Tips and Tools for Improving GPRA!

GPRA/GPRAMA RESOURCE GUIDE

Government Performance and Results Act (GPRA)

VERSION 4 : UPDATED for 2015 GPRA Year

CALIFORNIA AREA INDIAN HEALTH SERVICE

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GPRA/GPRAMA Resource Guide Version 4.0 (FY 2015)

The Government Performance and Results Act (GPRA) is a federal law requiring agencies to demonstrate that they are using their funds effectively toward meeting their missions. The GPRA Modernization Act (GPRAMA) strengthens GPRA by requiring federal agencies to use performance data to drive decision making. The Indian Health Service reports data for 21 annual clinical GPRA measures (4 of which are classified as GPRAMA measures) and one long-term GPRA measure. 20 of these measures have annual targets at the Area and site level. This resource guide was developed to assist clinic staff with improving care at their clinic as well as improving performance on the clinical GPRA measures.

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

California Area Office Contacts:

- CAO Office of Public Health Contacts

Intro to GPRA/GPRA 101:

- Important Websites for GPRA
- GPRA 101 for Patients flyer
- GPRA for Providers flyer
- GPRA numerator and denominator definitions Cheat Sheet
- Provider Article – March 2012: Intro to GPRAMA
- Provider Article – Jan 2012: Strategies of Sites Meeting All GPRA Measures

Data Entry:

- PCC Data Entry Cheat Sheet *Updated!
- EHR Data Entry Cheat Sheet *Updated!

CRS Tools:

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

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
- Article - Integrating Clinical Decision Support to Increase HIV and Chlamydia Screening *New!

CAO Trainings, Calls, & Conferences:

- FY 2015 California GPRA Monthly Webinar flyer *Updated!

- Instructions for joining the California GPRA/GPRAMA Portal
- FY 2015 California Providers Best Practices & GPRA Measures Continuing Medical Education Save the Date Flyer *Updated!

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)

Shared Tools and Resources: (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
- Northern Valley Quality Improvement Calendar
- Lake County's Standing Orders for Diabetic Patients

Shared Best Practices:

- **From Monthly California Area webinars:**
  - Shared Tips for Improving Nephropathy Assessment rates
  - Mammography Best Practices
  - Alcohol Screening Best Practices
  - Influenza Vaccination Best Practices
  - Breastfeeding Best Practices
  - Retinopathy Screening Best Practices
- Article – 2013: Use of Electronic Clinical Reminders to Increase Preventive Screenings in a Primary Care Setting *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.

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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
- CAO Portals
    - Site Managers Portal
    - GPRA/GPRAMA Portal
    - Dental Portal
- 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, EHR, and Improving Patient Care Initiative

Understanding the Government Performance and Results Act (GPRA)

What is GPRA?

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

What are GPRA measures?

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

Does GPRA mean my health information is made public?

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

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

- **Immunizations**

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

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

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

- **Dental Care**

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

- **Prenatal Care**

  Have all pregnant women received an HIV test?

- **Diabetes**

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

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

- **Cancer Screening**

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

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

- **Behavioral Health**

  Are all adult patients being screened for depression?

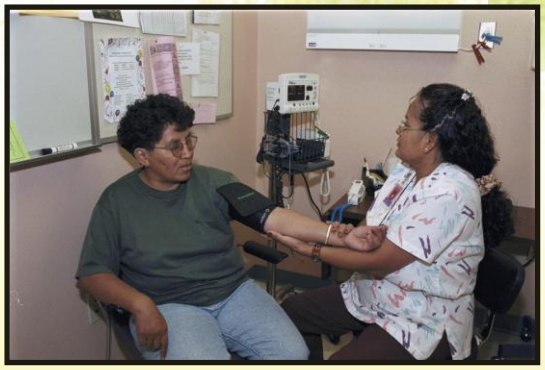
  Are women being screened for domestic violence and alcohol use (to prevent birth complications like Fetal Alcohol Syndrome)?

  Are tobacco-using patients being offered counseling to quit?

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

What Can You Do To Help?

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



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

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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?

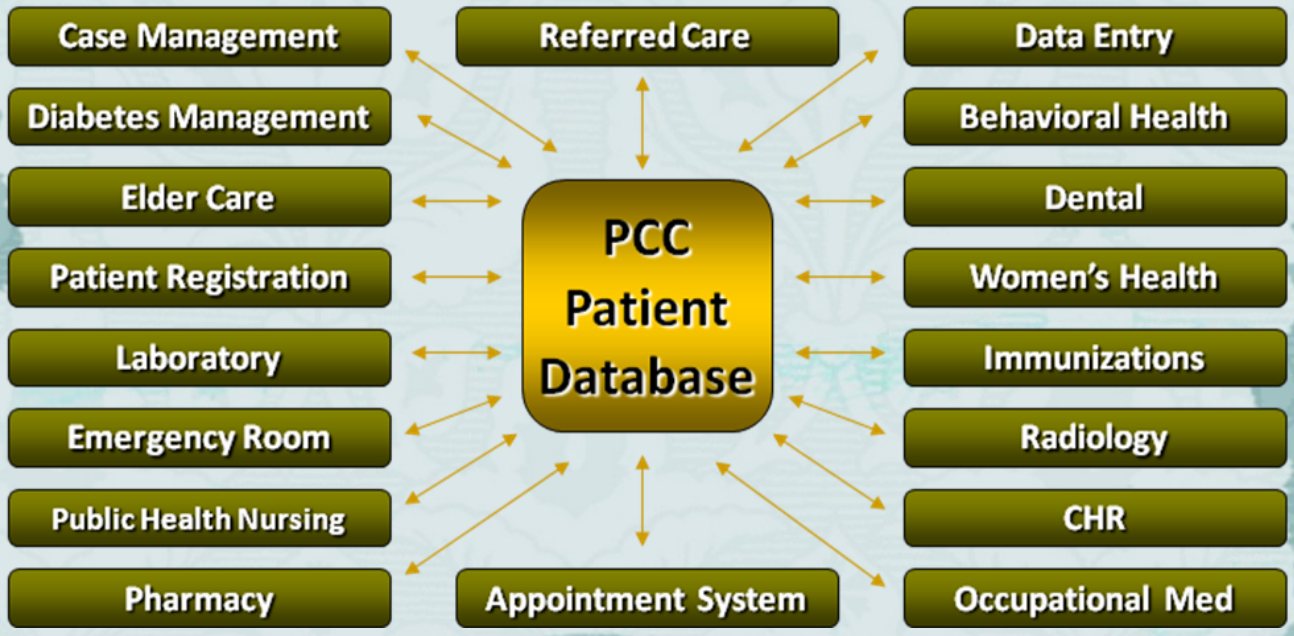
- At the end of each GPRA quarter and at the end of the GPRA year, facilities run their National GPRA report and export their data to their respective Area Offices.
- Area GPRA Coordinators load the facility reports and run an Area Aggregate report. This report shows if the overall Area GPRA measures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

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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 DIABETES	Numerator	(GPRAMA Measures listed in red) 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 or contraindication documented ever, and, if patient is older than 65 years, either a dose of pneumovax after the age of 65 or a dose of pneumovax in the past five years	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 a Pap smear documented in the past three years, or if patient is 30 to 64 years of age, either a Pap smear documented in the past 3 years or a Pap smear and an HPV DNA documented in the past 5 years	Female active clinical patients age 24-64 (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, received an Rx for smoking cesssation aid, or quit their tobacco use anytime during the report period	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
Breastfeeding Rates	# patients who, at the age of two months (45 through 89 days), were either exclusively or mostly breastfed	Active clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of two months (45 through 89 days)
Controlling High Blood Pressure	# patients with a BP less than 140/90	GPRA User Population patients ages 18 through 85 years diagnosed with hypertension and no documented history of ESRD or current diagnosis of pregnancy

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 UACR 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

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Significant Changes to GPRA Beginning in Fiscal Year 2013

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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…

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*.

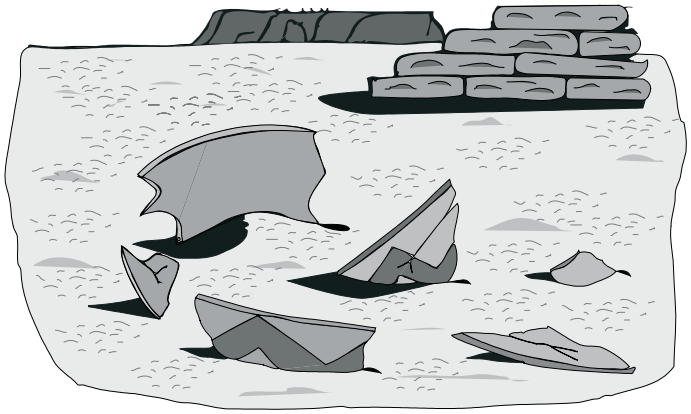
List of Abbreviations

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.*



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

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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…

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."

***Cheat Sheet* for PCC Documentation and Data Entry for CRS Version 15.0**
Last Updated November 2014

Data Entry Best Practices to Meet Measures

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.
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 when determining if a performance measure is met. To review that information, view the CRS short version logic at: http://www.ihs.gov/CRS/documents/crsv15/GPRAMeasuresV150.pdf

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

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 in PCC: • Date received • Location • Results	**Diabetes Prevalence Diagnosis POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: 250.00-250.93 or ICD-10: E10.*-E13.* Provider Narrative: Modifier: Cause of DX:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetes: Glycemic Control	Active Clinical Patients DX with diabetes and with an A1c: • Less than (<) 8 (Good Glycemic Control)	Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in 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] **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: • Less than (<) 140/90 (mean systolic less than (<) 140, mean diastolic less than (<) 90)	Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC: • Date received • Location • Results	**Standard PCC data entry:** **Blood Pressure Data Entry** Value: [Enter as Systolic/Diastolic (e.g., 140/90)] Select Qualifier: Date/Time Vitals Taken:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 in 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] 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetes: LDL Assessment (cont)			**LDL CPT** Mnemonic CPT enter Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F, G9271, G9272 Quantity: Modifier: Modifier 2:
Diabetes: Nephropathy Assessment	Active Clinical Patients DX with diabetes with a Nephropathy assessment: • Estimated GFR with result during the Report Period • Urine Albumin-to-Creatinine Ratio 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 in 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: **Urine Albumin-to-Creatinine Ratio CPT** Mnemonic CPT enter Enter CPT: 82043 AND 82570 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetes: Nephropathy Assessment (cont.)			**ESRD CPT** *Mnemonic CPT enter* Enter CPT: 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, 3066F, G0257, G9231, S2065 or S9339 Quantity: Modifier: Modifier 2: **ESRD POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: 585.6, V42.0, V45.11, V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2 Provider Narrative: Modifier: Cause of DX: **ESRD Procedure** *Mnemonic IOP enter* Operation/Procedure: ICD-9: 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)]

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetic Retinopathy	Patients with diabetes and no bilateral blindness 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 in 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 teleophthalmology 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, 67039, 67040, 92002, 92004, 92012, 92014 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetic Retinopathy (cont.)			**Other Eye Exam POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: V72.0 Provider Narrative: Modifier: Cause of 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 in 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: Exam Type: 30 Result: Comments: Encounter Provider:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Access to Dental Service (cont.)			**Dental Exam (ADA code)** *Mnemonic ADA enter* Dental Service Code: 0000, 0190, 0191 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 CPT** *Mnemonic CPT enter* Enter CPT: D0190, D0191 Quantity: Modifier: Modifier 2: **Dental Exam POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: V72.2; ICD-10: Z01.20, Z01.21 Provider Narrative: Modifier: Cause of DX:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Dental Sealants	Patients should have one or more intact dental sealants. **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 in PCC: • Date received • Location • Results	**Standard PCC data entry:** **Dental Sealants (ADA)** *Mnemonic ADA enter* Dental Service Code: 1351, 1352 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, D1352 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Topical Fluoride	Patients should have one or more topical fluoride applications. **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 in PCC: • Date received • Location • Results	**Standard PCC data entry:** **Topical Fluoride (ADA code)** *Mnemonic ADA enter* Dental Service Code: 1206, 1208, 5986 Type: No. Of Units: Operative Site: **Historical Fluoride (ADA code)** *Mnemonic HADA enter* Date of Historical ADA: Type: Location Name: ADA Code: 1206, 1208, 5986 Units: **Topical Fluoride CPT** *Mnemonic CPT enter* Enter CPT: D1206, D1208, D5986 Quantity: Modifier: Modifier 2: **Topical Fluoride POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: V07.31 Provider Narrative: Modifier: Cause of DX:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 PCC documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in 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, 144, 149, 150, 151, 153, 155, 158, 161 (other options are 111, 15, 16, 88) Lot: VFC Eligibility: **Historical Influenza Vaccine** *Mnemonic HIM enter* Date of Historical Immunization: Type: Location: Immunization Type: 140, 141, 144, 149, 150, 151, 153, 155, 158 (other options are 111, 15, 16, 88) Series: **Influenza Vaccine POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: *V04.81, *V06.6 Provider Narrative: Modifier: Cause of DX: * NOT documented with 90663, 90664, 90666-90668, 90470, G9141, G9142

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Adult Immunizations: Influenza (cont.)			**Influenza Vaccine CPT** *Mnemonic CPT enter* Enter CPT: 90654-90662, 90672, 90673, 90685-90688, G0008 Quantity: Modifier: Modifier 2: **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

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 PCC documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in 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, 152 Lot: VFC Eligibility: **Historical Pneumovax Vaccine** *Mnemonic HIM enter* Date of Historical Immunization: Type: Location: Immunization Type: 33, 100, 109, 133, 152 Series: **Pneumovax Vaccine POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: V06.6, V03.82 Provider Narrative: Modifier: Cause of DX: **Pneumovax Vaccine CPT** *Mnemonic CPT enter* Enter CPT: 90669, 90670, 90732, G0009, G9279 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Adult Immunizations: Pneumovax (cont.)			**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	How to Enter Data in PCC
Childhood Immunizations	Children age 19–35 months will be up-to-date for all ACIP recommended immunizations. This is the 4313*314 combo: 4 DTaP 3 IPV 1 MMR 3 Hepatitis B 3 or 4 Hib 1 Varicella 4 Pneumococcal Refusals should be documented. **Note**: Only NMI 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 in 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." • **OPV**: Immunization Package: "Immune Deficiency." • **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." • **Pneumococcal: Immunization Package**: "Anaphylaxis"	**Standard PCC data entry:** **Childhood Immunizations** *Mnemonic IM enter* Select Immunization Name: DTaP: 20, 50, 102, 106, 107, 110, 120, 130, 146; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113, 138, 139; 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; Pneumococcal: 33, 100, 109, 133, 152 Lot: VFC Eligibility:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Childhood Immunizations (cont.)		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 • 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 and IPV totaling three 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 or 4 doses of HIB, depending on the vaccine administered 1 dose of Varicella 4 doses of Pneumococcal	**Historical Childhood Immunizations** *Mnemonic HIM enter* Date of Historical Immunization: Type: Location: Immunization Type: DTaP: 20, 50, 102, 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; Pneumococcal: 33, 100, 109, 133, 152 Series:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 POV** *Mnemonic PPV enter* Purpose of Visit: DTaP: ICD-9: V06.1; DTP: ICD-9: V06.1, V06.2, V06.3; DT: ICD-9: V06.5; Td: ICD-9: V06.5; Diphtheria: ICD-9: V03.5; Tetanus: ICD-9: V03.7; Acellular Pertussis: ICD-9: V03.6; IPV: ICD-9: V04.0, V06.3; IPV (evidence of disease): ICD-9: 730.70-730.79, ICD-10: M89.6*; MMR: ICD-9: V06.4; Measles: ICD-9: V04.2; Measles (evidence of disease): ICD-9: 055*, ICD-10: B05.*; Mumps: ICD-9: V04.6; Mumps (evidence of disease): ICD-9: 072*, ICD-10: B26.*; Rubella: ICD-9: V04.3; Rubella (evidence of disease): ICD-9: 056*, 771.0, ICD-10: B06.*; Hepatitis B (evidence of disease): ICD-9: V02.61, 070.2, 070.3, ICD-10: B16.*, B19.1*, Z22.51; HIB: ICD-9: V03.81; Varicella: ICD-9: V05.4; Varicella (evidence of disease): ICD-9: 052*, 053*, ICD-10: B01.*-B02.*; Pneumococcal: ICD-9: V06.6, V03.82

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Childhood Immunizations (cont.)			**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: 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; Pneumococcal: 90669, 90670, 90732, G0009, G9279 Quantity: Modifier: Modifier 2: **NMI Refusal of Childhood Immunizations** *Mnemonic NMI enter* Patient Refusals For Service/NMI Refusal Type: Immunization Immunization Value: [See codes above] Date Refused: Provider Who Documented: Comment:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Childhood Immunizations (cont.)			**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

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Cancer Screening: Pap Smear Rates	Women ages 24-64 should have a Pap Smear every 3 years, or if patient is 30 to 64 years of age, either a Pap Smear documented in the past 3 years, or a Pap Smear and an HPV DNA documented in the past 5 years. **Note**: 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 in 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* Purpose of Visit: ICD-9: V72.32, V76.2, 795.0*; ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4 Provider Narrative: Modifier: Cause of DX: **Pap Smear CPT** *Mnemonic CPT enter* Enter CPT: 88141-88154, 88160-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 Quantity: Modifier: Modifier 2:

Cancer Screening: Pap Smear Rates (cont.)			**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] **HPV V Lab** *Mnemonic LAB enter* Enter Lab Test Type: HPV Results: [Enter Results] Units: Abnormal: Site: **HPV POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: V73.81, 079.4, 796.75, 795.05, 795.15, 796.79, 795.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51 Provider Narrative: Modifier: Cause of DX: **HPV CPT** *Mnemonic CPT enter* Enter CPT: 87620-87622 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 in 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Cancer Screening: Mammogram Rates (cont.)			**Mammogram POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: V76.11, V76.12, 793.80, 793.81, 793.89; ICD-10: R92.0, R92.1, R92.8, Z12.31 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: ICD-9: 87.36, 87.37; ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Colorectal Cancer Screening	Adults ages 50–75 should be screened for CRC (HEDIS). For GPRA, IHS counts any of the following: • Annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT) • Flexible sigmoidoscopy 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, or provider). Guaiac cards returned by patients to providers should be sent to Lab for processing. Ask and record historical information in 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: ICD-9: 153.*, 154.0, 154.1, 197.5, V10.05; ICD-10: C18.*, C19, C20, C78.5, Z85.030, Z85.038 Provider Narrative: Modifier: Cause of DX: **Total Colectomy CPT** *Mnemonic CPT enter* Enter CPT: 44150-44151, 44155-44158, 44210-44212 Quantity: Modifier: Modifier 2: **Total Colectomy Procedure** *Mnemonic IOP enter* Operation/Procedure: ICD-9: 45.8*; ICD-10: 0DTE*ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] **FOBT or FIT CPT** *Mnemonic CPT enter* Enter CPT: 82270, 82274, G0328 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Colorectal Cancer Screening (cont.)			**Flexible Sigmoidoscopy CPT** *Mnemonic CPT enter* Enter CPT: 45330-45345, G0104 Quantity: Modifier: Modifier 2: **Flexible Sigmoidoscopy Procedure** *Mnemonic IOP enter* Operation/Procedure: ICD-9: 45.24; ICD-10: 0DJD8ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] **Colon Screening CPT** *Mnemonic CPT enter* Enter CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121, G9252, G9253 Quantity: Modifier: Modifier 2: **Colon Screening Procedure** *Mnemonic IOP enter* Operation/Procedure: ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; ICD-10: (see logic manual for codes) Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Colorectal Cancer Screening (cont.)			**Historical CRC** *Mnemonic [from the following list] enter:* HCOL - Historical Colonoscopy HFOB - Historical FOBT (Guaiac) HSIG - Historical Sigmoidoscopy HBE - Historical Barium Enema Date: Type: Location of Encounter: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 in PCC: • Date received • Location • Results Document on designated Health Factors section of form: • HF–Current Smoker, every day • HF–Current Smoker, some day • HF–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Previous (Former) Smoker [or -Smokeless] (quit greater than (>) 6 months) • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<)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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 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 Education (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 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Use and Exposure Assessment (cont.)			**Smokeless Health Factor** *Mnemonic HF enter* Select V Health Factor: Current Smokeless or Cessation-Smokeless Level/Severity: Provider: Quantity: **ETS Health Factor** *Mnemonic HF enter* 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 or quit tobacco use. **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 in 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–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 6 months) Tobacco Patient Education Codes: • Codes will contain "TO-", "-TO", "-SHS" Prescribe Tobacco Cessation Aids: • Predefined Site-Populated Smoking Cessation Meds • Meds containing: - "Nicotine Patch" - "Nicotine Polacrilex" - "Nicotine Inhaler" - "Nicotine Nasal Spray"	**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 Education (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 Education (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 PCC
Tobacco Cessation (cont.)		**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 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 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 Quantity: Day Prescribed: Event Date&Time: Ordering Provider:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Cessation (cont.)			**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: **Quit Tobacco Health Factor** *Mnemonic HF enter* Select V Health Factor: Previous Smoker, Previous Smokeless Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Cessation (cont.)			**Quit Tobacco POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: 305.13, V15.82; ICD-10: F17.2*1, Z87.891 Provider Narrative: Modifier: Cause of DX:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 in PCC: • Date received • Location • Results Alcohol screening may be documented with either an exam code or the CAGE health factor in PCC. 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?	**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:

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 in PCC: • HF–CAGE 0/4 (all No answers) • HF–CAGE 1/4 • HF–CAGE 2/4 • HF–CAGE 3/4 • HF–CAGE 4/4	**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] Level/Severity: Provider: Quantity: **Alcohol Screening POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening (FAS Prevention) (cont.)		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	**Alcohol-Related Diagnosis POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: 303.*, 305.0*, 291.*, 357.5*; ICD-10: F10.1*, F10.20, F10.220-F10.29, F10.920-F10.982, F10.99, G62.1 Provider Narrative: Modifier: Cause of DX: Alcohol-Related Diagnosis BHS POV data entry Enter BHS problem code 10, 27, 29 **Alcohol-Related Procedure** *Mnemonic IOP enter* Operation/Procedure: ICD-9: 94.46, 94.53, 94.61-94.63, 94.67-94.69 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

Alcohol Screening (FAS Prevention) (cont.)		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 6 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.	**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 Education (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: Readiness to Learn: Level of Understanding: Provider: Length of Education (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 PCC
Alcohol Screening (FAS Prevention) (cont.)		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). A positive answer to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated. Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC: • Date received • Location • Results	**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* Patient Refusals For Service: Exam Exam Value: 35, ALC Date Refused: Provider Who Documented: Comment:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 in 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	How to Enter Data in PCC
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont.)			**IPV/DV Diagnosis POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: 995.80-83, 995.85, V15.41, V15.42, V15.49; ICD-10: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, Z91.410; IPV/DV Counseling: ICD-9: V61.11; ICD-10: Z69.11 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 Education (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 PCC
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont.)			**IPV/DV PED–Diagnosis** *Mnemonic PED enter* Select ICD Diagnosis Code Number: 995.80-83, 995.85, V15.41, V15.42, V15.49

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 in 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 • Mood Disorder Due to a General Medical Condition • Mood 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: ICD-9: V79.0 Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		**Note**: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below). Patient Health Questionnaire (PHQ-2 Scaled Version) Over the past two weeks, how often have you been bothered by any of the following problems? Little interest or pleasure in doing things • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Feeling down, depressed, or hopeless • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • 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** Provider should **Note** the screening tool used was the PHQ-2 Scaled at the Comment Mnemonic for the Exam Code.	**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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		PHQ9 Questionnaire Screening Tool Little interest or pleasure in doing things? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Feeling down, depressed, or hopeless? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Trouble falling or staying asleep, or sleeping too much? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Feeling tired or having little energy? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Poor appetite or overeating? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3	**Mood Disorder Diagnosis POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311; ICD-10: F06.31-F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0-F31.71, F31.73, F31.75, F31.77, F31.81-F31.9, F32.*-F39 Provider Narrative: Modifier: Cause of DX: Standard BHS Mood Disorder POV data entry Enter BHS problem code: 14, 15

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		Feeling bad about yourself—or that you are a failure or have let yourself or your family down? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Trouble concentrating on things, such as reading the newspaper or watching television? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • 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? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Thoughts that you would be better off dead, or of hurting yourself in some way? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3	

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		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 PCC
Childhood Weight Control	Patients ages 2–5 at the beginning of the report period whose BMI could be calculated and have a BMI equal to or greater than (=>) 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 in 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).	**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>How to Enter Data in PCC</th></tr>
<tr><td>Childhood Weight Control (cont.)</td><td></td><td>Patients with BMI either 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><td>Low-High</td><td></td><td>BMI >= 85</td><td>BMI >= 95</td><td colspan="2">Data Check Limits</td></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>Controlling High Blood Pressure - Million Hearts</td><td>User Population patients ages 18 through 85 diagnosed with hypertension and no documented history of ESRD or current diagnosis of pregnancy who have BP less than (<) 140/90 (mean systolic less than (<) 140, mean diastolic less than (<) 90).</td><td>Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC:
• Date received
• Location
• Results</td><td>Standard PCC data entry
Blood Pressure Data Entry
Mnemonic BP enter
Value: [Enter as Systolic/Diastolic (e.g., 140/90)]
Select Qualifier:
Date/Time Vitals Taken:</td></tr>
</table>

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Comprehensive CVD-Related Assessment	Active Clinical Patients ages 22 and older diagnosed with Coronary Heart Disease (CHD) prior to the Report Period, AND at least 2 visits during the Report Period, AND 2 CHD-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 PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in 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 greater than (>) 6 months) • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 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** **CHD Diagnosis POV** (Prior to the report period) *Mnemonic PPV enter* Purpose of Visit: ICD-9: 410.0-413.*, 414.0-414.9, 429.2, V45.81, V45.82; ICD-10: I20.0-I22.8, I24.0-I25.83, I25.89, I25.9 Provider Narrative: Modifier: Cause of DX: **CHD Diagnosis CPT** (Prior to the report period) *Mnemonic CPT enter* Enter CPT Code: 33510-33514, 33516-33519, 33521-33523, 33533-33536, S2205-S2209, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, G0290 Quantity : Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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	**CHD Diagnosis Procedure** (Prior to the report period) *Mnemonic IOP enter* Operation/Procedure: ICD-9: 36.1*, 36.2*, 00.66, 36.06-36.07; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*, 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734** Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] **Blood Pressure Data Entry** *Mnemonic BP enter* Value: [Enter as Systolic/Diastolic (e.g., 140/90)] Select Qualifier: Date/Time Vitals Taken: Results: Units: **LDL (Calculated) (REF)* Lab Test** *Mnemonic LAB enter* Enter Lab Test Type: LDL Abnormal: Site: [Blood, Serum] *REF – Reference Lab

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Comprehensive CVD-Related Assessment (cont.)			**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, G9271, G9272 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	How to Enter Data in PCC
Comprehensive CVD-Related Assessment (cont.)			**Tobacco Screening CPT** *Mnemonic CPT enter* Enter CPT Code: D1320, 99406, 99407, 1034F, 1035F, 1036F, 1000F, G9275, G9276 Quantity Modifier: Modifier 2: **Tobacco Related Diagnoses POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: 305.1, 649.00-649.04, V15.82; ICD-10: F17.2*, O99.33*, Z87.891 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 Education (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 PCC
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 Education (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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Comprehensive CVD-Related Assessment (cont.)			**Weight Measurement** *Mnemonic WT enter* Value: Select Qualifier: Actual Bed 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: ICD-9: V65.3; ICD-10: Z71.3 Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Comprehensive CVD-Related Assessment (cont.)			**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)] Readiness to Learn: Level of Understanding: Provider: Length of Education (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 PCC
Comprehensive CVD-Related Assessment (cont.)			**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 Education (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: Nutrition/Exercise/Lifestyle Adaption Patient Goals Enter via PATG menu Initial Goal Setting: Goal Set Select Goal Type: Nutrition or Physical Activity Goal Number: Goal Name: Reason for Goal: Provider: Goal Start Date: Goal Follow-up Date:

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 in PCC: • 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.	**Standard PCC data entry** **HIV Screen CPT** *Mnemonic CPT enter* Enter CPT Code: 86689, 86701-86703, 87390, 87391, 87534-39 Quantity: Modifier: Modifier 2: **HIV Diagnoses POV** *Mnemonic PPV enter* Purpose of Visit: ICD-9: 042, 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711-O98.73 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: Results:

Breastfeeding Rates

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.

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.

Feeding Choice (today) X	
Exclusive Breastfeeding	
Mostly Breastfeeding	
½ Breastfeeding ½ Formula feeding	
Mostly Formula feeding	
Formula only feeding	
One time data fields	
Mom's name or chart#	
Birth order	Birth wt.
started formula	___wks/mth
stopped breastfeeding	___wks/mth
started solids	___wks/mth

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

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

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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.	

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 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 Goal Codes: • GS–Goal Set • GM–Goal Met • GNM–Goal Not Met • GNS–Goal Not Set	**Patient Education Topic** 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 Education (minutes): Comment: Goal Code: GS, GM, GNM, GNS Goal Comment: **Patient Education Diagnosis** 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 Education (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 PCC
Patient Education Measures (Patient Education Report) (cont.)		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 • Follow-up • Home Management • Hygiene • Lifestyle Adaptation • Literature • Medical Nutrition Therapy • Medications • Nutrition • Prevention • Procedures • Safety • Tests • Treatment	

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Patient Education Measures (Patient Education Report) (cont.)		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	

***Cheat Sheet* for EHR Documentation and Data Entry for CRS Version 15.0**
Last Updated November 2014

Data Entry Best Practices to Meet Measures

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.
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/CRS/documents/crsv15/GPRAMeasuresV150.pdf

See Enter Information in EHR on Page 54 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: ICD-9: 250.00-250.93 or ICD-10: E10.*-E13.* Provider Narrative: Modifier: Cause of DX:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Glycemic Control	Active Clinical Patients DX with diabetes and with an A1c: • Less than (<) 8 (Good 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: **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: • Less than (<) 140/90 (mean systolic less than (<) 140, mean diastolic less than (<) 90)	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., 140/90)] Select Qualifier: Date/Time Vitals Taken:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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, G9271, G9272 Quantity: Modifier: Modifier 2:

Key Clinical Performance Objectives

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 • Urine Albumin-to-Creatinine Ratio 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: **Urine Albumin-to-Creatinine Ratio CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 82043 AND 82570 Quantity: Modifier: Modifier 2: **ESRD CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 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, 3066F, G0257, G9231, S2065 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: ICD-9: 585.6, V42.0, V45.11, V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2 Provider Narrative: Modifier: Cause of DX: **ESRD Procedure** Procedure Entry Operation/Procedure: ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6* Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX (ESRD)]

Diabetic Retinopathy	Patients with diabetes and no bilateral blindness 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 teleophthalmology 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, 67039, 67040, 92002, 92004, 92012, 92014 Quantity: Modifier: Modifier 2: **Other Eye Exam POV** Visit Diagnosis Entry Purpose of Visit: ICD-9: V72.0 Provider Narrative: Modifier: Cause of DX: **Other Eye Exam Clinic** Clinic Entry Clinic: A2, 17, 18, 64

Key Clinical Performance Objectives

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 CPT** Visit Services Entry (includes historical CPTs) Enter CPT: D0190, D0191 Quantity: Modifier: Modifier 2: **Dental Exam POV** Visit Diagnosis Entry Purpose of Visit: ICD-9: V72.2; ICD-10: Z01.20, Z01.21 Provider Narrative: Modifier: Cause of DX:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Dental Sealants	Patients should have one or more intact dental sealants. **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, D1352 Quantity: Modifier: Modifier 2:
Topical Fluoride	Patients should have one or more topical fluoride applications. **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 Fluoride CPT** Visit Services Entry (includes historical CPTs) Enter CPT: D1206, D1208, D5986 Quantity: Modifier: Modifier 2: **Topical Fluoride POV** Visit Diagnosis Entry Purpose of Visit: ICD-9: V07.31 Provider Narrative: Modifier: Cause of DX:

Key Clinical Performance Objectives

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, 144, 149, 150, 151, 153, 155, 158, 161 (other options are 111, 15, 16, 88) Lot: VFC Eligibility: **Influenza Vaccine POV** Visit Diagnosis Entry Purpose of Visit: ICD-9: *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, 90672, 90673, 90685-90688, G0008 Quantity: Modifier: Modifier 2: **NMI Refusal of Influenza** *NMI Refusals can only be entered in EHR via Reminder Dialogs.*

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Adult Immunizations: Influenza (cont.)			**Contraindication Influenza** Immunization Entry - Contraindications Vaccine: [See codes above] Reason: Egg Allergy, Anaphylaxis

Key Clinical Performance Objectives

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, 152 Lot: VFC Eligibility: **Pneumovax Vaccine POV** Visit Diagnosis Entry Purpose of Visit: ICD-9: 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, G9279 Quantity: Modifier: Modifier 2: **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

Key Clinical Performance Objectives

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 4313*314 combo: 4 DTaP 3 IPV 1 MMR 3 Hepatitis B 3 or 4 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." • **OPV**: Immunization Package: "Immune Deficiency." • **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." • **Pneumococcal: Immunization Package**: "Anaphylaxis"	**Childhood Immunizations** Immunization Entry (includes historical immunizations) Select Immunization Name: DTaP: 20, 50, 102, 106, 107, 110, 120, 130, 146; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113, 138, 139; 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; Pneumococcal: 33, 100, 109, 133, 152 Lot: VFC Eligibility:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations (cont.)		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 • 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 and IPV totaling three 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 or 4 doses of HIB, depending on the vaccine administered 1 dose of Varicella 4 doses of Pneumococcal	**Childhood Immunizations POV** Visit Diagnosis Entry Purpose of Visit: DTaP: ICD-9: V06.1; DTP: ICD-9: V06.1, V06.2, V06.3; DT: ICD-9: V06.5; Td: ICD-9: V06.5; Diphtheria: ICD-9: V03.5; Tetanus: ICD-9: V03.7; Acellular Pertussis: ICD-9: V03.6; IPV: ICD-9: V04.0, V06.3; IPV (evidence of disease): ICD-9: 730.70-730.79, ICD-10: M89.6*; MMR: ICD-9: V06.4; Measles: ICD-9: V04.2; Measles (evidence of disease): ICD-9: 055*, ICD-10: B05.*; Mumps: ICD-9: V04.6; Mumps (evidence of disease): ICD-9: 072*, ICD-10: B26.*; Rubella: ICD-9: V04.3; Rubella (evidence of disease): ICD-9: 056*, 771.0, ICD-10: B06.*; Hepatitis B (evidence of disease): ICD-9: V02.61, 070.2, 070.3, ICD-10: B16.*, B19.1*, Z22.51; HIB: ICD-9: V03.81; Varicella: ICD-9: V05.4; Varicella (evidence of disease): ICD-9: 052*, 053*, ICD-10: B01.*-B02.*; Pneumococcal: ICD-9: V06.6, V03.82 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; Pneumococcal: 90669, 90670, 90732, G0009, G9279 Quantity: Modifier: Modifier 2: **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 24-64 should have a Pap Smear every 3 years, or if patient is 30 to 64 years of age, either a Pap Smear documented in the past 3 years or a Pap Smear and an HPV DNA documented in the past 5 years. **Note**: 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: ICD-9: V72.32, V76.2, 795.0*; ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4 Provider Narrative: Modifier: Cause of DX: **Pap Smear CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 88141-88154, 88160-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 Quantity: Modifier: Modifier 2: **HPV V Lab** Lab Test Entry Enter Lab Test Type: [Enter site's defined HPV Lab Test] Clinical Indication:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Cancer Screening: Pap Smear Rates (cont.)			**HPV POV** Visit Diagnosis Entry Purpose of Visit: ICD-9: V73.81, 079.4, 796.75, 795.05, 795.15, 796.79, 795.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51 Provider Narrative: Modifier: Cause of DX: **HPV CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 87620-87622 Quantity: Modifier: Modifier 2:

Key Clinical Performance Objectives

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: ICD-9: V76.11, V76.12, 793.80, 793.81, 793.89; ICD-10: R92.0, R92.1, R92.8, Z12.31 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: ICD-9: 87.36, 87.37; ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

Key Clinical Performance Objectives

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 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: ICD-9: 153.*, 154.0, 154.1, 197.5, V10.05; ICD-10: C18.*, C19, C20, C78.5, Z85.030, Z85.038 Provider Narrative: Modifier: Cause of DX: **Total Colectomy CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 44150-44151, 44155-44158, 44210-44212 Quantity: Modifier: Modifier 2: **Total Colectomy Procedure** Procedure Entry Operation/Procedure: ICD-9: 45.8*; ICD-10: 0DTE*ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

