment:** Patient Education Diagnosis **Patient Education Entry** **(includes historical patient education)** **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:** **Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]** **Goal Comment:**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Patient Education Measures (Patient Education Report) (cont)		Goal Codes: GS–Goal Set GM–Goal Met GNM–Goal Not Met GNS–Goal Not Set Diagnosis Categories: Anatomy and Physiology Complications Disease Process Equipment Exercise Follow-up Home Management Hygiene Lifestyle Adaptation Literature Medical Nutrition Therapy Medications Nutrition Prevention Procedures Safety Tests Treatment	**Provider's Narrative:**

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.

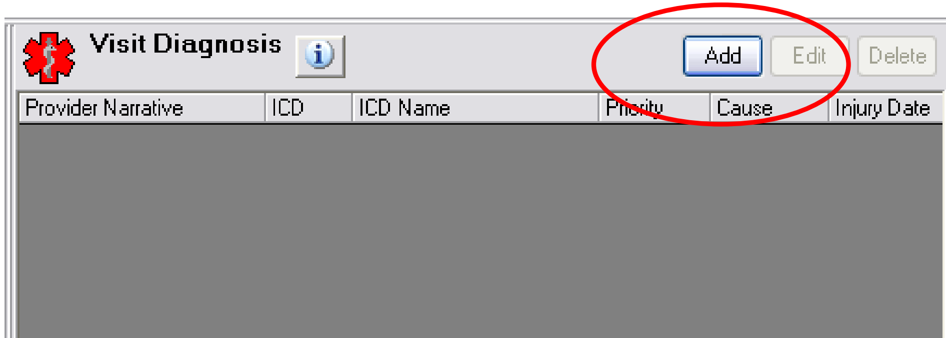
Clinic Codes

Clinic codes are chosen when a visit is created.

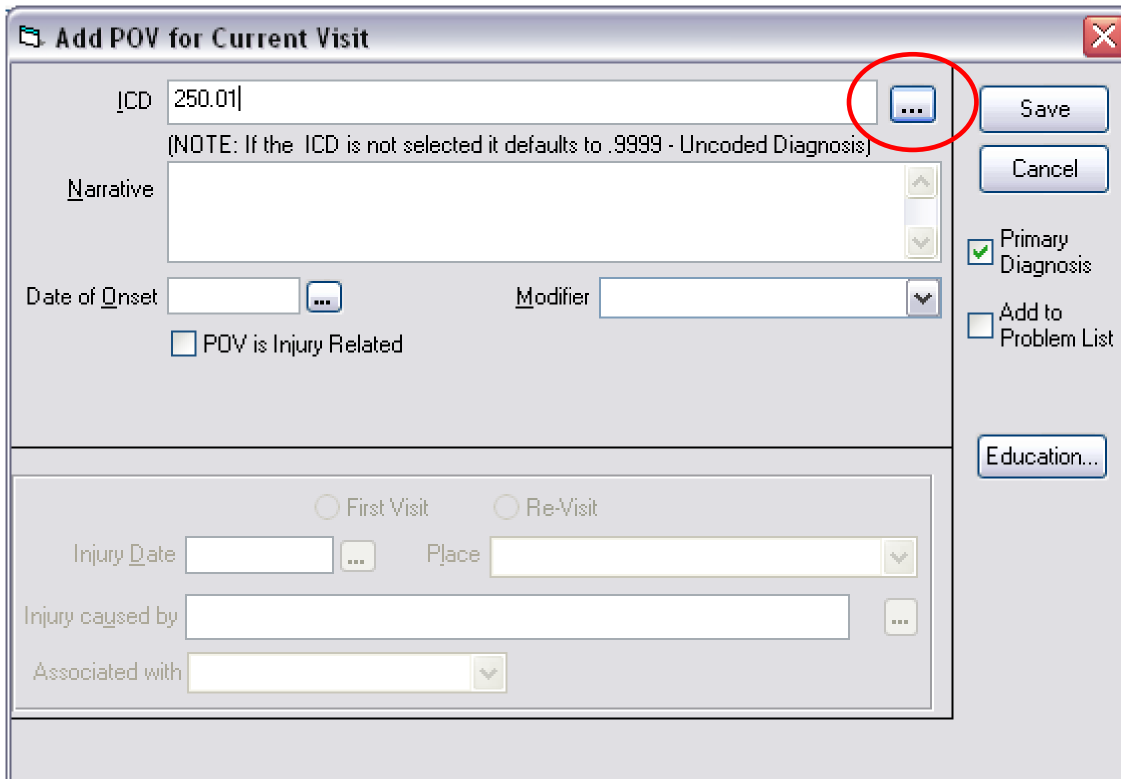
Purpose of Visit/Diagnosis

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

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 250.01 [Search]

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 [OK] [Cancel]

Enter in any other pertinent information and click Save.

Add POV for Current Visit

ICD: ention Of Complication, Type I [juvenile Type], Not Stated As Uncontrolled ...

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

Narrative: Diabetes Mellitus Without Mention Of Complication, Type I [juvenile Type], Not Stated As Uncontrolled

Date of Onset ... Modifier

POV is Injury Related

First Visit Re-Visit

Injury Date ... Place

Injury caused by ...

Associated with

Save

Cancel

Primary Diagnosis

Add to Problem List

Education...

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

Visit Diagnosis

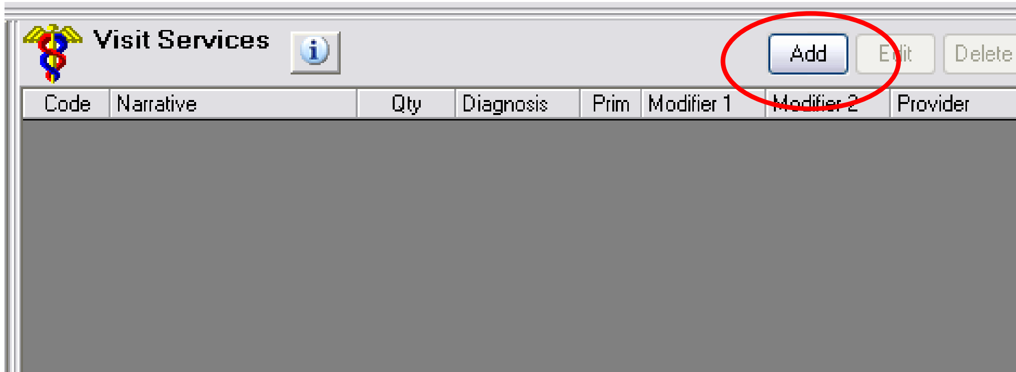
Add Edit Delete

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					

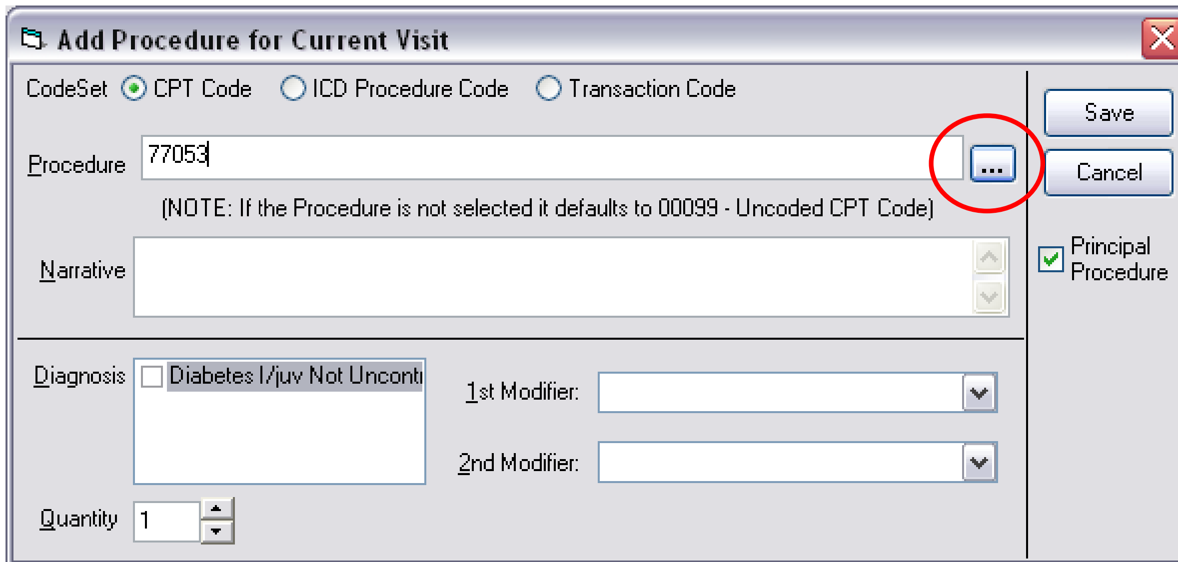
CPT Codes

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

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 [Search]

Included Code Sets: [x] Medical [x] Surgical [x] HCPCS [x] E & M [x] Radiology [x] Laboratory [x] Anesthesia [x] 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 [OK] [Cancel]

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 Uncontı

1st Modifier:

2nd Modifier:

Quantity: 1

Save

Cancel

[x] Principal Procedure

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.

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

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

Pick List:

Add Historical Service

Pick List | Procedure

GPRA SERVICES

- Barium Enema
- Colonoscopy
- Fobt (guaiac)
- Hiv-1
- Hiv-1 And Hiv-2
- Hiv-2
- Mammography, Bilat
- Mammography, Unilat
- Pap Smear
- Sigmoidoscopy

Date

Location

IHS/Tribal Facility

Other

Save

Cancel

Procedure/CPT code:

Add Historical Service

Pick List | Procedure

Procedure

(NOTE: If the Procedure is not selected it defaults to 00099 - Uncoded CPT Code)

Narrative

Quantity 1

1st Modifier

2nd Modifier

Date

Location

IHS/Tribal Facility

Other

Save

Cancel

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.

