KARUK TRIBE
ANNUAL HEALTH BOARD MEETING AGENDA
Thursday, November 7, 2013, **3 PM,** *Happy Camp, CA*

A) CALL MEETING TO ORDER – PRAYER - ROLL CALL

AA) HEALTH MISSION STATEMENT

The mission of the Karuk Tribal Health Program is to provide quality healthcare for Native Americans, and other people living in the communities we serve as resources allow. Our purpose is to appropriately assess or reassess conditions of illness, disease, or pain, provide culturally appropriate educational, preventative, and therapeutic services in an environment of continuous quality improvement.

CH) APPROVAL OF THE AGENDA

EE)APPROVAL OF THE MINUTES *(October 3, 2013)*

F) GUESTS *(Ten Minutes Each)*

1.

H) OLD BUSINESS *(Five Minutes Each)*

1.

I) DIRECTOR REPORTS *(Ten Minutes Each)*

1. April Attebury, Children and Family Services
2. Rondi Johnson, Deputy Director (written report)
3. Carolyn Ash, Dental Director (written report)
4. Annie Smith, Director of Community Services
5. Lester Alford, TANF Program
6. Eric Cutright, IT Director
7. Lessie Aubrey, Executive Director of Health & Human Services (written report)
8. Patricia White, RPMS Site Manager (written report)
9. Laura Mayton, CFO

II) REQUESTS *(Five Minutes Each)*

1.

K) INFORMATIONAL *(Five Minutes Each)*

1.

M) CLOSED SESSION *(Five Minutes Each)*

1. CHS (dinner break)
2. Tribal Council Members

N) SET DATE FOR NEXT MEETING ***(Thursday, December 5, 2013*** *at 3 PM in Happy Camp)*

OO) ADJOURN

Karuk Tribe – Health Board Meeting
October 3, 2013 – Meeting Minutes

Meeting called to order at 2:56pm by Buster Attebery, Chairman

Present:
Russell "Buster" Attebery, Chairman
Dora Bernal, Member at Large
Elsa Goodwin, Member at Large
Amos Tripp, Member at Large
Crispen McAllister, Member at Large
Charron "Sonny" Davis, Member at Large
Alvis "Bud" Johnson, Member at Large

Absent:
Jody Waddell, Secretary/Treasurer (excused)
Michael Thom, Vice-Chairman (excused)

Sonny Davis completed a prayer and Dora Bernal read the Health Mission Statement.

Agenda:
Amos Tripp moved and Bud Johnson seconded to approve the agenda with changes, 6 haa, 0 puuhara, 0 pupitihara.

Minutes of September 12, 2013:
Sonny Davis moved and Bud Johnson seconded to approve the minutes of September 12, 2013, 6 haa, 0 puuhara, 0 pupitihara.

Guests:

1.) **Anna Myers, CHS Supervisor:**
Anna is present to seek approval of the CHS policies and procedures for FY14. She would like to increase the line item coverage for the eye glasses because Terry Williams shut down and the Tribe now is under contract with Siskiyou Eye Center, which is higher cost. Amos inquired about the close social economic ties. Anna agrees that it needs revised. Anna explained that any Native American that is in the Tribes service area and works for the Tribe they are eligible for CHS.

Amos asked about the service area and if it's included in the policies. She then explained that the policies state that there are eligible Native Americans within the Tribes service area, but she follows the Federal Register on their eligibility.

Amos Tripp moved and Crispen McAllister seconded to approve the CHS policies and procedures manual, 6 haa, 0 puuhara, 0 pupitihara.

Director Reports:

1.) **April Attebury:**
Not present, no report provided. April arrived late and provided her report (4:25pm)

She updated the Health Board on the staffing for the LCSW positions. Le Loni is having difficulties recruiting through government websites because of the shutdown. Staff meeting

notes was provided to the Health Board, so they know the staff is meeting and they are communicating with each other.

The storage situation in Yreka at the office is ongoing but they are evaluating the needs to determine a solution.

April commented that she and Pat Hobbs have been working on billing codes that are needed to ensure there is correct billing. This will ensure the correct reimbursement rates and then going back to CRIHB options program.

She then went on to discuss some options for the staffing for the Orleans. April commented that the LCSW's are trying to expand services so in the future they need to have space. April commented that she is not trying to complain but space is needed.

Erin provided information on the building and what the requirements are and the planning processes for drafting the ICDBG grant each year. Erin updated the Council on the office spaces discussions and the requirements of use based on previously funded grants.

April then clarified that David Arwood's schedule has now firmed up from previously staff discussions, in the notes, there was also discussions about the Sheriff's Office work crew that can provide work in Happy Camp.

April then provided a final report from Region IX. There is some smaller funding from Title IVB and there is additional information that has to be provided so she completes the report with the assistance of Laura Olivas.

Amos Tripp moved and Dora Bernal seconded to approve April's report, 6 haa, 0 puuhara, 0 pupitihara.

2.) Carolyn Ash, Dental Director:

Annie is present to provide Dr. Ash's report. She is not present.

Buster inquired about the heating and cooling system. Erin noted that the funding source may be Indian Health Services but Lessie and Annie were unsure. Erin noted that there were no bids received to repair the system. Buster noted that this needs to be repairs because the staff cannot continue to work.

Erin noted that the clinic remodel when done was inspected and once that was done and completed then the warranty is no good.

Erin also commented that the use of space heaters cannot be used in a clinic as a health and safety issue, so this needs resolved. This will be referred to Fred. The Council wants the fix to be a priority and to ensure a vender is selected to complete the repairs immediately.

Crispen McAllister moved and Amos Tripp seconded to approve Carolyn's report, 6 haa, 0 puuhara, 0 pupitihara.

3.) Annie Smith, Director of Community Services:

Annie is present to provide her report. Flo interrupted and noted that the flu shots need to be done and she is very proactive in getting front line responders, elders and kids vaccinated.

She would like to provide them this evening, as she brought some with her. Flo provided vaccines for several people. Annie commented that she is real happy to have Erin back.

There is a flu clinic in Orleans next Thursday. Melodee and Annie will be going to senior housing to provide vaccines. Annie then noted that Melodee's report doesn't show her visit count because she is having computer issues. Michelle attended CHR school, so she is certified and is provided training. Annie provided information about the diabetes grant and it not being affected by recent budget issues.

Annie commented that the BIA does not assist Native Americans with wills any longer and especially with land. The California Indian Legal Services, Redding Office, will send someone to the elder's home to provide assistance with wills. Annie noted that many elders have property that they received through generations and it should be specified where it goes.

Elsa Goodwin moved and Sonny Davis seconded to approve Annie's report, 6 haa, 0 puuhara, 0 pupitihara.

4.) Lester Alford, TANF Director:

Lester is present to provide his report; he also provided an agreement which is 14-M-001 between the Siskiyou Union High School District and the TANF program.

Amos Tripp moved and Bud Johnson seconded to approve MOU, 14-M-001, 5 haa, 0 puuhara, 1 pupitihara (Elsa Goodwin).

Lester then sought approval for out of state travel in Arizona, November 4-6, 2013 in Mesa AZ.

Amos Tripp moved and Crispen McAllister seconded to approve out of state travel for Lester Alford and 4 TANF clients, 6 haa, 0 puuhara, 0 pupitihara.

He then noted that the 1st NEW annual report is attached to his report. There were 14 clients that were provided assistance since April 2013.

All offices are closed from October 21-24, 2013 for training. The staff requires TAZ training and Eagle Sun is coming onsite to provide training. He noted that all the clients have been notified that they are closed. Lisa Marie and Lester will cover anything that comes up. Family Service plans training will also be provided.

This month is breast cancer awareness and there will be fall festivals at each location.

Amos Tripp moved and Bud Johnson seconded to approve Lester's report, 6 haa, 0 puuhara, 0 pupitihara.

5.) Eric Cutright, IT Director:

Eric is present to review his report. He has one additional action item, which is 14-A-001. It is a special use permit with the USFS for the broadband project. As soon as the USFS is off furlough he would like to turn this in.

Amos Tripp moved and Sonny Davis seconded to approve agreement 14-A-001, 6 haa, 0 puuhara, 0 pupitihara.

Eric then went on to provide highlights to his report. The Yreka fax issues have been repaired. Eric will be attending a Broadband meeting on October 15, 2013.

The Planning Meeting is set for October 17, 2013 and there will be a broadband project update that same day at 9:30am.

Buster asked about Orleans and the internet connection. Eric explained that the wireless isn't working in the area due to the office move and he's still doing trouble-shooting.

The fire alarm at the People's Center had faulty systems and it isn't known what the cause is but it is Bay Alarm issue and they are looking into it.

Amos Tripp moved and Bud Johnson seconded to approve Eric's report, 6 haa, 0 puuhara, 0 pupitihara.

6.) Lessie Aubrey, EDHHS:

Lessie is present to review her report. She read the clinic aide position description again and sought approval for it. The Happy Camp clinic needs a full time position, but it wasn't approved at the budget meeting.

Lessie then sought approval of a RN/LVN position description that is required for the Happy Camp clinic. The positions are budgeted for. After approval the positions will be posted.

Amos Tripp moved and Bud Johnson seconded to approve the Medical Clinic Aide position description with a salary change, 5 haa, 0 puuhara, 0 pupitihara (Elsa absent for vote).

Laura asked if the RN is replacing another position and Lessie commented that yes. A change to the position description was to add the location.

Amos Tripp moved and Crispen McAllister seconded to approve the RN, LVN, Medical Assistant position description for Happy Camp, 6 haa, 0 puuhara, 0 pupitihara.

Lessie noted that she purchased items on her VISA for Sue Burcell, which were un-allowed. She would like approval to allow the purchases, as Sue Burcell assisted in drafting the grant that funded the Orleans Clinic project and recognizing her was important.