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: ICD-9: 45.24; ICD-10: 0DJD8ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] **Colon Screening CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121, G9252, G9253 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening (cont.)			**Colon Screening Procedure** Procedure Entry Operation/Procedure: ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; ICD-10: (see logic manual for codes) 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–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Previous (Former) Smoker [or -Smokeless] (quit greater than (>) 6 months) • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<)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 Education (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 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: **ETS Health Factor** Health Factor Entry Select V Health Factor: Exp to ETS Level/Severity: Provider: Quantity:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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 or quit tobacco use. **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–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 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 Education (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 (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 Education (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, 4000F Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (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
Tobacco Cessation (cont.)			**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 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: **Quit Tobacco POV** Visit Diagnosis Entry Purpose of Visit: ICD-9: 305.13, V15.82; ICD-10: F17.2*1, Z87.891 Provider Narrative: Modifier: Cause of DX:

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: ICD-9: 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: ICD-9: 303.*, 305.0*, 291.*, 357.5*; ICD-10: F10.1*, F10.20, F10.220-F10.29, F10.920-F10.982, F10.99, G62.1 Provider Narrative: Modifier: Cause of DX: **Alcohol-Related Procedure** Procedure Entry Operation/Procedure: ICD-9: 94.46, 94.53, 94.61-94.63, 94.67-94.69 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

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	**Alcohol-Related PED - Topic** Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter Alcohol-Related Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Education (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 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 6 or more drinks on one occasion? • (0) Never • (1) Less than monthly • (2) Monthly • (3) Weekly • (4) Daily or almost daily	**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 Education (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-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 Education (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the related text)] Goal Comment: Provider's Narrative:

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). A positive answer to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated.	**Alcohol Screen AUDIT Measurement** Vital Measurements Entry (includes historical Vitals) Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken: **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:

Key Clinical Performance Objectives

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: ICD-9: 995.80-83, 995.85, V15.41, V15.42, V15.49; ICD-10: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, Z91.410; IPV/DV Counseling: ICD-9: V61.11; ICD-10: Z69.11 Provider Narrative: Modifier: Cause of DX:

Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont.)			**IPV/DV–Topic** Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter IPV/DV Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Education (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 Education (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:

Key Clinical Performance Objectives

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. Ask 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: ICD-9: 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 two weeks, how often have you been bothered by any of the following problems? Little interest or pleasure in doing things • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Feeling down, depressed, or hopeless • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • 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: ICD-9: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311; ICD-10: F06.31-F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0-F31.71, F31.73, F31.75, F31.77, F31.81-F31.9, F32.*-F39 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? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Feeling down, depressed, or hopeless? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Trouble falling or staying asleep, or sleeping too much? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Feeling tired or having little energy? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont.)		Poor appetite or overeating? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Feeling bad about yourself—or that you are a failure or have let yourself or your family down? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Trouble concentrating on things, such as reading the newspaper or watching television? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • 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? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • 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? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 PHQ9 Questionnaire (Continued) 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
Childhood Weight Control	Patients ages 2–5 at the beginning of the report period whose BMI could be calculated and have a BMI equal to or greater than (=>) 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 with BMI either 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><td>Low-High</td><td></td><td>BMI >= 85</td><td>BMI >= 95</td><td colspan="2">Data Check Limits</td></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>Controlling High Blood Pressure - Million Hearts</td><td>User Population patients ages 18 through 85 diagnosed with hypertension and no documented history of ESRD or current diagnosis of pregnancy who have BP less than (<) 140/90 (mean systolic less than (<) 140, mean diastolic less than (<) 90).</td><td>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:
Date received
Location
Results</td><td>Blood Pressure Data Entry
Vital Measurements Entry
(includes historical Vitals)
Value: [Enter as Systolic/Diastolic (e.g., 140/90)]
Select Qualifier:
Date/Time Vitals Taken:</td></tr>
</table>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment	Active Clinical Patients ages 22 and older diagnosed with Coronary Heart Disease (CHD) prior to the Report Period, AND at least 2 visits during the Report Period, AND 2 CHD-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 greater than (>) 6 months) • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 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"	**CHD Diagnosis POV (Prior to the report period)** Visit Diagnosis Entry Purpose of Visit: ICD-9: 410.0-413.*, 414.0-414.9, 429.2, V45.81, V45.82; ICD-10: I20.0-I22.8, I24.0-I25.83, I25.89, I25.9 Provider Narrative: Modifier: Cause of DX: **CHD Diagnosis CPT (Prior to the report period)** Visit Services Entry (includes historical CPTs) Enter CPT Code: 33510-33514, 33516-33519, 33521-33523, 33533-33536, S2205-S2209, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, G0290 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	**CHD Diagnosis Procedure (Prior to the report period)** Procedure Entry Operation/Procedure: ICD-9: 36.1*, 36.2*, 00.66, 36.06-36.07; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*, 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734** Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX (ESRD)] **Blood Pressure Data Entry** Vital Measurements Entry (includes historical Vitals) Value: [Enter as Systolic/Diastolic (e.g., 140/90)] 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

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont.)			Visit Services Entry (includes historical CPTs) Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F, G9271, G9272 Quantity: Modifier: Modifier 2: **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, 1000F, G9275, G9276 Quantity Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont.)			**Tobacco Related Diagnoses POV** Visit Diagnosis Entry Purpose of Visit: ICD-9: 305.1, 649.00-649.04, V15.82; ICD-10: F17.2*, O99.33*, Z87.891 Provider Narrative: Modifier: Cause of DX: **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 Education (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.)			**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 Education (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.)			**Tobacco Screening PED–CPT** Patient Education Entry (includes historical patient education) Select CPT Code Number: D1320, 99406, 99407, 1034F, 1035F, 1036F, 1000F, G8453, G9275, G9276 Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (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** Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont.)			**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: **Medical Nutrition Therapy Clinic** Clinic Entry Clinic: 67, 36 **Nutrition Education POV** Visit Diagnosis Entry Purpose of Visit: ICD-9: V65.3; ICD-10: Z71.3 Provider Narrative: Modifier: Cause of DX:

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

Key Clinical Performance Objectives

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: ICD-9: 042, 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711-O98.73 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:

Key Clinical Performance Objectives

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 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 Goal Codes: • GS–Goal Set • GM–Goal Met • GNM–Goal Not Met • GNS–Goal Not Set	**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 Education (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 Education (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
Patient Education Measures (Patient Education Report) (cont.)		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	

Enter Information in EHR

This section contains general instructions on how to enter the following information in EHR:

> **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.

> **Note**: 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.

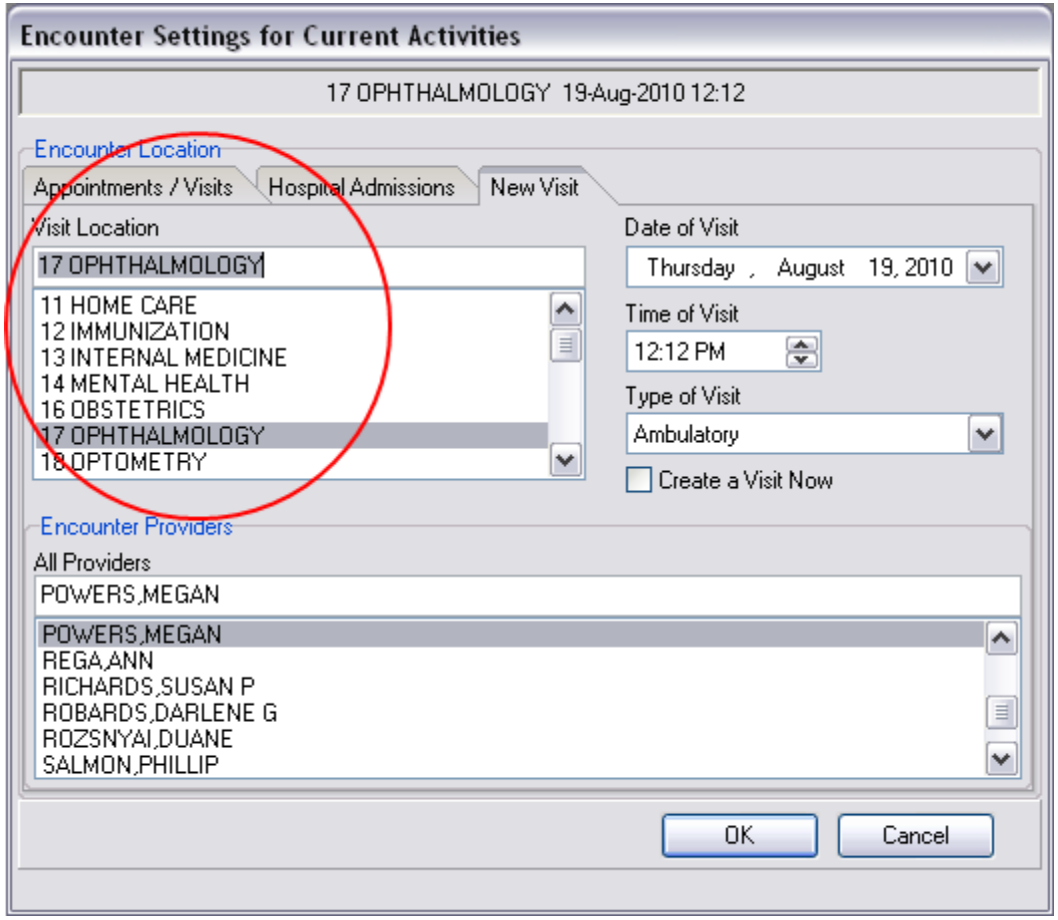


Figure 1: Choosing a clinic code

Purpose of Visit/Diagnosis

The purpose of visit (POV) is entered in the **Visit Diagnosis** component, located on the **Prob/POV** tab (Figure 2).

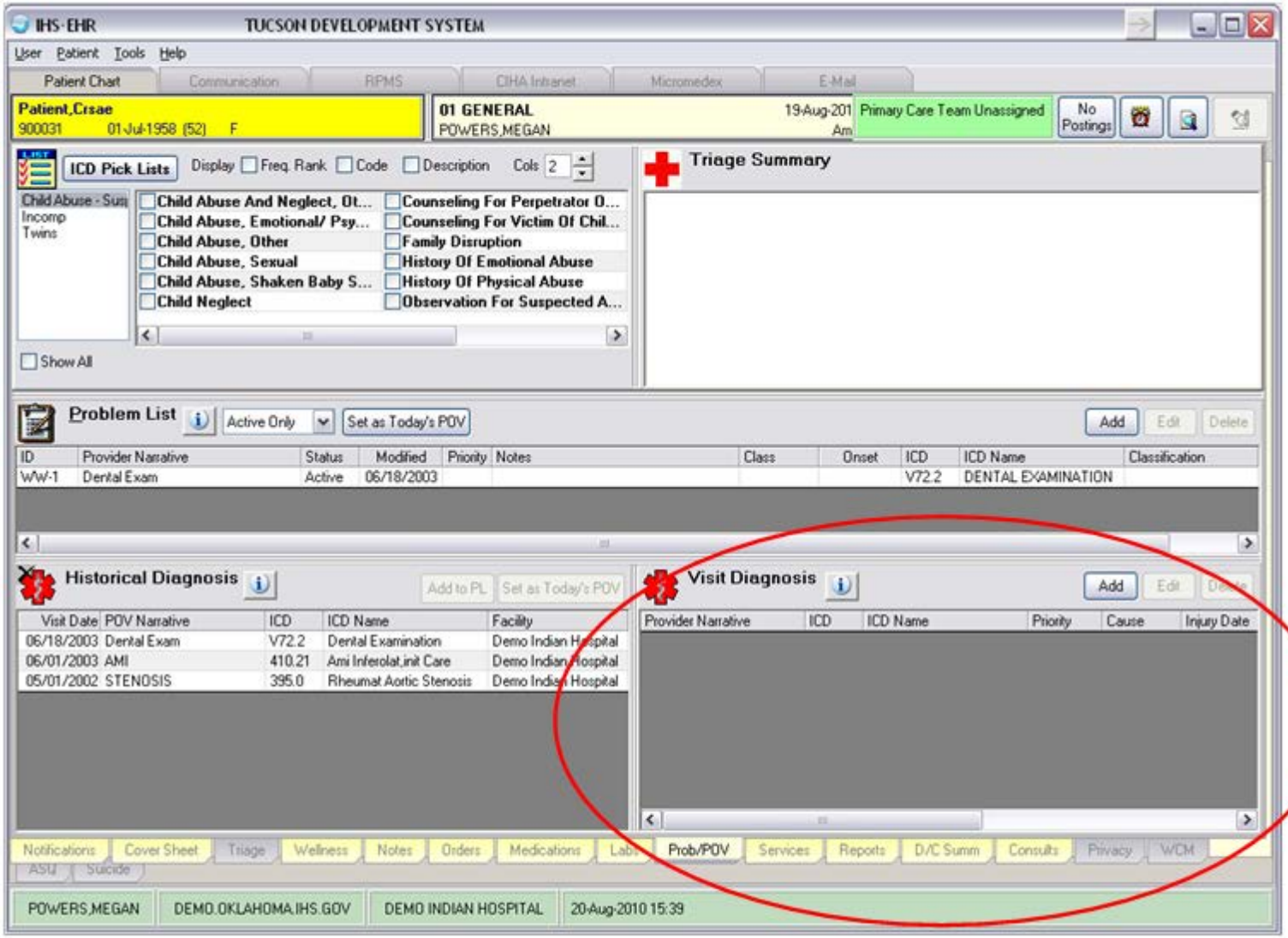


Figure 2: **Visit Diagnosis** component

To enter a POV:

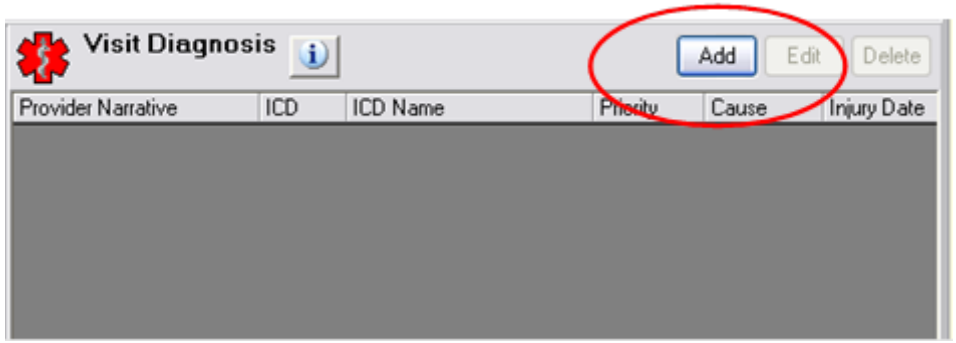


Figure 3: Entering a POV

1. Click **Add** in the **Visit Diagnosis** component. The **Add POV for Current Visit** dialog (Figure 4) displays.

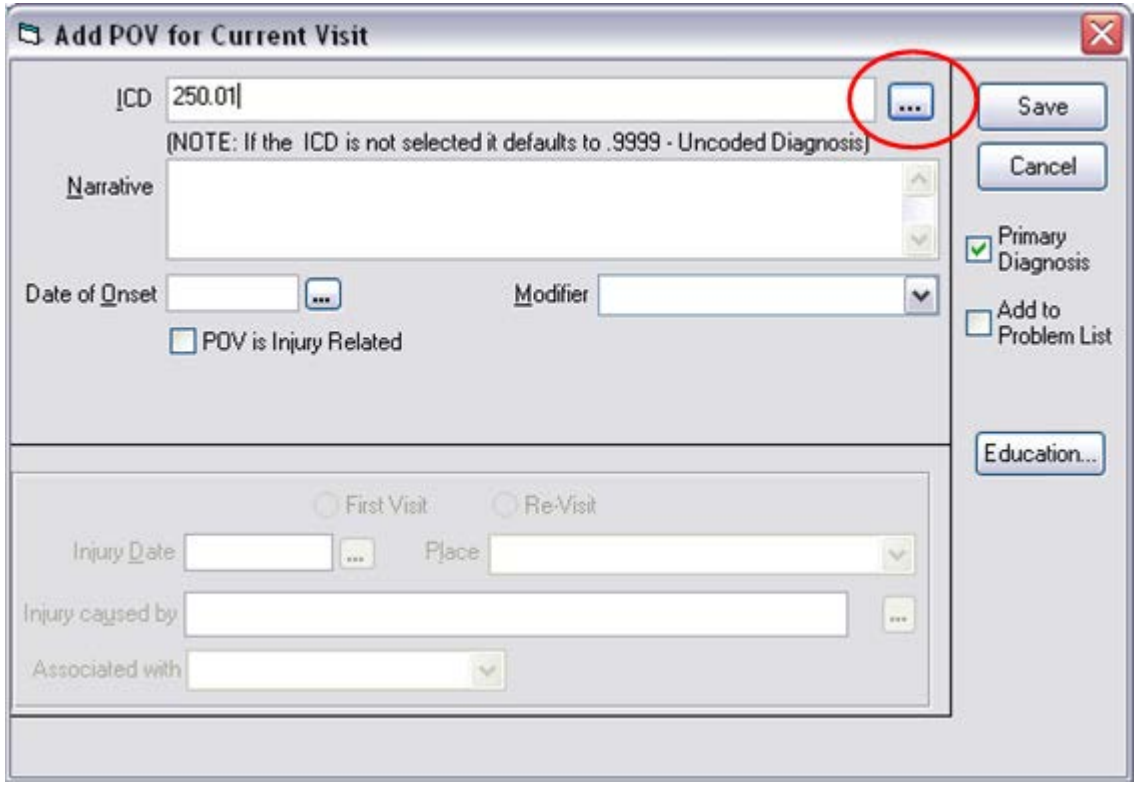


Figure 4: **Add POV for Current Visit** dialog

2. Type the **ICD** code and click the ellipses (**…**) button. The **Diagnosis Lookup** dialog (Figure 5) displays.

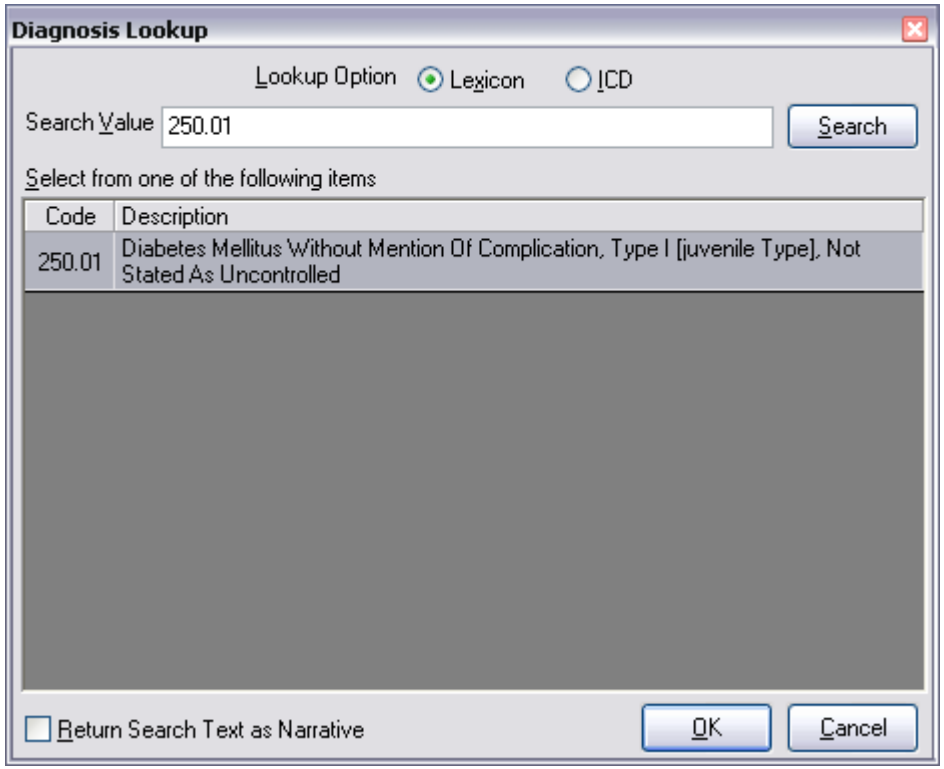


Figure 5: Entering the ICD code

3. Click to highlight the ICD to find and click **OK**. The **Add POV for Current Visit** dialog (Figure 6) displays.

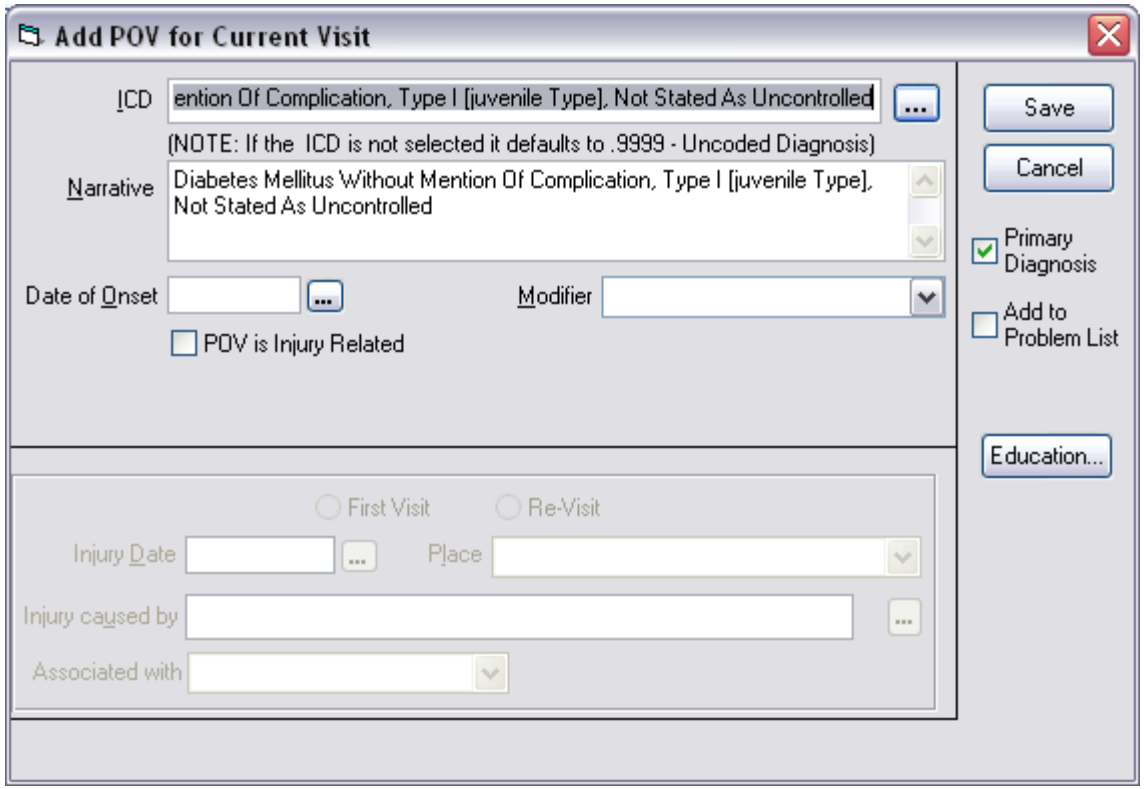


Figure 6: Entering additional POV information

4. Enter any other pertinent information and click **Save**. The newly added POV should display in the **Visit Diagnosis** component (Figure 7).

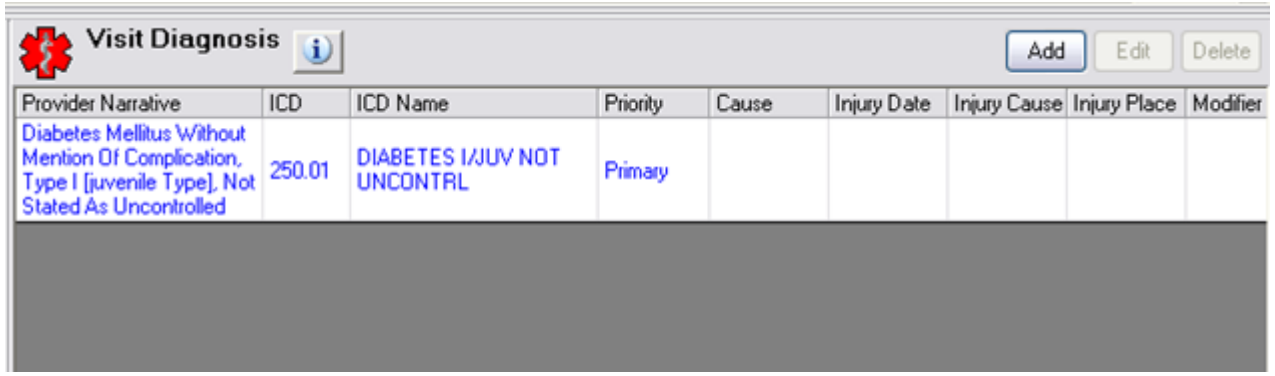


Figure 7: Example of a newly added POV

CPT Codes

CPT codes are entered in the **Visit Services** component, located on the **Services** tab (Figure 8).

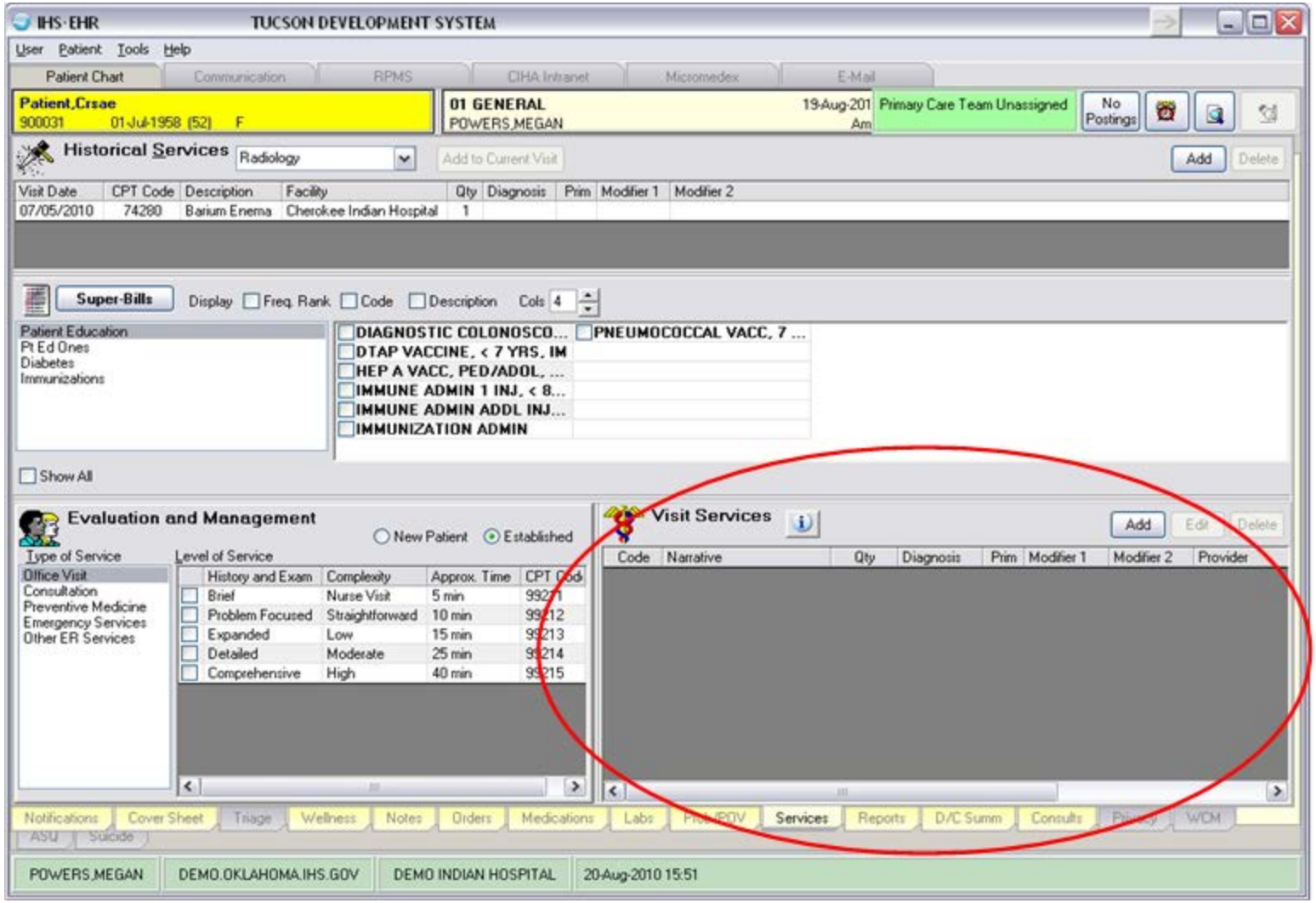


Figure 8: **Visit Services** component

To enter a CPT code:

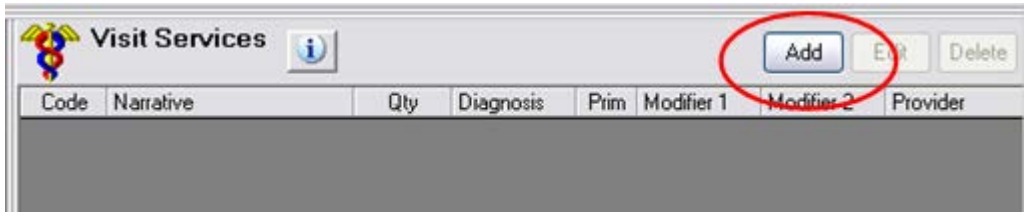


Figure 9: Entering a CPT code

1. Click the **Add** button in the **Visit Services** component. The **Add Procedure for Current Visit** dialog (Figure 10) displays.

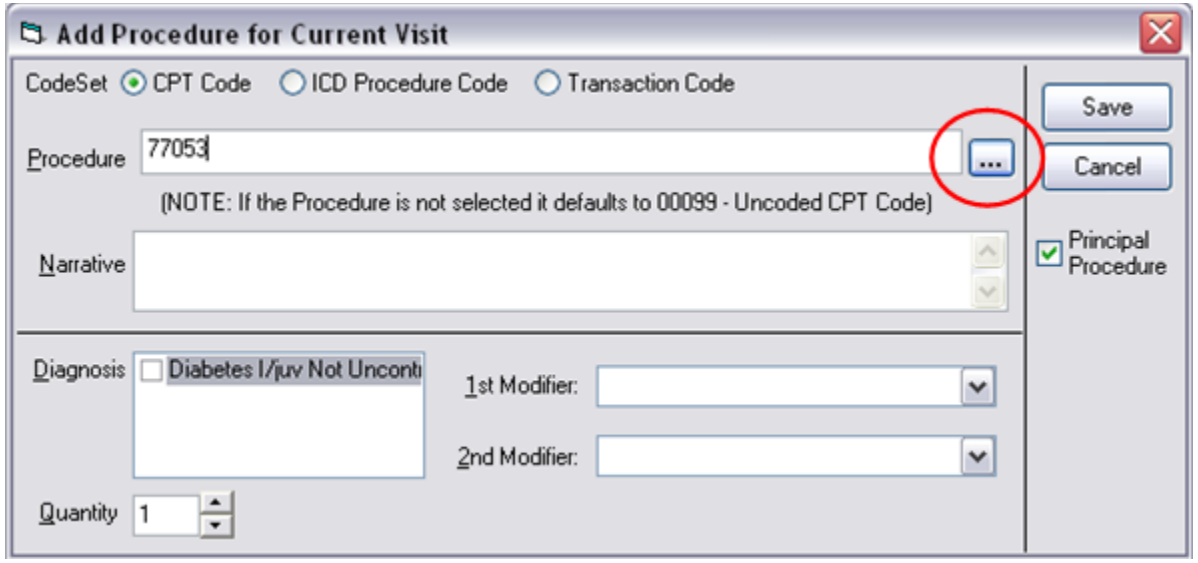


Figure 10: Entering the CPT code

2. In the **Procedure** field, type the CPT code and click the ellipses (…) button. The **Procedure Lookup** dialog (Figure 11) displays.

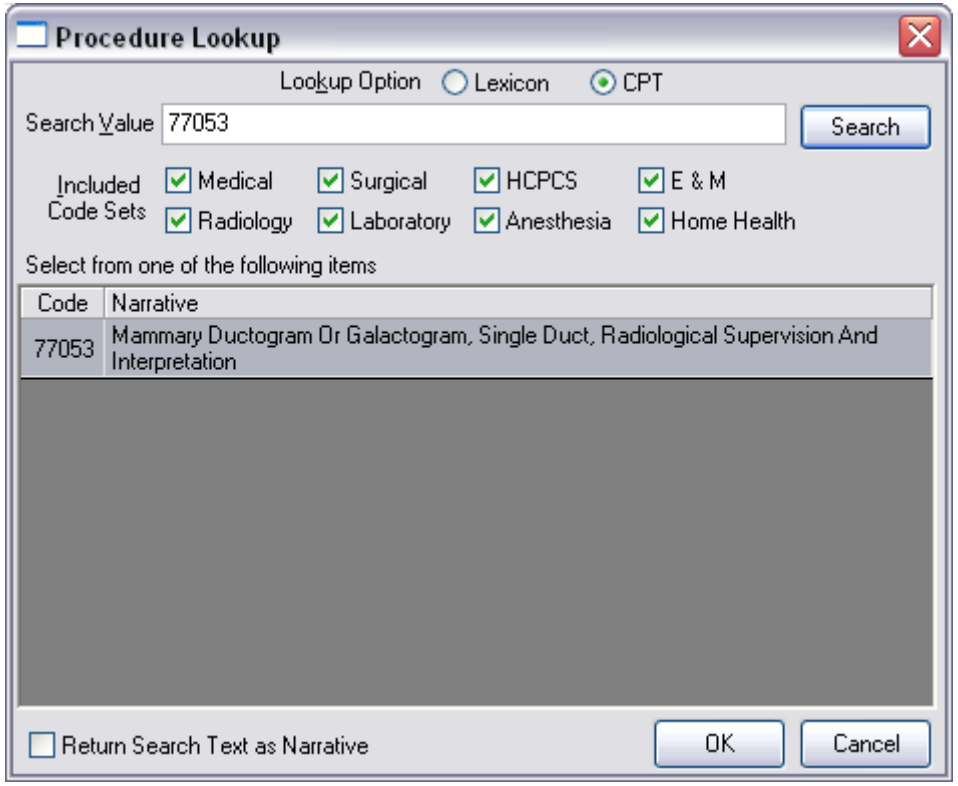


Figure 11: **Procedure Lookup** dialog

3. Click to select the CPT to enter and click **OK**. The Add Procedure for Current Visit dialog (Figure 12) displays. If you cannot find the CPT code, try the following:
   a. Ensure that **CPT** is chosen in the **Lookup Option**.
   b. Select additional **Included Code Sets**.

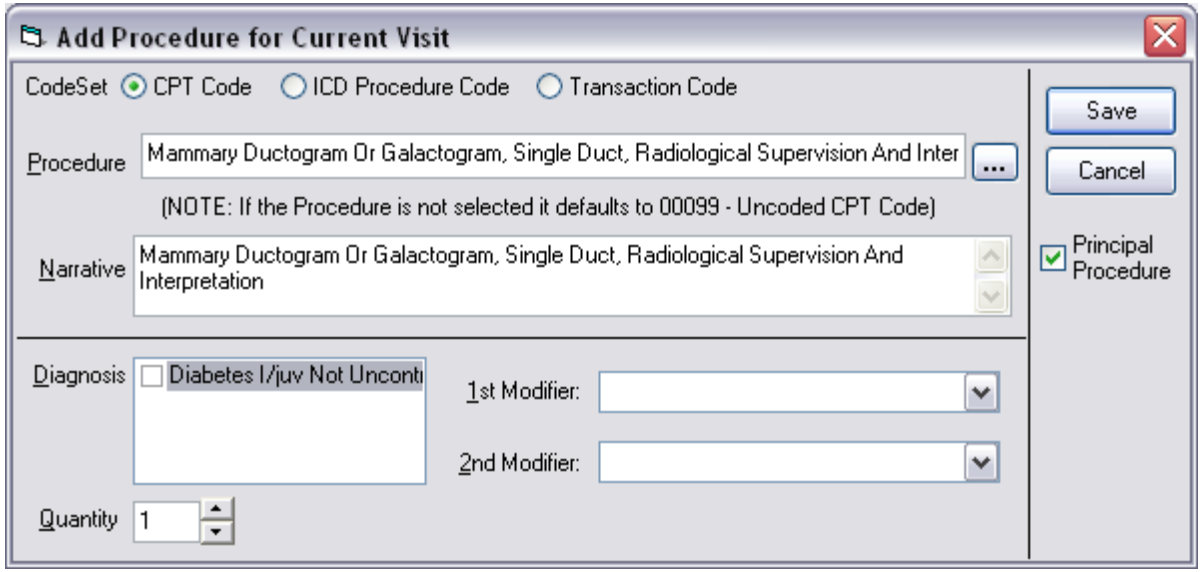


Figure 12: Entering additional Procedure information

4. Enter any other pertinent information and click **Save**. The newly added CPT code should display in the **Visit Services** component (Figure 13).