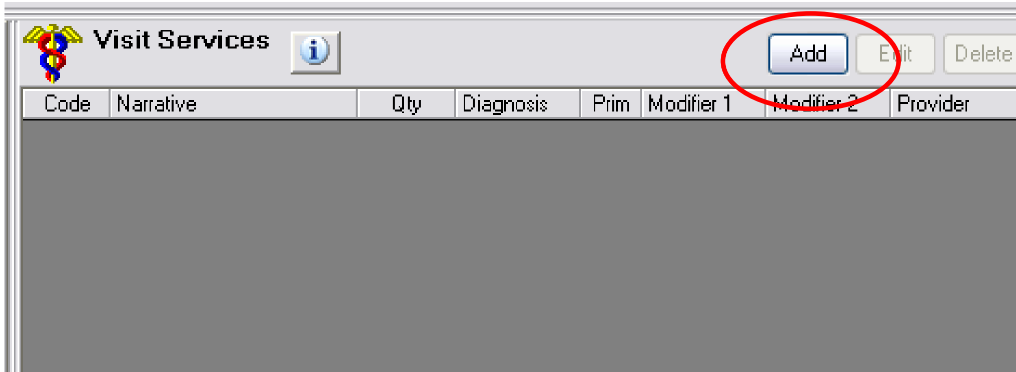
Historical Services | Radiology | Add to Current Visit | Add | Delete

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				

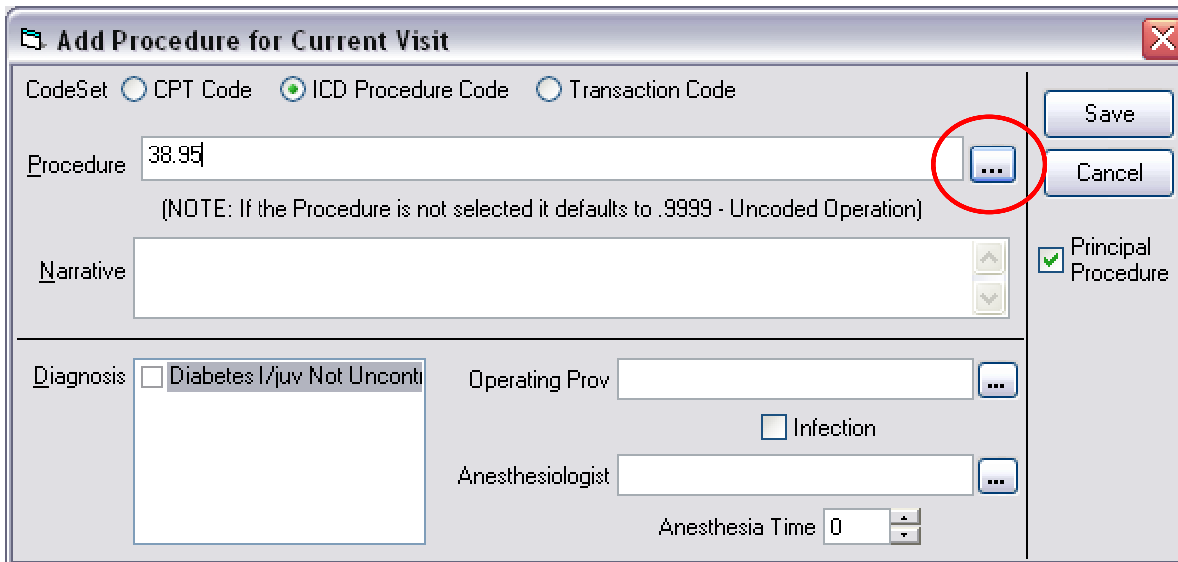
Procedure Codes

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

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



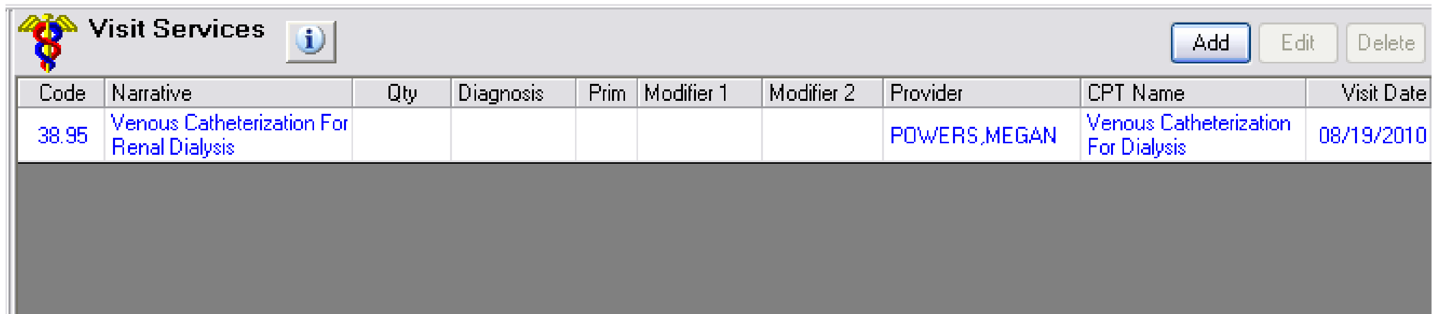
The Add Procedure for Current Visit dialog box will display. Make sure ICD Procedure Code is chosen for the CodeSet. Type in the Procedure code and click the ellipses (…) button.



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

Enter in any other pertinent information and click Save.

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



Visit Services

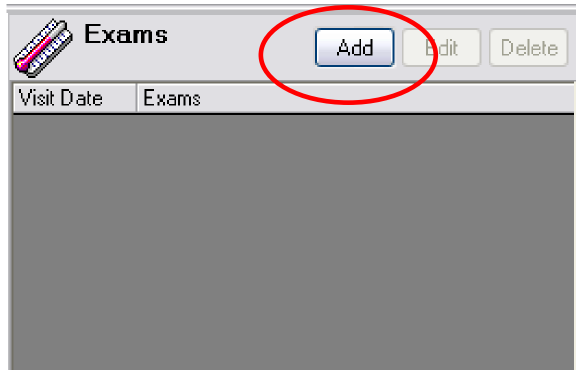
Add Edit Delete

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

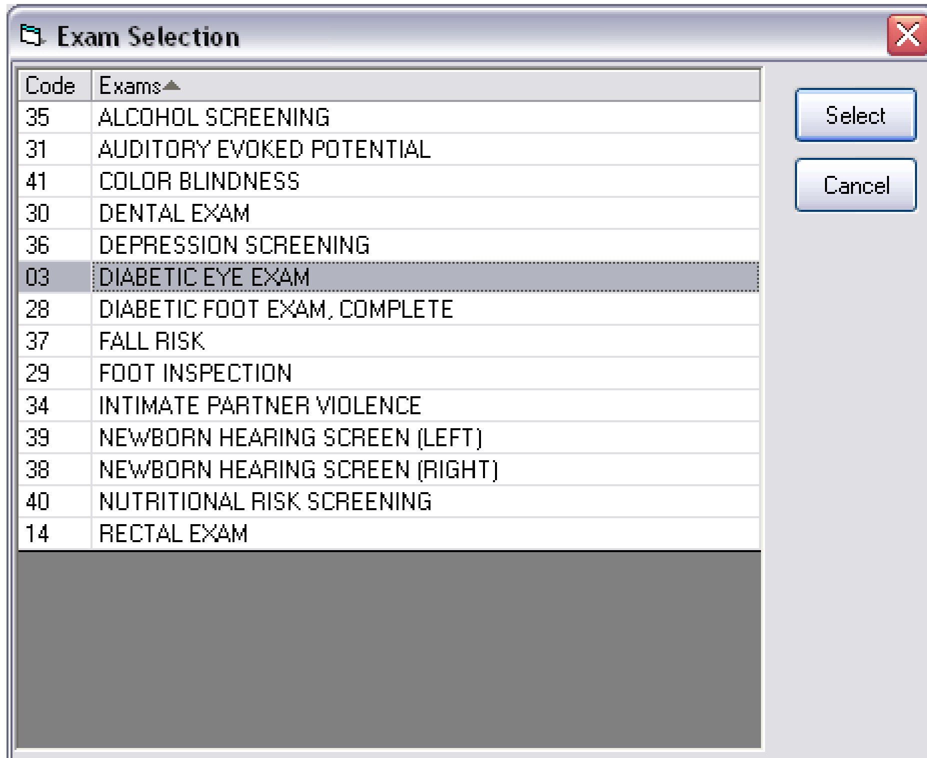
Exams

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

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.

Document an Exam

Exam DIABETIC EYE EXAM

Result NORMAL/NEGATIVE

Comment

Provider POWERS,MEGAN

Add

Cancel

Current

Historical

Refusal

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

Document an Exam

Exam DIABETIC EYE EXAM

Result NORMAL/NEGATIVE

Comment

Provider POWERS,MEGAN

Historical

Event Date 06/02/2010

Location CHEROKEE INDIAN HOSPITAL

IHS/Tribal Facility

Other

Add

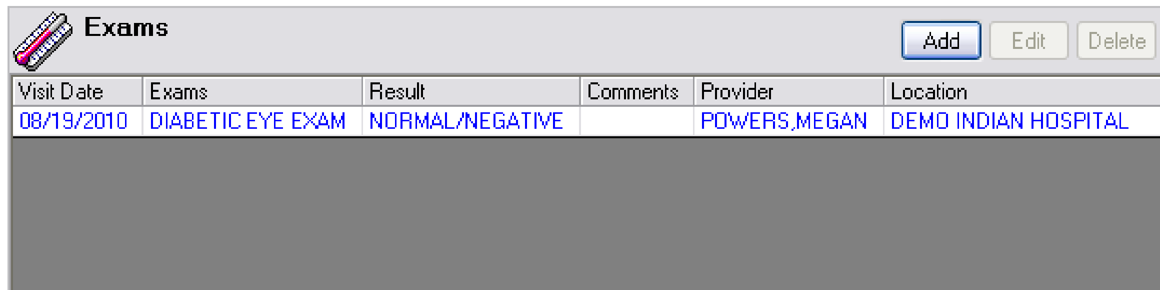
Cancel

Current

Historical

Refusal

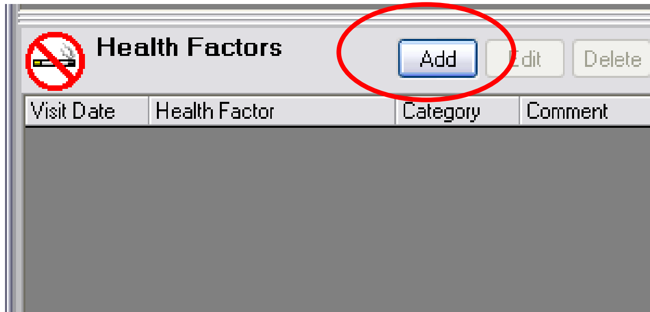
Your newly added Exam code should appear in the Exams component.