Amos Tripp moved and Bud Johnson seconded to approve paying $37.92 for expenses to Lessie's card, 4 haa, 0 puuhara, 2 pupitihara (Elsa Goodwin and Dora Bernal).

Lessie then commented that she needs approval of a support letter for Siskiyou County Health and Human Service Agency.

Elsa questioned the letter and the services provided. Lessie noted that this letter of support could be for a grant proposal to this entity in which they would provide services to the youth which provides additional services to the Tribes patients.

Amos Tripp moved and Bud Johnson seconded to approve the Siskiyou County Health and Human Service Agency support letter, 6 haa, 0 puuhara, 0 pupitihara.

Dr. Vasquez begins on October 14, 2013. A locum tennan, PA will begin on October 14, 2013 to cover the Orleans area. Melinda Bennet has returned to the Orleans clinic and they should be fully staffed. Lessie thanked Susanna Greeno for providing services to the Happy Camp clinic.

A government shutdown is in effect but Indian Health Services will remain open.

There are still issues with after hour care. She is hoping to have services provided to the patients and meet HRSA's requirements more clearly for them.

Amos asked for information on what is happening on the Affordable HealthCare Act. He is confused and would like additional information. Lessie noted that Native Americans are exempt. Amos asked Lessie to follow up on the Affordable Health Care Act to understand this exemption of Native Americans and Descendants and the exclusion process. She noted that it is very confusing but there is staff that is going to be following this. Amos asked for some information to begin to become familiar with the Act.

Lessie updated the Health Board on the reduction of services through Indian Health Services. Also, the confusion on the Affordable Healthcare Act and the exclusion. Erin noted that Tribal People should be exempt.

Vickie commented that if there is insurance requirements required however if native Americans don't sign up they cannot be penalized. Amos inquired for more information because the time frame is short and there needs to be an understanding on the requirements. Amos asked for this topic to be followed very close to ensure close communication for the next six months. He is unsure of this topic and he would like to have more information shared between the health officials. Also, it is confusing for everyone across the Country so he understands the frustration of the staff.

Buster asked about the two providers that were interested in the Orleans position. However, Lessie updated that those two providers aren't interested any longer.

Bud Johnson moved and Amos Tripp seconded to approve Lessie's report, 6 haa, 0 puuhara, 0 pupitihara.

7.) Patti White, RPMS Site Manager:

Patti is not present, on travel status. Eric is present to answer any questions that the Health Board may have.

Amos Tripp moved and Dora Bernal seconded to approve Patti's report, 6 haa, 0 puuhara, 0 pupitihara.

8.) Laura Mayton, CFO:

Laura is present to review her financial report with the Health Board and she has been submitting the report to HRSA as well.
Laura provided the Tribes equity and the deferred revenue of the Tribe. She went on to clarify what the cash balance is of the Tribe. She noted that she is trying to provide information on how much the program is worth.

She updated the Council on grants receivable and third party revenue. The overall health program is pretty close to budget.

Erin inquired about the grants receivable and if Title IVB is included in that line. Laura commented no, because there are health program funding streams that are included such as HIV grant, CalWorks, IHS, Diabetic Grant, etc. the report does not include TANF. There are some programs that are considered a part of the Health Program and what HRSA deems are not.

Crispen McAllister moved and Dora Bernal seconded to approve Laura's report, 6 haa, 0 puuhara, 0 pupitihara.

9.) **Rondi Johnson,**
Written report provided, not present.

Elsa Goodwin moved and Dora Bernal seconded to approve Rondi's report, 6 haa, 0 puuhara, 0 pupitihara.

Closed Session:
Amos Tripp moved and Bud Johnson seconded to approve the revised organizational chart and the move of the LIAP Program under TANF, also the revised position descriptions reflecting this change, 5 haa, 1 puuhara (Elsa Goodwin), 0 pupitihara.

Dora Bernal moved and Elsa Goodwin seconded to approve addendum (1) to contract 13-C-036 with Barbara North, 6 haa, 0 puuhara, 0 pupitihara.

Dora Bernal moved and Crispen McAllister seconded to approve $309.80 from Third Party for repairs to water lines, 6 haa, 0 puuhara, 0 pupitihara.

Crispen McAllister moved and Amos Tripp seconded to approve out of state travel to Washington DC., November 13, 2013 to the Tribal Nations Gathering, 6 haa, 0 puuhara, 0 pupitihara.

Informational: the recommendation on the health program organizational chart moving departments under the Council needs to be discussed.

Informational: Elsa would like clarification on the internship that was previously approved and also if a background was done.

Next Meeting Date: November 7, 2013 at 3pm in Happy Camp, CA.

Crispen McAllister moved and Dora Bernal seconded to adjourn the meeting at 5:14pm, 6 haa, 0 puuhara, 0 pupitihara.

Respectfully Submitted,

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Russell "Buster" Attebery, Chairman

Recording Secretary, Barbara Snider

DEPARTMENT OF QUALITY MANAGEMENT

Karuk Tribal Health Board Meeting
November 6, 2013
Rondi Johnson
October Report

** I AM ON TRAVEL TO COVERED CA TRIBAL CONSULTATION**

ACTION ITEMS: NONE

AUGUST ACTIVITIES:

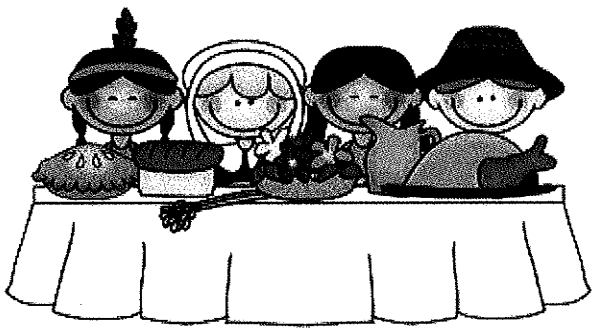
ACQI Meeting October 9th, Provider Compliance Audit October 16th, Disaster Preparedness October 16th, Head Start Meeting October 21st,

AUGUST TRAININGS/CONFERENCES & WEBINARS:

CPCA Conference October 2-4, Fiscal year 2013 Health Center Outreach & Enrollment Webinar October 9th, CPCA Grant Tracker Conference October 9th, Northern Region Monthly Conference Call October 11th, Northern CA Rural Roundtable October 23-26, Partnership of CA- ABC's of QI October 29-31

ACQI COMMITTEE MEETING:

The October 9th, ACQI meeting agenda, performance improvement projects, and reports are attached. The Meeting Minutes for August 14th & October 9th, are attached.



BUDGETS:

See below. Budget through 10/31/13. At this time I'm well under budget.

Program	CQI
Budget Code	300002
Program Year	2013-2014
Expenses to Date	Not available
Balance	Not available
Percent Used	Not available
Period Usage	1 month

Respectfully Submitted,
Rondi Johnson
Deputy Director of Health & Human Services

Karuk Tribal Health & Human Services Program
ACQI Committee
Meeting/Conference Call
KCHC Teleconference Room
October 9, 2013
9:00 am-10:00 am

1. Call Meeting to Order – Rondi Johnson

2. Roll Call/Sign In – Vickie Walden

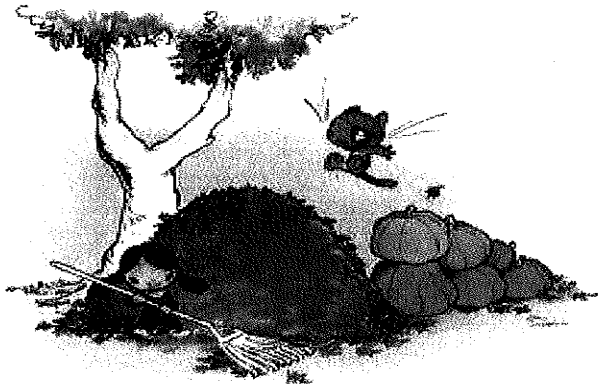
3. Approve Agenda – Rondi Johnson

4. Approve Minutes of August 14, 2013 – Rondi Johnson

5. Performance Improvement Reports Due
   - 5.1 BMI – Patti White
   - 5.2 HIV/AIDS, 3rd QTR – Mike Lynch – (Tabled)
   - 5.3 Yreka Dental Records – Susan Beatty
   - 5.4 HTN – (Tabled)

6. GPRA Reports
   - 6.1 Clinical Benchmarking – Vickie Simmons

7. New Business
   - 7.1 Complaints/Incidents/Suggestions –Rondi Johnson
   - 7.2 Patient Satisfactory Surveys – Rondi Johnson



8. Old Business
   - 8.1 HIV/AIDS, 2nd QTR – Mike Lynch
   - 8.2 CHDP Callback Report – Happy Camp – Chelsea Chambers - Tracy Burrell
   - 8.3 BMI – Patti White
   - 8.4 Happy Camp/Orleans Eligibility Report – Nadine Mc Elyea
   - 8.5 Yreka Eligibility Report – Sharon Denz
   - 8.6 Diabetes Report – Annie Smith
   - 8.7 Flu Vaccine – Jodi Henderson (tabled)
   - 8.8 Improve Childhood Immunization Rates Project Report – Vickie Simmons

9. Next Meeting November 6, 2013 at 8:15 am

10. Adjourn

Karuk Tribe

Karuk Tribal Health & Human Services Program
ACQI Committee Meeting/Conference Call
Meeting Minutes
KCHC Teleconference Room
August 14, 2013
8:15 am-9:00 am

1. Call Meeting to Order by Rondi Johnson at 9:00 am

2. **Roll Call/Sign In** – Attending in Happy Camp was: Lessie , Rondi, Chelsea, and Vickie Walden
Attending in Yreka was: Mike Lynch, Charleen, Amy, Dr. Ash, and Suzanna Hardenburger.