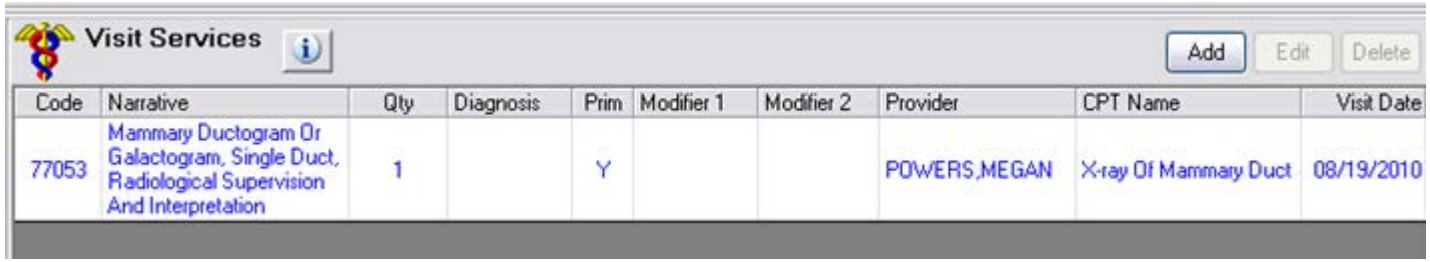


Figure 13: Example of a newly added CPT code

Historical CPT codes are entered in the **Historical Services** component, located on the **Services** tab (Figure 14).

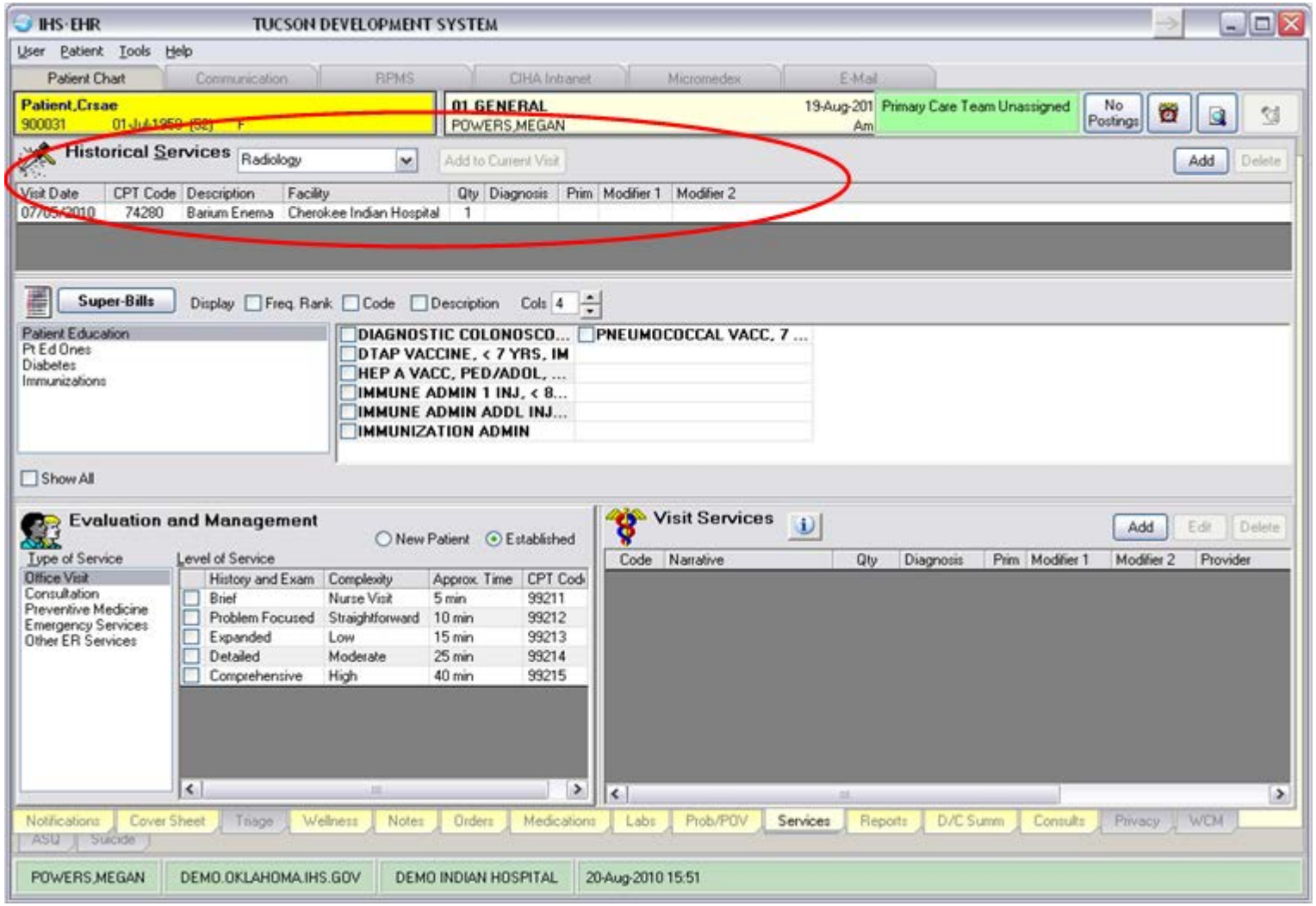


Figure 14: **Historical Services** component

To enter a CPT code:

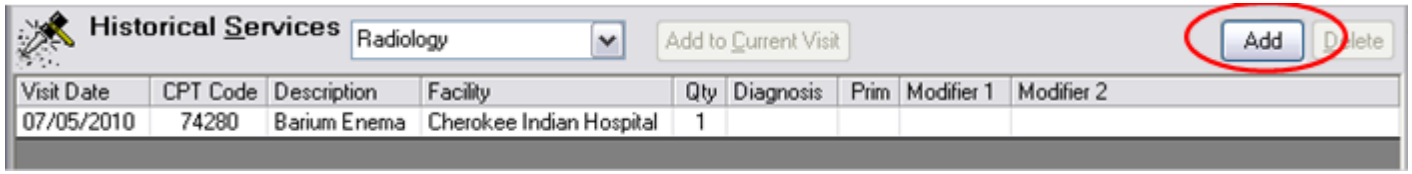


Figure 15: Example of entering a CPT code

1. Click **Add** in the **Visit Services** component. The **Add Historical Service** dialog (Figure 16) displays.
2. Do one of the following:

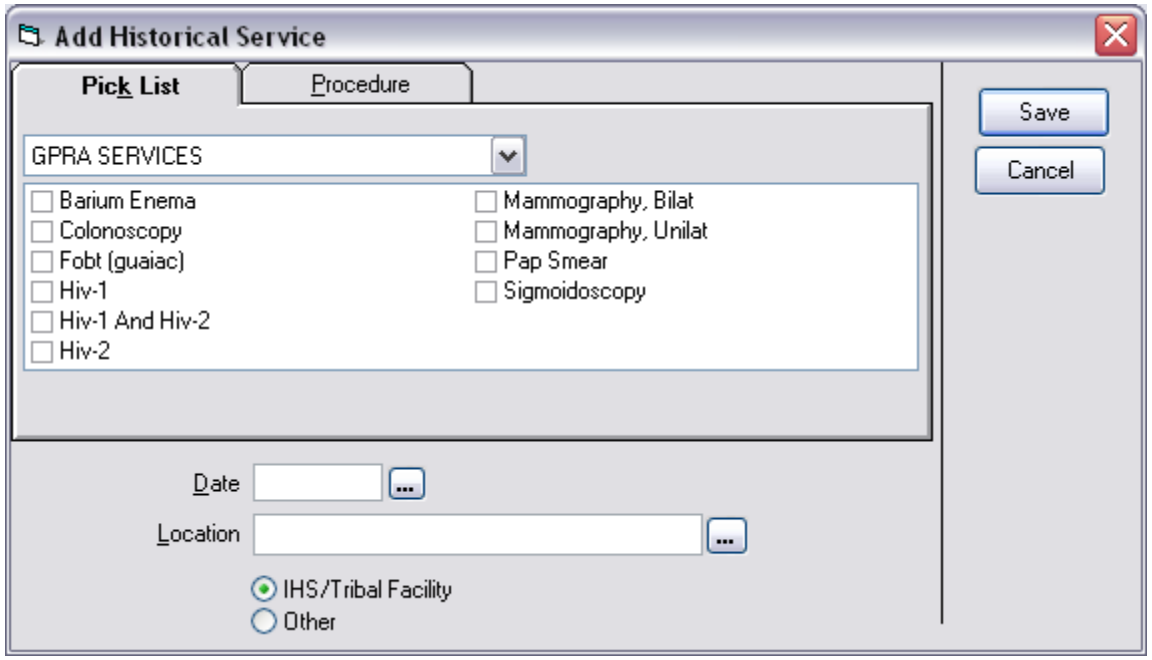


Figure 16: Adding a historical service using the **Pick List**

- At the **Pick List** tab (Figure 16), choose a service and select a procedure:

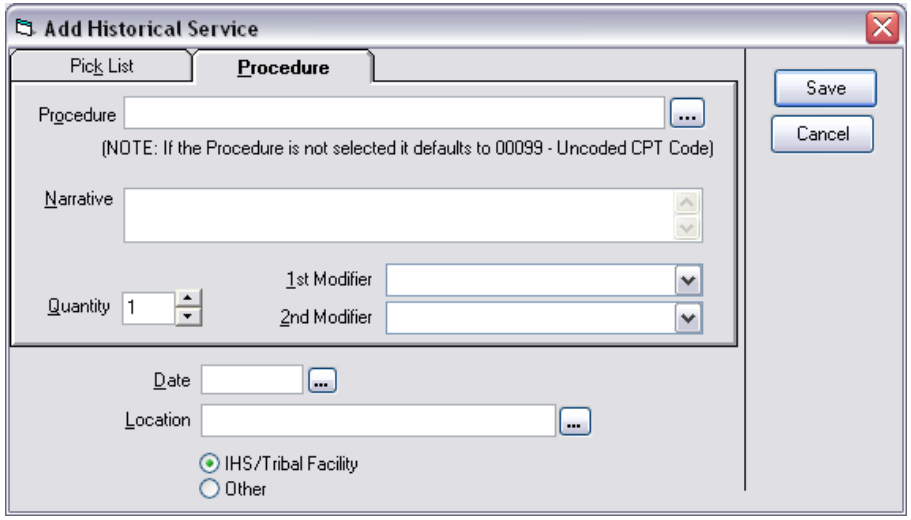


Figure 17: Adding a historical service by **Procedure**

- At the **Procedure** tab in the **Procedure** field (Figure 17), type the CPT code and proceed as in Steps 2-3 starting on Page 61.

3. Type the **Date** and **Location** of the service.
4. Click **Save**. The newly added CPT code should display in the **Historical Services** component (Figure 18).

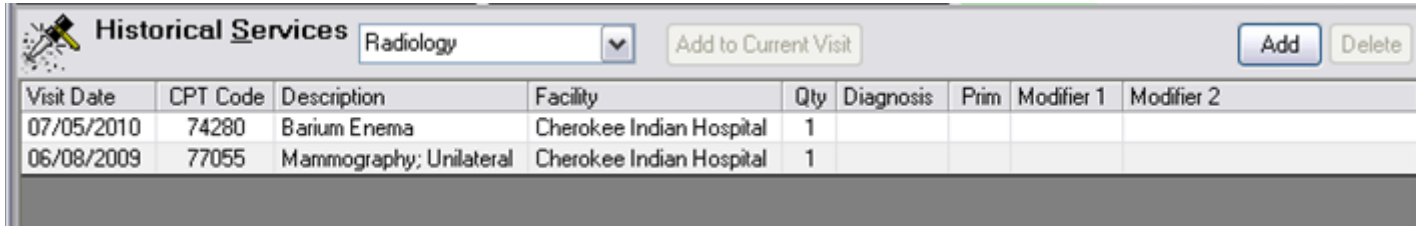


Figure 18: Example of a newly added Historical Service

Procedure Codes

Procedure codes are entered in the **Visit Services** component, located on the **Services** tab (Figure 19).

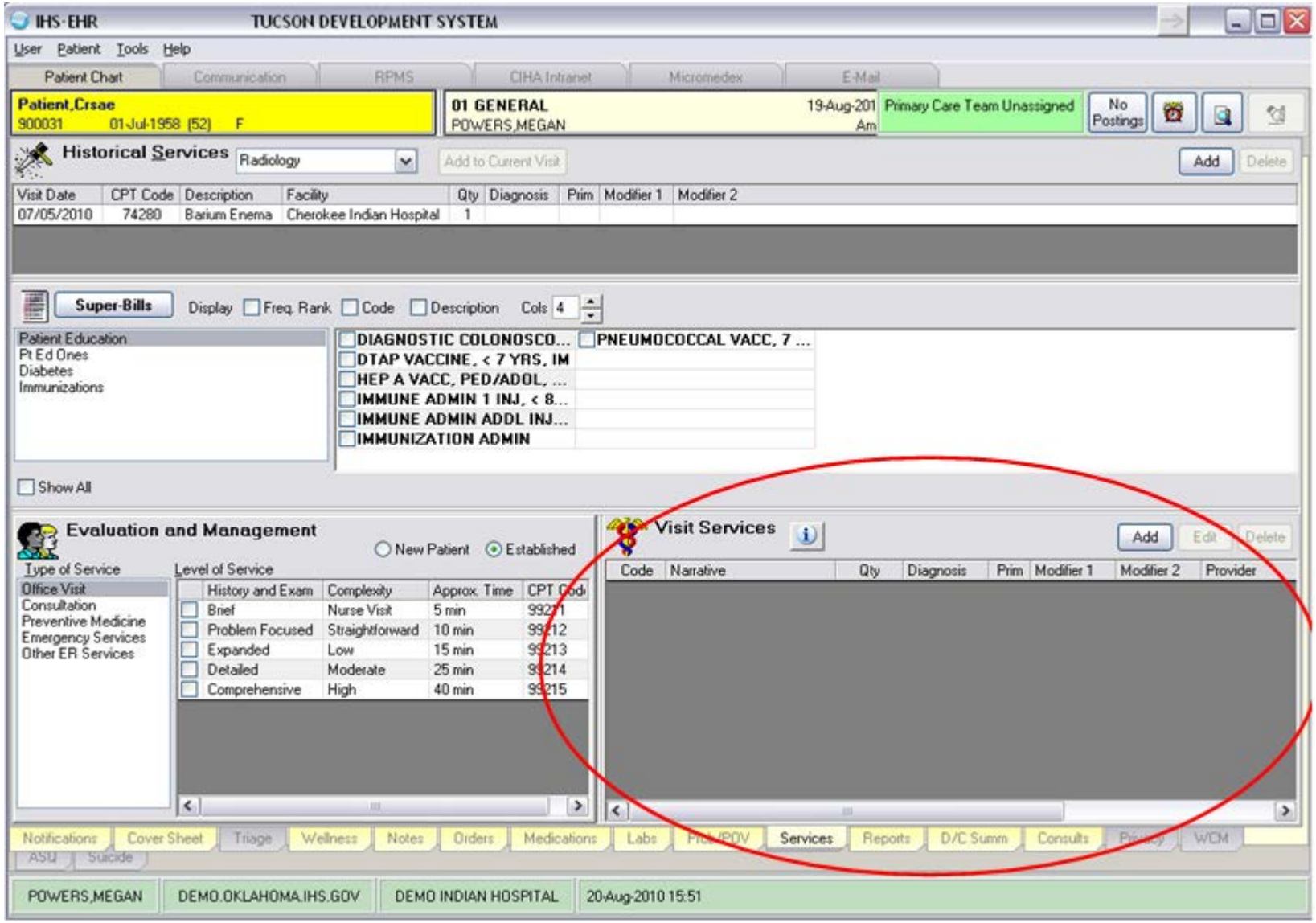


Figure 19: **Visit Services** component

To enter a Procedure code:

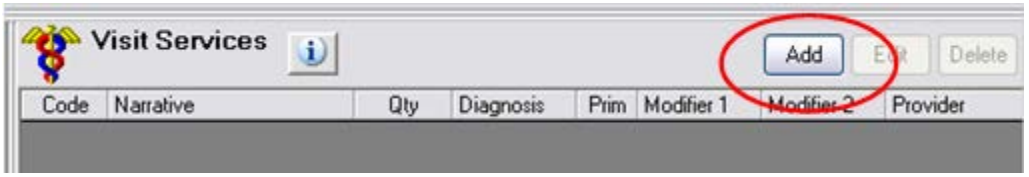


Figure 20: Entering a Procedure code

1. Click **Add** in the **Visit Services** component. The **Add Procedure for Current Visit** dialog (Figure 21) displays.

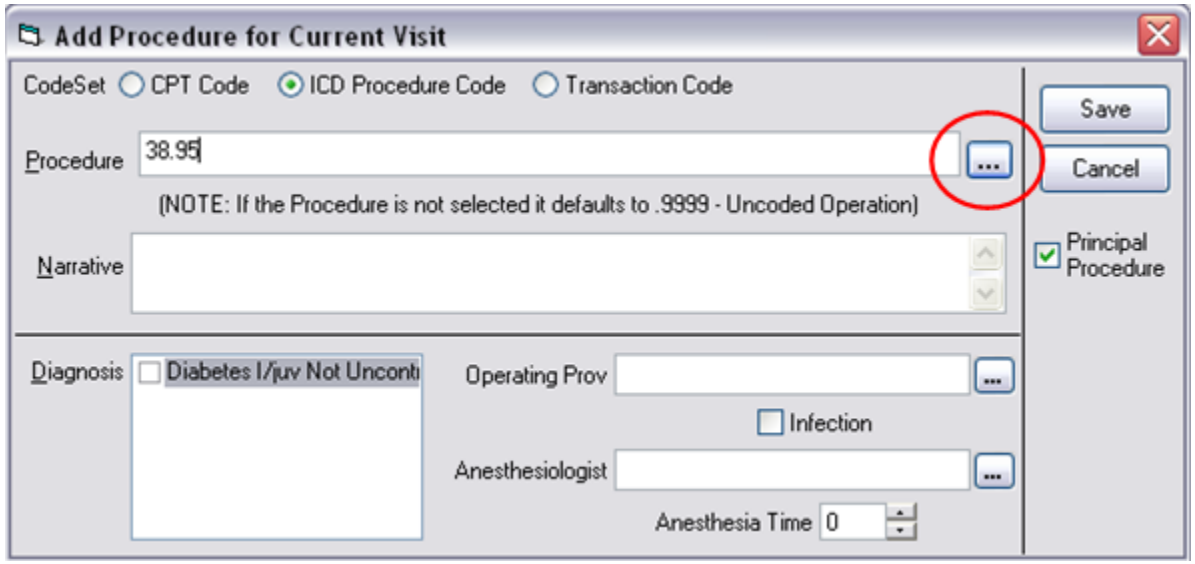


Figure 21: **Add Procedure for Current Visit** dialog

2. Ensure that the **CodeSet** value is set to **ICD Procedure Code**.
3. Type the **Procedure** code and click the ellipses (…) button. The **Lookup ICD Procedure** dialog (Figure 22) displays.

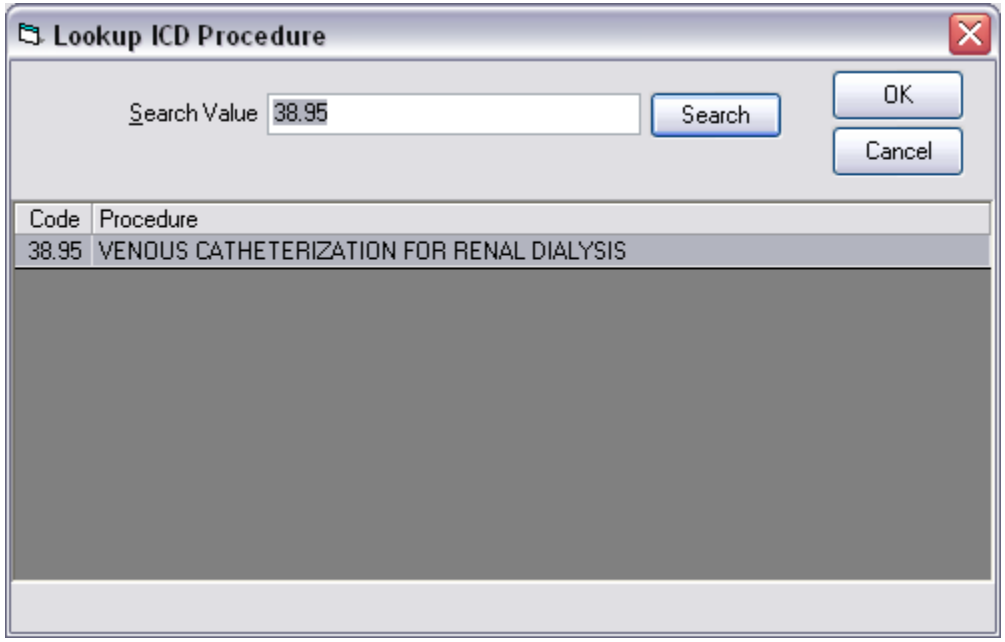


Figure 22: Choosing a Procedure

4. Click to select the **Procedure**.
5. Click **OK** to return to the **Add Procedure for Current Visit** dialog (Figure 23).

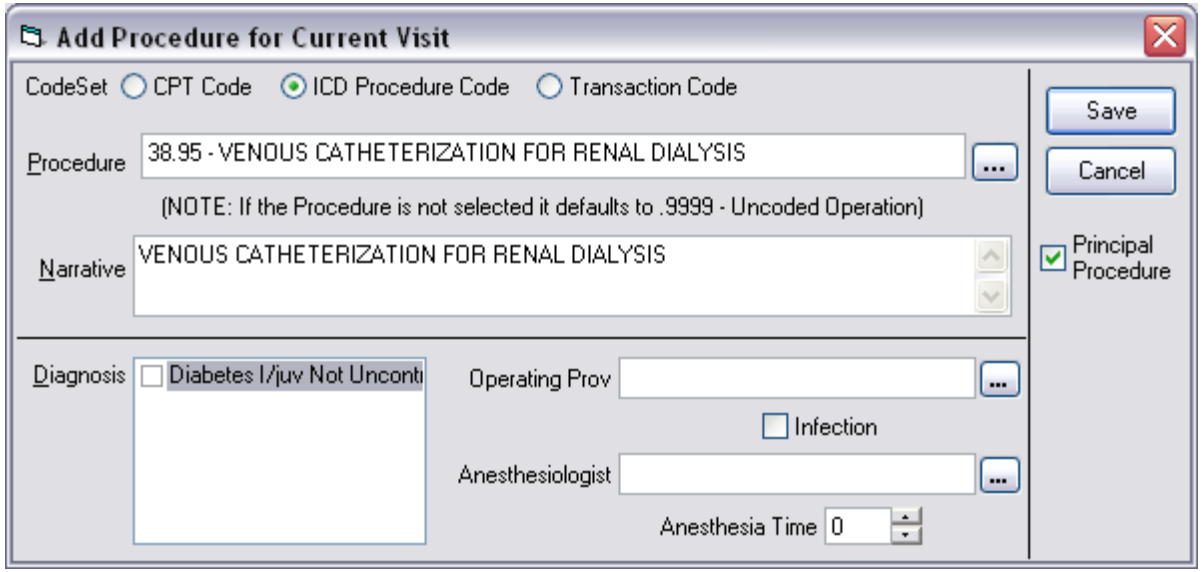


Figure 23: Entering additional Procedure information

6. Type any other pertinent information and click **Save**. The newly added CPT code should appear in the **Visit Services** component (Figure 24).

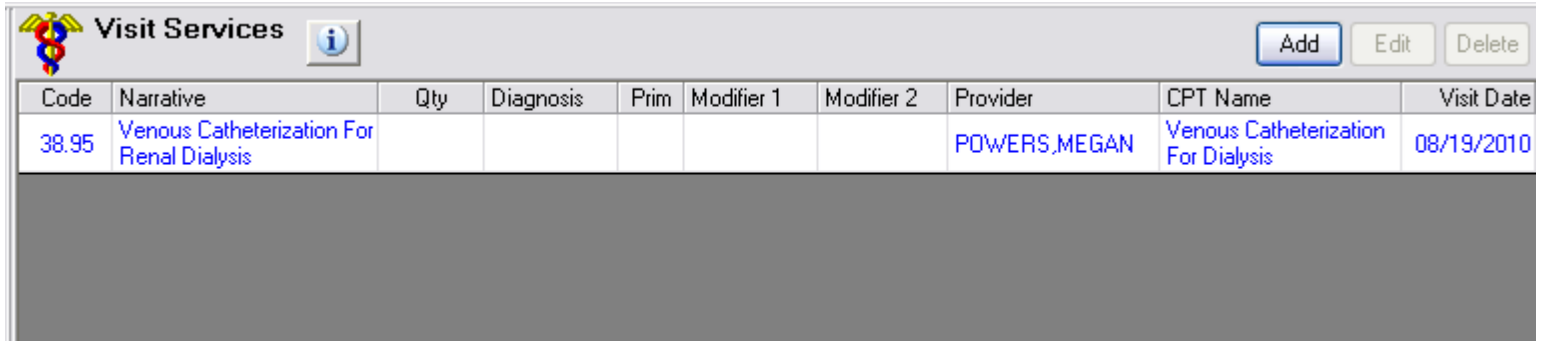


Figure 24: Example of a newly added Procedure code

Exams

Exam codes are entered in the **Exams** component, located on the **Wellness** tab (Figure 25).

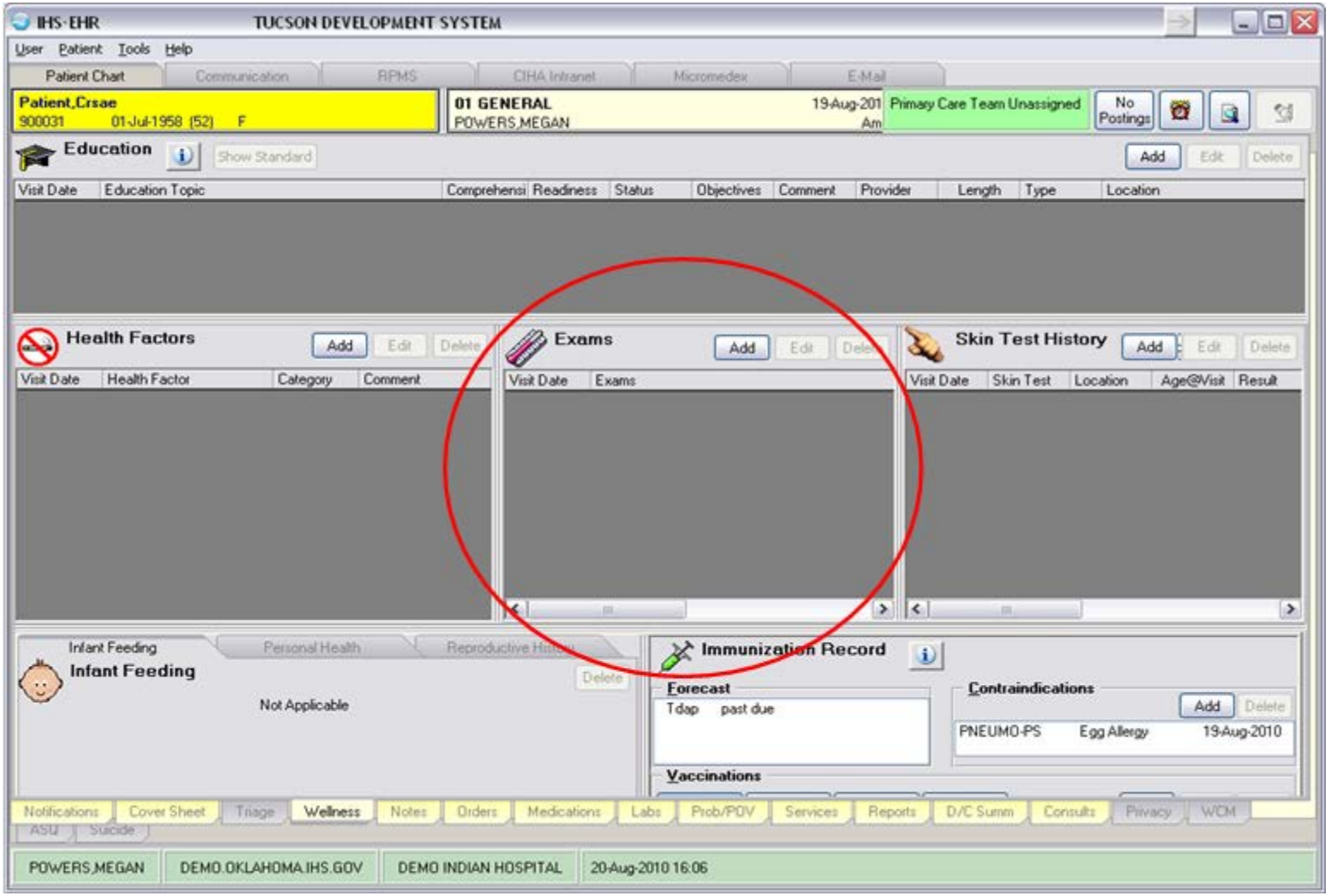


Figure 25: **Exams** component

To enter an Exam code:

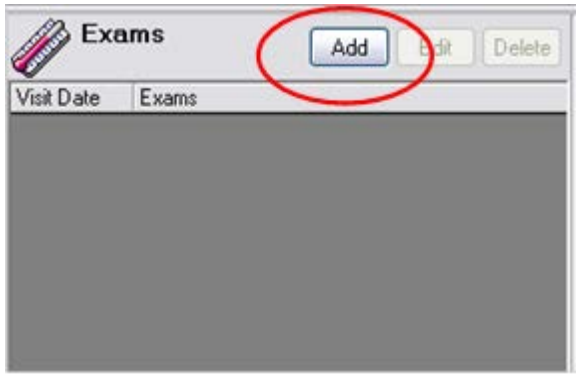


Figure 26: Entering an Exam code

1. Click **Add** in the **Exams** component. The **Exam Selection** dialog (Figure 27) displays.

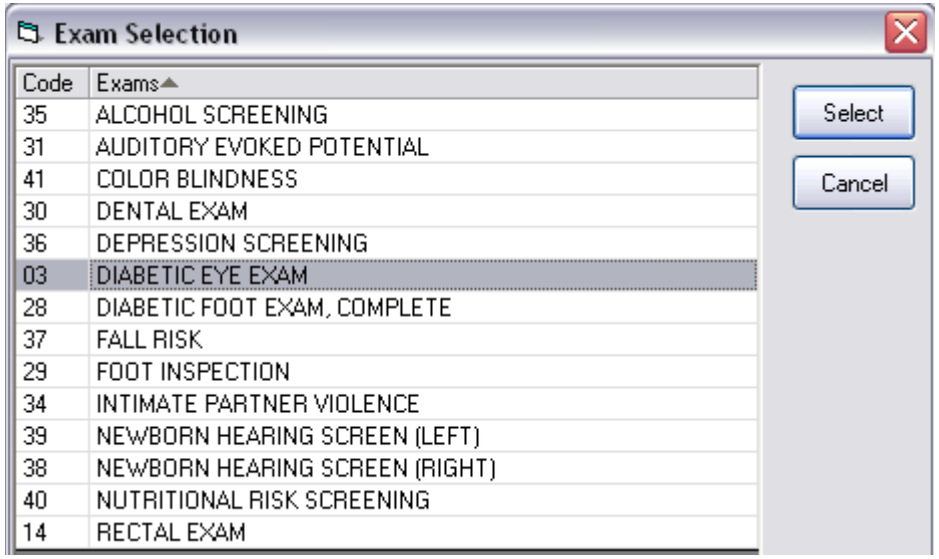


Figure 27: Selecting an exam

2. Click to highlight the **Exam** and click **Select**. The **Document an Exam** dialog (Figure 28) displays.

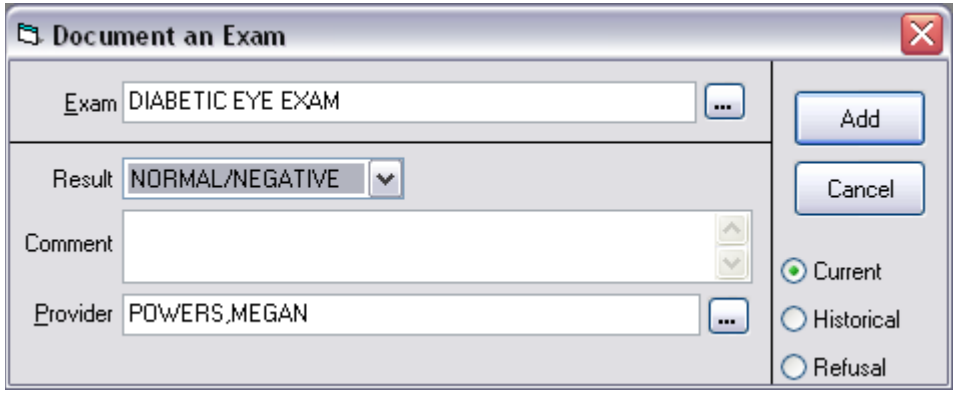


Figure 28: Entering a result and additional comments

3. Type the **Result** and any **Comments**.

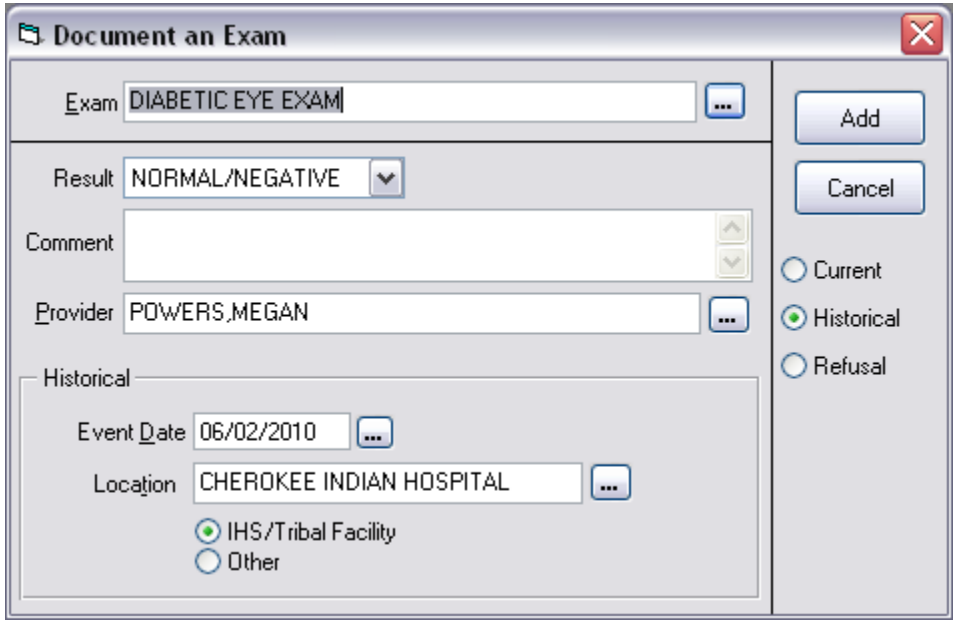


Figure 29: Entering a historical exam

4. If this is a historical exam, select **Historical** and type the **Date** and **Location** of the exam (Figure 29).
5. Click **Save**. The newly added Exam code should appear in the **Exams** component (Figure 30).

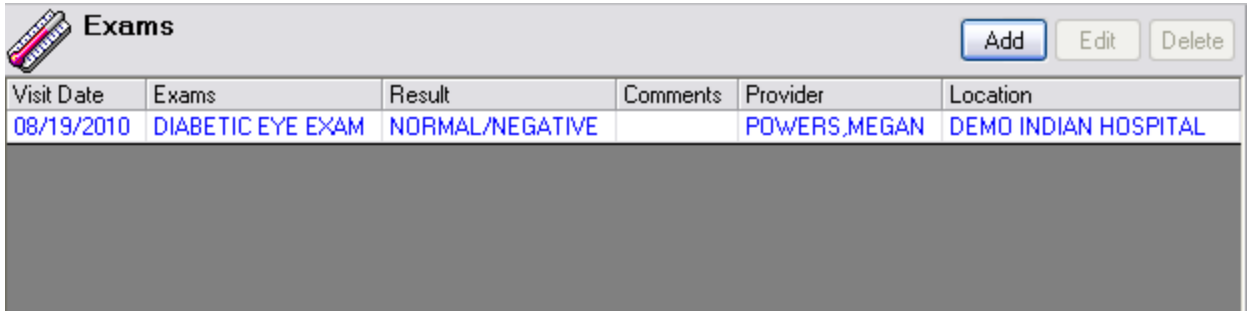


Figure 30: Example of a newly added Exam

Health Factors

Health Factors are entered in the **Health Factors** component, located on the **Wellness** tab (Figure 31).