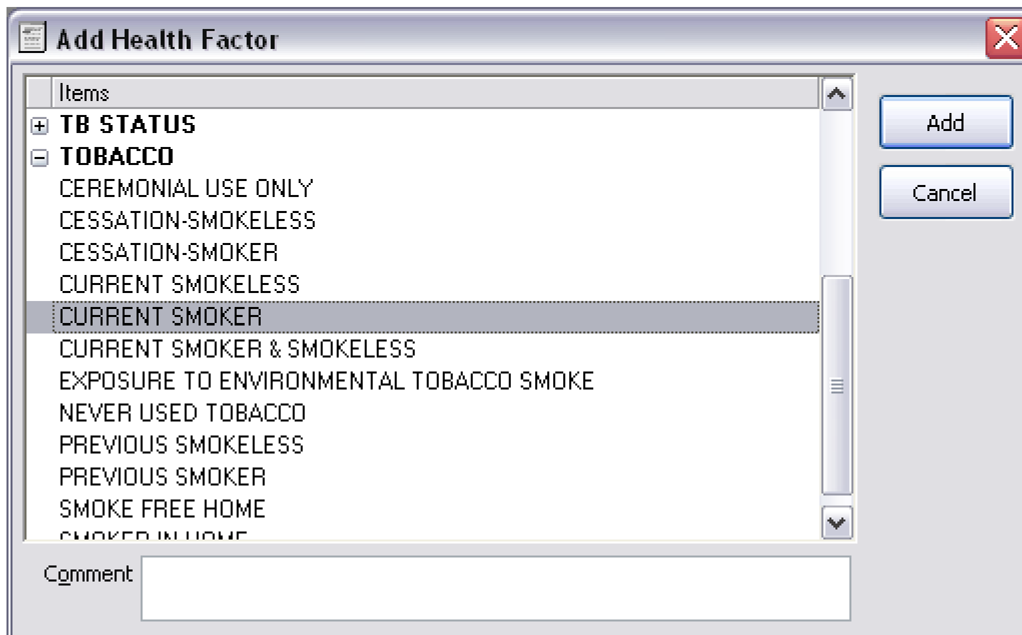
Health Factors

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

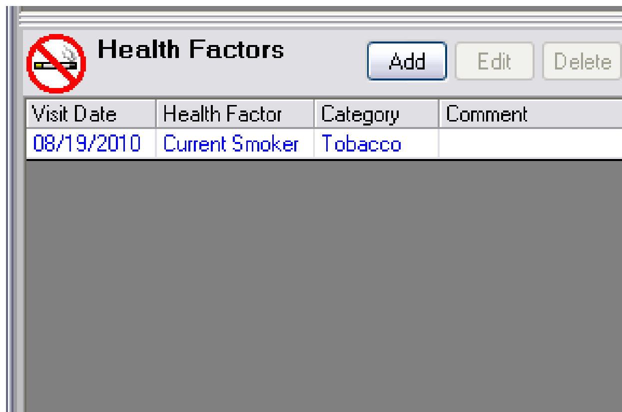
To enter a Health Factor, click Add in the Health Factors component.



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



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



Immunizations

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

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

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

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 Counselled by Provider

OK | Cancel

Current | Historical | Refusal

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

OK | Cancel

Current | Historical | Refusal

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

Immunization Record

Forecast

Tdap past due

Contraindications

Add Delete

PNEUMO-PS Egg Allergy 19-Aug-2010

Vaccinations

Print Record Due Letter Profile Case Data Add Edit Delete

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.

Immunization Record

Forecast

Tdap past due

Contraindications

Add Delete

PNEUMO-PS Egg Allergy 19-Aug-2010

Vaccinations

Print Record Due Letter Profile Case Data Add Edit Delete

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

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

Select the immunization and click OK.

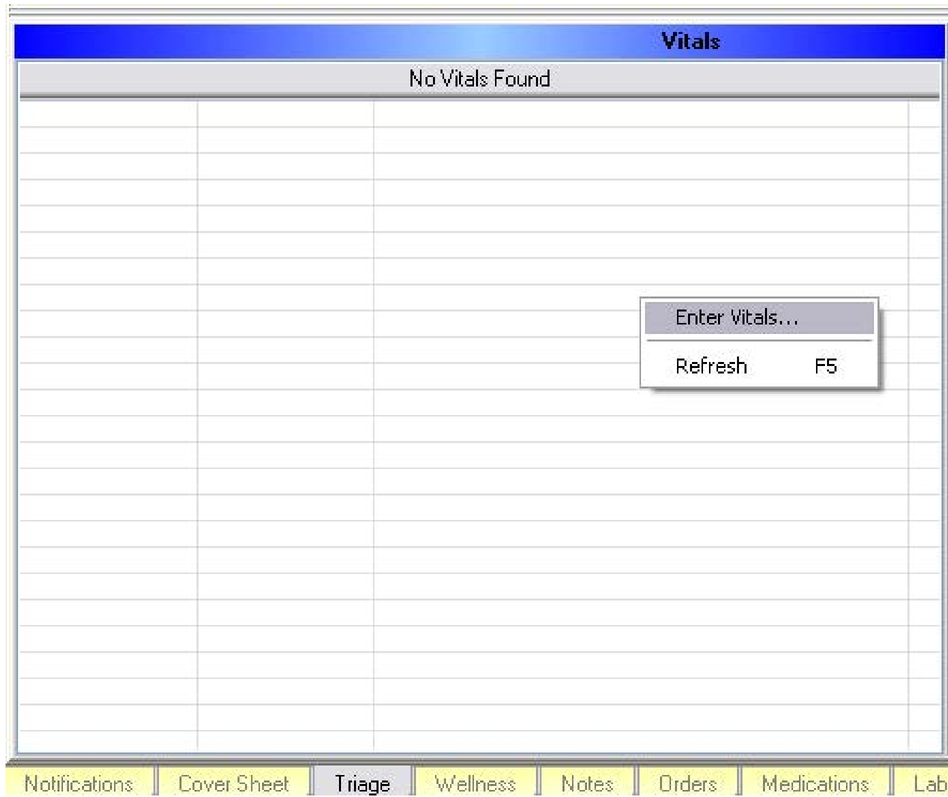
Click Add.

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

Vital Measurements

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

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
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			

Choose the historical date and click OK.

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

Vital Measurement Entry

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			
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

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

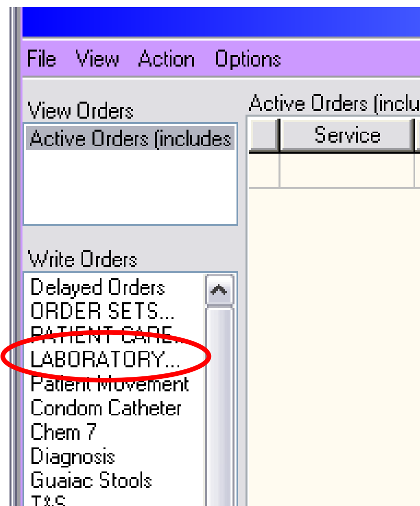
Vitals

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

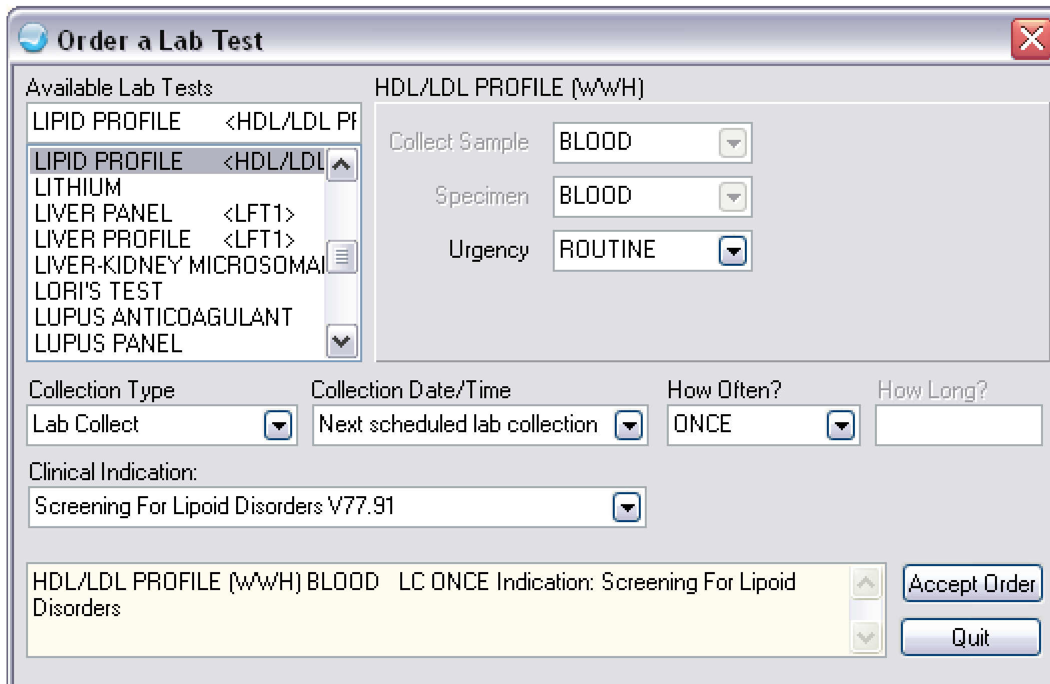
Lab Tests

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

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.