3. **Approve Agenda** - A motion made to approve the agenda with additions was made by Mike Lynch and 2nd by Lessie Aubrey, motion caries with no objections or abstentions.

4. **Approve Minutes** of July 10, 2013 with a motion made by Mike Lynch and 2nd by Lessie Aubrey, motion caries with no objections or abstentions

5. **New Business**
   5.1. Rondi – **Patient Satisfactory Surveys** (Moved up on the agenda from Old Business)
   5.1.1. Rondi said that the Yreka Clinic really came through for us; they greatly increased in the number of patient satisfaction survey's they sent in. Orleans Medical and both Dental Clinics are showing low returns. Because of the increased numbers from Yreka Medical we are on target to meet our goal 442 surveys (20% of our patients served) and we may be able to discontinue doing the surveys at the end of September 2013.
   5.2. **Agenda Addition New Policy for After Hours Care**
   5.2.1. This is a policy that was written to meet the HRSA Requirement for afterhours medical coverage. The policy was not attached to this meeting packet so Rondi read the draft policy to the committee. The policy was reviewed and there was some group discussion and it was decided that it will be reviewed at the next ACQI Meeting or do a phone vote on the policy. Lessie will be in Yreka tomorrow and said she will try to meet with the providers to review this draft policy.
6. Performance Improvement Reports Due
   6.1. Happy Camp Medical Records Audit – Carrie Davis
   6.1.1. Carrie Davis submitted a written report and Susanna Greeno presented Carrie's report to the committee today. The problems found this quarter were: 1 A1C was done with no documented order at the time of the visit; there was an order for a Depo shot but is not signed off by the MA; One health questionnaire was need was not done in paper chart or in E.H.R.
   6.1.2. Carrie included these comments in her written report: 1) I noticed that Chelsea sometime sees a patient and other times it would be the temporary doctor. When I notice they were not getting the health questionnaires done I started checking paper charts and it was then that I noticed the temporary doctor had signed off on it. 2) I noticed that Chelsea sometime sees a patient and other times it would be the temporary doctor. When I notice they were not getting the health questionnaires done I started checking paper charts and it was then that I noticed the temporary doctor had signed off on it. 3) I have found that many of the temporary doctors are not using the Note Titles correctly and are not even entering into EHR the hospital visits, x-rays, and health questionnaires. 4) I feel that many of these needed corrections will take place once we have a permanent doctor to work with Chelsea. Charts are attached to the written report. Lessie had a

question about the charts and said that she could help Carrie with her charts. Lessie said in Carrie's next report she needs to talk about her findings in this report and report on any improvement/changes it the problem areas.

6.2. **Orleans Medical Records Audit** – Isha Goodwin- **Tabled Isha has been out of the office.**

6.2.1. Yreka Medical Records Audit – Charleen Deala

6.2.1.1. Charleen report that data collection for this quarter showed the biggest problem area was competition of the Health Questionnaires; one injection site was not entered and a blood pressure was not entered on a 4 year old and one pain level was missing. Lessie asked Charleen, what her process was for correcting the problems found. She said talks it over with Mike and he works on the corrections. Lessie said that Charleen should have a plan on how the corrections are going to be addressed. Mike and Charleen will work on the corrections process i.e. writher Charleen talks with providers about the report findings; Mike talks with them or discuss the problem areas in the staff meeting like Susanna said Happy Camp Medical does.

6.2.2. EHR Reminders – Mike Lynch

6.2.2.1. Mike submitted a written report performance report and reviewed that report with the committee. Purpose: The project is to improve performance regarding provider completion of reminders as they appear on patient E.H.R.'s. Nine Measures were selected for this project and they are listed in the written report, which is attached to this meeting packet. The reminders are designed to assure that the key health issues, specific to each patient, are addressed during the course of the current examination. Unresolved reminders can pose a medical risk to the client and can place the Tribe in legal jeopardy. Reminders are also directly tied to our performance on federal grants. Certain unresolved reminders reduce our grant-related performance rates, potentially placing future funding in jeopardy. Mike went on to review the data collected in the last quarter. The data showed that our numbers are the lowest for: Colon Cancer, Diabetic foot exam, Mammograms and diabetic eye exams. Lessie asked for clarification on what was being measured, Amy said that the E.H.R reminders let the medical provider know what tests, immunizations and/or procedures, patients are due to have done. Then it is up to the provider to act upon the reminder i.e. do the procedures at the visit, do a referral, or schedule the patient for another appointment(s). Amy stated the data will show where we have missed opportunities to do the procedures patients were due for, which impacts our numbers needed to meet and maintain our healthy people goals and/or requirements (GPRA, HRSA and etc.). There was more discussion covering this performance improvement project i.e.: Current status the nine E.H.R reminders bring audited; the provider's performance in this reporting period; and Mike's plan to review the findings with the providers. Mike said that he will talk each provider about the report results with the objective of consistent improvements in performance. Also determine the reasons for variability among the individual reminders, and establish goals for improvement for each of the nine measures.

6.2.2.2. Vickie Walden suggested that page numbers and who wrote the report be included in the written reports.

6.2.2.3. Chelsea commented on the format that Mike used for comparing the quarterly comparisons saying that it was helpful to her as a provider.

7. **GPRA Reports** - Vickie S is not available for this meeting and Rondi presented her report.

7.1. Increase PAP Smears Project – Vickie Simmons written report done by Vickie Simmons and presented by Rondi. We will not have the final number of female clients who received a Pap until the end of 2013. Our computer system can monitor, but we will use the UDS report to track our Pap rates. The August 5 , 2013 UDS data shows our Pap rate was 40.1%, so we still have time to improve. Chelsea asked Amy, at what age does the Pap smear reminders go away; Amy said we set it at age 70. There was more

discussion on what age range was being monitored; the answer was that we are using HRSA guidelines, which are ages 24 years to 64 years. The written report is attached to this meeting packet.

7.2. Amy said the E.H.R Pap reminders are set for ages 21 to 70 years of age.

8. Other New Business

8.1. Complaints/Incidents/Suggestions –Rondi Johnson

8.1.1. Rondi said we are doing really well in these areas. She commented most of them are being handled in-house.

8.1.2. Vickie Walden reported that the housekeeper had an issue with a trespasser last night while working in the medical clinic. This person was outside the medical emergency door; they were ringing the bell and running off. There was some discussion and the conclusion the housekeeper needed to report

8.2. Time off Notification-Rondi Johnson

8.2.1. Rondi asked that the supervisors keep her and Lessie up to date on Staff leave schedules, that they had an incident, where one of our clinics did not have anybody in it except for a new person. Amy suggested that we use the Outlook Calendar program to manage the staff leave schedule and she said she will help set it up.

8.3. ACQI Reports – Rondi Johnson

8.3.1.1. Rondi stated she continues to receive the ACQI Reports very very last minute. Rondi said she is sending reminder notices way in advance. She asked the group if anyone had any suggestion for resolving this problem. That she needed help in resolving this problem, no suggestions or comments were made.

9. Tabled – The Remaining Old Business listed below

9.1. HIV/AIDS – Mike Lynch

9.2. CHDP Callback Report – Happy Camp – Chelsea Chambers (Tabled)

9.3. Diabetes Report – Annie Smith

9.4. BMI- Patti White

10. Announcements/Reminders

10.1. September 11, 2013 at 9:00 am

10.2. Mike said he will not be here for the next meeting

11. **Meeting Adjourned** – Motion made by Susanna Greeno, 2nd by Vickie Walden, motion caries with no objection or abstentions.

Meeting minutes typed and respectively submitted by Vickie Walden on September 26, 2013

Karuk Tribe

Karuk Tribal Health & Human Services Program
ACQI Committee Meeting/Conference Call
Meeting Minutes
KCHC Teleconference Room
October 9,2013
9:00 am-10:00 am

1) **Rondi Johnson** called the meeting to order at 9:01 am

2) **Roll call** done by Rondi (Vickie Walden not present for roll call)
   a) In Happy Camp - Rondi Johnson, Lessie Aubrey, Vickie Simmons, Patti White, Suzanna Hardenburger, Dr. Brassea, Susanna Greeno, Nadine McElyea, and joining the group at 9:06 was Vickie Walden. Joining the meeting for her report was Tracy Burcell.
   b) In Yreka - Dr. Milton, Mike Lynch, Annie Smith, Dr. Ash, Susan Beatty, and Sharon Denz.

3) **Agenda** was approved with a motion made by Vickie S, seconded by Patti White, motion caries with no objections or abstentions.