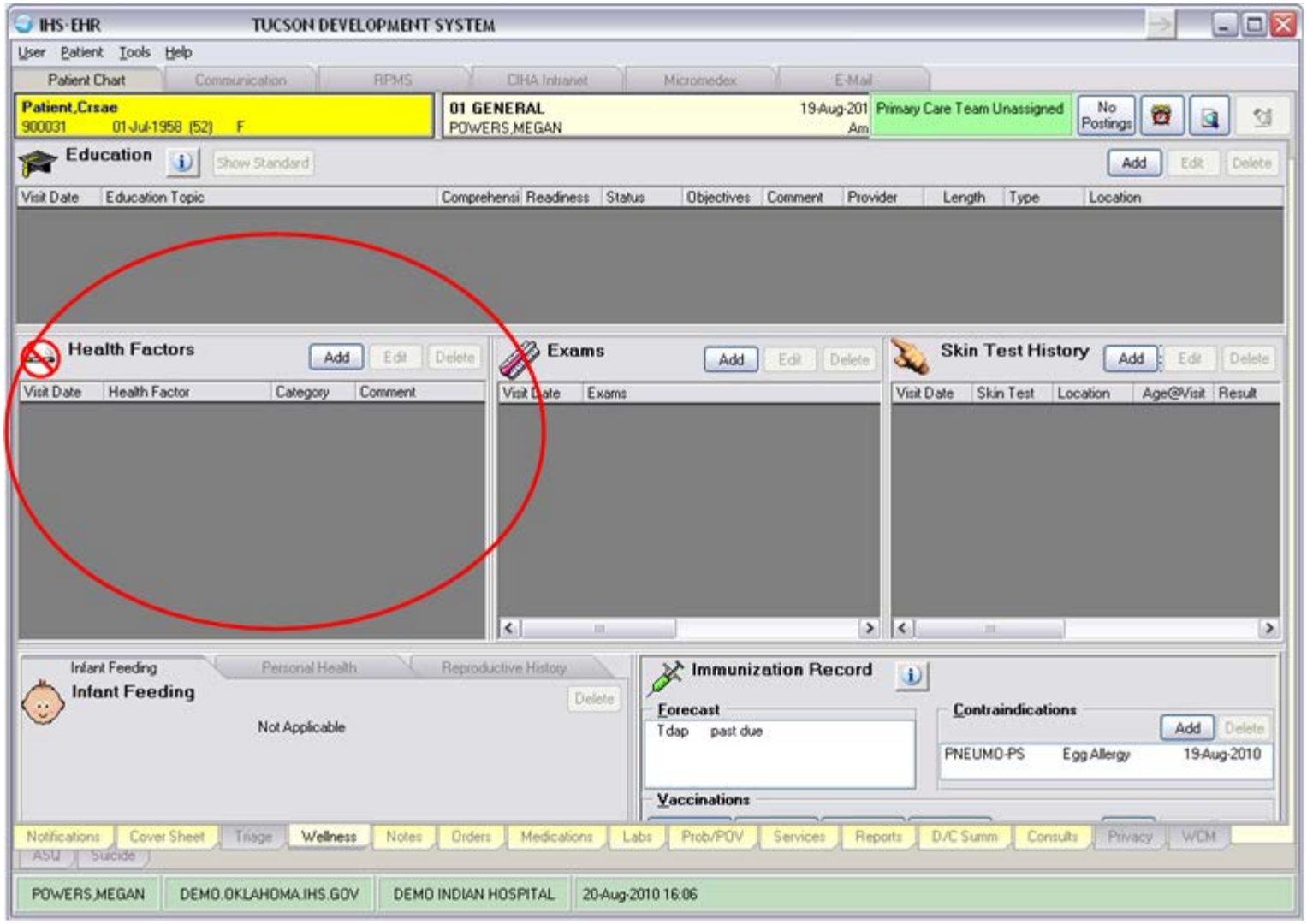


Figure 31: Health Factors component

To enter a Health Factor:

Figure 32: Entering a Health Factor

1. Click **Add** in the **Health Factors** component. The **Add Health Factor** dialog (Figure 33) displays.

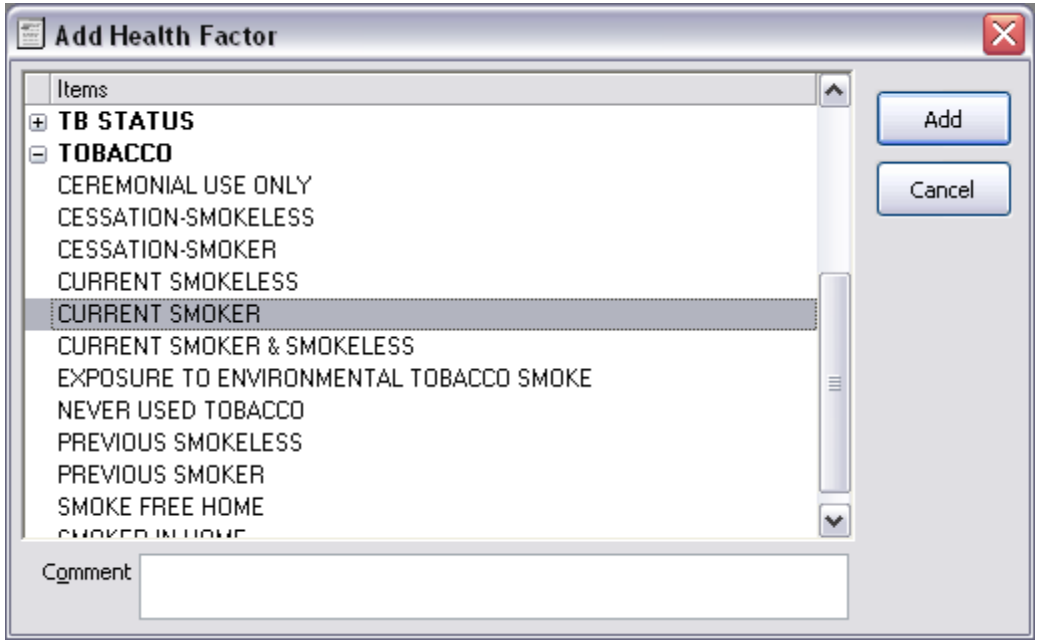


Figure 33: Choosing a **Health Factor**

2. Choose the **Health Factor** to enter and click **Add**. The newly added **Health Factor** should appear in the **Health Factors** component (Figure 34).

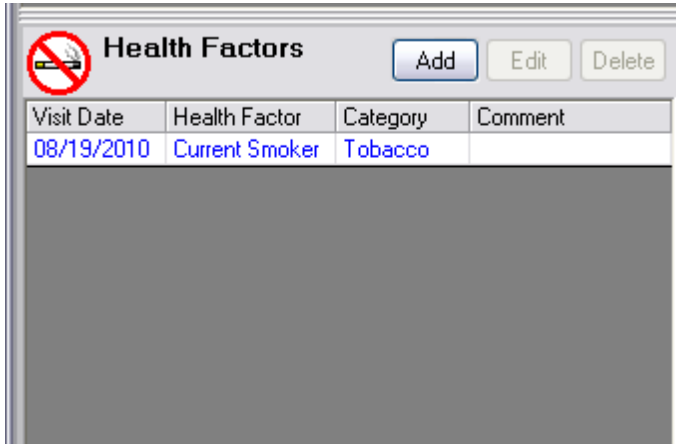


Figure 34: Example of a newly added **Health Factor**

Immunizations

Immunizations are entered in the **Immunization Record** component, located on the **Wellness** tab (Figure 35).

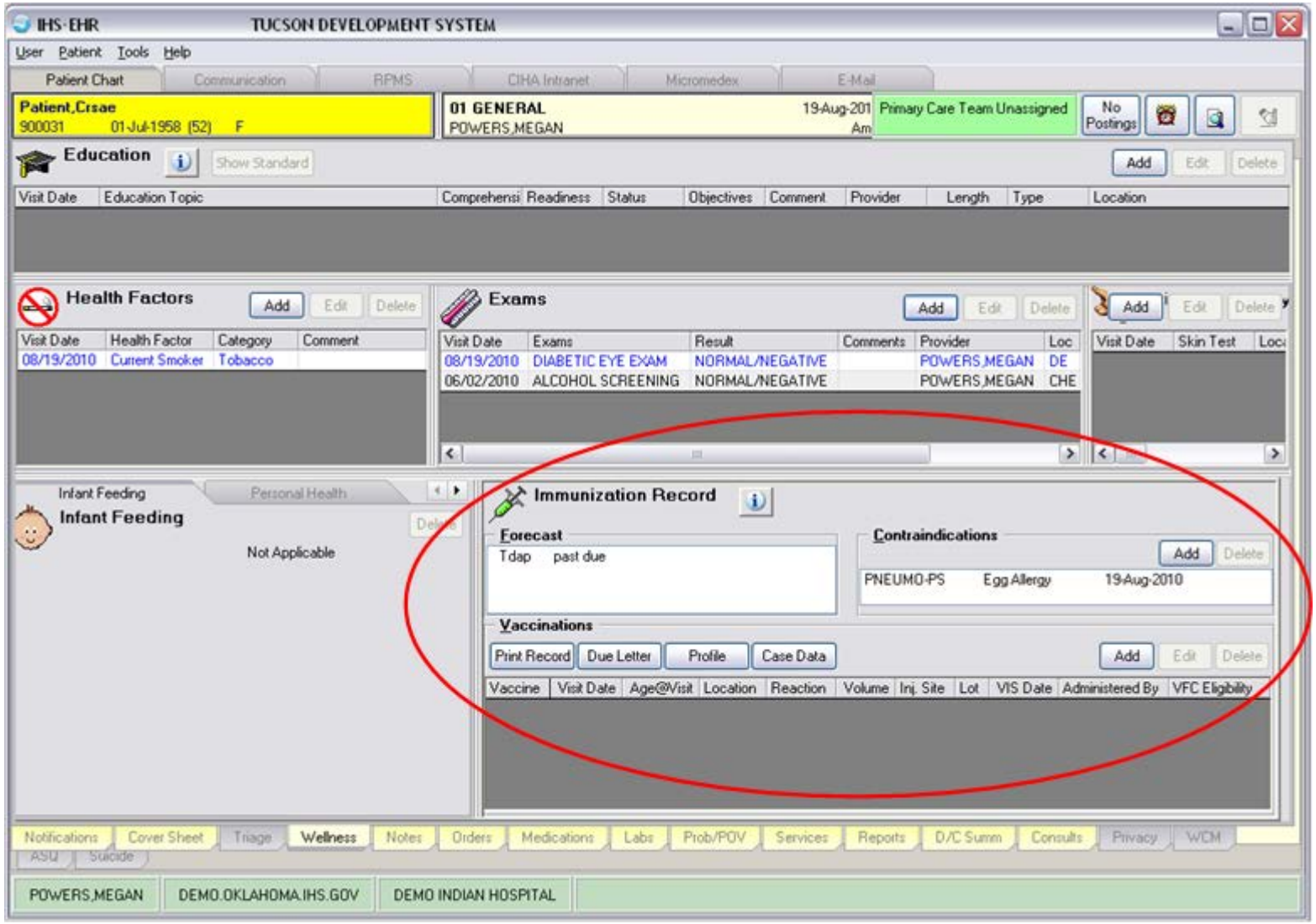


Figure 35: **Immunization Record** component

To enter an Immunization:

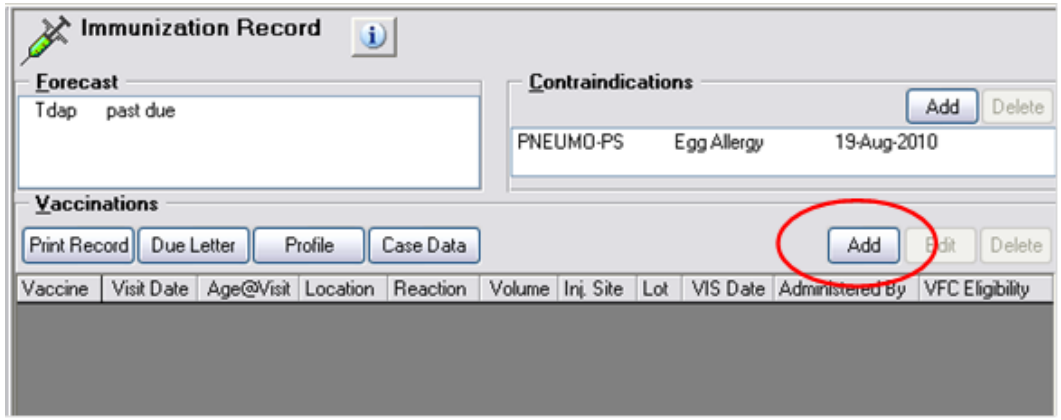


Figure 36: Entering an Immunization

1. Click **Add** in the **Vaccinations** section of the **Immunization Record** component. The **Vaccine Selection** dialog (Figure 37) displays.

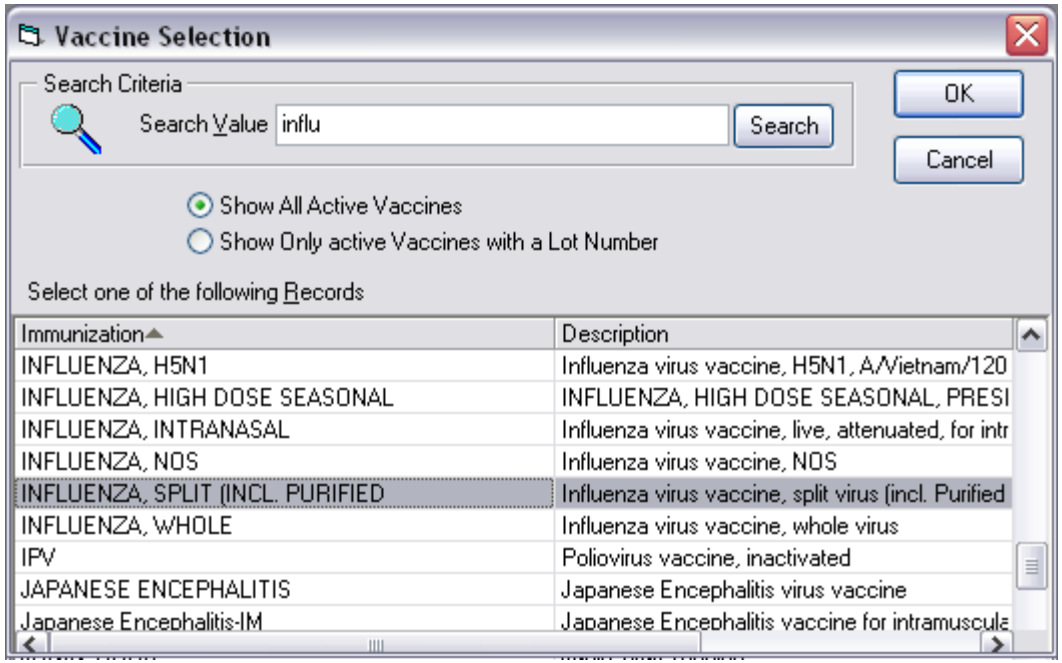


Figure 37: Choosing the Immunization

2. Highlight the chosen **Immunization** and click **OK**. The **Add Immunization** dialog (Figure 38) displays.

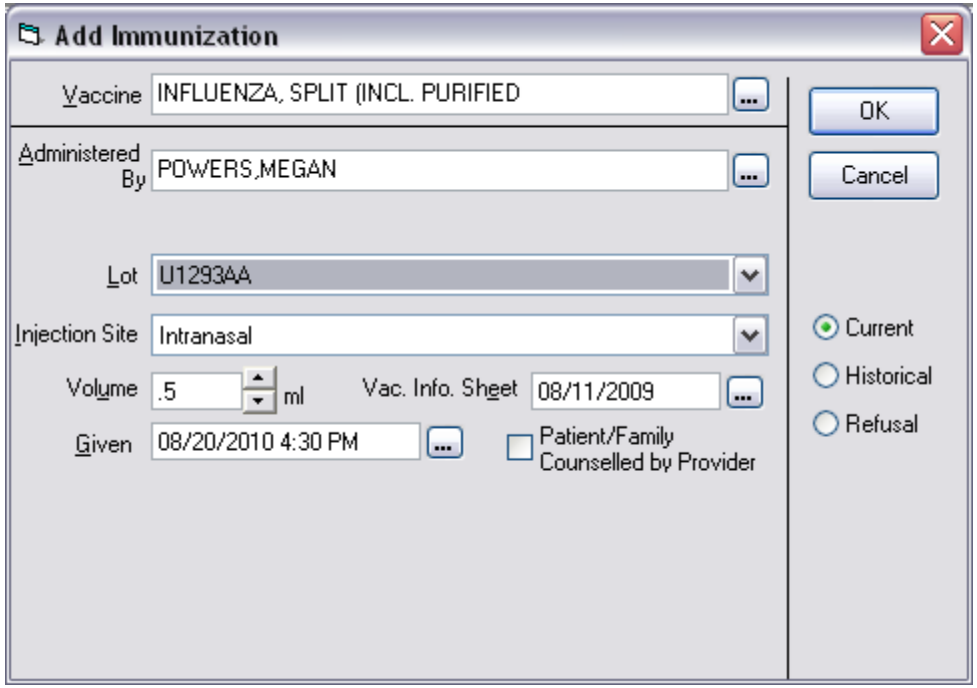


Figure 38: Entering additional immunization information

3. Type any other pertinent information and click **OK**.

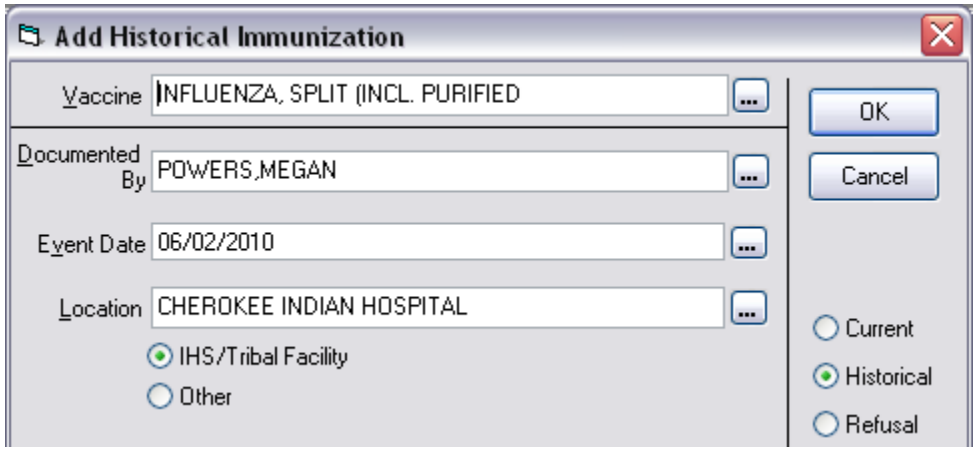


Figure 39: Entering a historical immunization

4. If this is a historical immunization, select **Historical** and enter the **Date** and **Location** of the immunization. The newly added Immunization should appear in the **Immunization Record** component (Figure 40).

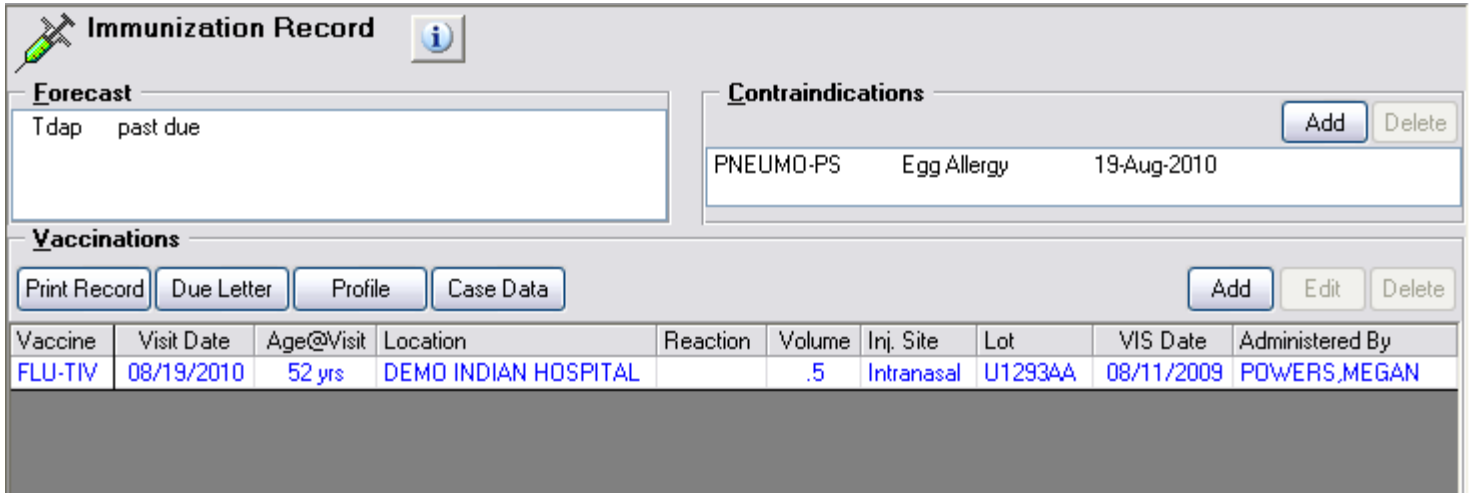


Figure 40: Example of a newly added Immunization

To enter a contraindication for an immunization:

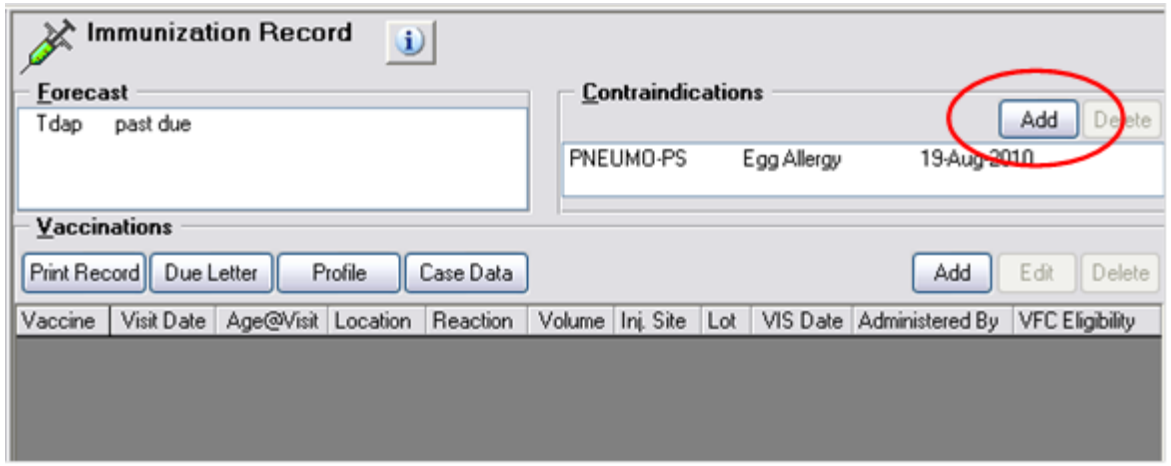


Figure 41: Entering a contraindication

1. Click **Add** in the **Contraindications** section of the **Immunization Record** component. The Enter Patient Contraindication dialog (Figure 42) displays.

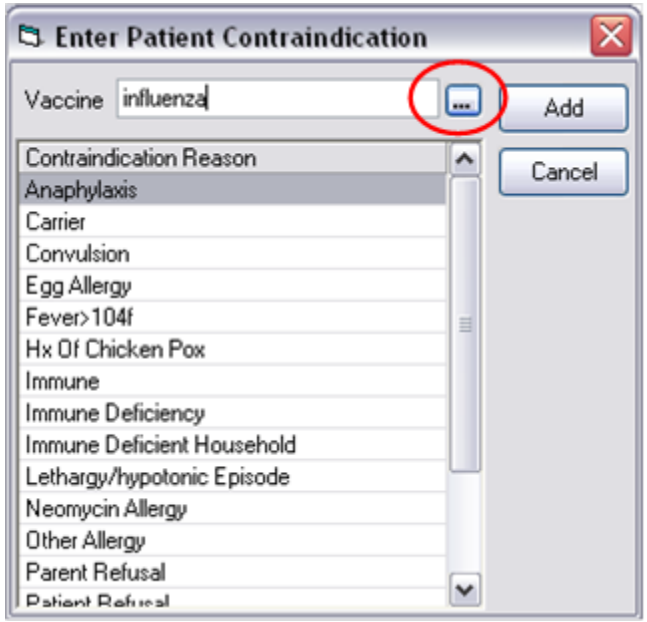


Figure 42: Choosing a contraindication

2. Choose the **Contraindication Reason** and type the **Vaccine** name.
3. Click the ellipses (…) button. The **Vaccine Selection** dialog (Figure 43) displays.

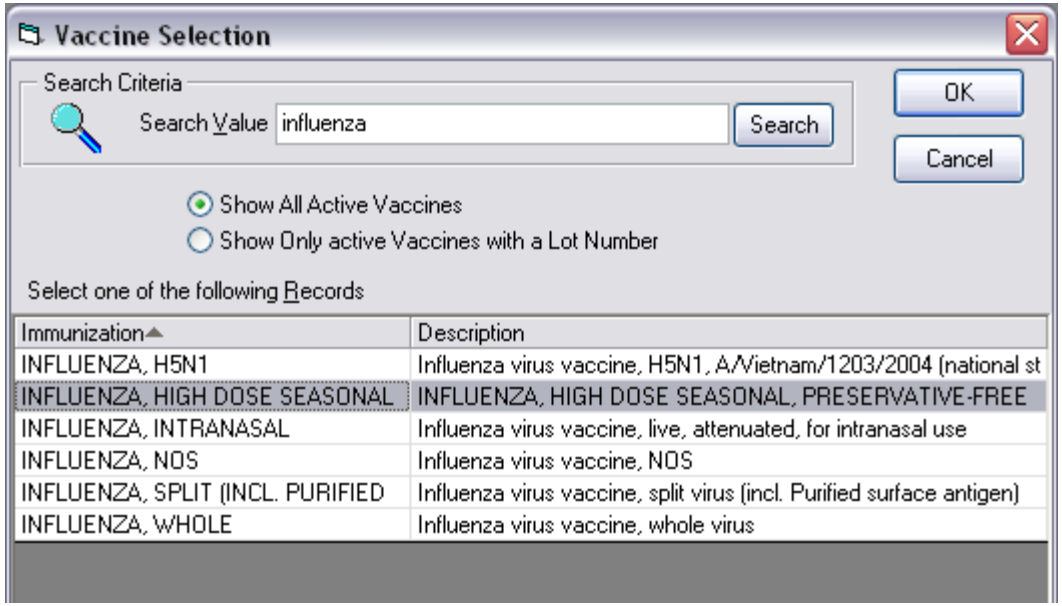


Figure 43: Selecting the immunization

4. Click to highlight the **Immunization** and click **OK**. The **Enter Patient Contraindication** dialog (Figure 44) displays.

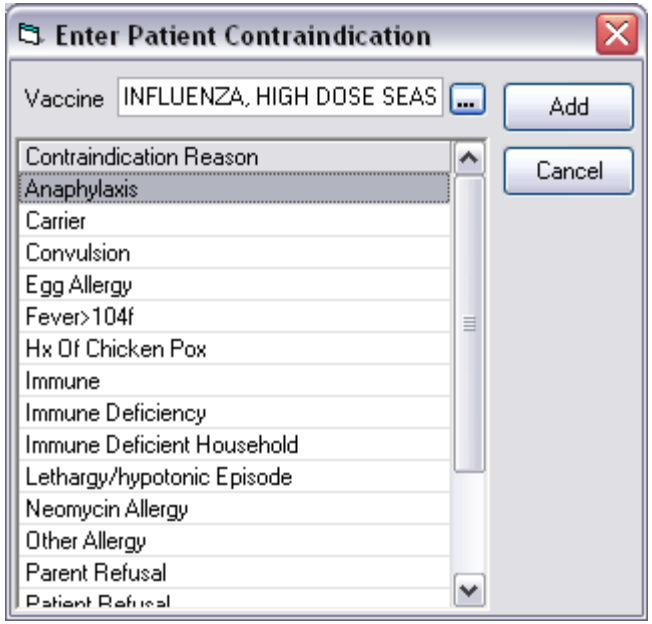


Figure 44: **Enter Patient Contraindication** dialog

5. Click **Add**. The newly added contraindication should appear in the **Immunization Record** component (Figure 45).

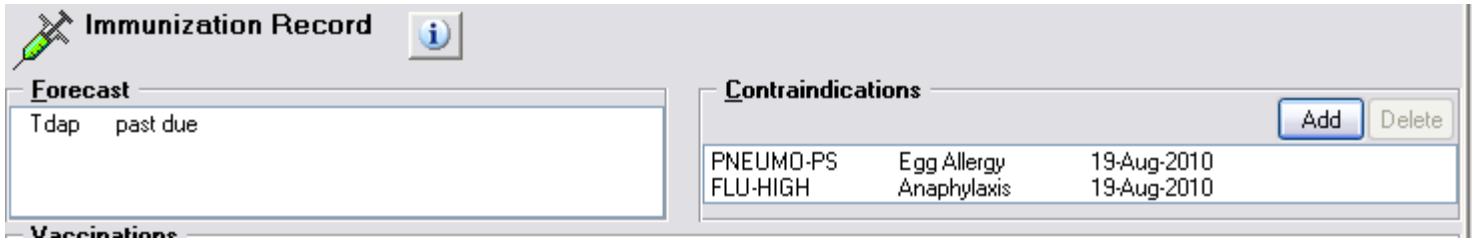


Figure 45: Example of a newly added contraindication

Vital Measurements

Vital Measurements are entered in the **Vitals** component, located on the **Triage** tab (Figure 46).

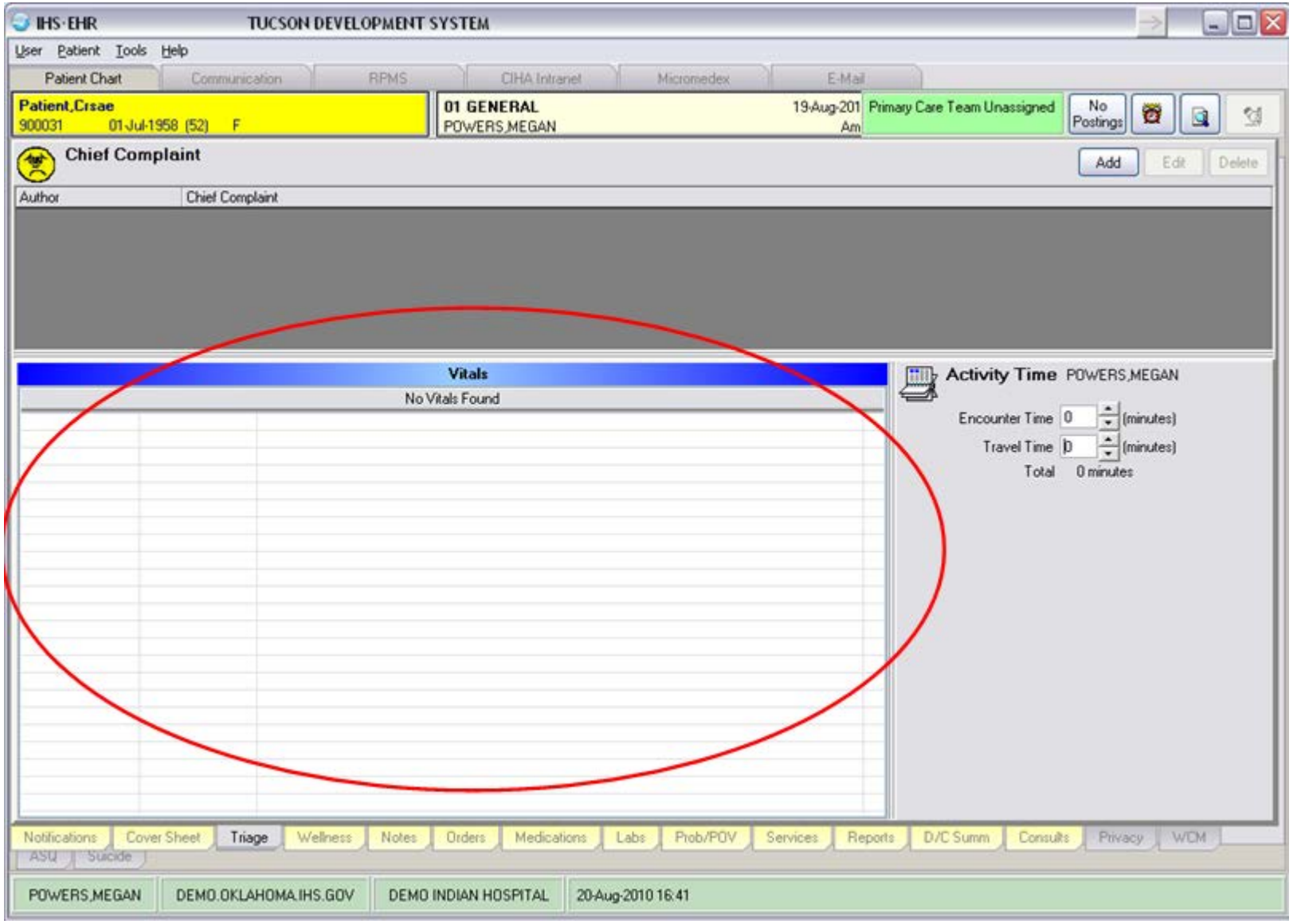


Figure 46: **Vitals** component

To enter Vital Measurements:

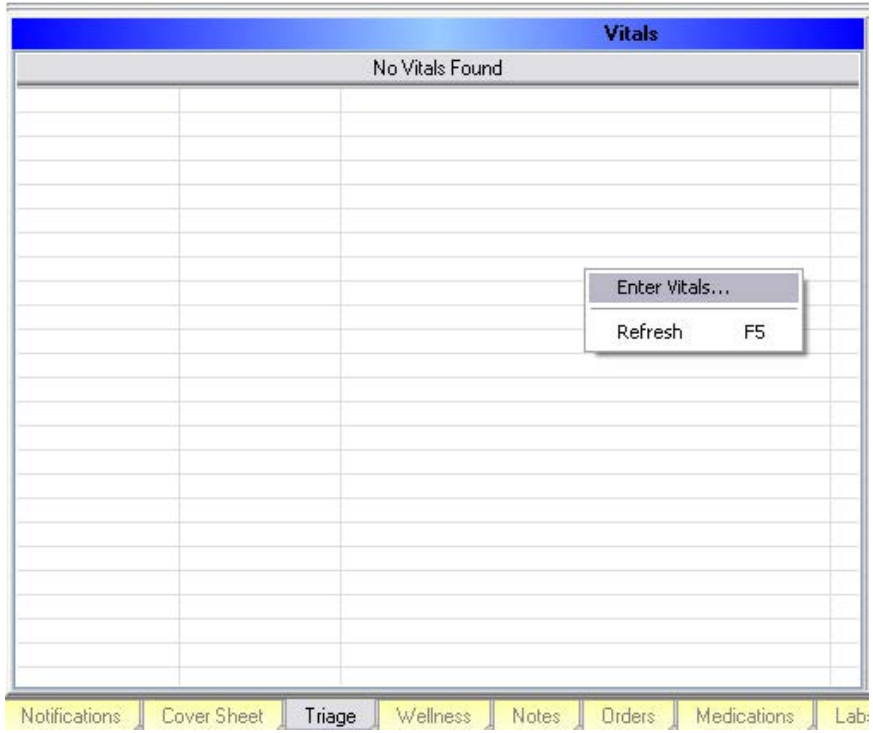


Figure 47: Entering a Vital Measurement

1. Right-click in the **Vitals** component and select **Enter Vitals** from the menu. The **Vital Measurement Entry** dialog (Figure 48) displays.

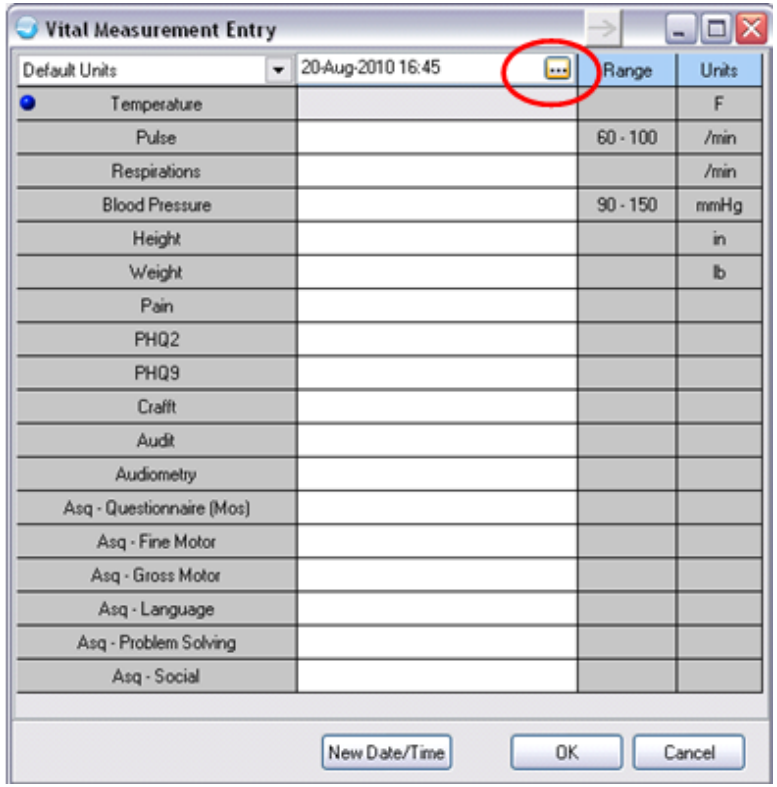


Figure 48: Entering an historical vital

2. To enter historical vitals:
   a. Click the date and time in the column header.
   b. Click the ellipses (…) button. The **Select Date/Time** dialog (Figure 49) displays.