Active Orders (includes Pending & Recent Activity) - ALL SERVICES

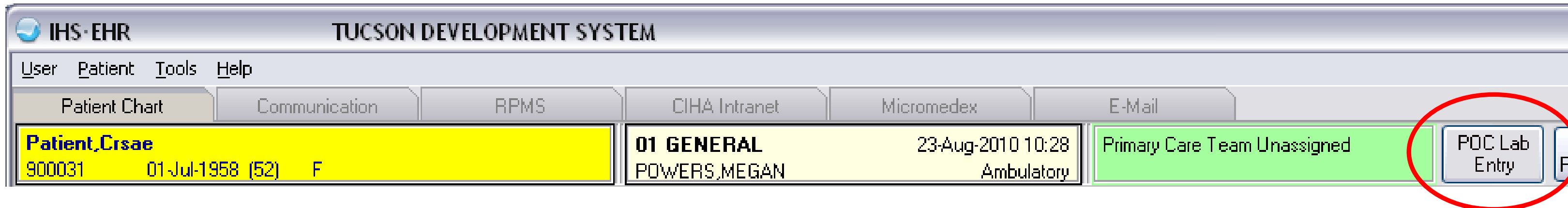
Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
Lab	HDL/LDL PROFILE (WWH) BLOOD LC ONCE Indication: Screening For Lipoid Disorders *UNSIGNED*	Start: NEXT	Powers,M				unreleased

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.

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.

Lab Point of Care Data Entry Form

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

Comment/Lab Description:

Add Canned Comment

TEST RESULTS

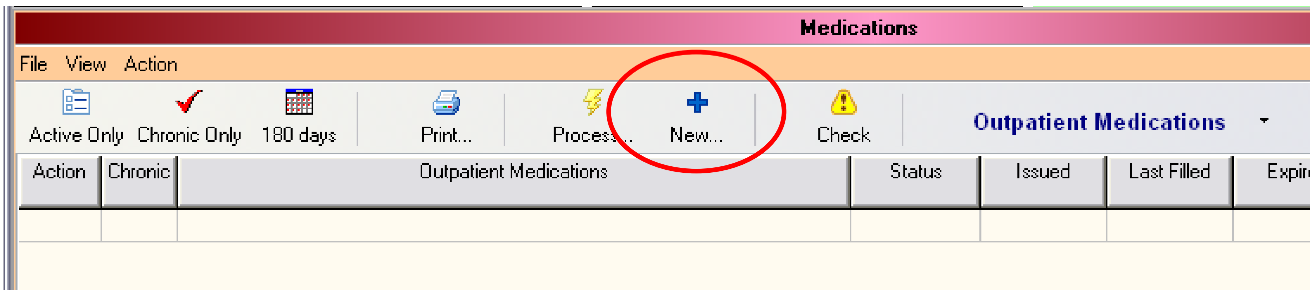
Test Name	Result	Result Range	Units
GLUCOSE	92	>70 to 105	mg/dL

Save   Cancel

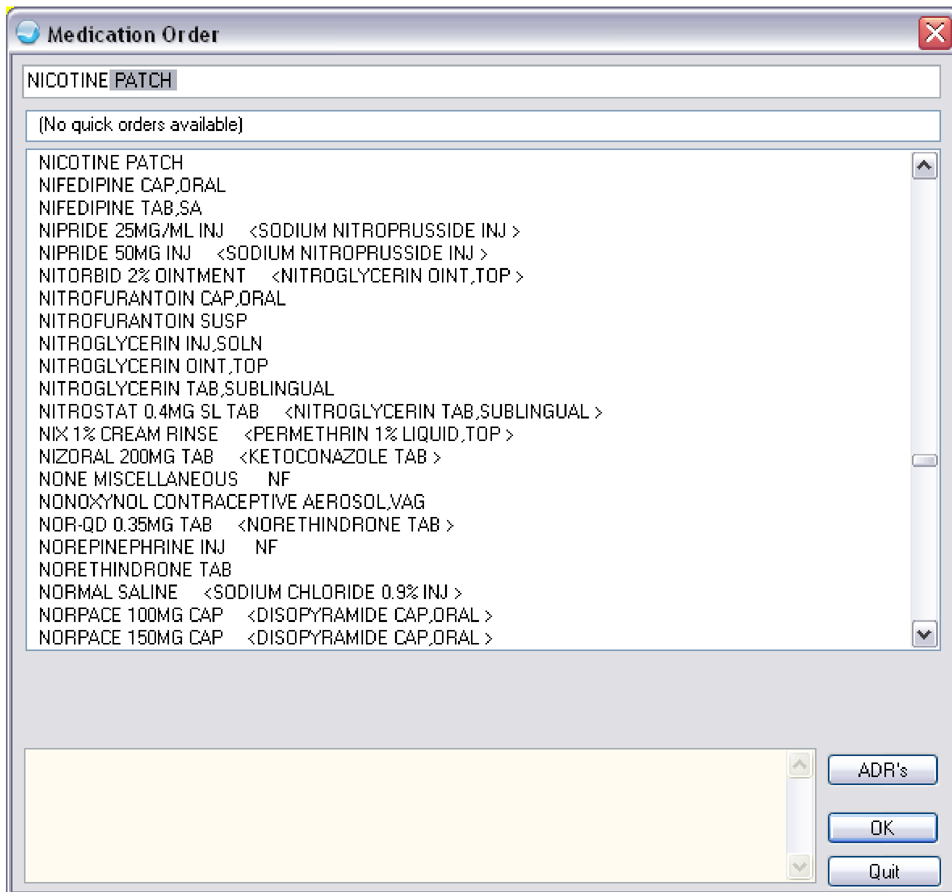
Medications

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

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: 1 patch

Route: TRANSDERMAL

Schedule: DAILY | PRN

BID (INSULIN)
CONTINUOUSLY
DAILY
FIVE TIMES/DAY
FR
FR-SA

Comments:

Days Supply: 90 | Quantity: 1 | Refills: 1 | Clinical Indication: Personal History of Tobacco I | Chronic Med | Dispense as Written | Priority: ROUTINE

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

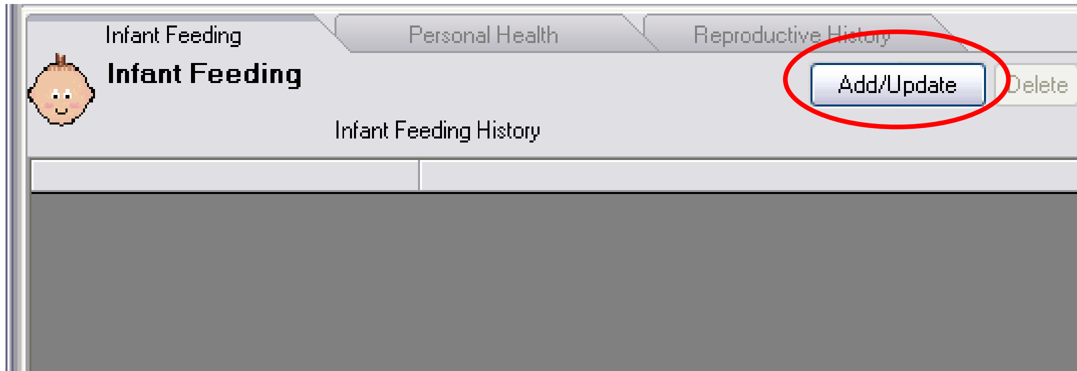
Action	Chronic	Outpatient Medications	Status	Issued	Last Filled	Expires	Refills Remaining	Rx #	Provider
New		NICOTINE PATCH APPLY ONE (1) PATCH TO SKIN DAILY Quantity: 1 Refills: 1 Dispense as Written: NO Indication: Personal History of Tobacco Use *UNSIGNED*							

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

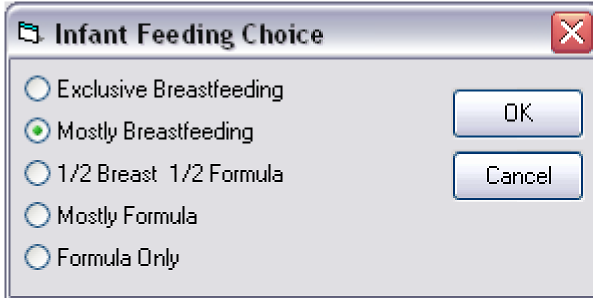
Infant Feeding

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

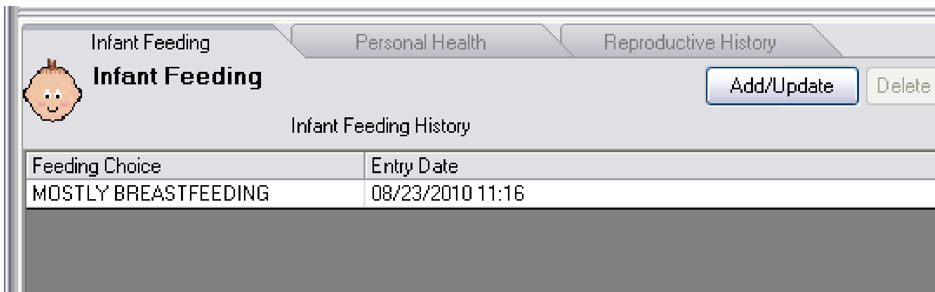
To enter Infant Feeding, click Add/Update in the Infant Feeding component.