4) **Meeting Minutes** approved for August 14, 2013, with a motion made by Mike Lynch, seconded by Annie Smith

5) **Performance Improvement Reports**
   a) **BMI – Patti White**
      i) Propose: To address the failure of appropriate data collection, assessment, and treatment of obesity.
      ii) Problem: Epidemic of obesity is directly related to serious medical disease states including: diabetics; cardiovascular disease; Renal Failure; Diminished self-esteem; mental disorders; general dysfunction and others.
      iii) Goal of this PI is to reduce weight in patients with a body Mass Index (BMI) above 30.
      iv) The plan is for all patients to have their BMI measured at each visit; a count of patients with BMI over 30 will be run each quarter; and then Patti will compare the number of patients with a BMI above 30 to the number from the previous quarters.
      v) Baseline data ran for Calendar year 2012 showed there were 1255 patients who had visits with a BMI greater than 30. Patti will use this number for the project baseline.
      vi) Data for this project will be run as a query report from RPMS (Patti said that the previous reports data was taken from the UDS Reports). This report will be a total count of patients who had a visit during the time period and a BMI documented that was equal or greater than 30. Patti said that a more detailed list of patients can be generated upon request for providers if they want to look at their own patients.
      vii) Data Analysis: 1st Quarter CY2013 there was a total of 853; 2nd quarter CY2013 there was a total of 833, making the total of the first 2 quarters 1030 patients with a BMI above 30. Patti reviewed the graphs in her report, one compared quarter to quarter and one compared year to year. She said we did drop a little in the second quarter but she thinks we are going to climb, because we are now activity looking the high BMI's.
      viii) Comparison: In the first two years of CY2013 there were 1030 unduplicated patients with visits and a BMI over 30, which are 225 patients less than then CY2012.
      ix) Implementation Corrective Actions: Document BMI at each visit; when rooming patients medical assistants and nurses can collect the data (instructions may be needed); we need to make sure that when children and adolescents have a BMI over 30 that parents/guardians/patients are counseled on nutrition, activity, and ensure it's documentation in the patient's record. Codes 97802-97804-5 can be used to document 15 minutes or more of nutritional counseling; or use ICD-9 code V65-41 for physical activity counseling. Code V85.5x can be used for recording the BMI percentage. She will continue to re-measure and the data and reports will be done on a quarterly base and compared to the previous quarter.
      x) Communication: this Performance Improvement Project Report will be included in the monthly ACQI report that's sent to the Health Board.

xi) Dr. Milton commented that eventually they hope to break this into a provider to-do list so that they are reminded to address the issue. He also said is really hard to do this for children, but since it is part of our GPRA requirements, it's important to mention to providers frequently that it needs to be done.

xii) Dr. Ash asked Patti if she ever did any correlative with the BMI and Diabetics or etc. and Patti said no.

b) **HIV/AIDS, 3rd QTR** – Mike Lynch – Tabled

c) Yreka Dental Records – Susan Beatty

i) *Dental/Medical Records 2nd Quarter report*

(1) Purpose: With the overload of patients and the hurry to get everyone seen as soon as possible, it is very easy to overlook the details of charting. The purpose for the review is to improve the thoroughness of charting and look for accuracy and care of our patient's charts.

(2) Their goal is to maintain the correctness in the paper chart order as well as E.D.E, so their report show a they has met their goal of 90%.

(3) Data: Twenty charts were audited and the audit findings for 2nd quarter of 2013, they went down in three areas, they were: Patients health history in paper chart (1 Health Summary); Treatment Plans signed and dated (95% down to 65%); and for the Medical Alerts category - Medical Alerts 100% down to 75%; Medications 65% down to 60%; Allergies came up 30% to75%; pain level remained constant at 100%; and pre-medication went down from 100% to 90%. Susan said that there corrective action, is to be at 90% by their 2013 fourth quarter report. Susan did submit a written report and it will be attached to this meeting's packet.

ii) *Dental/Medical Records 3rd Quarter Report*

(1) Susan said that for this quarter the data collected in the Medical alerts category they went up in three areas and stayed the same in the other three areas. Findings for the other areas: Face Sheet current dropped from 100% to 95% one record did not have a current ace sheet; medical history update signed 100% to95%; treatment plans signed/dated dropped from 50% to 15%.

(2) Corrective action is to be at 90% in all areas by their 4 quarter report in 2013.

(3) Susan's written report is attached to this meeting packet. This report will be reviewed with staff and through the organization, so that everyone is aware of the areas of concern and to show them we are striving to improve in the areas of concern. This will also raise their level of thoroughness.

iii) *Dental performance Improvement Project on Blood Pressures*

(1) Purpose: Our policy stated that we are to take blood pressures on very hypertensive patient that we see and we were falling behind in this area. The purpose of our review is to see how we are doing and to improve on taking of blood pressures on hypertensive patients, until they reach their goal of 90%.

(2) Data: The random review of 20 records showed: 2nd 75% were correct and in the 3rd quarter it dropped down to 70% correct, that out of the 20 records for each quarter, either blood pressures were not taken or not they didn't have one taken at each visit within the that quarter.

(3) Corrective actions are to communicate the problem with their staff and try to correct the problem. Susan said at their staff meeting tomorrow they will review the report and see if they can come up with a plan to resolve the problems.

(4) Susan's written report which was reviewed at this meeting will be attached to the meeting minutes, which are sent to the governing board.

d) Vickie Walden went off topic and said there were some new issues with the change fee schedules and that the fees in RPMS and Dentrix were not coming out the same. Vickie and Patti White will follow-up on this and on another issue where some codes and fees are not cross over in RPMS DDS package to the Billing Package. Vickie Walden said we may have missed some billing opportunities because these codes and fees cannot be seen in the billing package. Vickie Simmons commented since the sequester we cannot miss any billing opportunities, if we find problems in billing we need to fix them ASAP, that our billing this is where we're going to get our money to run our business. Vickie Walden said they are working on the dental billing issues and Patti White said she will follow-up with I.H.S. on the fixit ticket for the code cross over errors. In the meantime Vickie W. said she is putting the codes and charges on the schedules she sends to Billing so that we do not miss any of the billing.

e) **HTN** – Tabled due to the provider (Fabian's) vacancy at the Orleans Clinic

6) GPRA Reports- Clinical Benchmarking – Vickie Simmons

a) Vickie S said that in the 2013 final GPRA/GPRAMA Report we met 17 measures, but 9 of those 17 measures were a baseline that was counted as being met, that next year there will not be as many baseline measures and we will have to meet more of the measures.

b) We did not meet 5 of the measures for year 2013. Vickie S said that we definitely have opportunities to improve this next year.

c) For the unofficial GPRA 1st quarter 2014 measures we have met 4 of the measures (baseline measures) and have not met any of the other 18 measures. Suzanna H asked when the GPRA 1st quarter started and Vickie S said is started in July 2013 and is called the 2014 GPRA/GPRAMA report.

d) Vickie S went on to review our 1st quarter status for Good Glycemic Control, for 2013 we ended the year at 53.9% and in the 1st quarter of this year we are a 31.8% with a target of 48.3% we should be able to meet the measure this year because at the end of last year we were at 53.9%. As for Childhood Immunizations, at the end of last year we were at 47.7%, with the end of the year national average of 74.8% and our 1st quarter of 2014 we are at 9.3% so we have a lot of work to do in in this area. Vickie S said in her next report she will include some ideas on what we can do to improve the number ns this area. Annie asked Vickie S to clarify the ages for this measure, Vickie S said that it covers the under ages under 36 months, she said that we do much better on our immunizations for the children over 3 years old. The under age 36 months are considered the crucial years and we need to remember that the HRSA requirements the immunizations by 2 years of age. Depression Screening is another area we will need to work on, that we did not meet this measure last year and we are 18.3%, our target is 66.9% and last year we were 6% short of meeting this measure. Comprehensive CVD related assessments are going to be more difficult to do, because it involves many different things i.e. blood pressures, tests and medications, They want us to be at 51 % at the end of the year and we are currently at 7.1%,kast year we were at 44.2 % and if we keep on at the rate we were going last year we will meet the target. Mike L asked if this report included al patients and the answer was no only the Native Americans. Mike suggested that we try and generate a letter to send out to the active patients (ones that have been see at least once within the last three years) and ask them to come in for an annual visit and that should help bring our numbers up in this area. Vickie said she thinks that Patti may be able to do that for us and Patti said she would have to research letters but at this time she was not sure if this is something we can do or not do.

7) New Business

a) Complaints/Incidents/Suggestions –Rondi Johnson

i) Rondi said we are getting a few complaints lately and they are being dealt with and she hopes we can deal with them and get satisfactory outcomes.

b) Patient Satisfactory Surveys – Rondi Johnson

i) Rondi said "Thank you Yreka Clinic, you rocked it' from July to September they turned in 726 patient surveys, Rondi said they made her job much easier, we have met our patient satisfied survey quota. Happy Camp turned in 8, Orleans turned in 0 and Yreka carries us by turning in 726 surveys. Vickie S asked what they did to have such great results, Mike L said once he realized how important this survey was, they put a survey in each patient's check in folder and then the medical assistants or nurse assisted the patients in completing the survey, then collected and turned them in to Mike or Gina. Mike said the problems they experienced were that the weekly returning patients got tired of hearing about the surveys. Rondi thanked them again for their good work and Mike said it was a team effort and she was welcome.

8) Old Business

a) 2nd Quarter Plumas County HIV Report – Mike Lynch

i) For the second quarter reporting period 4/1/2013 to 7/31/2013, the Karuk Medical Clinic had 16 active patients, 3 females, 12 males and one transgender, which is one less than last quarter. One patient left to see new provider and two new patients registered. During this reporting period 8 patients were seen at least once and they currently have 4 who are non-compliant therapy and have high HIV viral loads, 12 patient's maintained excellent compliance, with low HIV viral loads and CD4 levels in the normal range.

ii) Findings: Monitoring of CD$ and HVI Viral Loads was completed for 13 patients during this reporting period. The remaining 3 patients did not respond to repeated contacts requesting follow-up blood testing. Osteoporosis screening was done with vitamin D levels in 8 patients and Dexa scans were ordered for 4 others. They found 6 of their patients are Vitamin D deficient and they have begun therapy. Also 12 patients have received their PCV13 vaccines, 2 patients have not responded to requests to be vaccinated, and the vaccine is currently contraindicated for the remaining 2 patients.

iii) Mike's and Lisa's written report is attached to this meeting packet. His chart/graphs show the results for patients that were screened for tobacco use during the last 12 months, Substance abuse screening last 12 months, Osteoporosis Screening last 12 months and patents that received Prevnar-13 vaccination.

iv) Susanna Greeno asked why they use the PVC13 vaccination, which is normally used for childhood vaccination. Mike said there is one form of phenomena that is covered in PVC13 that's not covered by Pneumovax (PPVSV23) and it's

kind of a critical one and that is why they recommend using the PVC13. He said that Lisa would have more information on this.