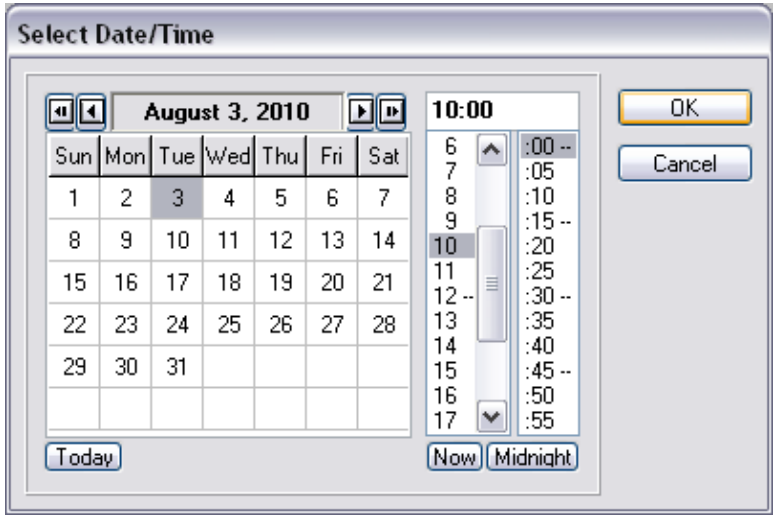


Figure 49: Choosing the historical date

c. Choose the historical date and click **OK**. The **Vital Measurement Entry** dialog (Figure 50) redisplays.

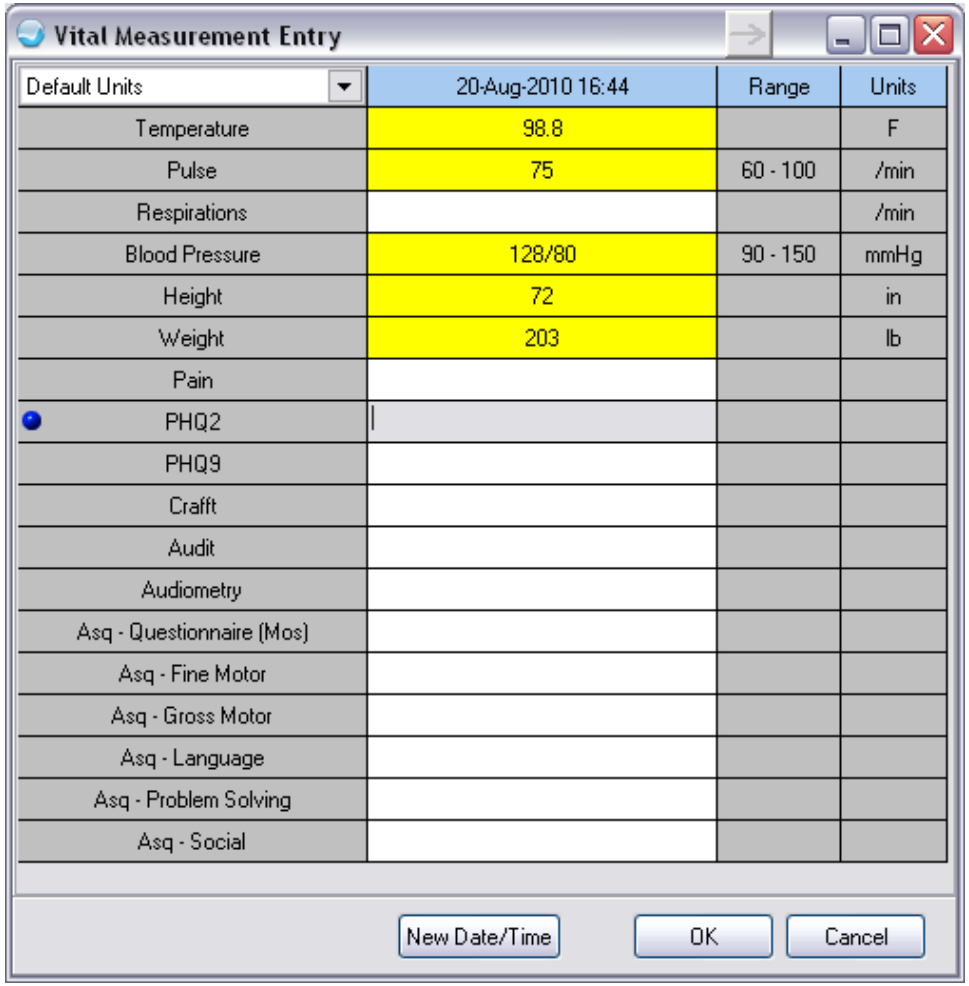
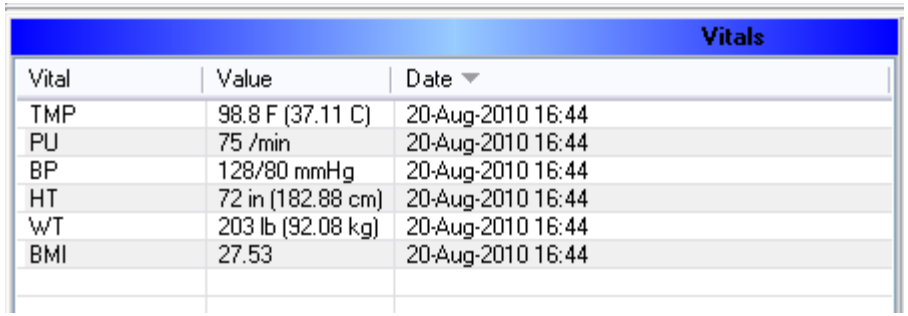


Figure 50: Entering Vital Measurements

3. Type the vital measurements to add and click **OK**. The newly added vital measurements should display in the **Vitals** component (Figure 51).



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

Figure 51: Example of a newly entered Vital Measurement

Lab Tests

Lab tests are entered in the **Orders** component, located on the **Orders** tab (Figure 52).

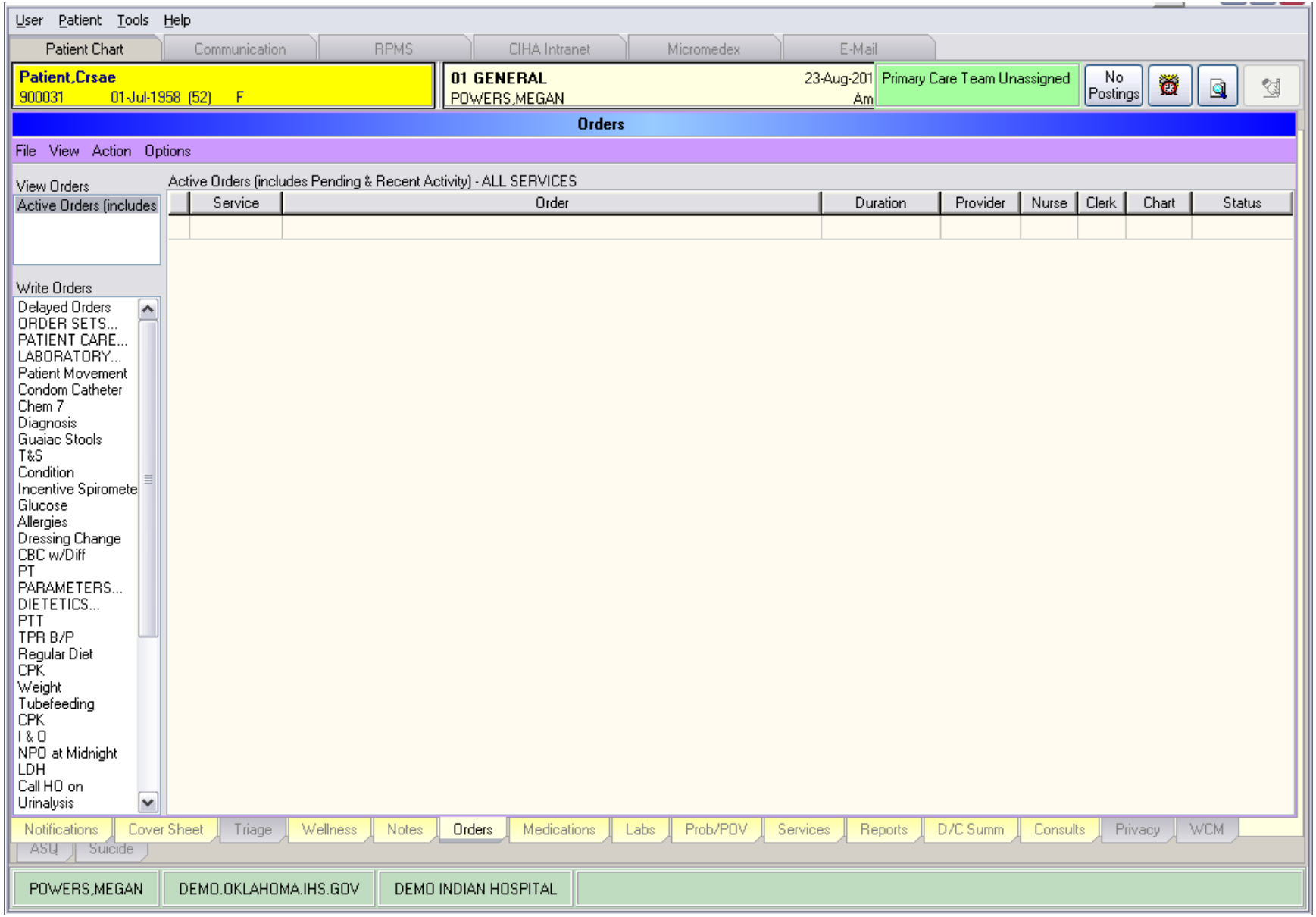


Figure 52: **Orders** component

To enter a Lab test:

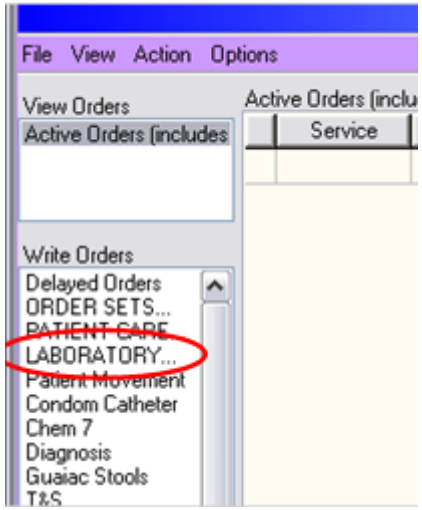


Figure 53: Entering a Lab test

1. Select the **Laboratory** option in the **Write Orders** section of the **Orders** component. The **Order a Lab Test** dialog (Figure 54) displays.

Note: This may be named differently at your site.

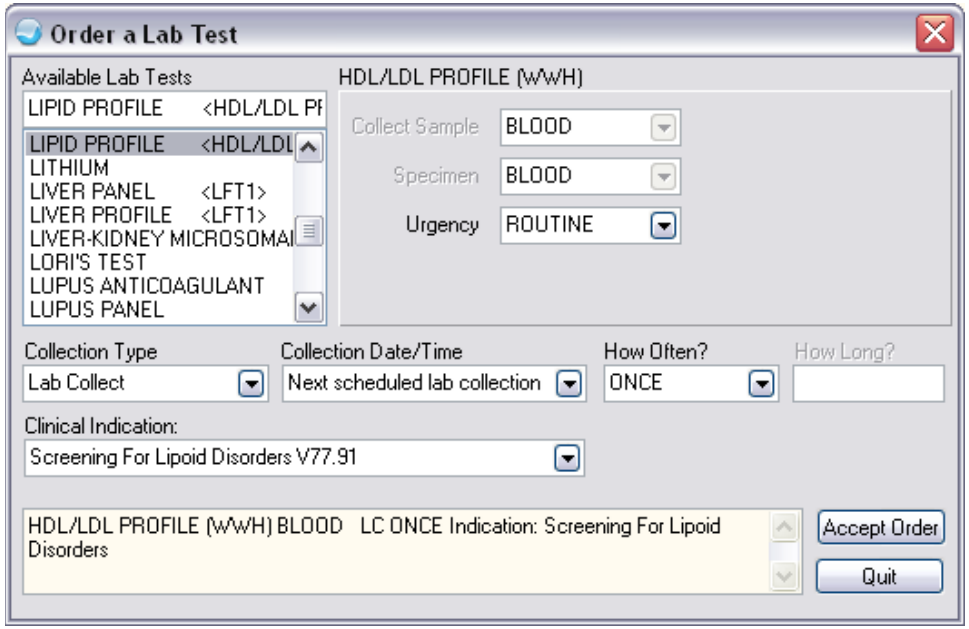


Figure 54: **Order a Lab Test** dialog

2. Select the appropriate lab test and enter any other pertinent information.
3. Click **Accept Order**. The newly added Lab test should display in the **Active Orders** section of the **Orders** component (Figure 55).

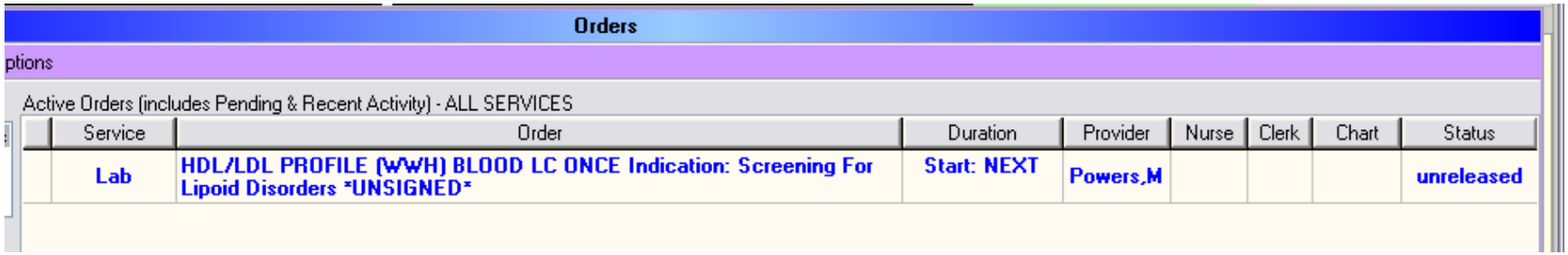


Figure 55: Example of a newly added Lab test

4. You must sign the order before it can be released.

Lab results can be viewed in the **Laboratory Results** component, located on the **Labs** tab (Figure 56).

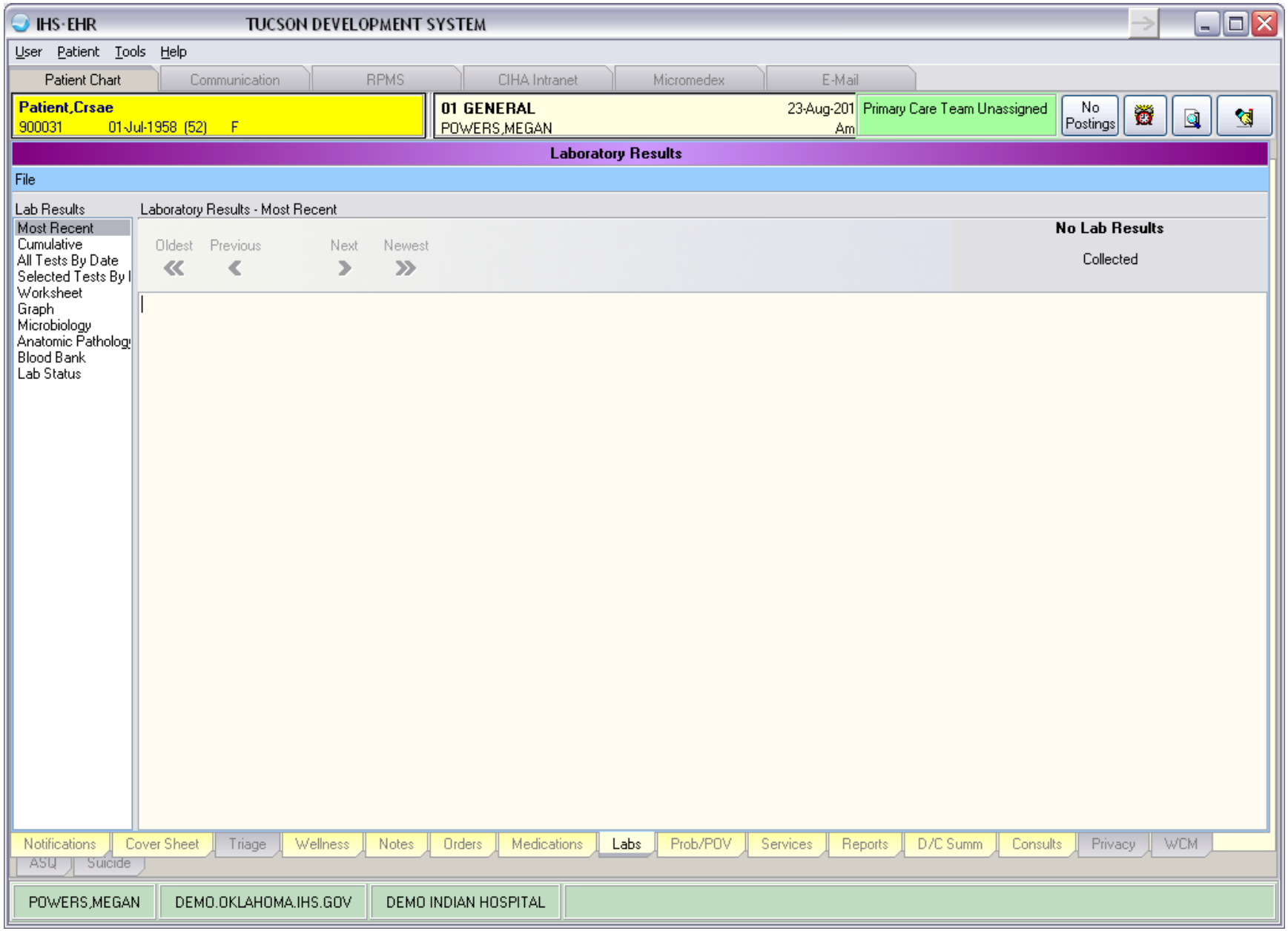


Figure 56: Viewing the lab results

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:

Figure 57: Entering a Point of Care Lab test

1. 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** dialog (Figure 58) displays.

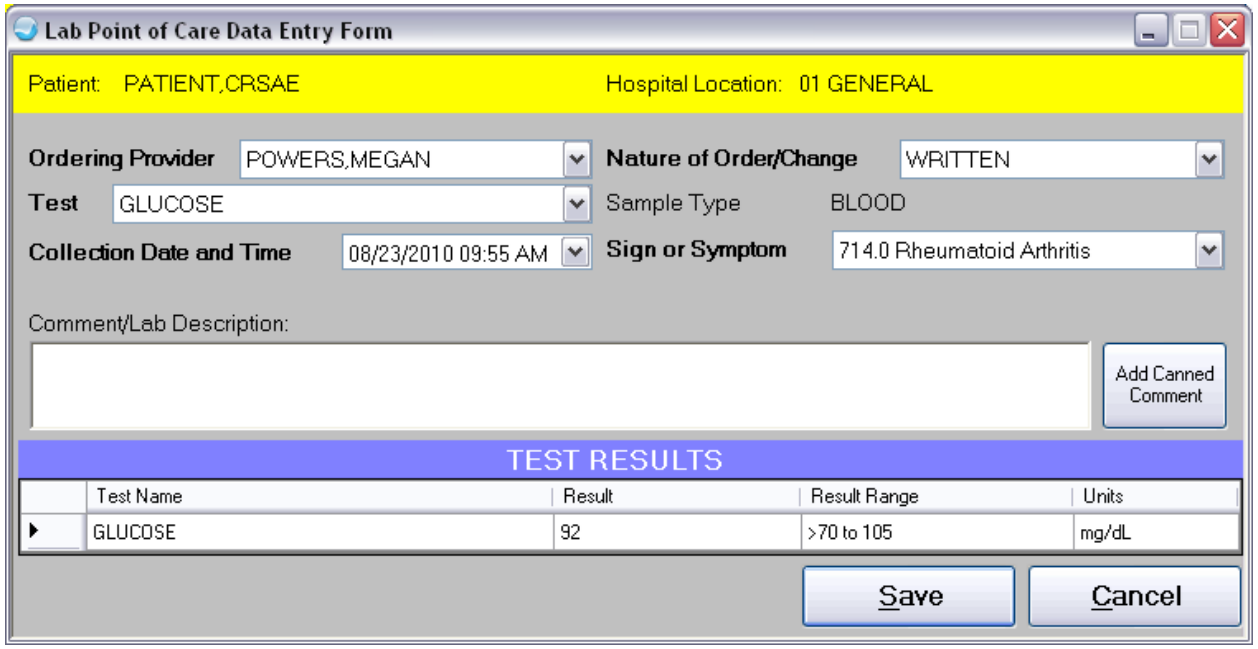


Figure 58: Lab Point of Care Data Entry Form dialog

2. Choose the appropriate laboratory **Test** and enter the test results and any other pertinent information.
3. Click **Save**.

Medications

Medications are entered in the **Medications** component, located on the **Medications** tab (Figure 59).

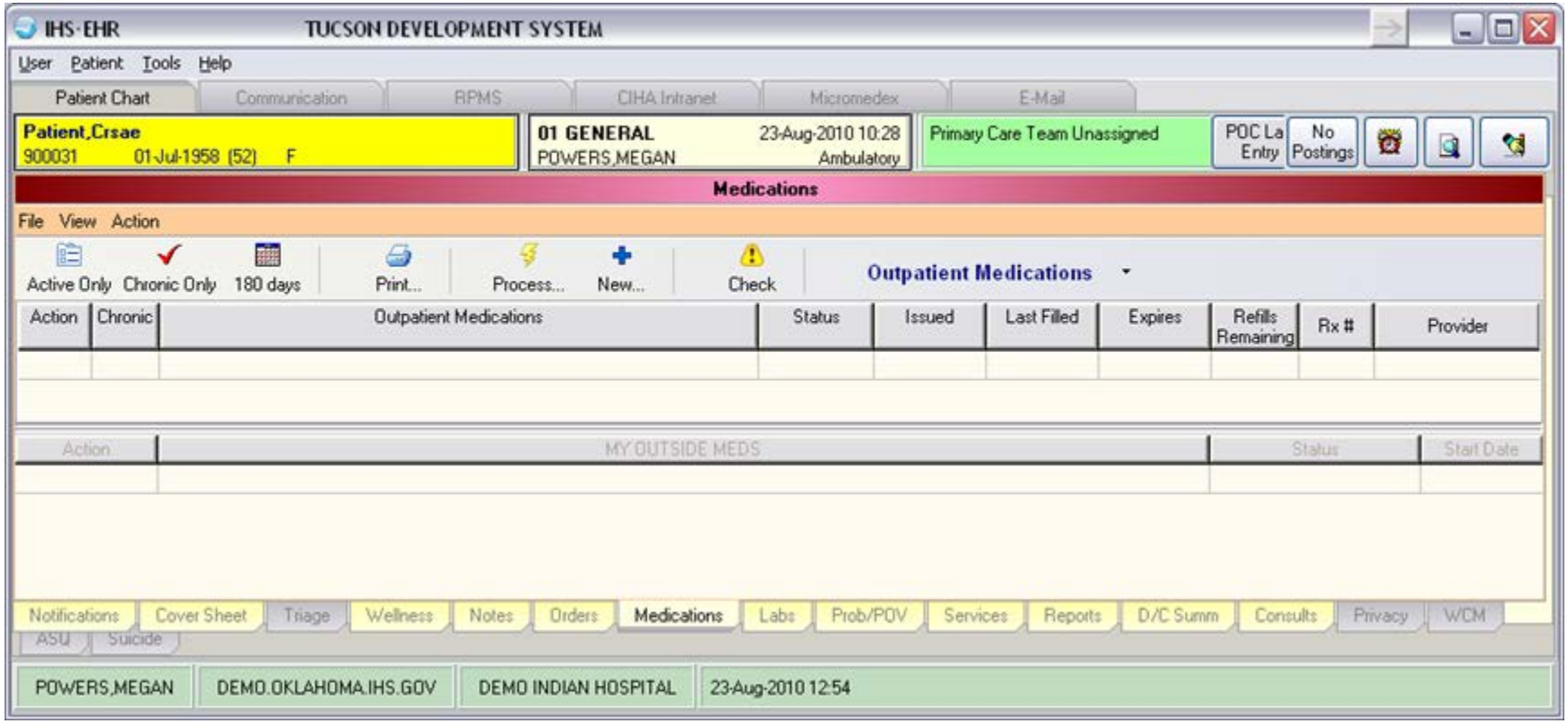


Figure 59: **Medications** component

To enter a prescription for a medication:

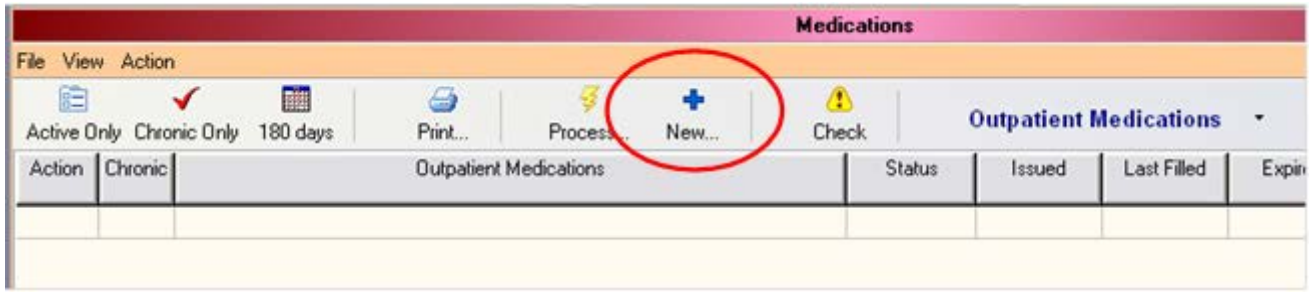


Figure 60: Entering a patient medication

1. Click **New**. The Medication Order dialog (Figure 60) displays.

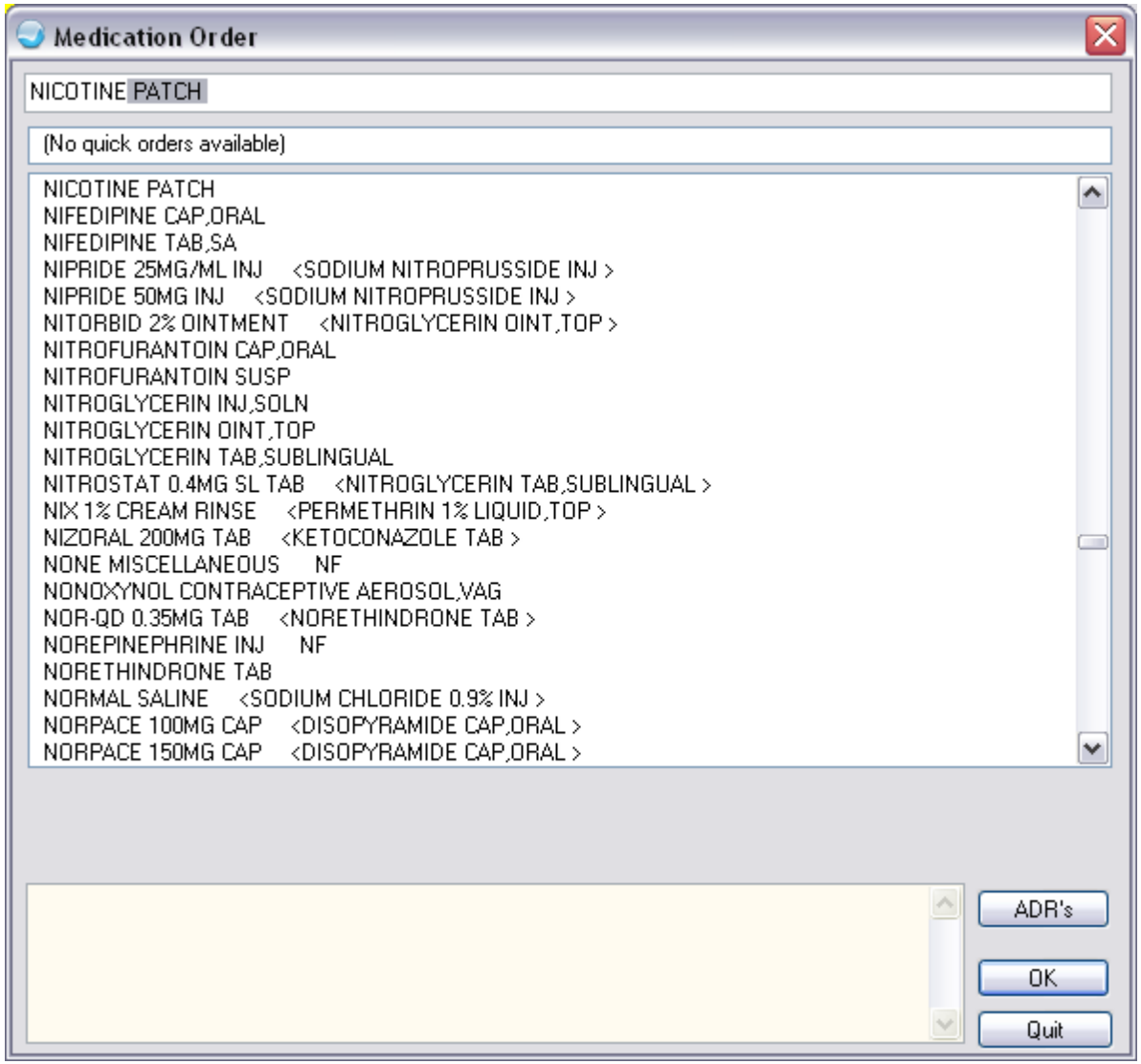


Figure 61: Medication Order dialog

2. Click to highlight the appropriate medication and click **OK**. The dialog redisplays with new fields (Figure 62).

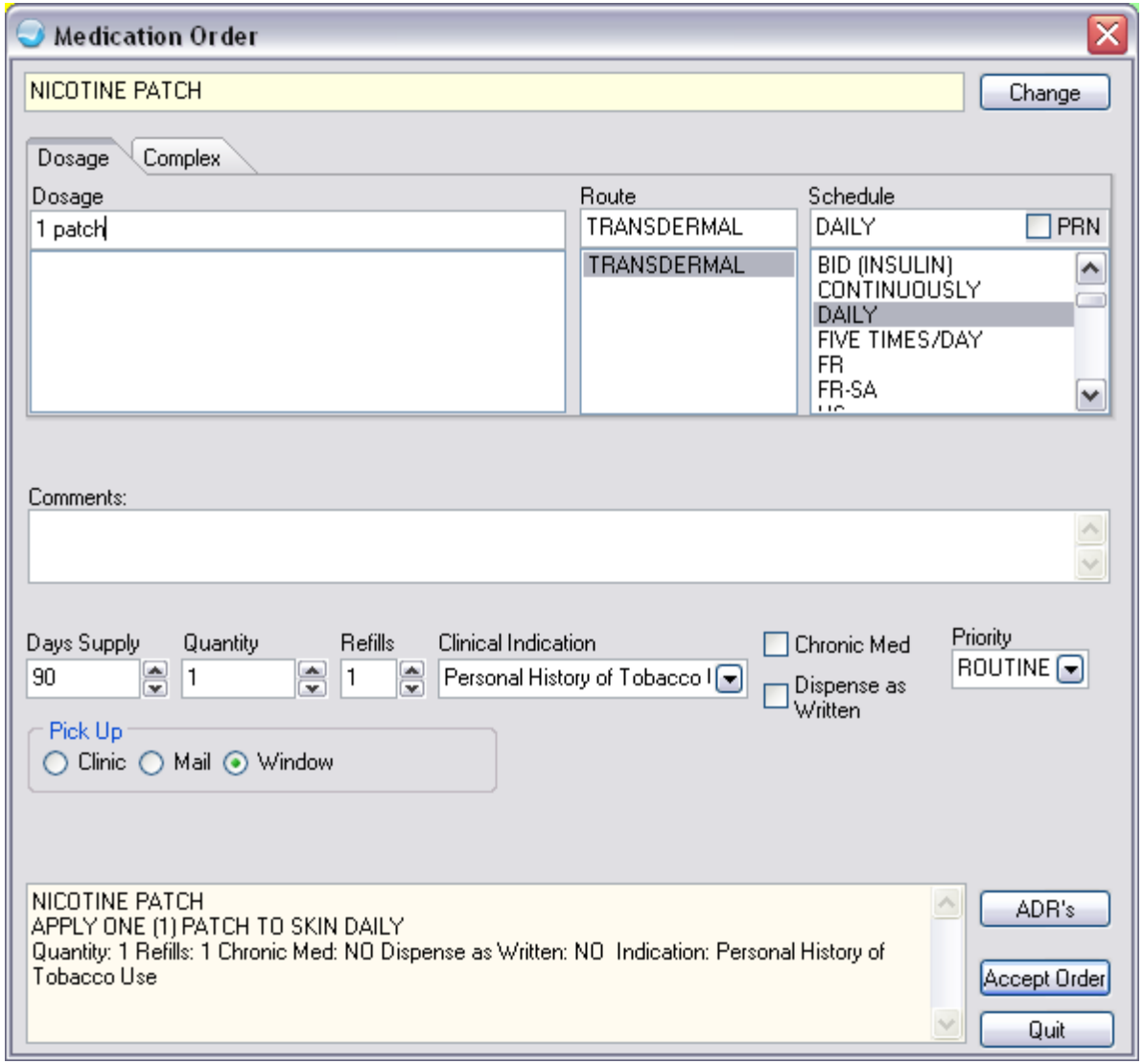


Figure 62: Entering additional medication information

3. Type other pertinent information about the prescription.
4. Click **Accept Order**. The updated **Medications** component (Figure 63) displays.

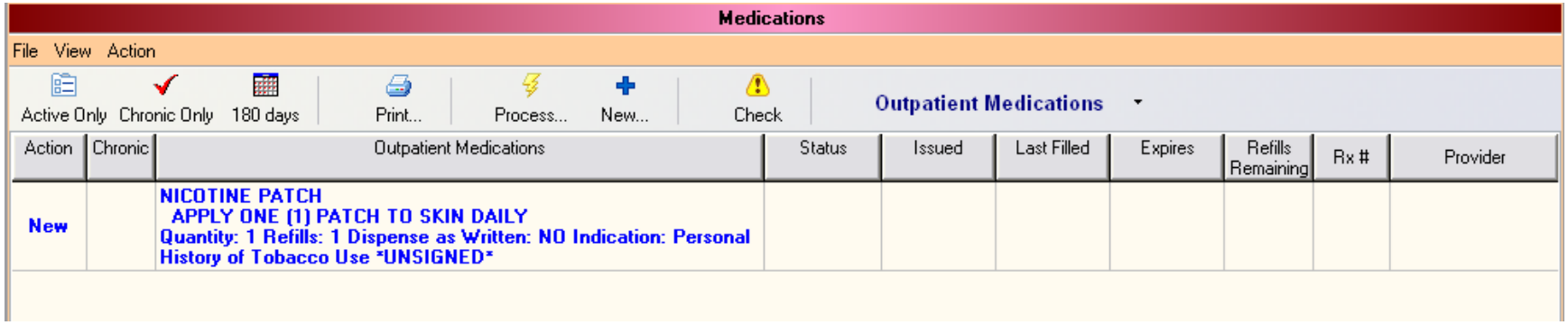


Figure 63: Example of a newly added medication

5. You must sign the order before it can be released.

Infant Feeding

Infant Feeding choices are entered in the **Infant Feeding** component (new in EHR v1.1 patch 6), located on the **Wellness** tab (Figure 64).