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



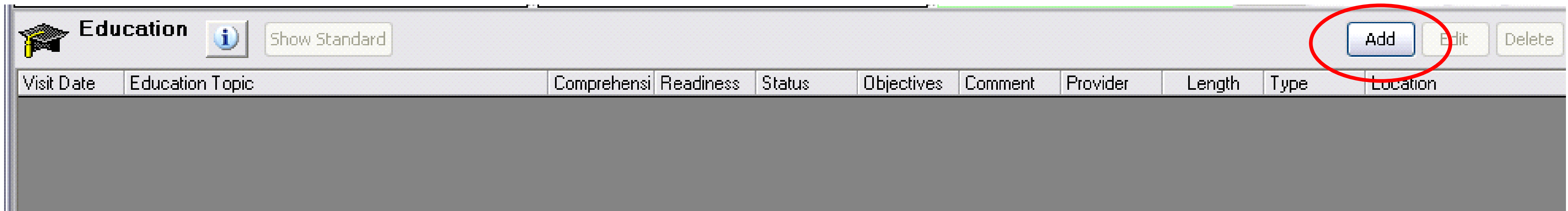
Your newly added Infant Feeding choice should display in the Infant Feeding component.



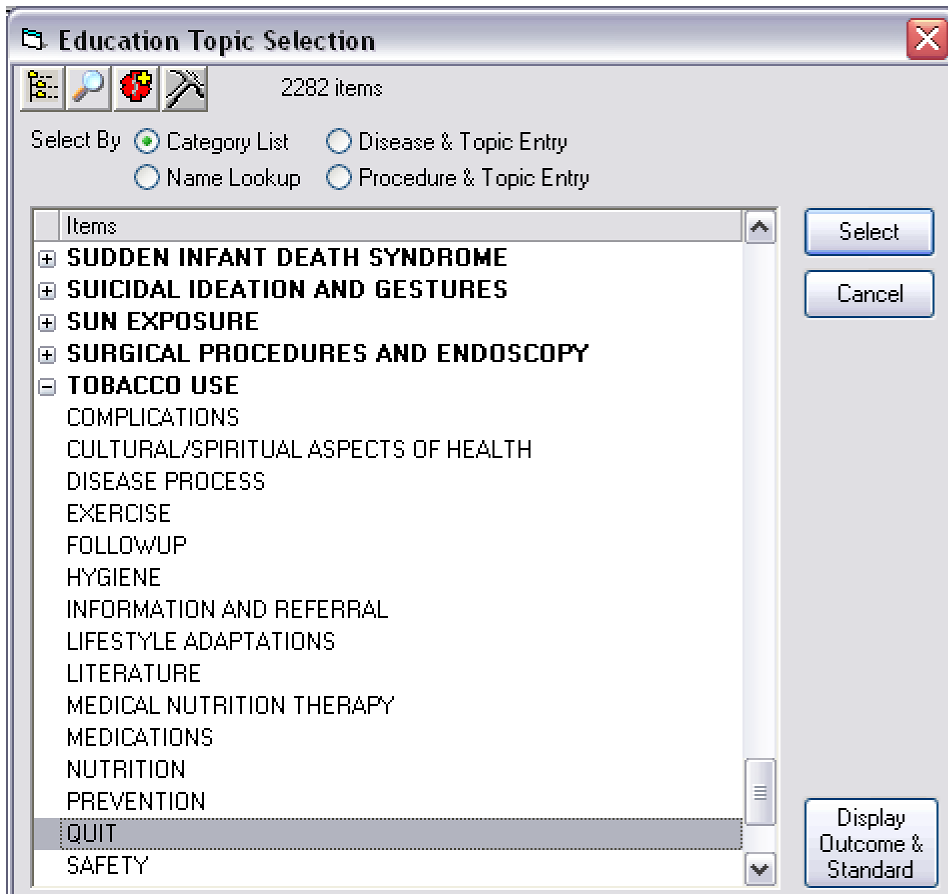
Patient Education

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

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

0 items

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.

OK

Cancel

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

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

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.

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

Historical
Event Date: 06/02/2010
Location: CHEROKEE INDIAN HOSPITAL
(•) IHS/Tribal Facility
( ) Other

Add
Cancel
[x] Historical
Display Outcome & Standard
Patient's Learning Health Factors

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

Education Show Standard Add Edit Delete

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….

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

Save
Cancel
Historical

Type of Training: Individual / Group
Comprehension Level: GOOD
Length: 10 (min)
Comment
Provided By: POWERS,MEGAN
Readiness to Learn: RECEPTIVE

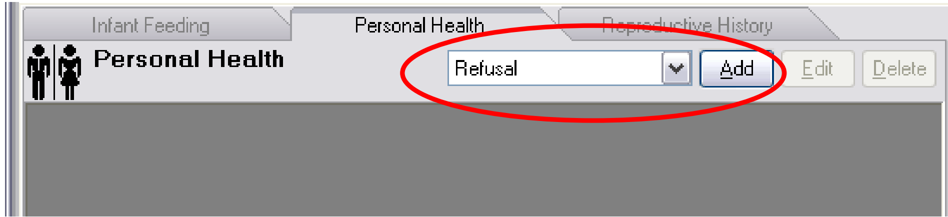
Patient's Learning Health Factors

Status/Outcome: Goal Set / Goal Met / Goal Not Met

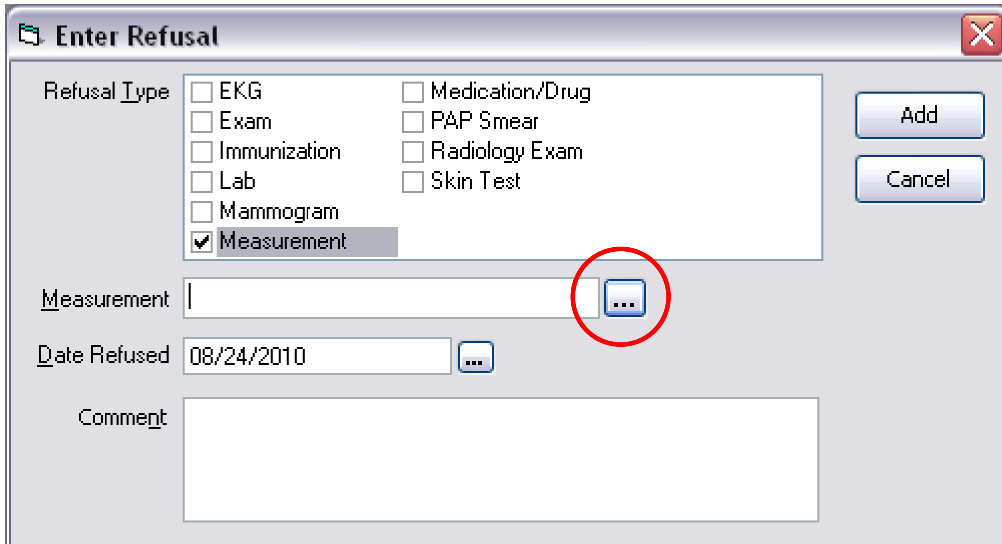
Refusals

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.*

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

- EKG
- Exam
- Immunization
- Lab
- Mammogram
- Measurement
- Medication/Drug
- PAP Smear
- Radiology Exam
- Skin Test

Add

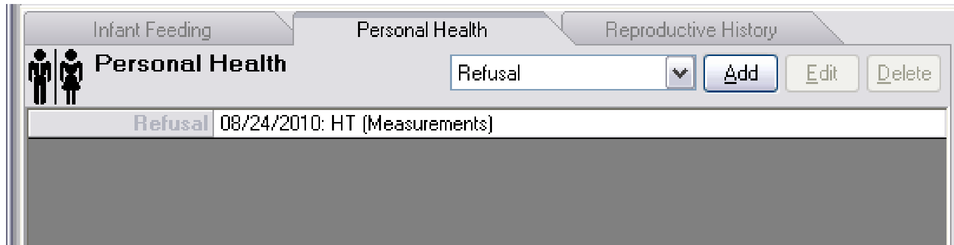
Cancel

Measurement HEIGHT

Date Refused 08/24/2010

Comment

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



Site Instructions for Running the National GPRA & PART Report

Task Summary:

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

To run the National GPRA & PART Report

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, **enter the most recent version of CRS** and press Enter; for example,

```
                ****************************************************
                **    IHS/RPMS CLINICAL REPORTING SYSTEM (CRS)    **
                ****************************************************
                                   Version 12.0

                               DEMO INDIAN HOSPITAL

   CI12   CRS 2012 ...
   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:  CI12 <Enter>  CRS 2012
```

2. At the "Select CRS XXXX Option" prompt (where XXXX represents the version of CRS), type **RPT** and press Enter to display the Reports menu; for example,

```
                         *********************************
                         **      IHS/RPMS CRS 2012      **
                         **  Clinical Reporting System  **
                         *********************************
                                   Version 12.0

                               DEMO INDIAN HOSPITAL


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

Select CRS 2012 Option:  RPT <Enter>  Reports
```

3. At the “Select Reports option” prompt, type **NTL** and press Enter to display the National GPRA Reports menu; for example,

```
                            *************************
                            **   IHS/RPMS CRS 2012  **
                            **     Reports Menu     **
                            *************************
                                  Version 12.0

                               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 Clinical Quality Measure Reports...

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

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

```
                        ********************************
                        **      IHS/RPMS CRS 2012     **
                        **    National GPRA Reports   **
                        ********************************
                                 Version 12.0

                             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:  GP <Enter>  National GPRA &
PART Report
```

Information about the report is displayed; for example:

```
                        IHS 2012 National GPRA & PART Report

This will produce a National GPRA & PART report.
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, 2011 through
June 30, 2012 with a Baseline Year of July 1, 1999 through June 30, 2000.  This
report will include beneficiary population of American Indian/Alaska Native only.


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.
```

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 National GPRA & PART 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.

The date ranges for the report are displayed; for example,

```
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
```

8. 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.

9. At the prompt to export the data to your Area office, type **Y** if the report is being run for quarterly reporting, or press **N** if the report is only being used at the clinic level, 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>
```

10. If the Height and Weight parameter is set to "No", the following warning will appear, select **Y** at the prompt asking "Do you wish to continue with generating this report?":

```
***WARNING***   Because your site parameter for exporting height and weight
data to the Area Office is set to "No" your Area Office export file (file
beginning with "BG12") will not contain height and weight data.  This data
is sent to the IHS Division of Epidemiology to track and analyze BMI data
over time.  All IHS and Urban facilities should have the site parameter set
to "Yes" and only Tribal facilities have the option of setting it to "No".
If you want to include the height and weight data in your Area Office export
file, please change the site parameter export option to "Yes" in Setup and
then run your National GPRA & PART Report.

Do you wish to continue with generating this report? Y//
```

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

```
              SUMMARY OF NATIONAL GPRA & PART REPORT TO BE GENERATED

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 Community
```

11. 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
```

12. 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):
DemoHospGPRA012712 <Enter>

When the report is finished your delimited output will be found in the D:\PUB
directory.  The file name will be DemoHospGPRA012712.txt
```

Because you are exporting the data to your Area office, CRS creates a file that begins with "BGXX" (where XX represents the version of CRS) in the PUB directory (e.g. BG12505901.14), 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 BG12505901.14 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

The GPRA Dashboard report in CRS 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.