b) *CHDP Call Back Performance Improvement Report- Tracy Burcell*
   i) Purpose: Identify areas for improving the follow-up on CHDP"s for patients ages 0-18 years.
   ii) Goal is to establish a follow-up system that will help us track patients who need CHDP's and to send notifications to parents along with an appointment date for patients to come in for their CHDP's and any immunizations that are due.
   iii) *Data:* A list has been compiled of all patients meeting the criteria age. The list was reviewed to see which patients are current with CHDP's, which ones are past due and patients that will need a CHDP in the future.
   iv) *Results*: Data shows there are a total of 80 patients between the ages of 0-18 years.
      (1) Twelve of those patients have moved out of the area, leaving us with a total of 68 patients.
      (2) Out of the 68 patients 17 are past due, Tracy is writing letter to the patients parents, letting them know what immunizations are needed and making appointments for them to be see and brought up to date.
      (3) There are 5 patients that are due for CHDP's within the next 3 months.
      (4) There are 25 patients that will need follow-up within the next two years.
      (5) There are 21 patients that will need follow-up in the 3-4 years.
   v) *Problem:* Tracy said the problem is there's no system in place to insure these patients do not fall behind in getting their CHDP's on time.
   vi) *Resolution*: Tracy said she is creating a tickler file for every month of the year; she will get a copy of the patients CHDP and place it in the month preceding the due date for the CHDP follow-up. For each month a patient(s) comes due for a CHDP, a letter will generated, sent to the patients parents with an appointment date, time and what immunizations may be needed. Parents will be asked to call the clinic immediately if the appointment date and time does not work for them, they will also be asked to bring in immunization record for any immunizations their child has received from another clinic.
   vii) Tracy said she has already scheduled 10 of the 17 delinquent patients and she is planning on doing the same with the other 7 delinquent patients. That she hopes to bring all their delinquent CHDP's up to date by next month.
   viii) Vickie S asked was this project was just for Happy Camp, the answer was yes.

c) *Other Discussion items on Project:*
   i) Vickie Simons asked if Tracy if she would be able to do the same process with her immunizations. Tracy did not have answer for Vickie S.
   ii) Annie Smith commented; tracking the immunizations is a bigger job because the ages of the children changes so often (they are a moving target), but Tracy has developed a process that may be used by clinics.
   iii) Patti White said this follow-up CHDP's will help increase our immunizations rates, Tracy said yes it should because she includes the immunizations due and received information in the follow-up letter she send out to the parents.
   iv) Vickie S. asked if this project was for Non-Native and Native, the answer was yes.
   v) Susanna Greeno explained, that within the CHDP program children with private insurance or do not qualify for the program, are considered to be a Well Child Visit. Patti asked if this project included Well Child checks, the answer was no.

d) *Eligibility Report for April, May and June 2013- Nadine McElyea*
   i) Submitted an SSI/SSD application for one person; a reconsideration request for one person; 3 follow-up actions for three people; 4 new on-line MediCal applications; and 1 Medical re-certification.
   ii) She did see an increase in the requests for SSI/SSD and she did attend a great training on that. She is doing ok on filing the applications, but the applicants need an advocate because sometimes it is hard to keep in touch with the SSI/SSD applicants.
   iii) Nadine went on to say that the big thing that is coming up is the "Covered California" and many changes to the MediCal Program. She is schedule to attend a training tomorrow that is going to help with these news changes. She went on to say, CMSP is going away, it will all be MediCal. She is hoping threes changes will make things easier. Nadine said that the front office people should be referring all uninsured patients to the eligibility workers, so they can assist them in signing up for insurance. There are a lot of advantages to signing up for health coverage. Vickie W asked for confirmation that CMSP going away, and the answer was yes, they are being merged into the MediCal program. Nadine said she thinks eligibility will be easier once the changes are done.
   iv) Vickie S asked about Native Americans, if they exempt from the Affordable Care Act, Nadine said, that under the Affordable Care Act Native Americans who are members of a federally recognized tribe are not required to apply for any other coverage because they are already considered to have coverage through their federally funded Native American Clinics. But we should encourage them to apply insurances because it helps the clinics, CHS policy requirements to apply for alternate resources, it helps clinics with revenue generation needed to run clinics/programs

and when they are referred out to specialists. Vickie Walden stated that we need to be aware of the fact families may be comprised of members and descendants some of them are not be exempt from Affordable Care Act. Nadine agreed and stated some of the families have non-native spouses. Vickie S asked if the non-tribal members that are seen as direct care are exempt and Nadine said she thinks they are but no one who's been able to confirm that. Dr. Ash that we have individuals that come to these clinics, say they are Native American but do not have eligibility documentation proving their association. Vickie Simmons said that they have to show proof and Dr. Ash said that is not being focused on there, and the rest of the discussion was about the tribes current process is for collecting Native American Tribal Verifications. Currently the policy is we are to ask for verification of a person's Native American affiliation and we can look for that on file verification in the RPMS computer system. Vickie Walden commented that there are a few existing patients that have been seen for years prior to the policy change that we continue to see without documentation of their tribal affiliation. Rondi recommended that Dr. Ash contact Suzan Hardenburger regarding questions she might have about tribal verification. The conclusion of the discussion was that the clinics should be asking for native verification, and advising them they will be billed for services rendered if they do not bring it verification by their second visit. Other eligibility issues will have to be dealt with on case by case bases.

v) Dr. Ash asked if we can require that Native Americans sign up for insurance, the answer was no. The discussion on her question covered: We should be asking them to do so, because it helps the tribal programs and they will not be eligible for Tribal Contract Health Services (the program that pays for referrals for specialty services, which fall within the CHS Levels of Care) if they have not applied for or have another insurances. Nadine said we need to let them know that insurances do not go retroactive like medical and they are if they are hit with catastrophic costs they could be in real trouble, so we need to encourage people to apply for some kind of coverage. Dr. Ash said they had a situation with a child emergency patient, which they wanted to refer to a specialist, with no insurance coverage and the parents were asked sign up for coverage and they refused to do the paperwork. Suzanna said that is they do not want to fill out the paperwork there is nothing we can do for them and Vickie Walden stated at that as mandated reporters at this point it could be a CPS reportable offence.

vi) Mike Lynch asked when a person comes to the receptionist window saying they are Native American and their verification can be found in RPMS do we have to ask for verification and the answer was no, these patients we do not have to ask at each of their visits. Suzanna H. said that additional patient eligibility is placed on Page 8 in the Patient Registration section of RPMS.

vii) In closing Nadine said we want to encourage people to apply for the new health insurance coverage. The new California Health Exchange is www.Cover California.com, that's where people can go and sign up for health coverage, it's is easy to sign up and the California Health Exchange is up and working ok. Patti White said it is one application for all the insurances. Sharon Denz asked if anyone found out if our clients California insurance is going to be accepted in Oregon, Nadine said there has been no answer to that yet. Nadine said that it depends on whether the Oregon providers are willing to accept the out of State insurances. Suzanna H said she referred a couple if caller to Nadine, to get an answer to their question, which was could they as California Residents apply for insurance in Nevada or Oregon, because of the difference cost rate. Nadine said that was a good question and she did not know the answer.

e) Sharon Denz's Eligibility Report

i) Sharon said we need to change the 2012 to 2013 through her report.
   (1) No Problems to report on for these quarters.
   (2) Findings: April and May 2013 was 0 applicants and in June she received a denial letter for excessive property.
   (3) Vickie Simmons asked if the reason her numbers are lower than Nadine, is because she is in Yreka. Sharon said yes, that people there can go to the main office for assistance. Sharon said she takes either mails or delivers the application to the main office. Nadine commented that they do not always know if the applications are completed/approved/denied and when they make follow-up calls the client some of them cannot be found.

ii) *Annie Smith's Diabetic PI Report*
   (1) Annie commented that this is her very first PI report and her figures for this project are not based on GPRA. They were asked to do a PI Project on the Diabetic Program and they have chosen to audit the diabetic eye screenings/exams. The numbers which are taken from the Diabetic Audit, which runs differently than the Diabetic Grant and she not sure how she's going to make everything work for this report, but she'll find a way.
   (2) The Propose: To find ways to improve on their Best Practices eye exam/screenings rates.
   (3) Annie mentioned that she got her Notice of Award for the Diabetic Grant Award and they did not cut, the grant award was $157,000.00.

(4) Current Problem; Software issues with the Happy Camp Camera, and UC Davis not being able to read the Annie said Eric and Steve Viramontes at I.H. S has been helping her work with UC Berkeley to try and resolve the software issue with the translation of pictures taken with the eye camera in Happy Camp.
(5) They pulled data from last year's diabetic audit and it shows we were at 58% and the data from this year's Diabetic Audit data shows we are currently at 41% to date and we have until December 31, 2013 to meet the requirements.
(6) Annie stated that documentation is a key element in recording and collecting the data. Annie said that in Yreka She collects and enters the diabetic data on all the patients there and is going to start doing the same for Happy Camp and Orleans. Our E.H. R provides a reliable way to document and follow the path of any diabetic for retinopathy. The E.H.R also contains reminders if the patient has not been screened over the previous year. The standard that they are following is the Indian Health Services Special Diabetic Program for Indians, which lists eye exam national goal as 58.6%.
(7) Data is collected from E.H.R and they can only track accurate and consistent recording within E.H.R. But if the data for patients in our E.H.R but living and/or receiving services from outside providers is not collected and documented in our E.H.R, the E.H.R reports will not be accurate. Or if those that enter data into the E.H.R are not consistent in entering the status of each patient or it the direct dare nursing staff do not follow through with both questioning the patient and entering the data, then the records will be inaccurate. Additionally the Community Outreach Staff will continue to call, visit, and track the patients, ask questions, and/or do screenings in order to insure we have all the patient information.
(8) Annie said that Steve Viramontes is helping her trouble shoot the problems with the Happy Camp Eye Camera Software. They may have to buy a new camera if the cannot fix the software problem because them cannot go without a camera in Happy Camp. It a new camera is needed they can sell the old one and use that money to help buy the new one.
(9) Corrective Action: Community Health Outreach staff, will call all the patients on the diabetic register every three months to ask if they have been screened for retinopathy, an continue to perform eye screening exams while increasing the monthly eye clinic screening exams at each facility. Then they will do follow-up/ referrals for the individuals who have been diagnosed with specious Diabetic Retinopathy. Annie said that they do have some no shows and she follows up on those. Annie said that she will work with Pat and Tracy to track down patients who were referred to a specialist for retinopathy but has no report on file from the specialist.
(10) This project will be re-measured in three months and hopefully their percentage of completed retinopathy screening/exams will be at 60%, by audit year end, December 31, 2103.
(11) Vickie Simons stated that if we can just get the patients in and take pictures with our eye camera, it help improve our numbers.
(12) Annie said that they are seen a slow improvement in all the required diabetic audit areas, that she is very proud of the staff for working hard to improve our patient care.