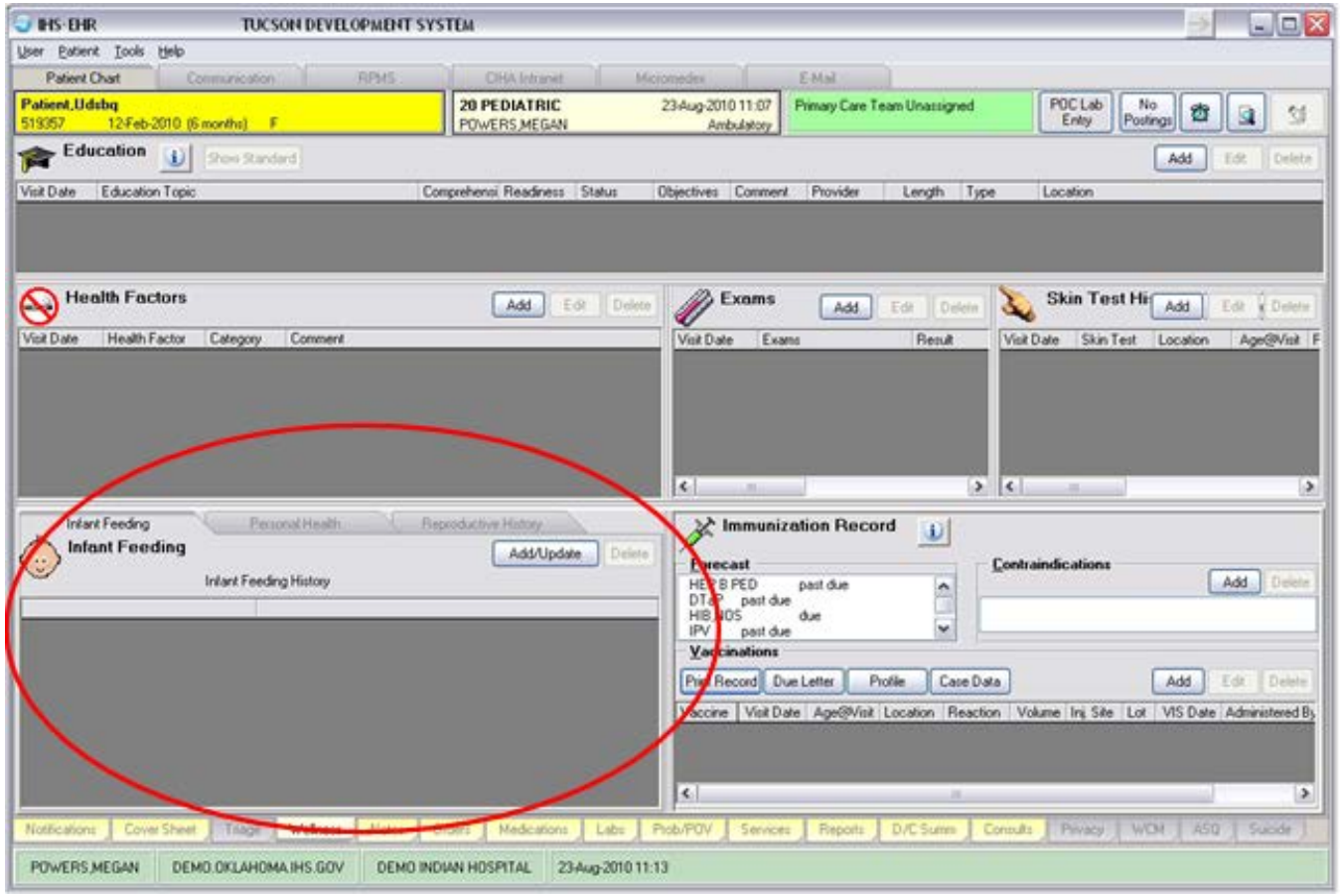


Figure 64: **Infant Feeding** component

To enter Infant Feeding:

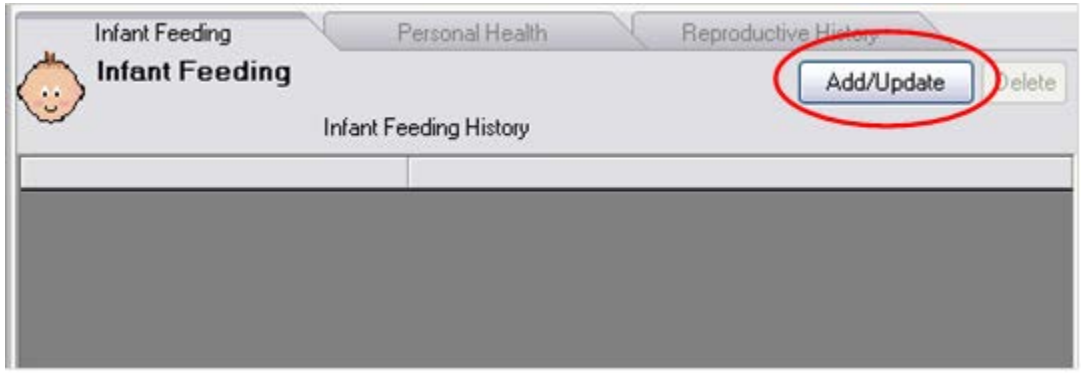


Figure 65: Entering Infant Feeding information

1. Click **Add/Update** in the **Infant Feeding** component. The **Infant Feeding Choice** dialog (Figure 66) displays.

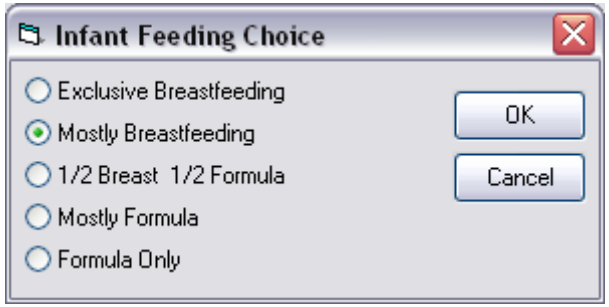


Figure 66: Selecting an Infant Feeding choice

2. Select the infant feeding choice to enter and click **OK**. The newly added choice should display in the **Infant Feeding** component (Figure 67).

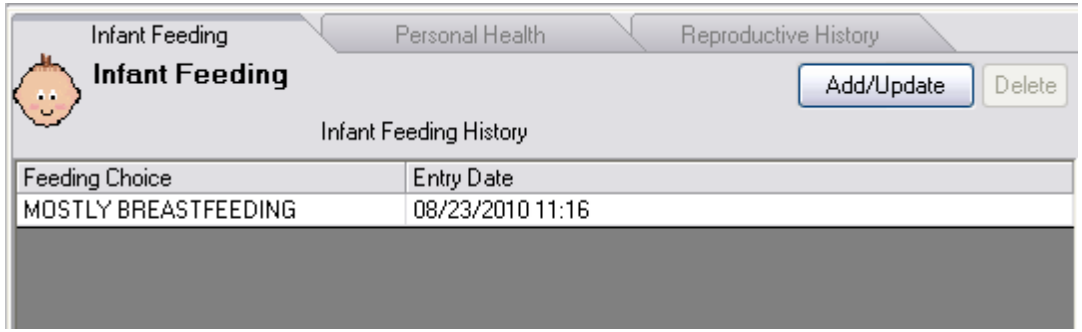


Figure 67: Example of a newly added Infant Feeding choice

Patient Education

Patient Education can be entered several ways. The most common method is through the **Education** component, located on the **Wellness** tab (Figure 68).

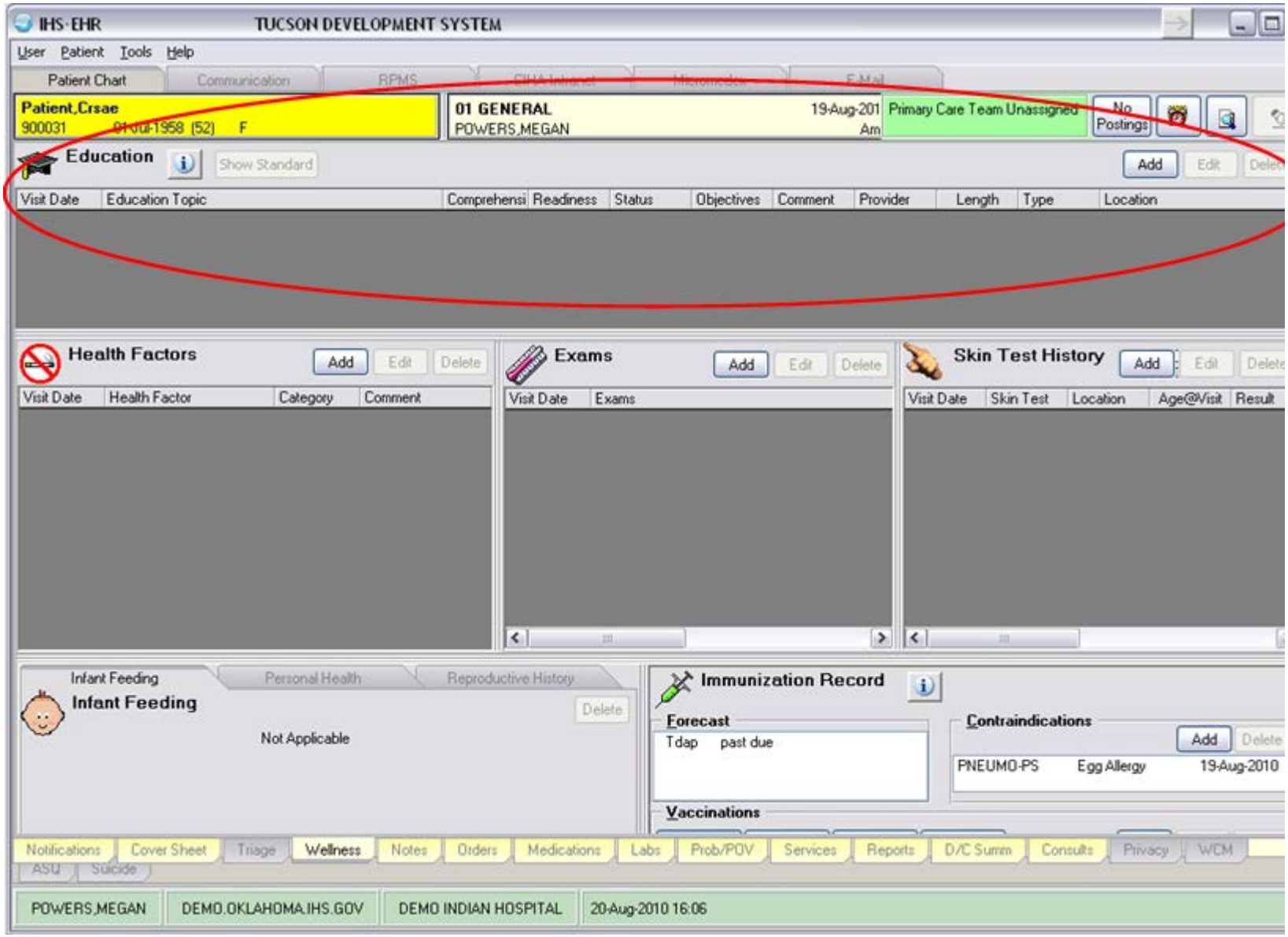


Figure 68: **Education** component

To enter Patient Education:

Figure 69: Entering Patient Education

1. Click **Add** in the **Education** component. The **Education Topic Selection** dialog (Figure 70) displays.

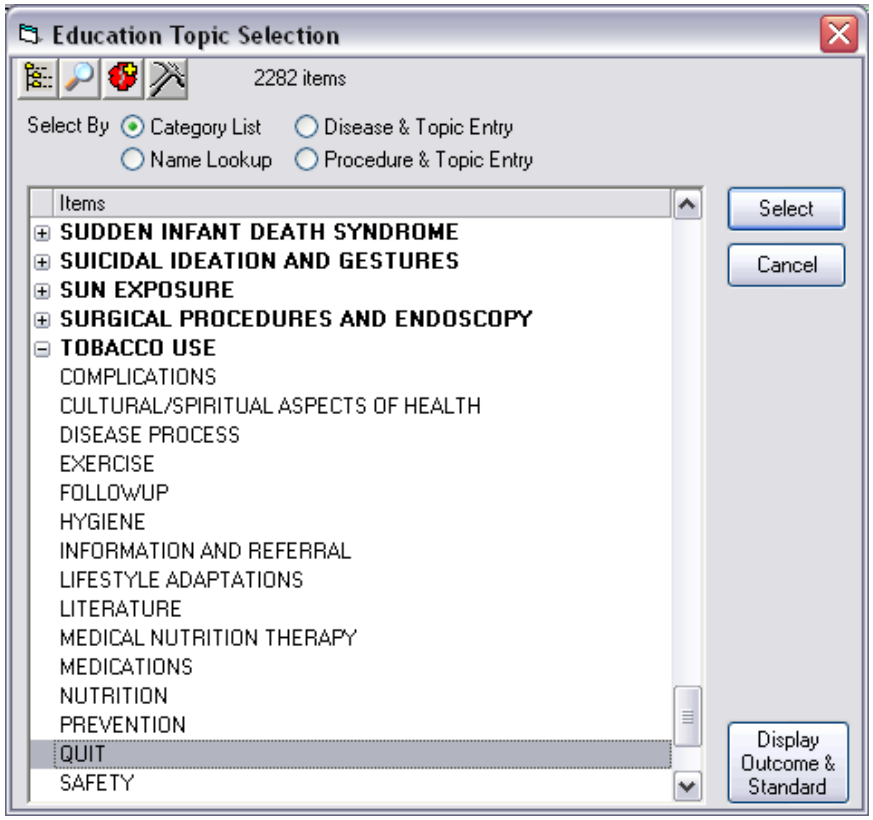


Figure 70: Selecting the education

2. Choose the education item to enter and click **Select**. To expand a topic, click the plus sign (+) next to the topic.

To enter Patient Education by disease:

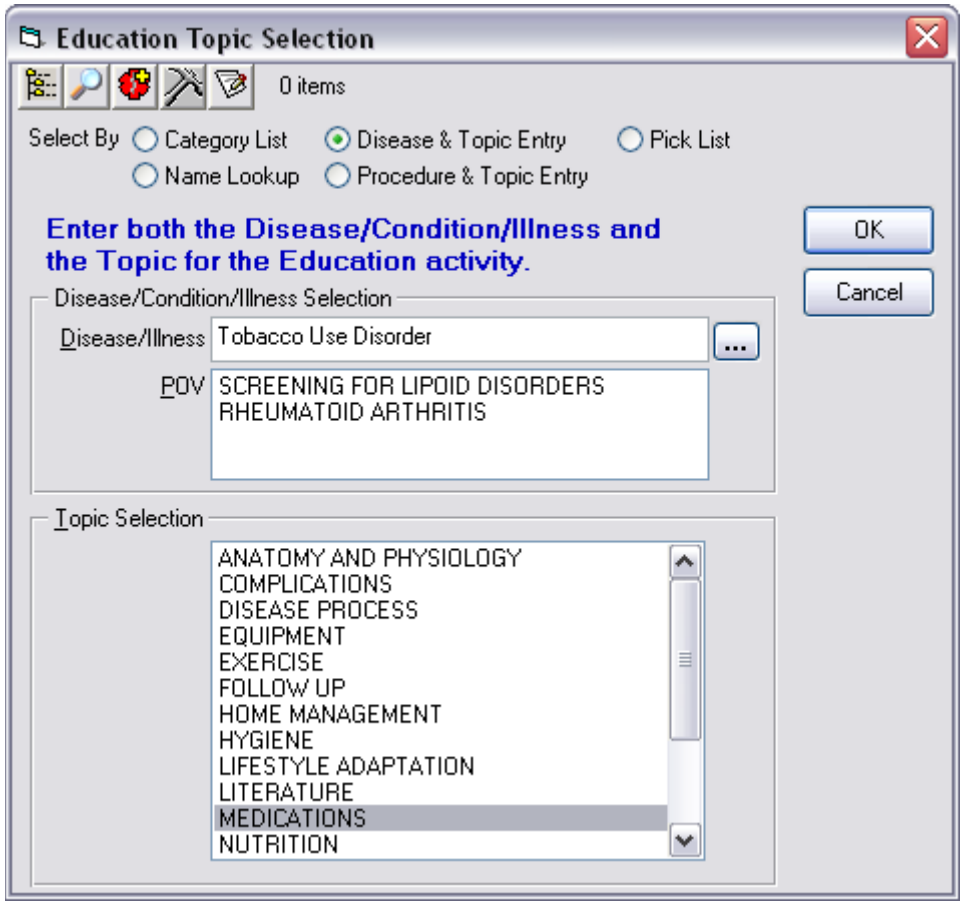


Figure 71: Entering Patient Education by disease

1. Select **Disease & Topic Entry**.

   Note: Patient Education can be entered using any of the radio buttons.

2. Select values for **Disease/Illness** and **Topic Selection**.
3. Click **OK**. The **Add Patient Education Event** dialog (Figure 72) displays.

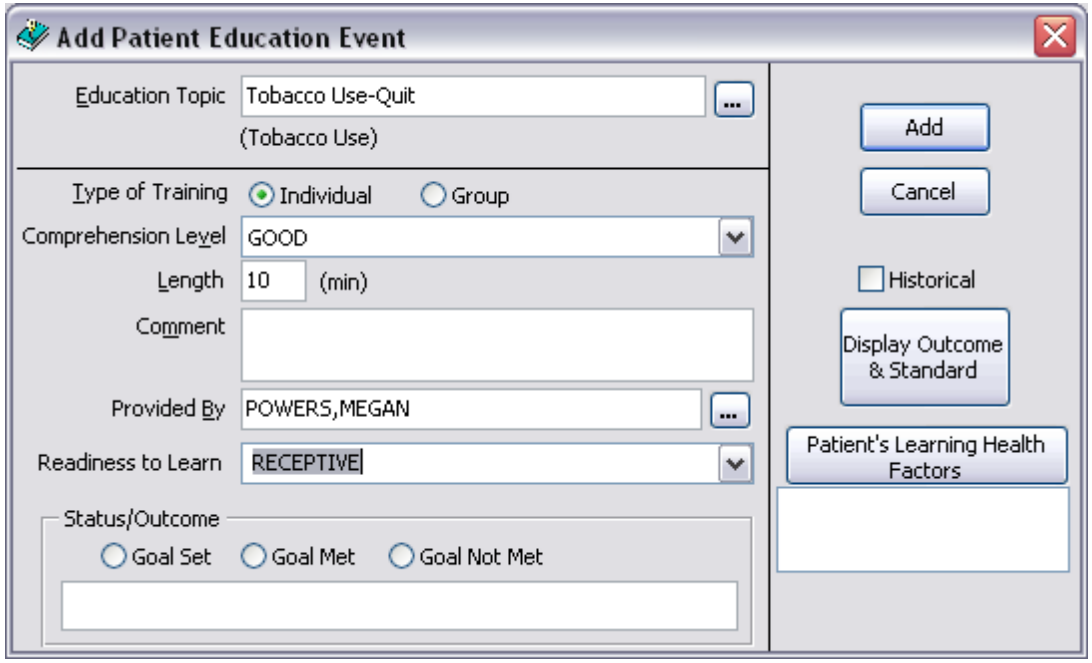


Figure 72: Add Patient Education Event dialog

4. Type any pertinent information and click **Add**.

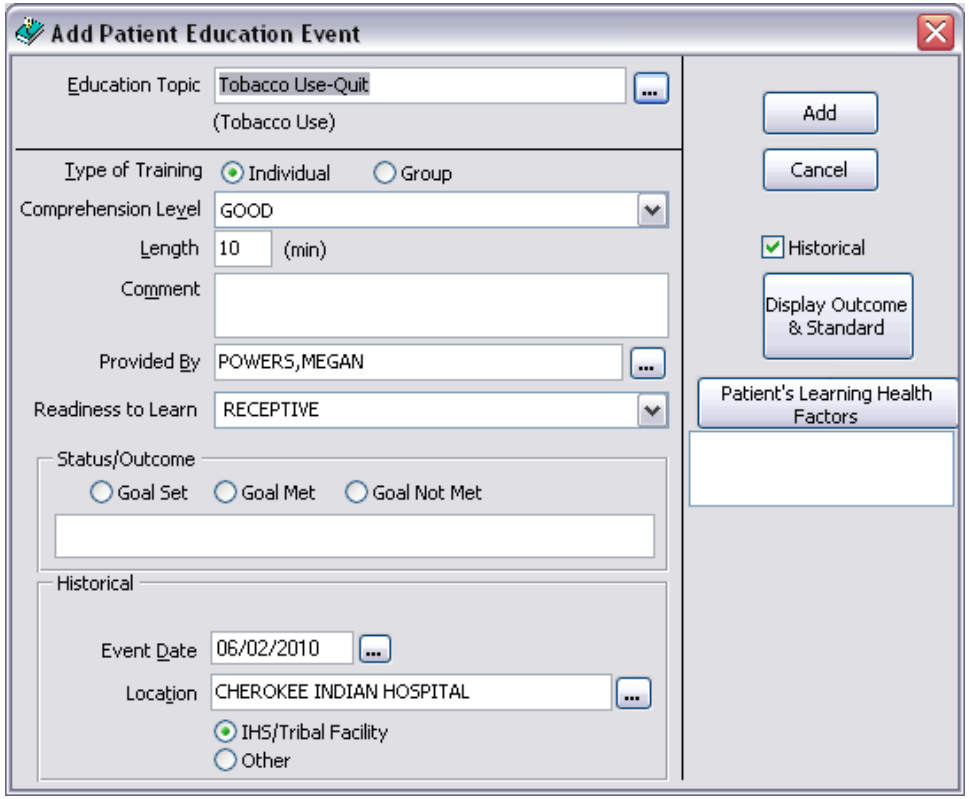


Figure 73: Entering historical education

5. If this is historical education:
   a. Select **Historical**.
   b. Type the **Event Date** and **Location** of the education.

The newly added Patient Education should display in the **Education** component.

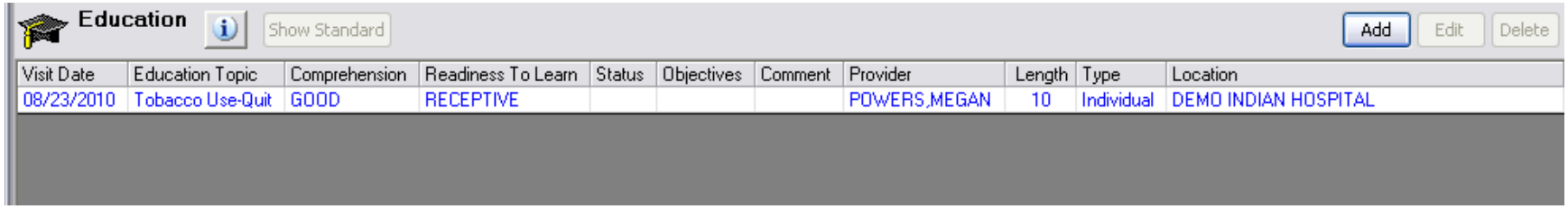


Figure 74: Example of a newly added Patient Education

Patient Education can also be entered when the Visit Diagnosis is entered:

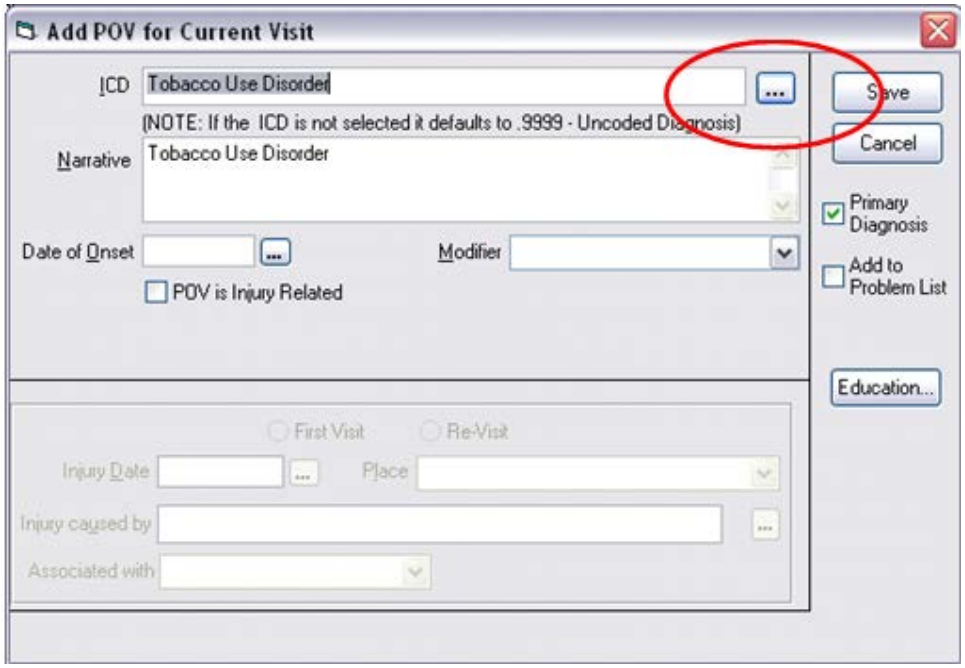


Figure 75: Entering the Patient Education

1. After entering the POV, click **Education**. The **Document Patient Education** dialog (Figure 76) displays.

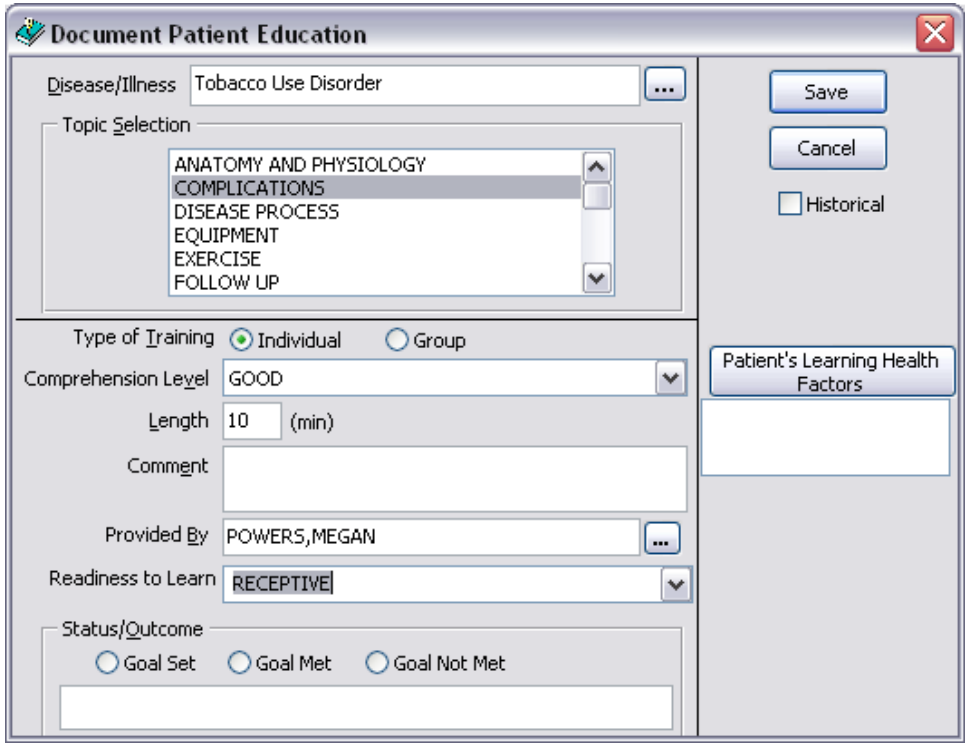


Figure 76: Document Patient Education dialog

2. Type any pertinent information and click **Save**.

Refusals

Refusals are entered in the **Personal Health** component, located on the **Wellness** tab (Figure 77).

> **Note**: Refusals are not counted toward the GPRA measure, but should still be documented.

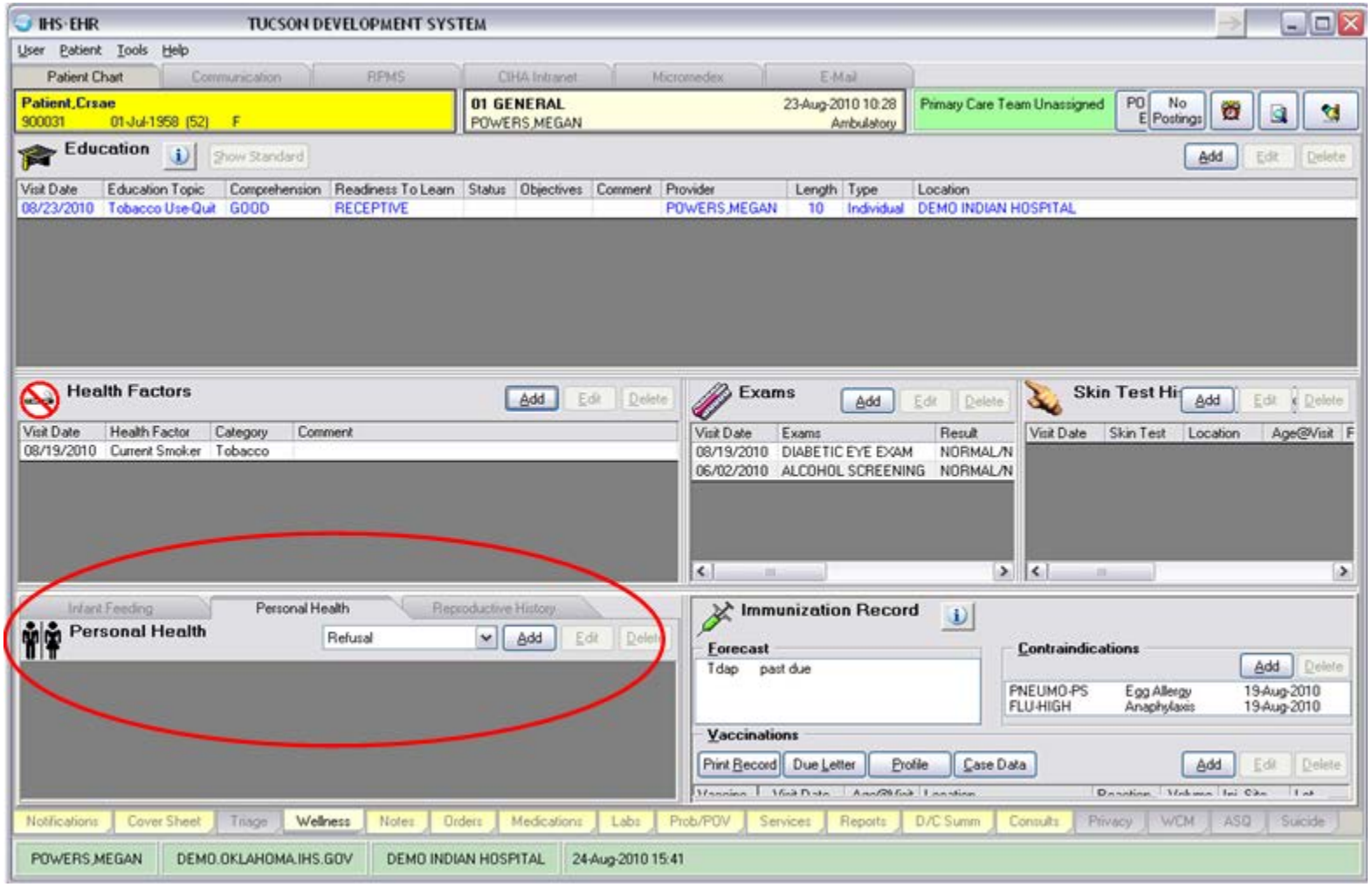


Figure 77: **Personal Health** component

To enter a Refusal:

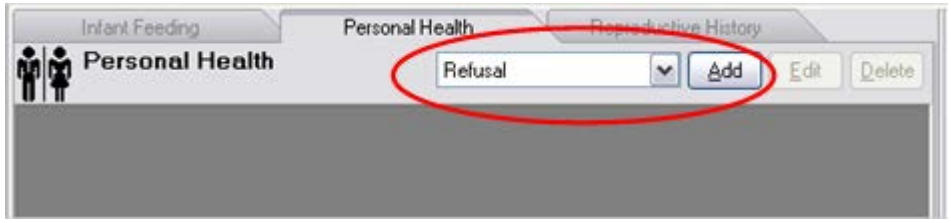


Figure 78: Entering a Refusal

1. Select **Refusal** from the drop-down list.
2. Click **Add**. The **Enter Refusal** dialog (Figure 79) displays.

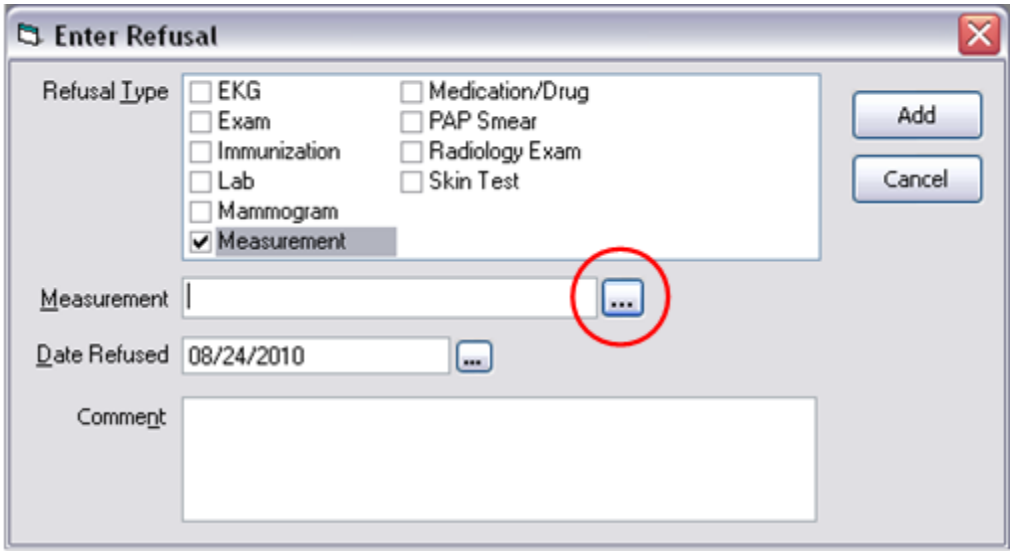


Figure 79: Selecting the Refusal Type

3. Select the **Refusal Type** and click the ellipses (…) button. The Lookup Measurement dialog (Figure 80) displays.

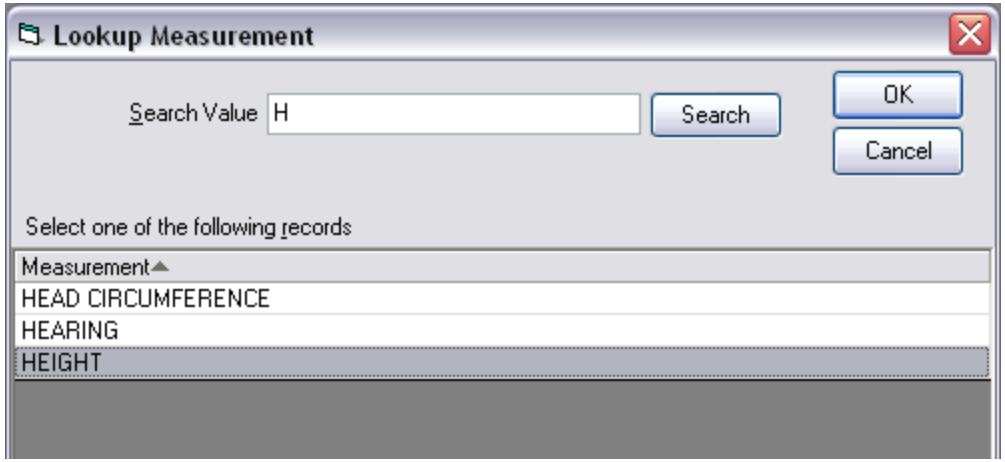


Figure 80: Lookup Measurement dialog

4. Find the refusal item:
   a. Type the first few letters of the item's name in the **Search Value** field.
   b. Click **Search**. A list of matching items displays in the lower portion of the dialog.
5. Click to highlight the item and click **OK**. The Enter Refusal dialog (Figure 81) displays.

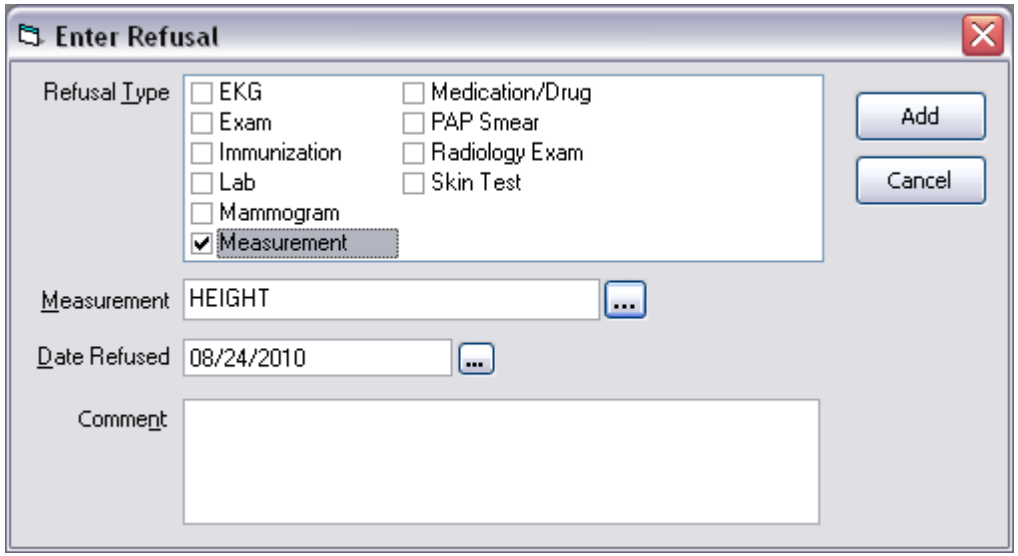


Figure 81: Entering a comment

6. Type a **Comment** (if applicable) and click **Add**. The newly added Refusal should display in the **Personal Health** component (Figure 82).