To run the National GPRA Dashboard:

1. Select the most recent version of CRS, and once in CRS, type **RPT** and press Enter to display the Reports menu; for example,

```
                         *********************************
                         **      IHS/RPMS CRS 2012      **
                         **  Clinical Reporting System  **
                         *********************************
                                    Version 12.1

                                DEMO INDIAN HOSPITAL


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

Select CRS 2012 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 2012      **
                     **    National GPRA Reports    **
                     ********************************
                               Version 12.1

                           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 2012 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, 2011 through June 30, 2012 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:

   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):
DemoHospGPRA102012 <Enter>

When the report is finished your delimited output will be found in the D:\PUB
directory.  The file name will be DemoHospGPRA102012.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	BORREGO SPRINGS	CAMP PENDLETON
CARDIFF-BY-THE-SEA	CARLSBAD	COASTAL AREA
ENCINITAS	ESCONDIDO	ESCONDIDO NORTH
ESCONDIDO SOUTH	FALLBROOK	JULIAN AREA
LA JOLLA RSV	LEUCADIA	LOS COYOTES RESV
MESA GRANDE RESV	MIRA MESA	NORTH COUNTY WIDE
OCEANSIDE	PALA NORTH	PALA RESERV.
PALOMAR MOUNTAIN	PAUMA VALLEY	POWAY NORTH
RAMONA	RINCON RESV.	SAN LUIS REY
SAN MARCOS	SAN PASQUAL RESV	SANTA YSABEL RESV
VALLEY CENTER	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 the National GPRA & PART Patient List

CI12 > RPT > NTL > LST

1. At the “Select IHS Clinical Reporting System (CRS) Main Menu Option” prompt, type **CIXX** (where XX represents the most current version of CRS) and press Enter to display the CRS Main Menu.
2. At the “Select CRS 20XX Option” prompt, type **RPT** and press Enter to display the CRS Reports menu.
3. At the “Select Reports Option” prompt, type **NTL** and press Enter to display the National GPRA Reports Menu.
4. At the “Select National GPRA & PART Reports Option” prompt, type **LST** and press Enter to display the following information about the National GPRA & PART Patient List:

```
                 IHS GPRA & PART Performance Report Patient List
                              CRS 2012, Version 12.1

This will produce a list of patients who either met or did not meet a
National GPRA & PART Report performance measure or a list of both those
patients who met and those who did not meet a National GPRA & PART Report
performance measure. You will be asked to select one or more performance
measure topics and then choose which performance measure numerators you
would like to report on.


You will also be asked to provide the community taxonomy to determine
which patients will be included, the beneficiary population of the
patients, and the Report Period and Baseline Year.
Press enter to continue: <Enter>
```

Figure 5-15: Running the National GPRA & PART Patient List: patient list description (Step 4)

5. At the prompt to continue, press Enter.
6. The system checks the site-populated taxonomies.
   - If the following message is displayed, press Enter.

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

All taxonomies are present.

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

Figure 5-16: Checking taxonomies message

- If the following message is displayed, your report results for the measure that uses the taxonomy specified are likely to be inaccurate.

```
The taxonomies are missing or have no entries
```

Figure 5-17: Missing taxonomies message

To exit from the report and edit your taxonomies, type a caret (^) at any prompt until you return to the Main menu.

7. The Performance Measure Selection list of available topics is displayed, as in the following example:

```
PERFORMANCE MEASURE SELECTION Jun 08, 2012 15:27:17          Page:   1 of
2
IHS GPRA & PART Clinical Performance Measures
* indicates the performance measure has been selected

1)  Diabetes Prevalence
2)  Diabetes: Glycemic Control
3)  Diabetes: Blood Pressure Control
4)  Diabetes: LDL Assessment
5)  Diabetes: Nephropathy Assessment
6)  Diabetic Retinopathy
7)  Access to Dental Service
8)  Dental Sealants
9)  Topical Fluoride
10) Influenza
11) Adult Immunizations
12) Childhood Immunizations
13) Cancer Screening: Pap Smear Rates
14) Cancer Screening: Mammogram Rates
15) Colorectal Cancer Screening
16) Colorectal Cancer Screening (Revised Logic #1-HEDIS)
+         Enter ?? for more actions
S    Select Measure       D    De Select Measure    Q    Quit
Select Action:+//
```

Figure 5-18: Running the National GPRA & PART Patient Lists: Performance Measure Selection screen (Steps 7 and 8)

8. The action bar appears at the bottom of the screen. At the “Select Action” prompt, do one of the following:

- To view multiple pages:
  - Type a plus sign (+) and press Enter to view the next page.
  - Type a minus sign/hyphen (-) and press Enter to return to the previous page.

- To select measure topics:
  - Type **S** and press Enter.
  - At the "Which Measure Topic?" prompt, type the number(s) preceding the measure(s) you want and press Enter.

    To select multiple topics, type a range (e.g., 1 through 4), a series of numbers (e.g., 1, 4, 5, 10), or a combination of ranges and numbers (e.g., 1 through 4, 8, 12).

    After pressing Enter, each measure you selected is marked with an asterisk (*) before its number (Figure 5-19).

- To deselect measure topics:
  - At the "Select Action" prompt, type **D** and press Enter.
  - At the "Which item(s)" prompt, type the number(s) preceding the measure(s) you want to remove.

    After pressing Enter, each measure you deselected is no longer marked with an asterisk (*) before its number.

- To save your selected topics, type **Q** (Quit) and press Enter.

```
PERFORMANCE MEASURE SELECTION Jun 08, 2012 15:31:38        Page:   1 of
2
IHS GPRA & PART Clinical Performance Measures
* indicates the performance measure has been selected

*1)  Diabetes Prevalence
2)  Diabetes: Glycemic Control
*3)  Diabetes: Blood Pressure Control
4)  Diabetes: LDL Assessment
5)  Diabetes: Nephropathy Assessment
6)  Diabetic Retinopathy
7)  Access to Dental Services
8)  Dental Sealants
9)  Topical Fluoride
10) Influenza
11) Adult Immunizations
12) Childhood Immunizations
13) Cancer Screening: Pap Smear Rates
14) Cancer Screening: Mammogram Rates
15) Colorectal Cancer Screening
16) Colorectal Cancer Screening (Revised Logic #1-HEDIS)
+         Enter ?? for more actions
S    Select Measure       D    De Select Measure    Q    Quit
Select Action:+//
```

Figure 5-19: Running the National GPRA & PART Patient Lists: selected performance measure topics (Step 8)

9. For each performance measure you selected, the patient lists available for that topic are displayed, as in the following example:

```
Please select one or more of these report choices within the
Diabetes Prevalence performance measure topic.

     1)  Diabetes DX Ever
```

```
Which item(s): (1-1): 1  <Enter>


Please select one or more of these report choices within the
Diabetes: Blood Pressure Control performance measure topic.

     1)  BP Assessed
     2)  BP Not Assessed
     3)  Controlled BP
     4)  Uncontrolled BP
     5)  BP Assessed (GPRA Dev)
     6)  BP Not Assessed (GPRA Dev)
     7)  Controlled BP (GPRA Dev)
     8)  Uncontrolled BP (GPRA Dev)
     9)  BP <140/90 (GPRA Dev)
    10)  BP >140/90 (GPRA Dev)
Which item(s): (1-10): 1,3  <Enter>
```

Figure 5-20: Running the National GPRA & PART Patient Lists: selecting patient lists for each topic (Step 10)

10. At the “Which item(s)” prompt, type the number of the item(s) on which you want to report.

```
Select List Type.
NOTE: If you select All Patients, your list may be
hundreds of pages and take hours to print.


     Select one of the following:

          R         Random Patient List
          P         Patient List by Provider
          A         All Patients

Choose report type for the Lists: R// P <Enter> List by Provider
Enter Designated Provider Name: PROVIDER1,FIRST  <Enter>
```

Figure 5-21: Running the National GPRA & PART Patient Lists: selecting Patient List by Provider report type (Step 11)

11. At the “Choose report type for the Lists” prompt, type the letter corresponding to the report type you want and press Enter, where:

    - **R** (Random Patient List) produces a list containing 10% of the entire patient list.
    - **P** (By List by Provider) produces a list of patients with a user-specified designated care provider.
    - **A** (All Patients) produces a list of all patients.

    If you select P (Patient List by Provider), type the name of a provider at the “Enter Designated Provider Name” prompt and press Enter.

> **Note:** Printed patient lists are likely to require a great deal of paper, even when you are producing a random list. Ensure that your selected printer has enough paper, particularly if you are running the report overnight.
>
> Print patient lists only when you need them, or print to an electronic file.

12. At the “Enter the date range for your report” prompt, do one of the following:

    - To select a predefined date range, type **1**, **2**, **3**, or **4** and press Enter.

      At the “Enter Year” prompt, type the calendar year of the report end date (for example, 2012) and press Enter.

    - To define a custom report period, type **5** and press Enter.

      At the “Enter End Date for the Report” prompt, type the end date in MM/DD/CCYY format (for example, 11/30/2012) and press Enter.

13. At the “Enter Year” prompt, type the four-digit baseline year and press Enter.

14. At the “Enter the Name of the Community Taxonomy” prompt, do one of the following:

    - Press Enter to accept the default community taxonomy. (The default community taxonomy can be set in Site Parameters.)
    - Type the name of a community taxonomy and press Enter.
    - Type the first few letters of the taxonomy name and press Enter to see a list of taxonomies beginning with those letters, or type two question marks (**??**) and press Enter to see the entire list. Then type the number of the taxonomy you want to use 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// <Enter>
Indian/Alaskan Native (Classification 01)
```

Figure 5-22: Running the National GPRA & PART Patient Lists: selecting beneficiary population (Step 15)

15. At the "Select Beneficiary Population to include in this report" prompt, type the number corresponding to the beneficiary (patient) population you want to include and press Enter, where:

    - **1** (Indian/Alaskan Native) reports only on AI/AN patients.
    - **2** (Not Indian Alaskan/Native) reports only on patients who are not AI/AN.
    - **3** (All) reports on your entire patient population.