iii) *Improve Childhood Immunizations PI Project – Vickie Simmons*

(1) The purpose of this study is to create an immunization recall system so our immunization rates for 2 year olds will increase by 2% or more per year from the 53% rate reported in 2008 on the UDS Report. Vickie S. said that is it time to review this project, develop a new with new goals. That at the start of this project we may have set our goals to high and in the middle of this project HRSA changed their required goals for childhood immunizations, which impacted this project. Vickie Simmons commented that Patti said that this year HRSA is removing some of the immunizations from their required list, but she has not seen where that has been done yet. Vickie S. said that the plan is to remove the rotavirus but which was one of our problem areas, but until the changes are finalized we will continue to show 0% met for the rotavirus. Patti said that UDS patch will probably be done in February. Vickie S. said that we will continue to show grim immunizations until the changes are made on paper and in the computer system.
(2) Vickie S. said that she sent out an email to some of the providers asking who sends out their patient immunization reminder letters. She only got two responses to the email, so even though Tracy is going to tack immunization reminders onto her CHDP reminder letters, Vickie said she will also be sending out immunization reminder letters. Vickie S. said that she has 14 more patients to get up to date and then she will begin sending her reminder letters. Patti White said if Vickie S. let's her know a couple weeks before her next report is due she will try exclude something's out of the report so she can get an accurate count of what is required for this year.
(3) There was some discussion on: where Chelsea numbers are now; which patients are counted (all are counted); and where we are now. Vickie S commented, we were concentrating on our Native American Children and forgot to

track the Non-Native American Children, when we needed to track both. Vickie S said that the recall list she is working on is for true active patients. That our numbers are going to look grim.

(4) Patti W suggested that we may want to show the patients we have caught up on their immunizations (ones that were not done on time but have been brought up to date since). Maybe we can show we are getting caught, Vickie S said that her monthly report will show the children that have been caught up. Vickie S. said that we really need the information on immunizations that is in Patti's report because that is the one that goes to HRSA.

(5) Patti White said there are only 26 kids in the 2013 HRSA year and we are at 0% on those. Vickie S said that it's important for us to know this.

(6) Annie commented that tracking the patients can be very difficult because we are not able to keep their contact information up to date. But we really need to find a way to collect accurate data for Vickie Simmons.

iv) Rondi reminded staff that the next meeting is November 6th at 8:15am

(1) That the Bi-Annual Training is scheduled for November 13th

(2) Vickie W asked about the date changes for the Health Board Meeting, it was changed to November 7th

(3) Vickie W asked about a date for the Karuk Annual Awards Banquet-Rondi said no new information.

v) Meeting Adjourned at 10:24am. By Rondi Johnson.

Meeting minutes respectively submitted by Vickie Walden on October 28, 2013

Karuk Tribe

Karuk Tribal Health & Human Services
Performance Improvement Project
Prepared for ACQI Meeting
October 9, 2013
BMI/Obesity Project 2013

1. **Purpose of the Study:** To address the failure of appropriate data collection, assessment, and treatment of obesity.

   a) Problem: Epidemic of obesity in all age groups. Obesity leads to a variety of physical and mental complications.

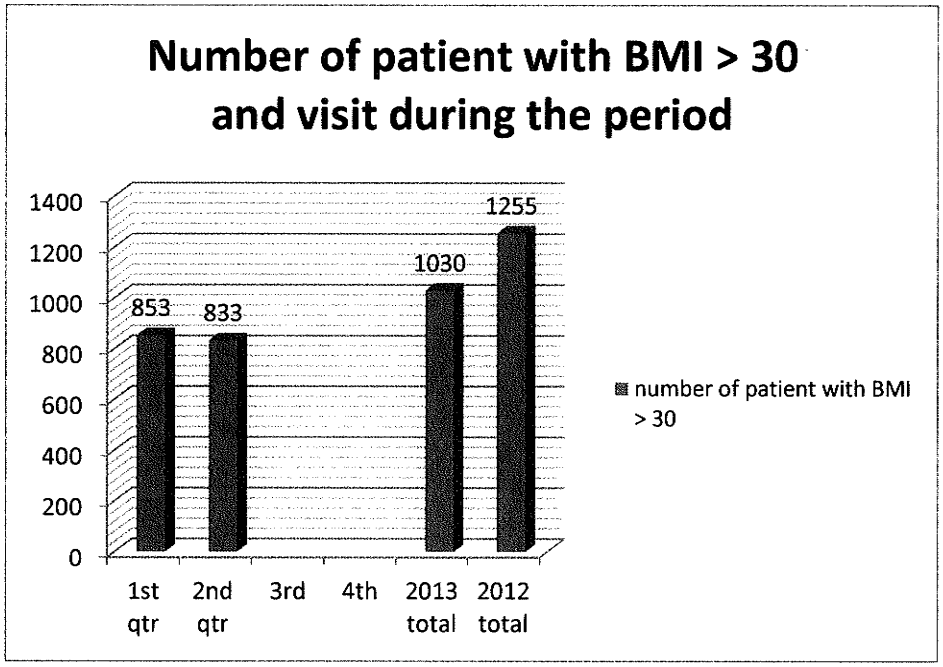
   b) Importance: Obesity is directly related to serious medical disease states including:
   - **i)** Diabetes
   - **ii)** Cardiovascular Disease
   - **iii)** Renal Failure
   - **iv)** Diminished self-esteem---mental disorders---general dysfunction
   - **v)** Others

2. **Goal of this Performance Improvement Project:** To reduce weight in patients with a BMI ≥ 30.
   - **a)** All patients will have their BMI measured at each visit.
   - **b)** A count of patients with BMI ≥ 30 will be run each quarter.
   - **c)** Compare number of patients with BMI ≥ 30 to number from previous quarters.

3. **Description of Data-Baseline data ran for CY 2012**
   For CY 2012 there were 1255 patients who had visits and a BMI ≥ 30. I will use this number for the baseline.

4. **Evidence of Data:**
   All data will be run as query report from RPMS. This will be a total count of patients who had a visit during the time period and a BMI documented that was equal to or greater than 30. A more detailed list of patients can be produced upon request.

5. **Data Analysis**
   - **a)** First quarter 2013 (1/1/13 to 3/31/13) - there were a total of 853 patients with a BMI ≥ 30 who had a visit during the quarter.
   - **b)** 2nd quarter 2013 (4/1/13 to 6/30/13) there were a total of 833 patients with a BMI ≥ 30 who had a visit during the quarter.
   - **c)** There 1030 patients with a BMI ≥ 30 for the first two quarters. (1/1/13 to 6/30/13)



6. **Comparison-**During the first two quarters of CY 2013 we have 1030 patients with visits and a BMI over 30. This is 225 less than during CY 2012. I think this number will climb to over the 2012 number due to the fact that we are now measuring BMI on each patient.

   The number of patients in the 2nd quarter is less than in the first quarter by 20 patients.

7. **Implementation of Corrective Actions to Resolve-**
   Have a BMI documented at each visit. Data can be collected by the Medical Assistant and by Nurses rooming the patients and taking vitals. They may need instructions.
   We need to make sure that when a child or adolescent has a BMI that the parents or the patient are counseled on nutrition and activity and this is documented. Documentation can be done by using codes 97802-97804-15 minutes or more of nutrition counseling and using ICD-9 Code V65-41 for physical activity counseling. Codes V85.5x is used for recording the BMI percentile.

8. **Re-measure-**
   Data and reports will be done on a quarterly basis and compared to previous data.

9. **Implementation of Additional corrective Actions if Performance Goals are not Met-**
   N/A at this time

10. **Communication to Governing Body-**Evidence of the PI project will be included in ACQI information that is reported to the Health Board each month.

Submitted by Patti White

MEDICAL RECORDS ANALYSIS REPORT
2nd Quarter 2013
YREKA DENTAL DEPT

PURPOSE:

With the overload of patients and the hurry to get everyone seen as soon as possible, it is very easy to overlook the details of charting. The purpose for the review is to improve the thoroughness of charting and look for accuracy and care of our patient's charts.

GOAL:

To have our charts in order and correct in the paper charts as well as EDR so our reports show our goal of 90%.

DATA:

Twenty charts are randomly pulled to collect information in the following areas.

1. Full Name, Chart Number on the outside of chart.
2. Current Face Sheet
3. Medical History Updated and Signed
4. Patient Health History in Chart
5. Dental Exam Record Complete
6. Treatment Plans Signed/Dated
7. Chart Entries Initialed by Staff
8. Clinical Notes Signed by Provider
9. Local Anesthesia Noted
10. X-ray Label Complete
11. Informed Consents Endo/Extraction

MEDICAL ALERT LABELS See Chart Attached.