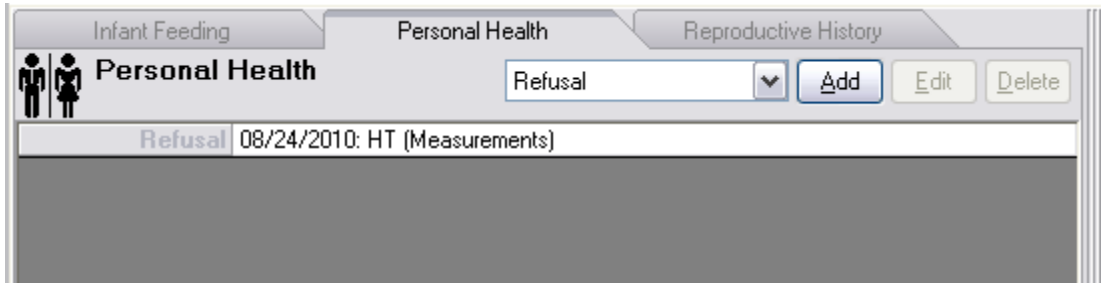


Figure 82: Example of a newly added Refusal

```
                          *************************
                          **   IHS/RPMS CRS 2015  **
                          **     Reports Menu     **
                          *************************
                                 Version 15.0

                             DEMO INDIAN HOSPITAL


   NTL    National /GPRAMA Reports ...
   LOC    Reports for Local Use: IHS Clinical Measures ...
   OTH    Other National Reports ...
   TAX    Taxonomy Reports ...
   MUR    Meaningful Use Clinical Quality Measure Reports...

Select Reports Option:  NTL <Enter>  National GPRA/GPRAMA Reports
```

Figure 3: Select Reports Option

4. At the "Select National GPRA/GPRAMA Reports Option" prompt, type **GP** and press Enter to run the National GPRA/GPRAMA Report as shown in Figure 4.

```
                        *********************************
                        **       IHS/RPMS CRS 2015     **
                        **    National GPRA Reports    **
                        *********************************
                                  Version 15.0

                               DEMO INDIAN HOSPITAL


   GP     National GPRA/GPRAMA Report
   LST    National GPRA/GPRAMA Patient List
   SUM    National GPRA/GPRAMA Clinical Perf Summaries
   DPRV   National GPRA/GPRAMA Report by Designated Provider
   DSH    National GPRA Dashboard
   NST    Create Search Template for National Patient List
   FOR    GPRA/GPRAMA Forecast Patient List
   FORD   GPRA/GPRAMA Forecast Denominator Definitions
   CMP    Comprehensive National GPRA/GPRAMA Patient List

Select National GPRA/GPRAMA Reports Option:  GP <Enter>  National
GPRA/GPRAMA Report
```

Figure 4: Selecting the National GPRA/GPRAMA Reports Option prompt

Information about the report is displayed as shown in Figure 5.

```
                    IHS 2015 National GPRA/GPRAMA Report

This will produce a National GPRA/GPRAMA 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, 2014 through June 30, 2015 with a Baseline Year
of July 1, 2009 through June 30, 2010.  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.
```

Figure 5: Report information

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 Figure 6.
   - 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/GPRAMA Report...

All taxonomies are present.

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

Figure 6: Taxonomy check

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>
```

Figure 7: Demo Patient Search Template warning

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 as shown in Figure 8.

```
The date ranges for this report are:
     Report Period:            Jul 01, 2014 to Jun 30, 2015
     Previous Year Period:     Jul 01, 2013 to Jun 30, 2014
     Baseline Period:          Jul 01, 2009 to Jun 30, 2010
```

Figure 8: Date Ranges

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, type **N** if the report is only being run for clinic use, and press Enter. An example is shown in Figure 9.

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

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

Figure 9: Export to Area prompt

A summary of the report to be generated is displayed as shown in Figure 10.

```
             SUMMARY OF NATIONAL GPRA/GPRAMA REPORT TO BE GENERATED

The date ranges for this report are:
     Report Period:            Jul 01, 2014 to Jun 30, 2015
     Previous Year Period:     Jul 01, 2013 to Jun 30, 2014
     Baseline Period:          Jul 01, 2009 to Jun 30, 2010

The COMMUNITY Taxonomy to be used is: GPRA Community
```

Figure 10: Example of Summary of National GPRA/GPRAMA Report to be generated

10. 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
```

Figure 11: Selecting Output option

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

    a. At the "Select output type" prompt, type **F** (File) and press Enter.

    b. At the prompt to enter a filename (maximum 40 characters), type a name for the file, and press Enter.

    The location and name of the output file is displayed as shown in Figure 12.

Instructions for Running National GPRA/GPRAMA Dashboard

The GPRA/GPRAMA 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/GPRAMA 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 2015       **
                        **  Clinical Reporting System   **
                        **********************************
                                  Version 15.0

                                DEMO INDIAN HOSPITAL


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

Select CRS 2015 Option:  RPT <Enter>  Reports
```

2. At the "Select Reports Option" prompt, type **NTL** and press Enter to display the National GPRA/GPRAMA Reports menu; for example,

```
                          *************************
                          **   IHS/RPMS CRS 2015  **
                          **     Reports Menu     **
                          *************************
                                 Version 15.0

                             DEMO INDIAN HOSPITAL


   NTL    National GPRA/GPRAMA 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/GPRAMA Reports
```

3. At the "National GPRA/GPRAMA Report" prompt, type **DSH** and press Enter to run the National GPRA/GPRAMA Dashboard; for example,

```
                        *********************************
                        **      IHS/RPMS CRS 2015      **
                        **    National GPRA Reports    **
                        *********************************
                                   Version 15.0

                              DEMO INDIAN HOSPITAL


   GP     National GPRA/GPRAMA Report
   LST    National GPRA/GPRAMA Patient List
   SUM    National GPRA/GPRAMA Clinical Perf Summaries
   DPRV   National GPRA & PART Report by Designated Provider
   DSH    National GPRA/GPRAMA Dashboard
   NST    Create Search Template for National Patient List
   FOR    GPRA/GPRAMA Forecast Patient List
   FORD   GPRA/GPRAMA Forecast Denominator Definitions
   CMP    Comprehensive National GPRA/GPRAMA Patient List

Select National GPRA/GPRAMA 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 2015 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 through June 30 of the year provided with a Baseline Year of July 1,
2009 through June 30, 2010.  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.

```
Select one of the following:

     F  Entire Facility
     P  One Designated Provider

Run report for: F//
```

6. At the prompt, do one of the following:

   - To run the report for the entire facility, press Enter
   - To run the report for one designated provider, type **P** and press enter, and then follow this step:
     - At the "Which Designated Provider" prompt, enter the name of the provider and press Enter.

7. At the "Run report for GPRA year 2015 or 2016" prompt, enter the GPRA year for which you would like to run the report.

8. The date ranges for this report are hard-coded, based on the GPRA year selected in Step 7. The system displays the dates, as in the following example:

```
The date ranges for this report are:
   Report Period:            Jul 01, 2014 to Jun 30, 2015
   Previous Year Period:     Jul 01, 2013 to Jun 30, 2014
```

9. 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.

```
      SUMMARY OF NATIONAL GPRA/GPRAMA DASHBOARD REPORT TO BE GENERATED

The date ranges for this report are:
     Report Period:            Jul 01, 2014 to Jun 30, 2015
     Previous Year Period:     Jul 01, 2013 to Jun 30, 2014

The COMMUNITY Taxonomy to be used is: GPRA COMMUNITIES
```

10. At the "Select an Output Option" prompt, type one of the following, depending on your Area preference, and press Enter:

- **D** (delimited output file for use in Excel), or
- **B** (both a printed report and delimited file)

For example,

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

     Select one of the following:

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

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

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

    a. At the "Select output type" prompt, type **F** (File) and press Enter.

    b. At the prompt to enter a filename (maximum 40 characters), type a name for the file, and press Enter.

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

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

Select one of the following:

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

Select output type: S// F <Enter>  FILE - delimited output will be written to a file
in pub.
Enter a filename for the delimited output (no more than 40 characters):
DemoHospGPRA102014 <Enter>

When the report is finished your delimited output will be found in the D:\PUB
directory.  The file name will be DemoHospGPRA102014.txt
```

12. 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/GPRAMA Dashboard - Example

Cover Page

*** IHS 2013 National GPRA Dashboard ***
CRS 2013, Version 13.0 patch 1
Date Report Run: Aug 20, 2013
Site where Run: SANTA YSABEL
Report Generated by: BRENNAN,CHRISTINE
Report Period: Jul 01, 2013 to Jun 30, 2014
Previous Year Period: Jul 01, 2012 to Jun 30, 2013

Measures: GPRA Denominators and Numerators

Population: AI/AN Only (Classification 01)

RUN TIME (H.M.S): 0.7.24

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 Sample 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 Program

	National 2013 Target	2013 Final	Numerator	Denominator	2014*	# Needed to Achieve Target
Good Glycemic Control <8	Baseline	0	0	0	0	N/A
Controlled BP <140/90	Baseline	0	0	0	0	N/A
LDL Assessed	68	0	0	0	0	0
Nephropathy Assessed	64.2	0	0	0	0	0
Retinopathy Assessed	56.8	0	0	0	0	0
Dental Access General	26.9	0	0	13	0	4
Sealants	Baseline	0	0	3	0	N/A
Topical Fluoride	Baseline	0	0	3	0	N/A
Influenza 65+	62.3	0	0	1	0	1
Pneumovax Ever 65+	84.7	100	1	1	100	0
Active IMM 4313*314	Baseline	0	0	0	0	N/A
Pap Smear Rates 25-64	Baseline	40	0	0	0	N/A
Mammogram Rates 52-64	49.7	25	0	0	0	0
Colorectal Cancer 50-75	Baseline	40	1	1	100	N/A
Tobacco Cessation Counsel or Quit	Baseline	0	0	0	0	N/A
FAS Prevention 15-44	61.7	0	0	0	0	0
IPV/DV Screen 15-40	58.3	0	0	0	0	0
Depression Screen 18+	58.6	0	0	3	0	2
Childhood Weight Control	24	0	0	0	0	0
CHD Comp CVD Assessment	32.3	0	0	0	0	0
Prenatal HIV Testing	82.3	0	0	0	0	0
Breastfeeding Rates	Baseline	0	0	0	0	N/A

*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/GPRAMA Patient List

CI15 > 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/GPRAMA Reports Menu.
4. At the "Select National GPRA/GPRAMA Reports Option" prompt, type **LST** and press Enter to display the following information about the National GPRA/GPRAMA Patient List:

```
                IHS GPRA/GPRAMA Performance Report Patient List
                          CRS 2015, Version 15.0

This will produce a list of patients who either met or did not meet a
National GPRA/GPRAMA Report performance measure or a list of both those
patients who met and those who did not meet a National GPRA/GPRAMA 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 1: Running the National GPRA/GPRAMA 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 2: 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 3: 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/GPRAMA 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 4: Running the National GPRA/GPRAMA 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/GPRAMA 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: Running the National GPRA/GPRAMA 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