16. At the "Select an Output Option" prompt, type the letter corresponding to the type of output you want and press Enter, where:

    - **P** (Print) sends the report file to your printer, your screen, or an electronic file.
    - **D** (Delimited Output) produces an electronic delimited text file that can be imported into Excel or Word for additional formatting and data manipulations.
    - **B** (Both) produces both a printed report and a delimited file.

    Detailed instructions for the Print and Delimited Output options are found in Step 12, Section 5.2.2.

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

GPRA Monthly Webinars

2nd Wednesday of Each Month: 10:00 – 11:00 A.M.

Call-in Number:
800-832-0736

Room Number:
***5677206#**

Future Monthly Webinars:

- September 12, 2012
- October 10, 2012
- November 14, 2012
- December 12, 2012
- January 9, 2013
- February 13, 2013
- March 13, 2013
- April 10, 2013
- May 8, 2013
- June 12, 2013

GPRA monthly webinars, including quarterly CA GPRA Coordinator Webinars (dates listed in red) will be held the 2nd Wednesday of each month.

The first half of each monthly webinar will feature presentations on GPRA, CRS, or quality improvement topics relevant to California Tribal and Urban Indian health programs (Quarterly CA GPRA Coordinator Webinars will have a more formal agenda). Attendees will also be able to share improvement strategies and ideas. The remainder of the call will be open for any GPRA or CRS-related questions.

National GPRA Support Team

Ph 916.930.3927 | **Fx** 916.930.3953
650 Capitol Mall, Suite 7-100
Sacramento, CA 95814

The GPRA Team can be reached at:

916-930-3927

caogpra@ihs.gov

HAVE GPRA OR CRS QUESTIONS???

Call in to our Office Hours to get answers to your CRS or GPRA questions.

Staff from GPRA Support Team and IT will be available to answer questions including but not limited to:

- *GPRA measure logic*
- *Data entry*
- *CRS reports and patient lists*
- *Improvement strategies*

Instructions for Joining and Using the California Area GPRA Listserv

The California Area GPRA Listserv was created to provide California Area Tribal and Urban Indian health clinics a means to easily communicate with one another to share GPRA and quality improvement strategies and to ask questions of one another to help improve GPRA performance and clinical care.

To Join the Listserv, sign up at the following link:

http://www.ihs.gov/listserver/index.cfm?module=signUpForm&list_id=250

An email will be sent to the GPRA team, and once your subscription is approved, you will receive an email.

To Email the Listserv:

Address email to:

CA-GPRA@listserv.ihs.gov

For questions about the Listserv, email 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/

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
(Office Use Only) Totals				

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**

1. Have you ever felt you should *cut* down on your drinking?
   ☐ Yes
   ☐ No
2. Have people *annoyed* you by criticizing your drinking?
   ☐ Yes
   ☐ No
3. Have you ever felt bad or *guilty* about your drinking?
   ☐ Yes
   ☐ No
4. 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)*:

1. Are you in a relationship with a person who physically hurts or threatens you?
   ☐ Yes
   ☐ No
2. Have you ever been in a relationship with a person who hurt you?
   ☐ Yes
   ☐ No
3. 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

COMMUNITY RSOURCES

1. **Catalyst Domestic Violence Services, Chico: 343-7711; Oroville 532-6427 or 1-800-895-8476**
2. **FOCIS: Feather River Tribal Health, Native American DV/Sexual Assault Services: 534-5394, ext. 270**
3. **Native American Anger Management, Tom May, 534-5394, ext 282**
4. **Victim Witness Program, 538-7340, 891-2812**
5. **Child Abuse Reporting, 538-7617**
6. **Family Violence Education Program/ couples counseling, 342-2566**
7. **New Beginnings, Anger Management, 891-0973**
8. **Butte County Behavioral Health, 1-800-334-6622,**
9. **HERE, 891-2794**
10. **Glenn County Mental Health Services, 1-800-500-6582**
11. **Rape Crisis, 342-7273**
12. **Adult Protective Services, 1-800-664-9774**

Northern Valley Indian Health
207 N. Butte Street
Willows, CA 95988
Phone: 530-934-4641
Fax: 530-934-4081

845 W. East Ave
Chico, CA 95928

Phone: 530-896-9400
Fax: 530-896-9407

Health Factors Screening Questionnaire

Northern Valley Indian Health, Inc
Bringing Health to the Community

Why Ask These Questions?

Northern Valley Indian Health is committed to providing complete and comprehensive medical care for our patients.

Part of providing this care is to screen for conditions like depression, domestic abuse and alcohol problems. The questions in this brochure help us to know when to ask more questions and, in some cases, offer additional help to our patients.

This information you provide on this is a part of your medical record and is confidential. In some cases concerning active domestic violence NVIH is required by law to report to local authorities.

INTIMATE PARTNER /DOMESTIC VIOLENCE :

1. Have you ever been in a relationship with a person who hurt you?

   YES **NO**

2. Are you currently in a relationship with a person who physical hurts or threatens you?

   YES **NO**

3. Do you feel unsafe in your current relationship and home?

   YES **NO**

DEPRESSION SCREENING:

Over the past 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things
   - ❑ Not at all
   - ❑ Several days
   - ☐ More than half the days
   - ❑ Nearly every day
2. Feeling down, depressed or hopeless?
   - ☐ Not at all
   - ❑ Several days
   - ❑ More than half the days
   - ❑ Nearly every day

ALCOHOL USE SCREENING

Have you consumed beer, wine or other beverages containing alcohol in the past 6 months?

YES **NO** (if NO, stop here)

1. Have you ever tried to cut down on your drinking?

   YES **NO**

2. Do you ever get annoyed when people talk about your drinking?

   YES **NO**

3. Do you ever feel guilty about your drinking?

   YES **NO**

4. Have you ever had a drink first thing in the morning?

   YES **NO**

Medications **Diabetic/Hypertension** **Yrs _____/_____/_____**

Date	Medication (Dose/Frequency)	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /

Pnemovax / / Flu / / Td / / PPD / /

DATE	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Weight											
B/P											
Diabetic Foot Exam											
HG A1C (4x/yr)											
Date of Lab											
Total Cholesterol											
LDL/HDL	/	/	/	/	/	/	/	/	/	/	/
Triglycerides											
ALT											
Ur. Micro Alb or Alb Cr Ratiio											
Creatine											

Eye Exam 1x/yr	/ /	/ /	/ /
ECASA 81 325	Y / N		
ACE / ARB	Y / N		

Depression Screen	/
Domestic Violence Screen	/
CAGE	/

Patient ____________________ **DOB** ____________________

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 1year since their last Mammogram.
Opto. if due

6 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 starts 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).

Northern Valley Indian Health-Patient Chart Audit Tool

HRN #:________________Service Date:____________Time of Appt:________Time seen:_________Delay: Yes or No

Provider:__________________________________Chart Review Date:_______________Reviewer initials:__________________

Demographics	Y	N	N/A
Name Address and Phone number entered (MU)			
Emergency Contact information entered (MU)			
Preferred method of contact entered (MU)			
Ethnicity entered (MU)			
Race entered (MU)			
Homeless status information entered (MU)			
Migrant worker Status entered (MU)			
Number of people in household entered (MU)			
Employer information entered			
Spouse employer information entered			
Primary Language entered (MU)			
Preferred Language entered (MU)			
Internet Access: E mail address entered (MU)			
Total Household income entered			
Consents signed			
Insurance information entered			
Coding and billing compliance			
Insurance information documented			
Patient's consent and signature documented for release of medical information and assignment of benefits			
Providers signature documented			
Level of service documented (dependent on history, examination, and medical decision making)			
Medical necessity documented			
All reports/consultations initialed and/or dated by the provider			
Category of services (new or established patient) documented			
Review of systems included in history of medical problem			
Diagnosis code is correct			
Care rendered supports codes billed			
Missing modifiers and/or incorrect modifier used			
CPT® codes coded but not documented			
CPT® codes documented but not coded			
Fragmented billing found (unbundling)			
E/M (evaluation and management) codes documented			
Chart completed per NVIH time lines			
Nursing Department			
CPOE (MU)			
Medication List entered (MU)			
Medical Allergies listed (MU)			
Clinical Summaries entered (MU			
Vital Signs (MU)			
Smoking Status accessed and entered (MU, GPRA,Rural Quality ***)*** ***Reminders Tab***			
Immunizations: patient queried and data entered (GPRA) ***Reminders Tab***			
DM Eye Exam (GPRA) ***Reminders Tab***			
Mammography (GPRA) ***Reminders Tab***			
PAP Smear (GPRA) ***Reminders Tab***			
Alcohol (FAS) Screening (GPRA) ***Reminders Tab***			
Depression screen (GPRA) ***Reminders Tab***			
Intimate Partner Violence/Domestic Violence Screen (GPRA) ***Reminders Tab***			
A1c q 3 months for DM patients (GPRA, Rural Quality) ***Reminders Tab***			