FINDINGS: This quarter we went down in three areas

1. Patient Health History in Chart – 5% . One of the 20 charts did have the health summary in it.
2. Treatment Plans Signed/Dated – we really dropped from 95% to 65%.
3. Medical Alerts –
    a. Medical alter – dropped from 100% to 75%
    b. Medications – dropped from 65% to 60%
    c. Allergies – came up from 30% to 75%
    d. Pain level – consistant 100%
    e. Pre-Med – dropped from 100% to 90%

CORRECTIVE ACTIONS:

1. Goal is to be at 90% in all areas by our 4th quarter report in 2013.

We will also communicate the problem with our staff, governing body and throughout the organization. This way everyone is aware of the areas of concern and to show them we are striving to improve in those areas. This will also raise out level of thoroughness.

Respectfully Submitted, Susan Beatty, RDA

MEDICAL RECORDS ANALYSIS REPORT
3rd Quarter 2013
YREKA DENTAL DEPT

PURPOSE:

With the overload of patients and the hurry to get everyone seen as soon as possible, it is very easy to overlook the details of charting. The purpose for the review is to improve the thoroughness of charting and look for accuracy and care of our patient's charts.

GOAL:

To have our charts in order and correct in the paper charts as well as EDR so our reports show our goal of 90%.

DATA:

Twenty charts are randomly pulled to collect information in the following areas.

12. Full Name, Chart Number on the outside of chart.
13. Current Face Sheet
14. Medical History Updated and Signed
15. Patient Health History in Chart
16. Dental Exam Record Complete
17. Treatment Plans Signed/Dated
18. Chart Entries Initialed by Staff
19. Clinical Notes Signed by Provider
20. Local Anesthesia Noted
21. X-ray Label Complete
22. Informed Consents Endo/Extraction

MEDICAL ALERT LABELS – three out of six went up and the other three stayed the same. See Chart Attached.

FINDINGS: This quarter we went down in three areas

4. Current Face Sheet dropped from 100% to 95%. One of the 20 charts didn't have an update.
5. Medical History Update Signed - dropped from 100% to 95% .
6. Treatment Plans Signed/Dated – dropped from 50% to 15%.

CORRECTIVE ACTIONS:

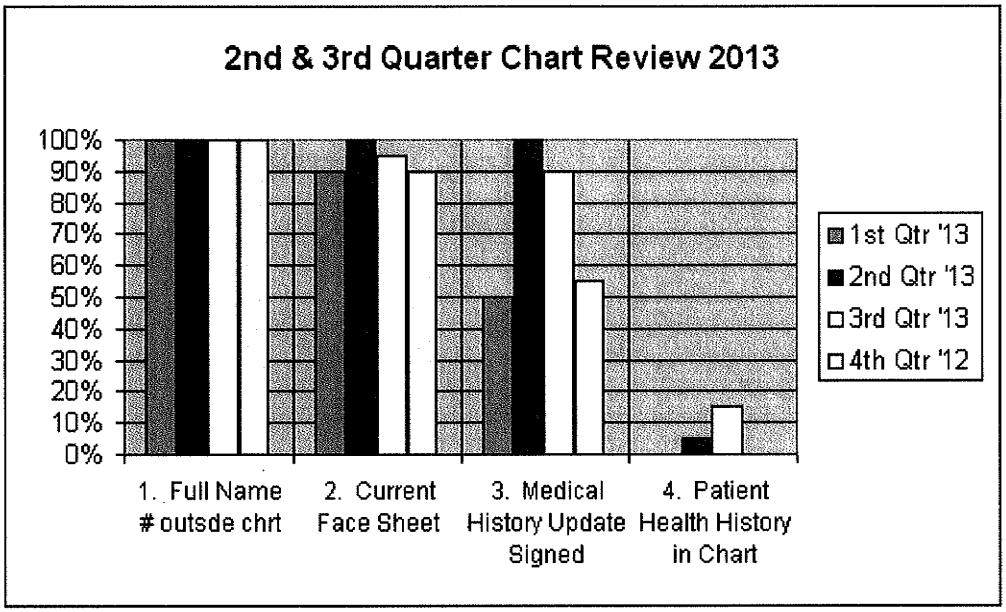
2. Goal is to be at 90% in all areas by our 4th quarter report in 2013.

We will also communicate the problem with our staff, governing body and throughout the organization. This way everyone is aware of the areas of concern and to show them we are striving to improve in those areas. This will also raise out level of thoroughness.

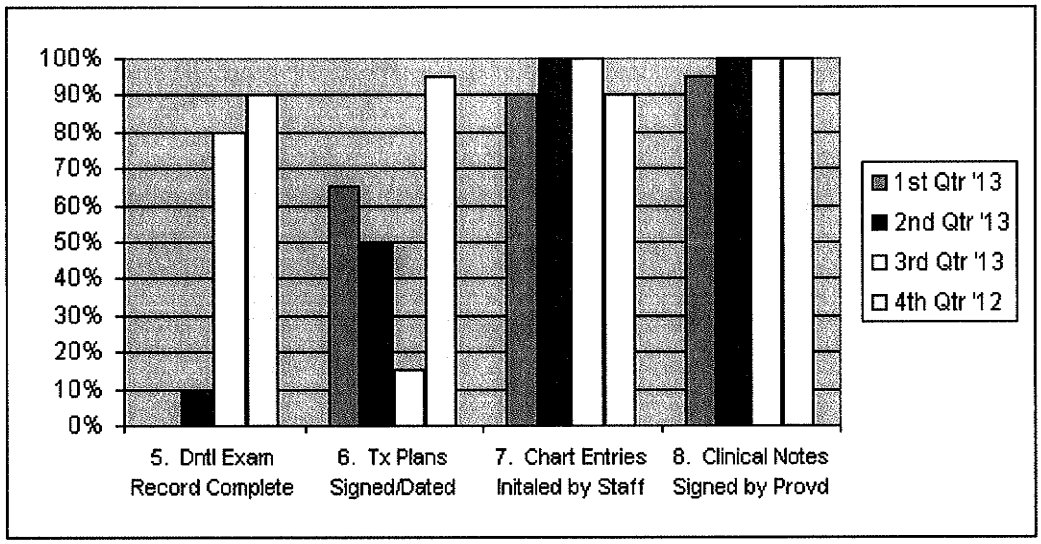
Respectfully Submitted, Susan Beatty, RDA

2nd & 3rd QUARTER CHART REVIEW 2013 / YREKA DENTAL OFFICE

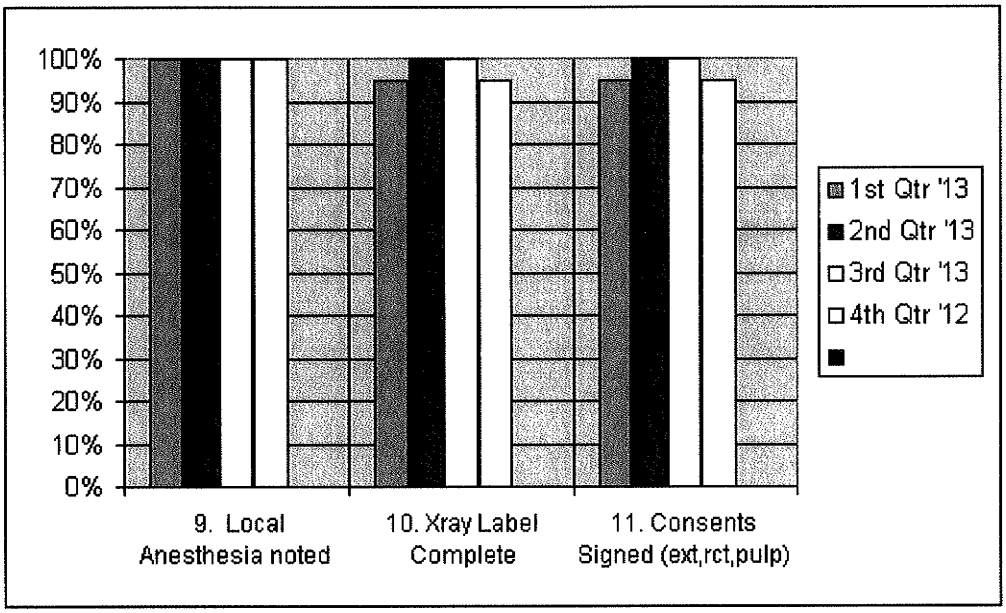
	1st Qtr '13	**2nd Qtr '13**	**3rd Qtr '13**	4th Qtr '12
1. Full Name # outsde chrt	100%	**100%**	**100%**	100%
2. Current Face Sheet	90%	**100%**	**95%**	90%
3. Medical History Update Signed	50%	**100%**	**90%**	55%
4. Patient Health History in Chart	0%	**5%**	**15%**	0%



	1st Qtr '13	**2nd Qtr '13**	**3rd Qtr '13**	4th Qtr '12
5. Dntl Exam Record Complete		**10%**	**80%**	90%
6. Tx Plans Signed/Dated	65%	**50%**	**15%**	95%
7. Chart Entries Initaled by Staff	90%	**100%**	**100%**	90%
8. Clinical Notes Signed by Provd	95%	**100%**	**100%**	100%