Which item(s): (1-4): 1,3   <Enter>
```

Figure 6: Running the National GPRA /GPRAMA 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 7: Running the National GPRA/GPRAMA 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, 2014) 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, 06/30/2014) 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 8: 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.

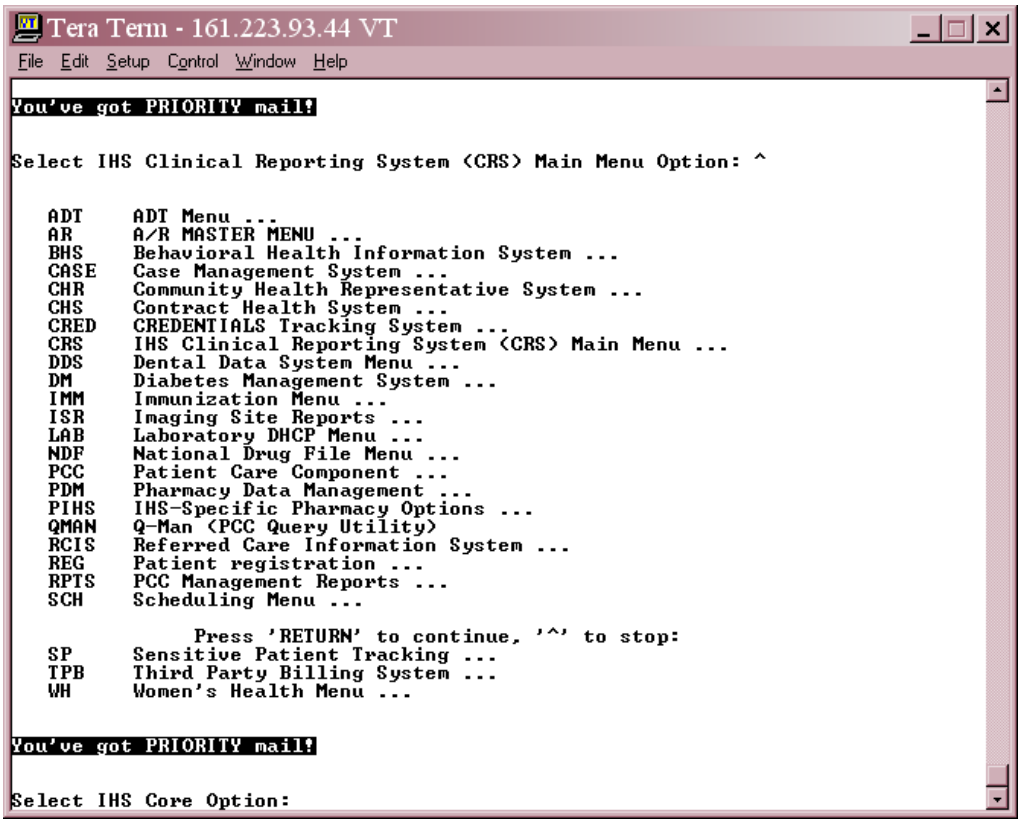
16. At the "Select an Output Option" prompt, type the letter corresponding to the type of output you want and press Enter, where:

    - **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.

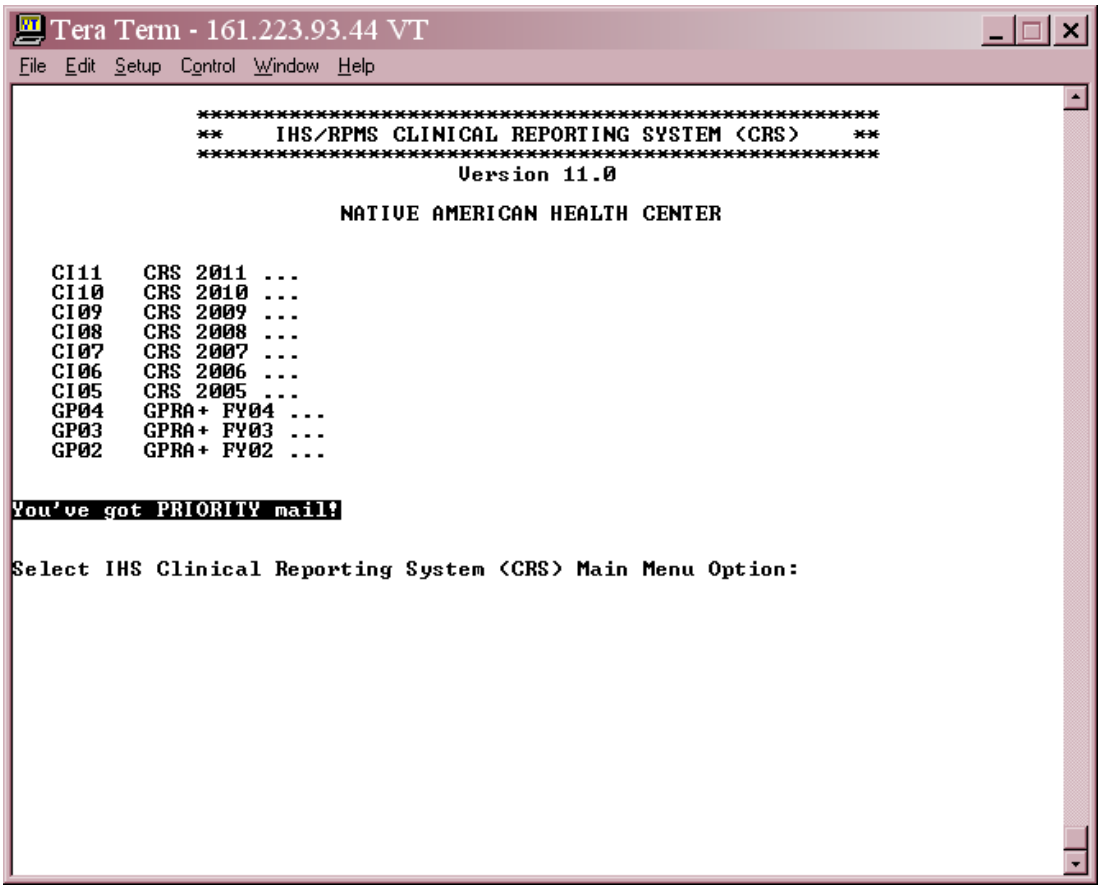
    Detailed instructions for the Print and Delimited Output options are found in Step 12, Section 5.2.2.

Instructions for Updating GPRA Medication Taxonomies in CRS:

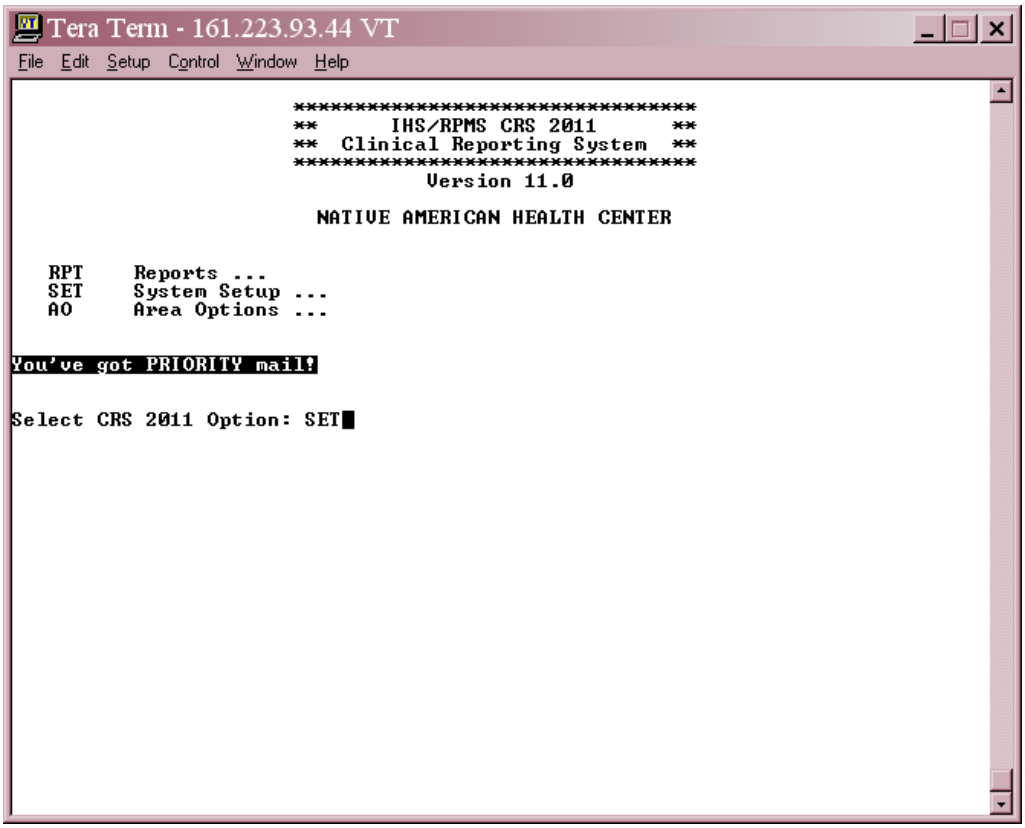
1. At the IHS Core Option, select **CRS** (or GPRA)



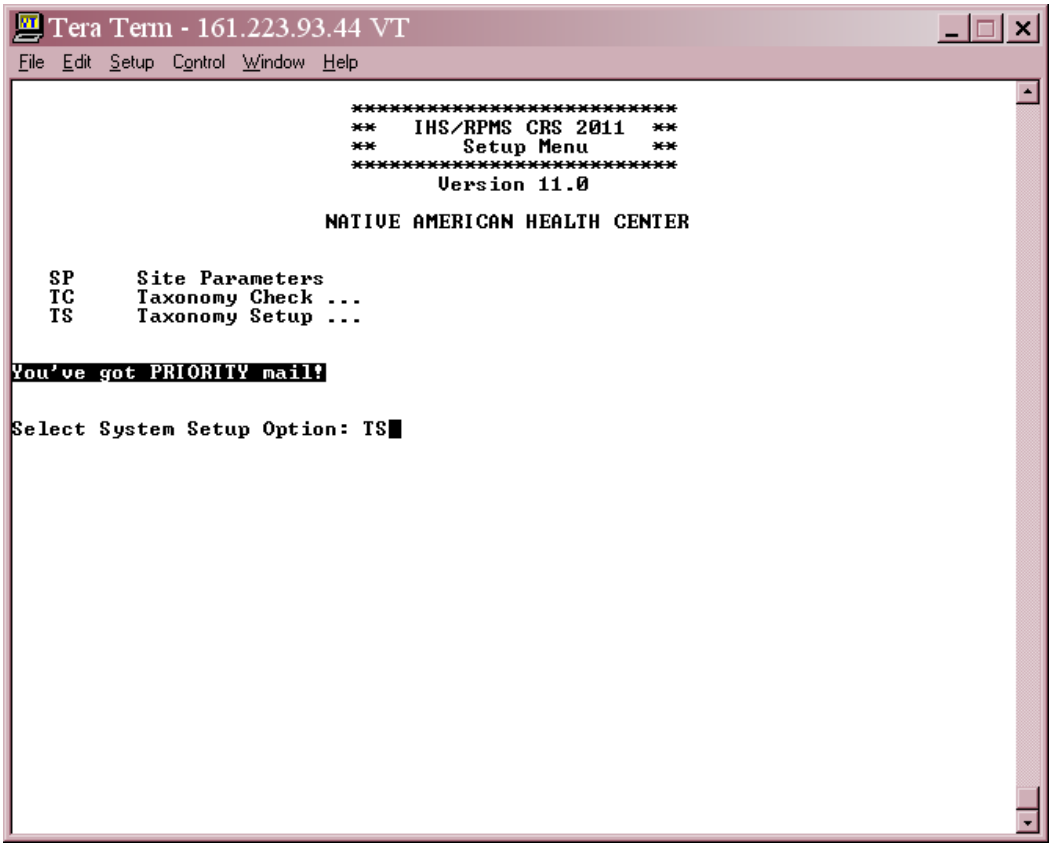
2. At the CRS main menu, select **CIXX (where XX is the most current version of CRS)**



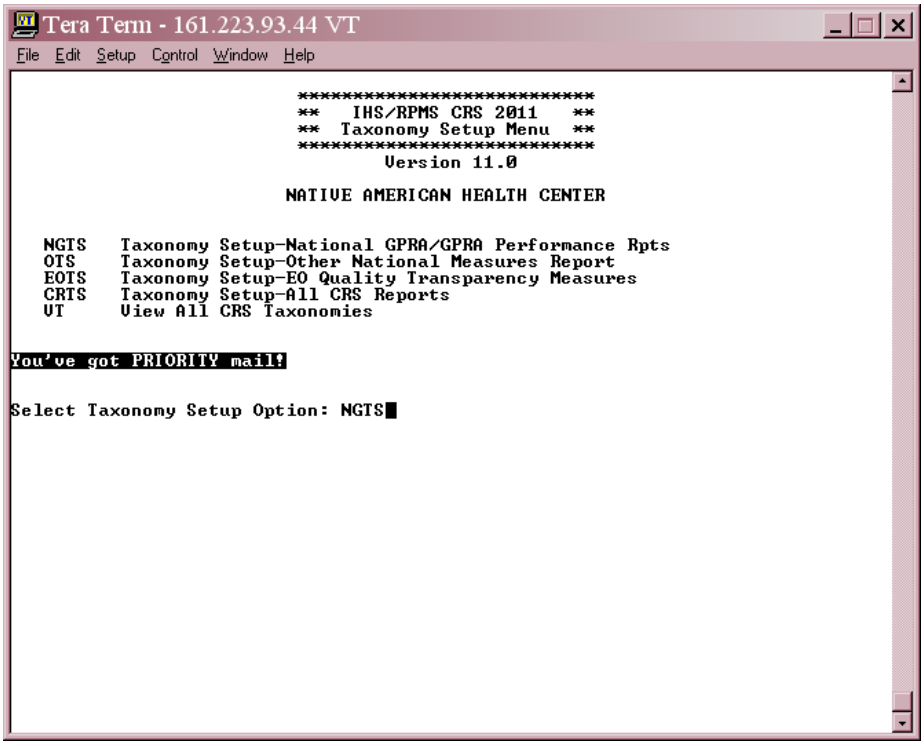
3. At the Select CRS Option, select **SET** (System Setup)



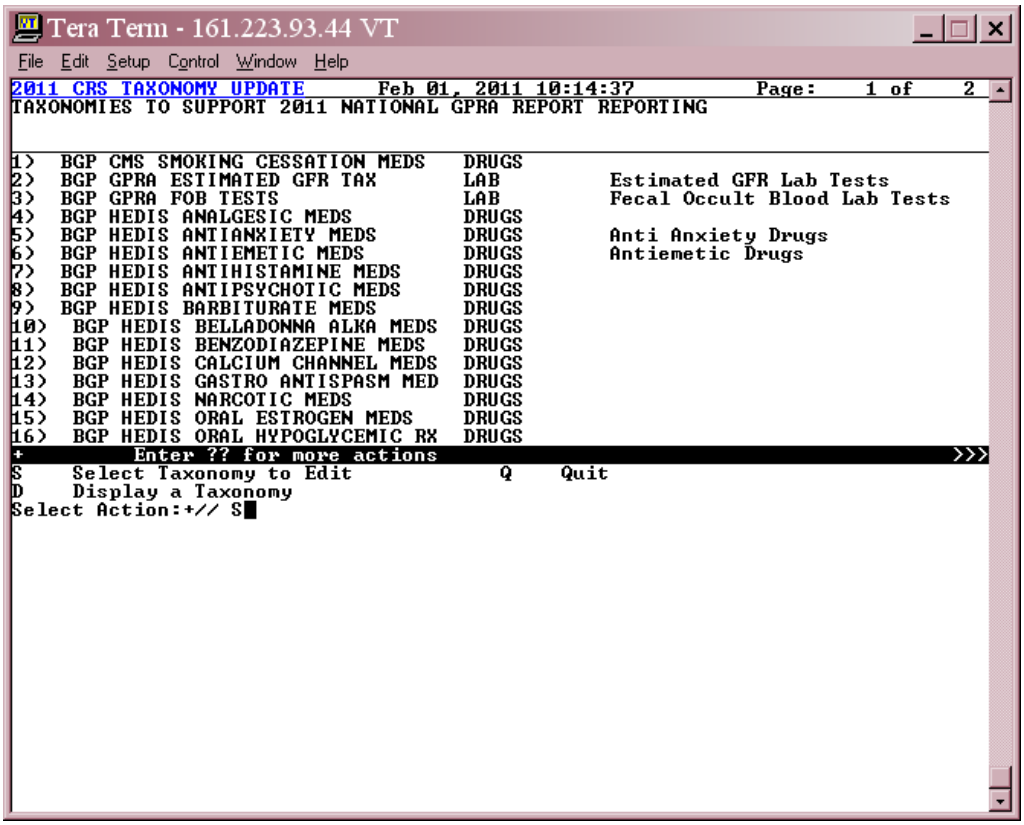
4. At the System Setup menu, select **TS** (Taxomony Setup)



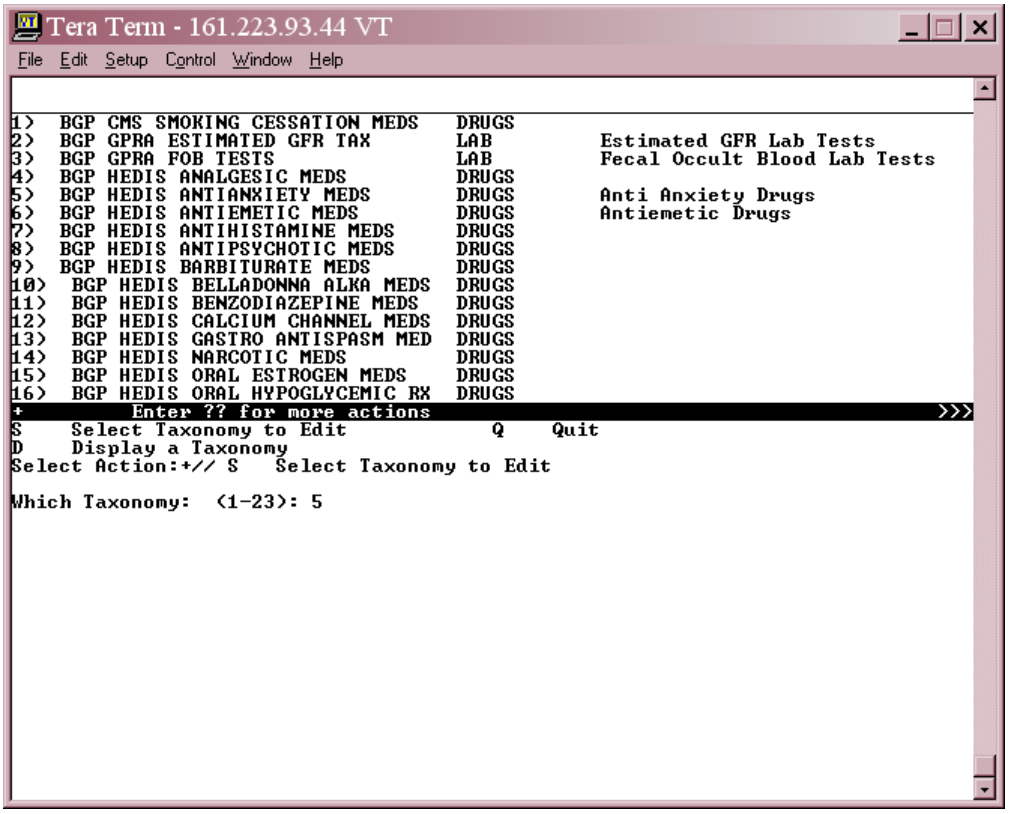
5. At the Taxonomy Setup menu, select **NGTS**



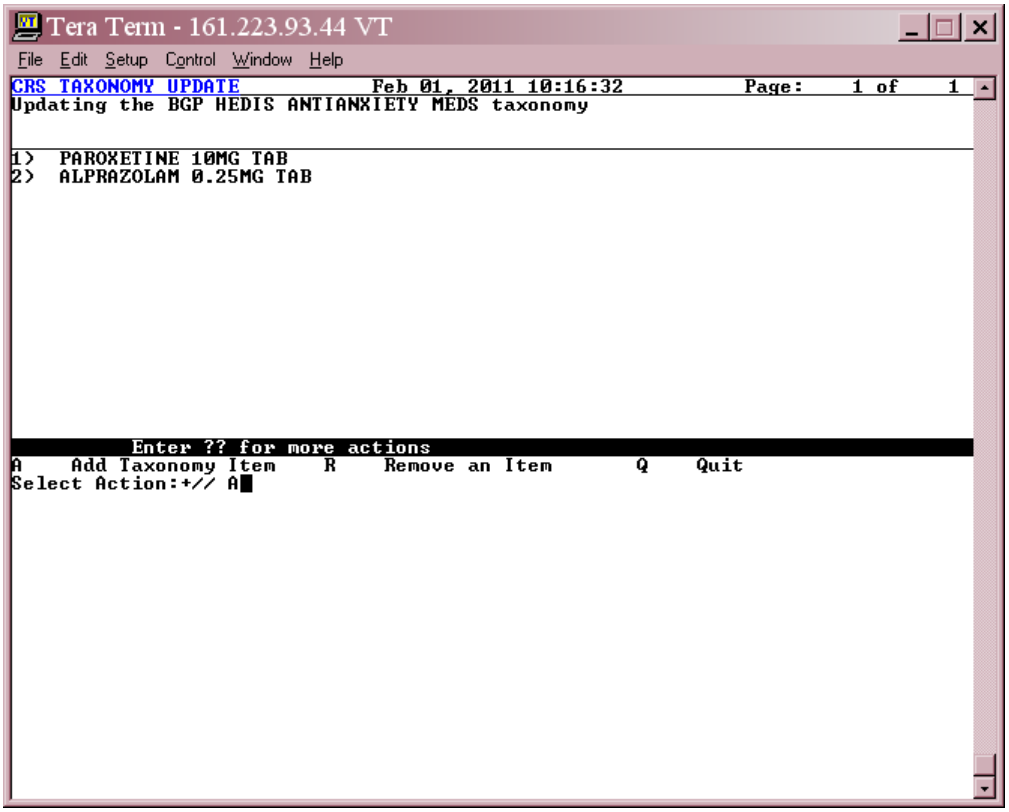
6. At the next screen, select **S** to choose a Taxonomy to Edit (to scroll to the next screen type "+" and press enter, use "-" to go back one screen)



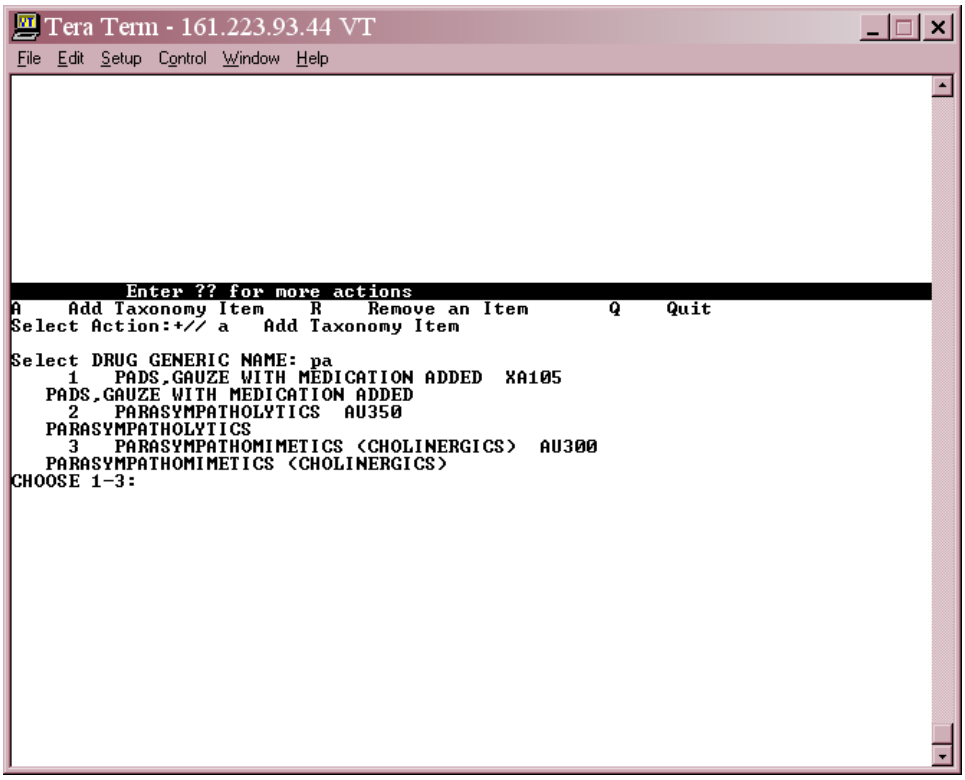
7. At the 'Which Taxonomy' prompt, **select the number for the taxonomy to edit** (for example, select 5 for BGP HEDIS ANTIANXIETY MEDS)



8. At the next screen, type **A** to add a taxonomy item



9. At the Select Drug Generic Name prompt, type in the name of the drug, or the first few letters of a drug name and press Enter.



10. A list of medications will appear, select the number of the medication you would like to add and press enter.
11. Repeat this process for each taxonomy that needs to be updated.

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

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Date

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Letter to the Editor

Integrating clinical decision support to increase HIV and chlamydia screening

Keywords:
American Indian/Alaska Native
HIV
Chlamydia
STDs
Screening
Public health
Clinical
Decision support
Rural

Routine HIV screening for adolescents and adults is recommended for early detection of HIV/AIDS. Persons aged 13–64 should receive at least one routine HIV screening, with repeat testing based on clinical judgment (Centers for Disease Control and Prevention, 2006). Early detection of HIV can improve patient health, increase linkages to care, and slow the rate of transmission as risk behaviors are modified and reduced (Marks et al., 2005; US Preventive Services Task Force, 2013).

Chlamydia infection is the most commonly reported notifiable disease in the United States. Since 1994, it has represented the largest proportion of all reported STDs, and has the highest burden of disease among persons aged ≤25 (Centers for Disease Control and Prevention, 2012). Annual chlamydia trachomatis (CT) screening among young sexually active women is recommended to avert possible sequelae, including pelvic inflammatory disease (PID), ectopic pregnancy and infertility (Centers for Disease Control and Prevention, 2010; Meyers et al., 2008). There is no recommendation for routine chlamydia screening of women 26 years of age or older, absent of risk (Centers for Disease Control and Prevention, 2010; Meyers et al., 2008).

The U.S. Indian Health Service (IHS) is a federal agency responsible for providing health services to American Indian and Alaska Native (AI/AN) people. The IHS provides a comprehensive health service delivery system for approximately 2.1 million AI/AN in 35 states (http://www.ihs.gov/newsroom/factsheets/ihsyear2013profile/). Most IHS health facilities are primary care clinics serving rural populations.

An IHS clinic in the Pacific Northwest with a population catchment area of approximately 6500 tribal members targeted HIV and CT screening, using a semi-standardized process that included clinical reminders. Newly released or updated evidence-based clinical practice guidelines from national public health agencies such as CDC, United States Preventive Task Force (USPTF), or Agency for Healthcare Research and Quality (AHRQ) inform clinical priority-setting. As the facility prioritizes new preventive care targets, the clinic-based Medical Informaticist (MI) and Clinical Director (CD) determine if adding a reminder to the Electronic Health Record (EHR) is appropriate. Newly proposed screening policies and practices are presented by the CD and discussed with all clinicians.

When the clinic implements a new reminder, it is developed and deployed by the MI. New reminders are usually pilot tested with 1–2 providers. After pilot testing, the reminder is implemented clinic-wide. To avoid overloading medical staff, each member of the medical team sees and is responsible for checking and acting on a certain subset of reminders. Reminder icons can be engaged or bypassed at the clinician's discretion, and are automatically deactivated when the EHR detects the relevant laboratory procedure has been completed.

This process was implemented for HIV screening in June 2010, and for CT screening in December 2011, with the reminder fulfillment delegated to nurses. Compared to the year prior to implementing the reminder, HIV testing increased from 250 to 1340 unique patients aged 13–64, and is well above national IHS rates (see Fig. 1). The clinic has achieved the highest rate of HIV screening among this age cohort in IHS at 65.9% of active clinical patients (defined as two or more visits in the past three years) ever tested for HIV, compared to 30.6% for IHS nationwide.

Compared to the year prior to implementing the EHR reminder, annual CT screening among women ≤25 years increased from 56 to 200 unique patients. The screening rate increased to 48.9%, well above the national IHS screening rate of 29.2%. CT screening among women ≤25 has resulted in a higher proportion of positive CT tests (from 9.5% to 11.2%) identified. However, these data cannot differentiate whether the increased positivity is due to higher rates of chlamydia, increased case-finding of asymptomatic infections, or a combination of both factors. Conversely, the total number of tests among women ≥26 was reduced from 430 to 352, with no significant change in the overall positivity rate (pre-EHR Reminder — 2.8% vs. post-EHR Reminder — 2.6%; $p = 0.84$).

This clinic has systemically integrated HIV and CT screening into its delivery of care, putting its screening rates at or near the top of all of its peer health facilities. The clinic's medical leadership has established processes that set preventive care priorities, obtained medical consensus on clear screening policies and protocols, leveraged local medical informatics to develop and test reminders, and delegated responsibility to appropriate medical team members.

The clinic has successfully used this process to target several key preventive health measures, including tobacco-use screening and childhood immunizations. Once preventive measures have been integrated into care, screening rates remain high, even as a new screening measure is targeted. The clinic usually sets 2–4 new preventive care targets per year utilizing this process.

EHR and clinical reminders have an important role within this quality improvement process. Although clinical reminders have had uneven success in some settings (DesRoches et al., 2010; Romano and Stafford, 2011), they can provide a scalable and standardized tool across a health care system that utilizes a common health IT platform (Menachemi and Collum, 2011). Notably, the Veterans Administration has shown improvement on HIV screening using a reminder-based intervention (Goetz et al., 2013).

This process of establishing clinical support and reminder deployment will take longer in larger facilities where quality improvement is targeted in separate medical services rather than facility-wide. Similarly, urgent care and emergency care are more challenging settings to integrate this process, yet these are critical points of medical contact for hard to reach

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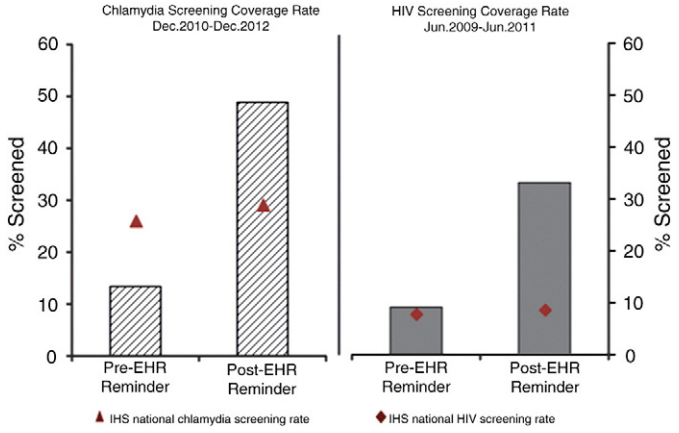

Fig. 1. HIV and chlamydia screening rates, Northwest Indian Health Service Clinic, twelve months before and after deployment of electronic clinical reminders.

patient populations (Mumma and Suffoletto, 2011; Williams Torres et al., 2011).

Our results are subject to some limitations. There is no direct comparison group that did not use the clinical reminders. In addition, we were unable to determine from these data which patients were sexually active. CDC recommends annual CT screening among sexually active women younger than 26; not having that information may make findings more difficult to interpret. These data describe the efforts of one IHS clinic and may not be representative of all IHS facilities. However, these findings may provide an important framework for other facilities to improve HIV and CT screening rates.

Conflict of interest
The authors have no conflicts of interest to disclose.

References

Centers for Disease Control and Prevention, 2006. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR Recommendations and Reports 2006/55(RR14), pp. 1–17.

Centers for Disease Control and Prevention, 2010. Sexually Transmitted Diseases Treatment Guideline, No. RR-12, 59. MMWR (accessed online February 21, 2013).

Centers for Disease Control and Prevention, 2012. Sexually Transmitted Disease Surveillance 2011. Department of Health and Human Services, Atlanta: U.S. 7.

DesRoches, C.M., et al., 2010. Electronic health records' limited successes suggest more targeted uses. Health Aff. 29 (4), 639–646.

Goetz, M., et al., 2013. Central implementation strategies outperform local ones in improving HIV testing in Veterans Healthcare Administration facilities. J. Gen. Intern. Med. 1–7.

Marks, G., Crepaz, N., Senterfitt, J.W., Janssen, R.S., 2005. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. J. Acquir. Immune Defic. Syndr. 39, 446–453.

Menachemi, N., Collum, T., 2011. Benefits and drawbacks of electronic health record systems. Risk Management and Healthcare Policy, 4, pp. 47–55. http://dx.doi.org/10.2147/rmhp.s12985 ([PMC free article] [PubMed]).

Meyers, D., et al., 2008. USPSTF recommendations for STI screening. Am. Fam. Physician 77, 819–824.

Mumma, B., Suffoletto, B., 2011. Less encouraging lessons from the front lines: barriers to implementation of an emergency department-based HIV screening program. Ann. Emerg. Med. 58 (1), 44–48.

Romano, M.J., Stafford, R.S., 2011. Electronic health records and clinical decision support systems: impact on national ambulatory care quality. Arch. Intern. Med. 171 (10), 897–903. http://dx.doi.org/10.1001/archinternmed.2010.527.

US Preventive Services Task Force, 2013. Screening for HIV: recommendation statement. http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm (April).

Torres, G.W., Heffelfinger, J.D., Pollack, H.A., Barrera, S.G., Rothman, R.E., 2011. HIV screening programs in US emergency departments: a cross-site composite of structure, process, and outcomes. Ann. Emerg. Med. 58 (1), 104–113.

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GPRA Monthly Webinars

2nd Thursday of Each Month: 10:00—11:00 A.M.

Call-in Number:
800-832-0736

Room Number:
*5677206#

Adobe Connect Link:
http://ihs.adobeconnect.com/gpra-ca/

GPRA monthly webinars, including quarterly CA GPRA coordinator webinars (dates listed in blue) will be held the 2nd Thursday of each month.

Each monthly webinar will feature presentations on GPRA, CRS, or quality improvement topics relevant to California tribal and urban Indian healthcare programs. 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.

Monthly Webinar Dates:

- **September 11, 2014**
- October 9, 2014
- November 13, 2014
- **December 11, 2014**
- January 8, 2015
- February 12, 2015
- **March 12, 2015**
- April 9, 2015
- May 14, 2015
- **June 11, 2015**

Call-in to our monthly webinars to get answers to your CRS or GPRA questions!

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

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

National GPRA Support Team
Telephone: 916.930.3927
E-mail: caogpra@ihs.gov
650 Capitol Mall, Suite 7-100
Sacramento, CA 95814

Now Available!

GPRA/GPRAMA Portal

What is the portal? It is a password-protected webpage specific to your work!

How to join the GPRA/GPRAMA portal:

Visit http://www.ihs.gov/california/ and click the button that looks like this:

CA Member Portal Access

Select GPRA/GPRAMA Portal and follow the prompts to Create Account as a new member. You will receive a password to via e-mail that will enable you to log-in.

Use the forum to ask questions and share best practices with other California healthcare staff!

Visit the *new* GPRA/GPRAMA portal to view:

- Current GPRA results;
- GPRA reporting instructions;
- GPRA flyers;
- Conference presentations;
- Webinar recordings;
- Behavioral health screening tools; and,
- Much more!

E-mail caogpra@ihs.gov for more information.

Save The Date

California Provider's Best Practices & GPRA Measures Continuing Medical Education

May 4-6, 2015

Audience: physicians, nurses, behavioral health professionals, mid-level practitioners, dietitians, clinic support staff, GPRA coordinators, community outreach professionals, Tribal officials, healthcare program directors, and other interested community members

Featuring clinical experts from UC Davis Medical Center!

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Register for FREE :

http://www.ihs.gov/AdminMngrResources/IHS_Calendar/index.cfm?module=Register%20for%20an%20Event&event_ID=1611

If you have special needs questions or concerns, a grievance concerning this conference, or for more information, please contact Rachel Harvey at 916-930-3981, extension 361 or Rachel.Harvey@ihs.gov.

Sacramento, CA

Hosted by the California Area Indian Health Service and the National GPRA Support Team

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):*

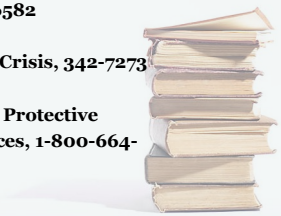
1. Are you in a relationship with a person who physically hurts or threatens you?
   ☐ Yes
   ☐ No
2. Have you ever been in a relationship with a person who hurt you?
   ☐ Yes
   ☐ No
3. Would you like to talk to someone about Intimate Partner/Domestic Violence?
   ☐ Yes
   ☐ No

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**

INDIAN HEALTH SERVICE · PHS · 1955 ·

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).

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*

Counseled to quit tobacco?	**Condition**	**Understanding** Good-Fair-Poor-Group	**Minutes**	**Initials**	**Goal?**	**Comments**
	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)**	**0-2 = Negative 3-6 = Positive**
Little or no interest in doing things?					
Feeling down, depressed, hopeless?					

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					

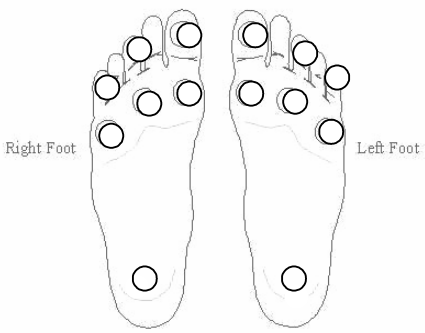
Date _____ Name_____ Age _____ RPMS # _____

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 # _____

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

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				

Additional Standing Orders for Diabetic Patients

Purpose: To ensure a CBC, Lipid Panel, CMP, Micro albumin, and A1C is collected on diabetic patients at least annually.

Policy: Under these standing orders, the nursing staff (RN's, LVN's and MA's) at LCTHC will collect a CBC, Lipid Panel, CMP, Micro albumin, and A1C on diabetic patients at least annually.

Procedure:

This policy and procedure shall remain in effect for all diabetic patients of the LCTHC outpatient clinic until rescinded.

1. The nursing staff at LCTHC will collect a CBC, Lipid Panel, CMP, Micro albumin, and A1C on diabetic patients at least annually.

Medical Director's Signature:_____Effective date:_____

Nephropathy Assessment
Best Practices from California Healthcare Programs

K'ima:w Medical Center (Hoopa):

- Use EHR and EHR reminders
- Ensure nursing staff pay attention to EHR reminders
- Review reports monthly
- Make lab orders convenient
- Utilize tools and team (to include provider, nurse, DM Case Manager, etc.)

Lake County Tribal Health Clinic:

- Catch patients at every visit regardless of point of visit
- Ensure LVN looks at schedule ahead of time and marks patients that are due for nephropathy assessment
- Complete nephropathy assessment on-site, rather than sending patient to lab
- Capture outside visits (such as ER visits) and enter into EHR as historical records
- Utilize Diabetic Educator to empower patients by explaining nephropathy assessment and need for it
- Hold monthly GPRA team meeting with everyone in clinic
- Complete chart audits at the end of the year
- Institute standing orders (example attached)

Round Valley Indian Health Center:

- Develop monthly awareness campaign (including radio PSA's, posters in exam rooms, community bulletin boards, electronic newsletters, Facebook, and mailings)
- Run patient status reports, by provider
- Complete case management of diabetic patients
- Print out monthly audits
- Send patient reminder letters
- Call patients to remind them of upcoming appointment
- Provide transportation, as needed
- Follow-up with back office and providers to obtain labs
- Utilize RN to provide education prior to provider seeing patient
- Institute standing orders for care labs and exams
- Check for DM patients each morning

Tule River Indian Health Center:

- Host DM clinic once a week
- Complete DM audits daily
- Institute standing orders & protocols
- Improve communication
- Host monthly events
- Utilize outreach department
- Use EHR

Tuolumne Me-Wuk Indian Health Center:

- Work with community and GPRA team (to include Medical Director, IT, nurse, outreach, medical records, coder, etc.)
- Educate staff at provider meetings, twice a month
- Host GPRA meetings monthly
- Call patients and request that they make an appointment
- Obtain medical records from other facilities
- Go into the community
- Provide transportation to patients, as needed
- Use EHR and VistA Imaging

Breast Cancer Screening (Mammography)
Best Practices from California Healthcare Programs

Chapa-De Indian Health Program, Inc.:

- Improve awareness and education to staff and clients by having a 'Think Pink' organization-wide event and offer prize for those staff wearing the most pink
- Promote staff awareness by participating in the Susan G. Komen Race for the Cure
- Remind patients of upcoming appointments and provide transportation vouchers
- Work with the diabetes team to utilize patient education board

K'ima:w Medical Center (Hoopa):

- Include mammography activities in community events (e.g. health fair)
- Provide prizes for women who complete their mammogram
- Place posters and raffle box in the community to promote education

Northern Valley Indian Health, Inc.:

- Partner with imaging center
- Obtain grant(s)
- Involve community advocates
- Host biannual "Wellness Event: Think Pink Day"
- Provide educational materials to women and men
- Involve media for community education
- Utilize CRS reports (including list of patients who did not meet the mammography measure)
- Remind patients via flyers and phone calls
- Educate patients via flyers
- Provide transportation
- Incorporate culturally appropriate activities, such as crafts
- Develop council of Native women
- Involve administrative staff
- Follow-up with patients
- Work with younger women so that when they are of age they will understand the importance of mammograms

Alcohol Screening (Fetal Alcohol Syndrome Prevention)
Best Practices from California Healthcare Programs and IHS/CAO

Anav Tribal Health Clinic (Quartz Valley Program):

- Ensure CEO is involved
- Improve communication between departments regarding GPRA
- Dedicate in-services, trainings, and monthly meetings to GPRA
- Encourage staff to participate in Area conferences and webinars
- Use EHR
- Utilize MAs to enter data from screenings
- Ensure all departments are aware of what other departments are doing
- Train providers so they are not afraid to ask the behavioral health screening questions
- Appoint GPRA Coordinator
- Utilize screening bundle in note template
- Invite CAO GPRA Team to conduct individual site training
- Educate patients

Indian Health Council, Inc.:

- Empanel patients (each clinic team to include one physician, one mid-level practitioner, one MA, one nurse, and one CHR or PHN)
- Ensure CHRs and PHNs follow-up on referrals for behavioral health screenings
- Utilize EMR template for all screenings
- Train staff across all departments
- Develop Improved workflows
- Screen everyone over the age of 15 (male or female) for alcohol use
- Involve all departments (to include medical, community health, dental, and behavioral health)
- Involve CMO
- Empower patients

IHS/CAO:

- Provide staff with proper orientation on how to ask questions
- Universally screen all patients
- Utilize CAGE Questionnaire
- Provide referrals and treatment if patients answer “yes” to screening questions

Influenza 65+
Best Practices from California Healthcare Programs and IHS/CAO

Lake County Tribal Health Consortium:

- Meet monthly as a team (to include medical, coder, dental, behavioral health, and outreach) to review GPRA statistics, GPRA dashboard, and patient lists
- Use EHR reminders, especially for walk-in patients to decrease missed opportunities
- Send mass mailings to educate patients on influenza vaccinations
- Utilize team approach and ensure staff is pro-active
- Run CRS patient forecast lists daily and provide to nursing to prepare for upcoming appointments
- Utilize nursing staff to notify providers at time of visit if patients need immunizations
- Enter refusals so that immunization forecast informs providers of which patients are hesitant and need more education
- Offer immunizations to every patient
- Enter historical data
- Utilize outreach department to conduct flu clinics in the community
- Set-up table outside of clinic's front door to allow easy access to immunizations
- Reward patients for getting vaccinated
- Celebrate successes (to include posters, e-mails from executive director, presentations at all-staff meetings and to health board)

Northern Valley Indian Health, Inc.:

- Host vaccination clinics and vaccination events for both Indian and non-Indian patients
- Host diabetic standards clinic and provide attendees with "passport" to obtain immunizations
- Run patient lists constantly and provide to outreach and community health staff
- Flag charts of patients with upcoming appointments that need flu vaccine
- Involve dental providers
- Include flu article that dispels fly myths in community health newsletter
- Call patients (adult and children) that need immunizations to ensure all are captured
- Utilize team approach (to include nursing, quality, medical, and clerical)

IHS/CAO:

- Provide targeted patient and provider education
- Offer incentives for vaccinations
- Offer no-cost vaccines on multiple occasions at various venues
- Monitor vaccination status routinely
- Implement reminder notifications for patients and health care personnel

Breastfeeding
Best Practices from Sonoma County Indian Health Project

- Identify a champion
- Empower emerging leadership
- Develop a lactation policy
- Create a breastfeeding friendly workplace and establish a lactation room in clinic
- Survey community and incorporate their needs into action plan
- Consider developing a native council
- Implement infant feeding measurement tool
- Increase awareness in community about benefits of breastfeeding and provide support
- Educate staff about how to provide education and support to families
- Reach out to other tribal communities
- Participate in community events with “breastfeeding tent” and provide education
- Host community events (to include community gathering about breastfeeding, family wellness fair, family fun night, and puppet show)
- Collaborate with community resources (such as Comprehensive Perinatal Services Program and WIC peer counselors)
- Celebrate World Breastfeeding Week in August

February 2013

Retinopathy Exam
Best Practices from K'ima:w Medical Center (Hoopa)

- Utilize these resources:
    - EHR and EHR reminders
    - iCARE
    - DM Registry
    - CRS (GPRA lists)
    - IPC panels
    - Eye clinics
- Know your patients and consider patient preference
- Maintain extended clinic hours for ophthalmology
- Run list of patients due for screenings for walk-ins
- Work as a team:
    - Check-in clerks notify staff
    - All providers, including locums, utilize reminder prompts
    - Include diabetes staff
    - Include telemedicine coordinator
- Analyze the data:
    - Active DM registry
    - GPRA DM retinopathy denominator
    - Retinal evaluations in the past year
- Designate provider to each DM patient
- Hold monthly case management meetings with DM team

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Use of Electronic Clinical Reminders to Increase Preventive Screenings in a Primary Care Setting: Blueprint From a Successful Process in Kodiak, Alaska

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Abstract

Purpose: The Kodiak Area Native Association (KANA) provides primary health care in Kodiak, Alaska and 6 outlying villages. KANA sought to actively improve key preventive screening rates for its patients. **Methods:** KANA adopted an electronic health record in 2008 and deployed national clinical reminders from the Indian Health Service for 5 key preventive screenings: tobacco use, alcohol use, depression, intimate partner violence, and a comprehensive cardiovascular exam. Clinical reminders were deployed in a 5-step process: (*a*) establish clinical demand, (*b*) pilot test reminder, (*c*) expand reminder to all providers, (*d*) measure outcomes and share results, and (e) delegate clinical reminder follow-up (primarily to nurses). **Results:** Data from 2007-2011 show screening rates for all 5 measures improved considerably, to levels significantly above the national average for Indian Health Service facilities. **Conclusions:** Clinical reminders have been a key part of a multistep process to improve screening for depression, tobacco cessation, intimate partner violence, alcohol use, and cardiovascular disease. If deployed correctly, reminders are valuable tools in identifying patients who are overdue for preventive health screenings.

Keywords

preventative care, primary care, screening, clinical reminders

Introduction

Despite evidence of the effectiveness of preventative services and the development of published national guidelines[1,2] rates of preventative health care services nationwide remain low.[3] Electronic clinical reminders (ECRs) have been shown to be effective in primary care to increase certain preventative services.[4,5] However, studies have shown that ECRs have had uneven success, generally because of human factors rather than technical reasons, including provider workload, overwhelming number of reminders for each patient, lack of coordination between doctors and nurses, decrease in quality of doctor–patient interaction, and reminder inflexibility.[6-11] In an environment where provider time is limited, health care systems must be streamlined to increase preventative screening measures during visit time. In a small case study in Alaska, one health care system has been able to increase screening on a number of preventative health care measures using ECR.

In 2009, the Kodiak Area Native Association (KANA)* adopted the use of ECR. As of 2012, KANA had deployed more than 40 reminders. From documentation aids (pregnancy education, pain agreement) to grant-based documentations (elder fall risk) to evidence based screening recommendations (colorectal cancer screening, HIV screening), KANA has used ECRs to efficiently broaden its services of appropriate preventative care.

Methods

KANA uses the Resource and Patient Management System as its health information technology platform, with support from Indian Health Service (IHS). The Resource and Patient Management System Electronic Health Record (EHR), is intended to help providers manage all aspects of patient care electronically by providing a full range of functions for data retrieval and capture to support patient review, encounter, and follow-up.

KANA has an in-house Clinical Applications Coordinator (CAC)/Medical Informaticist who is responsible for

*The Kodiak Area Native Association (KANA) was formed in 1966 as a 501(c)(3) nonprofit corporation, delivering health and social services for Alaska Native people of the Koniag region, consisting of the 10 federally recognized Tribes of Kodiak Island. The KANA service area includes the city of Kodiak, its connecting road system, and 6 remote villages accessible only by boat or plane. The patient population of KANA is 3400 and the clinic averages 23 000 patient visits per year.

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maintaining a comprehensive electronic health information and reimbursement system through ownership and coordination of health information technology such as EHR and other programs. The CAC also provides training to facility staff as needed.

Electronic clinical reminder in an EHR can be been designed and deployed at the local or national level. National-level reminders must be activated by the facility, and must ensure that local taxonomies and codes are integrated into the reminder, but generally they represent an "off the shelf" resource for IHS facilities. Of the 40 ECRs in use, 27 are evidence based,[12,13] of which KANA prioritized a subset of 5 among the indicators that IHS tracks nationally: tobacco use, alcohol use, depression, intimate partner violence (IPV), and a comprehensive cardiovascular exam (documentation of blood pressure, body mass index, smoking status, low-density lipoprotein cholesterol level, and education of exercise/nutrition). Patient eligibility for screening and completed screenings are defined with standardized International Classification of Diseases, Logical Observation Identifier Names and Codes, and Current Procedural Terminology codes.[14]

Results

Implementation of Clinical Reminders

As part of a national improvement collaborative sponsored by IHS and facilitated by the Institute for Healthcare Improvement, KANA uses a 5-step process for implementation of ECR through the use of plan–do–study–act cycles.[15,16]

1. *Establish Clinical Demand for the Reminder.* KANA uses 2 steps to gauge and foster provider demand. First, share the evidence-based guidelines so providers understand the rationale for the screening. KANA only uses ECR for established screenings that are backed by a credible national body such as the US Preventive Services Task Force. Second, share local data that shows that current screening rates need to be improved. KANA generates their screening data from their own patient data. Establishing clinical demand is part of building a will for change, and is a necessary but not sufficient factor for the successful rollout of an ECR.

2. *Pilot Test Reminder.* KANA develops local ECRs or deploys ECRs from the national IHS reminder "library." After pilot testing, some reminders need the age range and screening intervals to be modified based on local data, whereas other reminders can be used locally without modification. All 5 prioritized indicators were targeted using national reminders that needed minor or no local modifications.

The CAC is the lead for all technical aspects of ECR. The CAC is based within the clinic, which allows for timely modifications to the reminders as needed, often same-day. The CAC deploys the new ECR for a small group of providers who have agreed to pilot test the reminder. Providers give feedback to the CAC via e-mail or informal updates; the CAC is often on the medical floor and will seek out providers who are piloting a new ECR for feedback. This process ensures that the ECR has been field-tested and reduces the false positives of a flawed reminder that results in an ECR being ignored for perceived inaccuracy.

KANA has all ECRs in one centralized location on the EHR, under the graphical user interface of an alarm clock that is red if any reminders are due for that patient. No ECRs are delivered using an active pop-up strategy. A provider may exit all reminders; compliance is not required.

3. *Expand Reminder to All Providers in Health Facility.* There is a scaling up of the process in step (Table 1), whereby all relevant providers are included. Feedback and modification are still needed or the ECR risks losing momentum.

4. *Measure Outcomes and Share Results.* The CAC keeps providers informed about results on the indicator associated with the new ECR. After the ECR has been deployed for a period, the screening results are broken down from aggregate to provider-specific rates. This can spur healthy competition and sharing of ideas among providers. It is a judgment call at what point the results are individually identifiable—if it is too early, it will produce distress rather than adaptive change, but if it is too late it will have lost momentum.

5. *Delegation of Clinical Reminders to Other Staff.* To the extent possible, responsibility for responding to ECRs and completing all due preventive screenings should be delegated to the appropriate staff level. This prevents the provider from being overwhelmed with reminders. KANA currently has 40 reminders deployed. Most are delegated to the nursing or medical assistant level, and only referred to the provider if the screen result is positive. When an ECR is due, it is clear who on the medical team (medical assistant, nurse, or provider) is responsible to ensure the screening is completed. This step was usually initiated 4 to 8 weeks after the beginning of the process.

Evaluation of Reminders

KANA deployed the national ECR for tobacco, alcohol, depression, and IPV screening in October 2009 and made local modifications based on outcomes of the pilot period. The cardiovascular disease reminder was deployed in January 2010.

Table 1. Key Steps and Timeline in ECR Reminder Deployment, KANA Clinic.

Step	Activities	Time Frame in Weeks (Cumulative)
Establish clinical demand for reminder	Discussions and meetings with medical staff	1-2
Pilot test reminder	Development/modification of reminder	5-6
	Pilot test and feedback with single provider	
	Pilot test and feedback with selected group of providers	
Expand reminder to all providers in service/facility	Brief providers on deployment of reminder	6-8
	Continue to actively elicit feedback on reminder performance	
Measure outcomes and share results	Share screening results with providers	7-12
	Can be provider-specific or aggregate data	
	Identify and discuss best practices	
Delegation of ECR to staff		

Abbreviations: ECR, electronic clinical reminder; KANA, Kodiak Area Native Association.

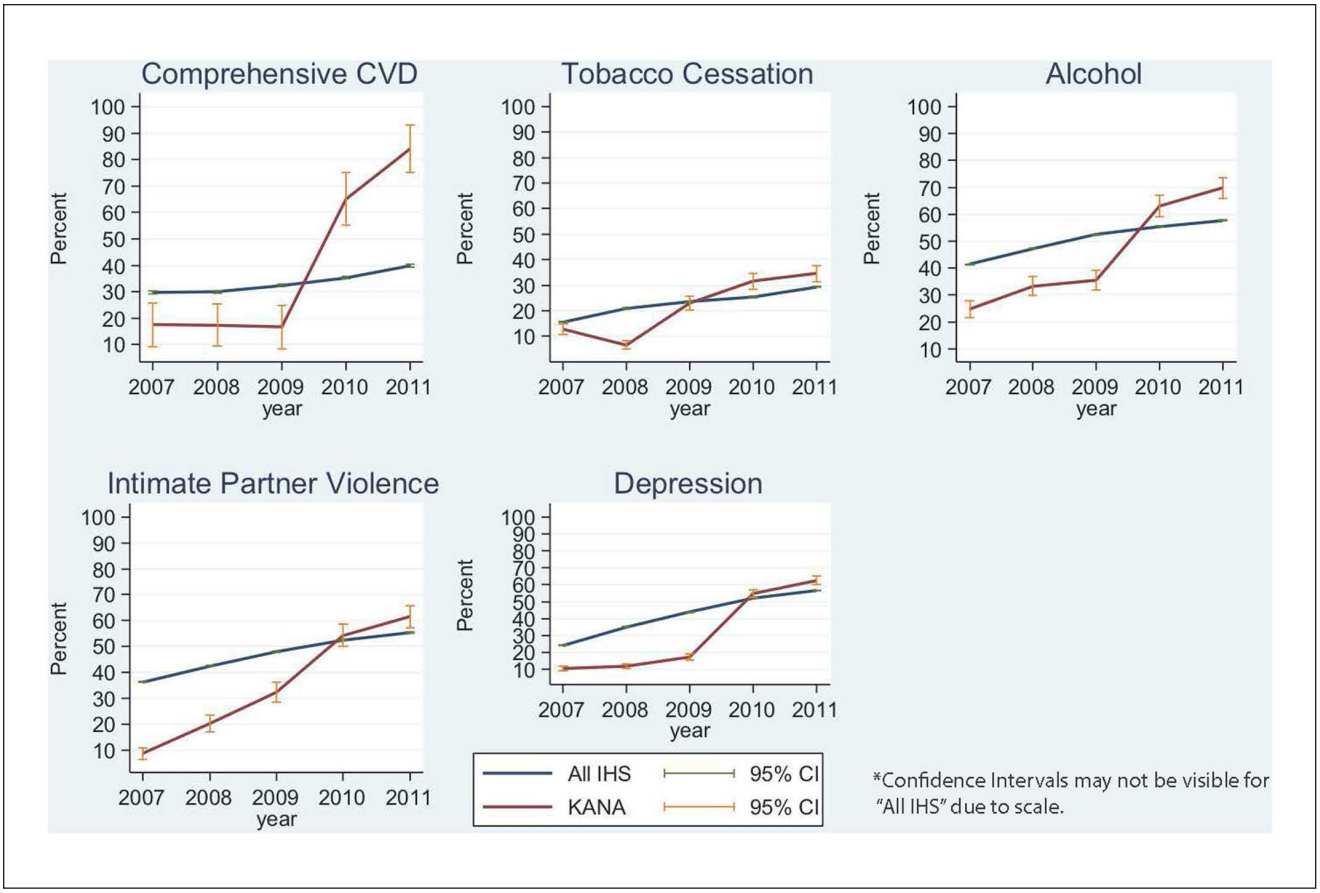

Figure 1. Screening rates for KANA and all IHS by year and test.
Abbreviations: KANA, Kodiak Area Native Association; HIS, Indian Health Service; CVD, cardiovascular disease; CI, confidence interval.

An audit of the cardiovascular disease measure found that almost all incomplete screenings was due to only 1 of the 5 requirements to meet that screening (patient education), and the reminder targeted that element.

An analysis of results from reporting year 2007 to reporting year 2011 showed that for all 5 measures, KANA started with significantly lower rates and ended with significantly higher rates than IHS sites nationwide (Figure 1).

Discussion

Electronic clinical reminders have been a key part of improving screening for depression, tobacco cessation, IPV, alcohol use, and cardiovascular disease. They are valuable tools in identifying patients who are overdue for preventive screenings. While many ECRs are in use at KANA, overload is avoided by delegating responsibility for reminder follow-up away from providers. In addition, KANA has experienced a virtuous cycle: reminders increase screening rates, which in turn reduce the number of screenings that are due for any given patient. Providers anecdotally report that their reduced screening burden gives them more time during a consultation to build relationships with patients.

The KANA model for deployment concentrates on both technical soundness as well as the "human factor" of provider acceptance and use. The model relies on an ongoing improvement process: establishing clinical demand with local development, pilot testing with provider feedback and modification, expanding to all providers, measuring outcomes and sharing information with staff, and delegation of clinical reminders. KANA's success is also partly attributable to ease of use; all ECRs are in one spot on the EHR for the provider to use or bypass as needed.

These data have some limitations. Although the successful deployment of ECR has been instrumental in screening improvements in these 5 measures, other variables are important. KANA is a setting with less than 10 providers, limited turnover, and a clearly defined user population. The facility hired its full complement of providers in 2008, reducing the patient load for each provider, and reducing the wait time for an appointment from 1 to 2 weeks to same day. The improvements in continuity of clinical staff, patient access to care, and team-based care sharing responsibility for preventive care are conditions that must be met prior to implementation of this ECR deployment process. The process may be difficult to replicate in health facilities that are understaffed, have high provider turnover, or it may need to be more formalized in a larger setting.

The cycle of measuring outcomes and sharing results is ongoing for continuous improvement in the delivery of care. Next steps and directions have been identified at staff to continue to strengthen and improve primary health care. KANA continues to seek ways for further enhance preventative health screenings to >90%.

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References

1. Healthy People 2000: National health promotion and disease prevention objectives (DHHS publication PHS 91-50212). Washington, DC: US Department of Health and Human Services; 1991.
2. Anderson LM, May DS. Has the use of cervical, breast, and colorectal cancer screening increased in the United States? *Am J Public Health*. 1995;85:840-842.
3. US Preventive Services Task Force. *Guide to Clinical Preventive Services*. 2nd ed. Baltimore, MD: Williams & Wilkins; 1996.
4. Dexheimer JW, Talbot TR, Sanders DL, Rosenbloom ST, Aronsky D. Prompting clinicians about preventive care measures: a systematic review of randomized controlled trials. *J Am Med Inform Assoc*. 2008;15:311-320.
5. Shea S, DuMouchel W, Bahamonde L. A meta-analysis of 16 randomized controlled trials to evaluate computer-based clinical reminder systems for preventive care in the ambulatory setting. *J Am Med Inform Assoc*. 1996;3:399-490.
6. Patterson E, Nguyen A, Halloran J, Asch S. Human factors barriers to the effective use of ten HIV clinical reminders. *J Am Med Inform Assoc*. 2004; 11:50-59.
7. Matheny ME, Sequist TD, Seger AC, et al. A randomized trial of electronic clinical reminders to improve medication laboratory monitoring. *J Am Med Inform Assoc*. 2008;15:424-429.
8. Sequist TD, Gandhi TK, Karson AS, et al. A randomized trial of electronic clinical reminders to improve quality of care for diabetes and coronary artery disease. *J Am Med Inform Assoc*. 2005;12:431-437.
9. Saleem JJ, Patterson ES, Militello L, Render ML, Orshansky G, Asch SM. Exploring barriers and facilitators to the use of computerized clinical reminders. *J Am Med Inform Assoc*. 2005;12:438-447.
10. Fung CH, Woods JN, Asch SM, Glassman P, Doebbeling BN. Variation in implementation and use of computerized clinical reminders in an integrated health system. *Am J Manag Care*. 2004;10(11 pt 2):878-885.
11. Sequist TD, Cullen T, Hays H, Taualii MM, Simon SR, Bates DW. Implementation and use of an electronic health record within the Indian Health Service. *J Am Med Inform Assoc*. 2007;14:191-197.
12. US Preventive Services Task Force. Recommendations for adults. http://www.uspreventiveservicestaskforce.org/adultrec.htm. Accessed June 23, 2011.

13. Institute for Clinical Systems Improvement. Guidelines & more. https://www.icsi.org/guidelines__more/. Accessed June 23, 2011.
14. Indian Health Service, Office of Information Technology. Clinical Reporting System Version 11.0. http://www.ihs.gov/cio/crs/. Accessed June 23, 2011.
15. Indian Health Service. http://www.ihs.gov/ipc/index.cfm?module=dsp_ipc_improvprog_models#modelforimprovement. Accessed March 1, 2012.
16. Institute for Health Improvement. How to improve. http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx. Accessed March 1, 2012.

Author Biographies

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