Medical Providers			
CPOE-Computerized provider order entry (MU)			
POV entered (MU)			
Problem list updated/entered (MU)			
eRX Clinical indication for eRx (Mandatory requirement) (MU)			
Medication List entered (MU)			
Medication Allergy List reviewed same day as visit and before new meds prescribed (MU)			
Medication Reconciliation (list reviewed) (MU)			
Smoking Education/Counseling documented in Education tab (MU, GPRA, Rural Quality) ***Reminders tab***			
Referral (reason for) entered in Consult tab & need for explained to patient (MU, Rural Quality)			
Active problems updated and addressed (MU)			
Diabetes/CVD Patients: Nephropathy assessed (GPRA)			
Diabetes/ CVD Patients: Retinopathy assessed and documented in wellness tab (GPRA)			
Diabetes/ CVD Patients: BMI addressed with referral to dietitian if applicable (GPRA, Rural Quality)			
Diabetes/ CVD Patients: LDL assessed (GPRA, Rural Quality) ***Reminders tab***			
Diabetes: Glycemic Control (<.7 for GPRA and <8.0 for Rural Quality) ***Reminders tab***			
Summary of care documented (MU)			
Chart completed per NVIH time lines			
Dental Providers			
Medication List entered (MU)			
Medication Allergy List reviewed same day as visit and before new meds prescribed (MU)			
eRx-Clinical indication for eRx (Mandatory Requirement) (MU)			
Vital Signs documented (MU)			
Smoking Status documented (MU, GPRA, Rural Quality) ***Reminders tab***			
Smoking Cessation/Counseling documented in Education tab (MU, GPRA, Rural Quality) ***Reminders tab***			
Behavior Health			
Medication List entered (MU)			
Medication Allergy List reviewed same day as visit and before new meds prescribed (MU)			
eRx Clinical indication for eRx (Mandatory Requirement) (MU)			
Depression Screening documented (GPRA) ***Reminders tab***			
Alcohol Screening (FAS) documented (GPRA) ***Reminders tab***			
Intimate Partner Violence/domestic Violence Screen documented (GPRA) ***Reminders tab***			

Definitions and Information:

MU: Meaningful use Using the E H R to improve quality, safety, efficiency and reduce health care disparities
GPRA: Government Performance Reporting Act (report is due quarterly by the clinic)
Rural Quality: Measures-Performance Measures applicable to Grant Funding (report is due monthly by the clinic)
CPT®-Current Procedural Terminology (types of procedures that a patient might receive)
ICD-9-CM: International Classification of Diseases, Ninth Review on (clinical modification)-a type of diagnosis code that must be used on claims submitted to insurance companies the ICD-I-CM code must match the procedure code (CPT® code)

Demographics (MU): More than 50% of patients have specific demographic information recorded in the RPMS (preferred language, gender, race, ethnicity, date of birth, household income).

Vital Measurements (MU): More than 50% of the patients age 2 and older have vital measurements recorded in the E H R, (height, weight, BMI and blood pressure, including growth charts for children.

Smoking Status (MU): More than 50% of outpatients age 13 and older have their smoking status recorded in the E H R. Also, evidence of education for cessation to meet GPRA and Rural Quality Measures

CPOE (Computerized physician/provider order entry) (MU): More than 30% of all orders must be entered directly into E H R by the provider.

Medication List (MU): At least 80% of patients must have a medication list documented in the E H R (or notation of no medications).

eRX: e Prescribing (MU): More than 40% of prescriptions must be entered and transmitted electronically. Clinical indication must be documented for the medication at the time of prescribing.

Medication Allergy List (MU): At least 80% of patients must have drug allergies documented in the E H R (or notation of no allergies).

Medication Reconciliation (MU): Performed when new meds ordered, or existing orders rewritten. The patients list of current medication and list of prescribed medication is compared; clinical decision is based on the comparison. New list is communicated to the patient or appropriate care giver and documented with education code M-MR

Problem List (MU): At least 80% of patients seen by a provider must have a current Problem List (or notation of no problems).

Summary of care (MU): at least 50% of patients be provided with a summary of care within 3 days of visit.

Definitions for GPRA and Rural Measures:

Screening: Pap smear, mammography, tobacco use, depression, IPV/DV, and alcohol (FAS) Fetal Alcohol Syndrome to be performed during report period and entered as done GPRA measures

Immunizations: Adult patients 65 & older) assessed for Immunizations for Influenza, Pneumococcal. Pediatric ages19-35 months) assesses for Immunization package 4:3:1:3:3:1:4 GPRA Measures

Education: BMI, referral for nutritional consult or specific documentation addressing a follow-up plan for weight management. Alcohol (FAS) (Fetal Alcohol Syndrome) education and tobacco cessation documented by a nurse or provider in the Education tab of the EHR GPRA and Rural Quality Measures

Diabetes Nephropathy assessment: GFR and a quantitative urinary protein assessment, or evidence of diagnosis and/or treatment of end-stage renal disease. GPRA Measure

Diabetes Retinopathy assessment: Evidence of a qualified retinal exam performed GPRA Measure

CVD-Comprehensive assessment: consists of documented BP, LDL tobacco use, BMI calculated and lifestyle counseling. GPRA Measure and Rural Quality Measure

Diabetes/CVD LDL assessment: GPRA defines control LDL <=100, Rural Quality Measures defines control <100.

Diabetes Glycemic control: GPRA measures defines ideal control as HgbA1c <7, Rural Quality Measures defines control as <8.

Diabetes BP Control: GPRA defines control as <130/80, Rural Quality Measures defines control <140/90 (measurements are most recent in last 12 months)

Reminder Tabs: Utilized to alert the healthcare professional when a component of the patients care is due

Following chart review/audits forward the results to the appropriate manager for appropriate follow-up
Medical Records: Traci Ellis or Beya Villegas
Coding Compliance: Theresa Cameron
Medical Department: Sharon McClure, Quality Coordinator
Dental: Robin Brownfield

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? **Yes** **No**	Do you ever feel guilty about your drinking? **Yes** **No**	Do people complain about your drinking? **Yes** **No**	Do you drink in the morning to relieve symptoms of a hangover? **Yes** **No**

If results are positive, ask "Would you be interested in speaking with our counselors?"

[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*

	Condition	Understanding (Good-Fair-Poor-Group)	Minutes	Initials	Goal?	Comments
Counseled to quit tobacco?	TO-QT-					

Depression "Spirit of Sadness" Screen [EX 36] ***Age 18+*** **POSITIVE** **NEGATIVE** ***If positive complete PHQ-2***

[PHQ-2] PATIENT HEALTH QUESTIONAIRE 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 ½ (2)	Nearly daily (3)	
Little or no interest in doing things?					**0-2 = Negative**
Feeling down, depressed, hopeless?					**3-6 = Positive**

If results are positive, ask "Would you be interested in speaking with our counselors?"

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?**
[ ] Last Dental Exam	[ ] Pap Smear, GC/CT (*age 21-64*)	[ ] Influenza	DM [ ] A1c (twice)
[ ] Sealants (*age <12;12-18*)	[ ] Mammogram (*age 40-69*)	[ ] Pneumovax (*age 65+)*	DM [ ] UA Dip, Alb, Protein
[ ] Topical Fluoride	[ ] Colorectal Screen FOBT (*age 51-80*)	[ ] Child immunization	DM [ ] Lipid (twice)
[ ] Oral Hygiene	[ ] HIV Screening (all *age 12+*)	[ ] Td or DTaP (10 years)	DM [ ] CMP, Liver Panel
	[ ] EKG (yearly)		DM [ ] Eye, Retinal, Exam
	[ ] Tuberculosis Screen (PPD) (yearly)		DM [ ] Foot, Exam

[PED] Patient Education Topics *Example: PED-MNT-Good-10min-HL-GS:eat 2 vegetables/day starting today*

	Condition	Understanding (Good-Fair-Poor-Group)	Minutes	Initials	Goal	Comments
Nutrition	HPDP-N					
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					

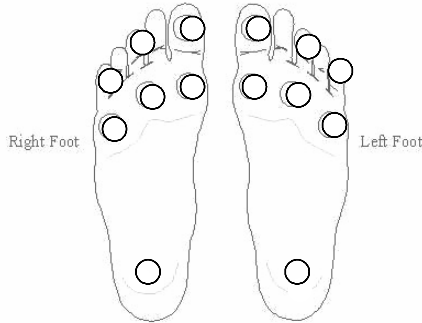
Date ____________ Name ____________________________________ Age _________ RPMS # _________________

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 # ________________

Quality Improvement Calendar 2012
Individual Department Initiative to be reported to Continuous Quality Improvement Committee Quarterly

Department	Improvement Initiative	Goal	1st Qtr 2012	2nd Qtr.	Action Plan Implemented? Improvement Initiative to be continued if the goal has not been met for the quarter tracked
Behavioral Health	IPV/DV screening Depression Screening Alcohol (FAS) Screening Medication lists Tobacco Cessation Screening				
Community Health Willows and Outreach-Chico	Immunization Registries (support) Women's Wellness – mammograms (GPRA) CDAC- Grindstone and Mechoopda DM Standards of Care compliance DM pts w/ A1C>9% will receive additional services Community Diabetes Screening Youth (7-17) Adults(18+)				
Dental Dept	CPOE Tobacco screening/education eRx				
Dental Reception	Tribal Verification Insurance information/copy Address proof CHS eligibility Ethnicity data Race data Primary Language Preferred Language Internet Access Email address Number in Household Total Household income				

Diabetes Education	Nutritional Education entered on all patients Tobacco Education on all patients				

Quality Improvement Calendar 2012

Department	Improvement Initiative	Goal	1st Qtr 2012	2nd Qtr 2012	Action Plan Implemented? Improvement Initiative to be continued if the goal has not been met for the quarter tracked
Human Resources	CPR certifications Coastal Training TB tests Physicals				
IT	Exchange Key Clinical Information Privacy/Security Timely Electronic Access to health Information				
Medical Department	CPOE (computerized provider order entry) Medication List & Allergy List Medication Reconciliation Vital signs Smoking Status Clinical Summaries Patient Reminders Immunization Registries				
Medical Records	Outside lab and radiology reports to be put in chart				
Medical Reception	Tribal Verification Insurance information/copy Address proof CHS eligibility Ethnicity data Race data Primary Language Preferred Language				

	Internet Access Email address Number in Household Total Household income				
Patient Accounts Contract Health Services	MUP reports and attestation Summary of Care CHS eligibility Financial agreements with outside providers				