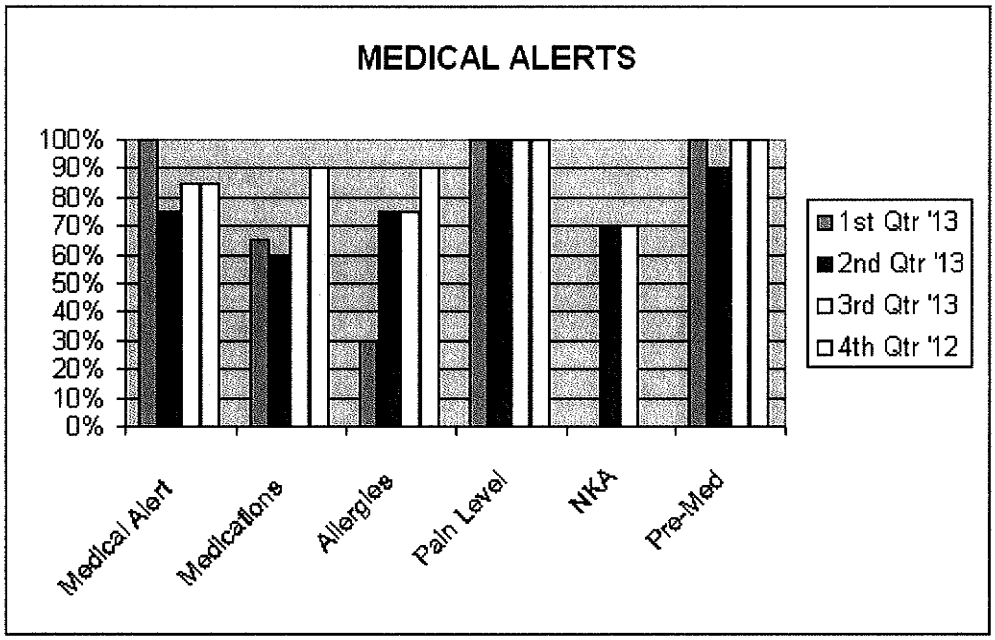


	1st Qtr '13	**2nd Qtr '13**	**3rd Qtr '13**	4th Qtr '12
9. Local Anesthesia noted	100%	**100%**	**100%**	100%
10. Xray Label Complete	95%	**100%**	**100%**	95%
11. Consents Signed (ext,rct,pulp)	95%	**100%**	**100%**	95%



Medical Alert Labels

	1st Qtr '13	**2nd Qtr '13**	**3rd Qtr '13**	4th Qtr '12
Medical Alert	100%	**75%**	**85%**	85%
Medications	65%	**60%**	**70%**	90%
Allergies	30%	**75%**	**75%**	90%
Pain Level	100%	**100%**	**100%**	100%
NKA	0%	**70%**	**70%**	0%
Pre-Med	100%	**90%**	**100%**	100%



Performance Improvement Project
BLOOD PRESSURES
2nd and 3rd Qtr 2013
Yreka Dental Dept

PURPOSE:

Our policy states that we are to take blood pressures on every hypertensive patient that we see and we are falling behind in this area. The purpose of our review is to see how we are doing and to improve on the taking of blood pressures on hypertensive patients.

GOAL:

To ensure that our patients have their blood pressure taken at every visit and to raise our percentage up to 90%.

DATA:

Twenty charts were randomly pulled for each quarter to collect the data for this report.

FINDINGS:

1st Qtr 2013: 80% were correct
2nd Qtr 2013: 75% were correct
3rd Qtr 2013: 70% were correct
4th Qtr 2012: 85% were correct

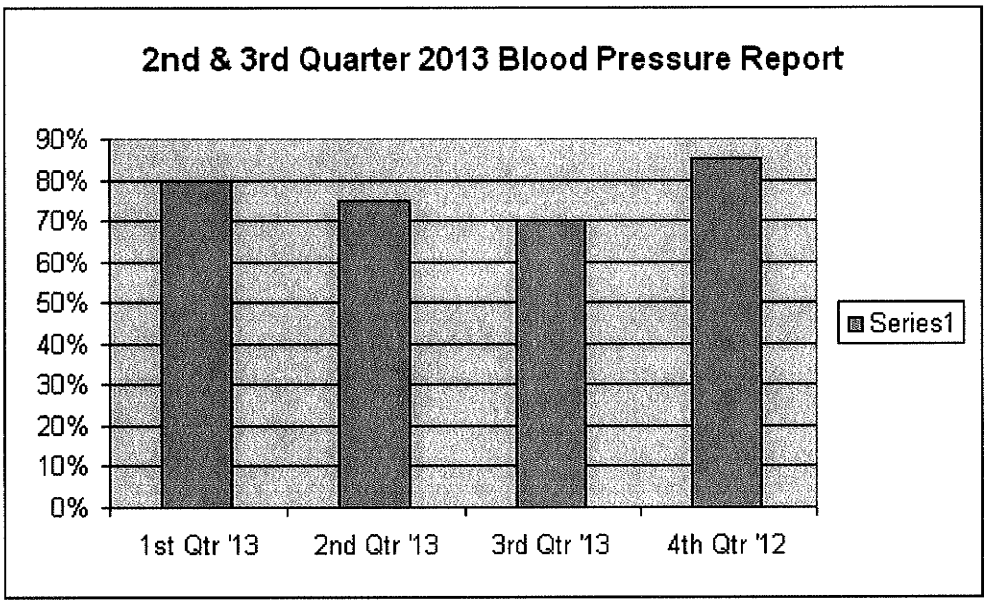
Out of the twenty charts for each quarter reviewed either the blood pressure was not taken or they didn't have one taken at every visit within that quarter.

CORRECETIVE ACTIONS:

To communicate the problem with our staff so they are aware of the problem and can try to correct the problem. We will also communicate with our governing body and throughout the organization.

Respectively Submitted,
Susan Beatty, RDA

1st Qtr '13	80%
2nd Qtr '13	**75%**
3rd Qtr '13	**70%**
4th Qtr '12	85%



Karuk Dashboard
2013 Final GPRA/GPRAMA Report

2013 Final GPRA Dashboard DIABETES	Karuk 2013 Final	Karuk 2012 Final	California Area 2013 Final	National 2013 Final	National 2013 Target	2013 Final Results - Karuk
Diabetes Dx Ever	9.0%	8.7%	10.8%	13.9%	N/A	N/A
Documented A1c	85.9%	86.3%	85.7%	85.2%	N/A	N/A
Good Glycemic Control[a]	53.9%	46.0%	51.5%	48.3%	Baseline	
Controlled BP <140/90[a]	69.5%	36.0%	64.5%	64.6%	Baseline	
LDL Assessed	58.6%	69.8%	71.9%	72.7%	68.0%	
Nephropathy Assessed	56.3%	61.9%	61.3%	68.2%	64.2%	
Retinopathy Exam	44.5%	41.7%	50.2%	57.6%	56.8%	
DENTAL						
Dental Access	39.3%	40.4%	41.2%	28.3%	26.9%	
Sealants[a]	10.1%	464	13.7%	13.9%	Baseline	
Topical Fluoride[a]	26.3%	427	30.0%	26.7%	Baseline	
IMMUNIZATIONS						
Influenza 65+	64.6%	53.4%	57.5%	68.0%	62.3%	
Pneumovax 65+	91.5%	87.0%	83.9%	89.2%	84.7%	
Childhood IZ[a]	47.8%	45.5%	62.2%	74.8%	Baseline	
PREVENTION						
Pap Screening[a]	60.9%	54.4%	54.8%	61.7%	Baseline	
Mammography Screening	57.4%	45.4%	42.6%	53.8%	49.7%	
Colorectal Cancer Screening[a]	35.8%	57.0%	30.8%	35.0%	Baseline	
Tobacco Cessation[a]	44.4%	39.0%	37.4%	45.7%	Baseline	
Alcohol Screening (FAS Prevention)	60.3%	71.0%	56.1%	65.7%	61.7%	
DV/IPV Screening	58.5%	65.5%	57.9%	62.4%	58.3%	
Depression Screening	60.9%	66.0%	57.2%	65.1%	58.6%	
CVD-Comprehensive Assessment[a]	44.2%	27.6%	38.6%	46.7%	32.3%	
Prenatal HIV Screening	*37.5%*	*28.6%*	70.6%	87.7%	82.3%	
Childhood Weight Control[b]	21.8%	23.1%	24.6%	22.8%	24.0%	
Breastfeeding Rates[a]	*100%*	N/A	43.0%	29.0%	Baseline	

[a]Measure logic revised in FY 2013

[b]Long-term measure as of FY 2009, reported in FY 2013.

Measures Met: 17

Measures Not Met: 5

Results in italics represent measures with fewer than 20 patients in the denominator; use caution when interpreting these results.

Measures in red are GPRAMA measures

Karuk Dashboard
2014 - 1st. Qtr.
GPRA Report Unofficial

TO: ACQI Committee
FROM: Vickie Simmons, Clinical Operations Administrator
DATE: October 9, 2013
SUBJECT: GPRA 1st Quarter Report 2014
Please find the **unofficial** 2014 GPRA 1st Quarter Report below.
We have now entered the second quarter of the 2014
GPRA year.

GY2014 1st Qtr. Dashboard **DIABETES**	End of Year Karuk 2013	End of Year National Avg. 2013	End of 1st Qtr. Karuk 2014	GPRA14 Target	2014 End of 1st Qtr. Results - Karuk
Diabetes Dx Ever	9.0%	13.9%	9.3%	N/A	N/A
Documented HbA1c	85.9%	85.2%	56.1%	N/A	N/A
Good Glycemic Control <8	53.9%	48.3%	31.8%	48.3%	
Controlled BP <140/90	69.5%	64.6%	30.8%	64.6%	
LDL Assessed	58.6%	72.7%	29.0%	73.9%	
Nephropathy Assessed	56.3%	68.2%	14.0%	Baseline	
Retinopathy Exam	44.5%	57.6%	12.1%	58.6%	
DENTAL					
Dental Access	39.3%	28.3%	21.6%	29.2%	
Sealants	10.1%	13.9%	3.8%	13.9	
Topical Fluoride	26.3%	26.7%	12%	26.7	
IMMUNIZATIONS					
Influenza 65+	64.6%	68.0%	26.3%	69.1%	
Pneumovax 65+	91.5%	89.2%	88.8%	Baseline	
Childhood Izs	47.8%	74.8%	28.6%	74.8%	
PREVENTION					
Pap Screening	60.9%	61.7%	52.3%	Baseline	
Mammography Screening	57.4%	53.8%	44.2%	54.7%	
Colorectal Cancer Screening	35.8%	35.0%	28.8%	35.0%	
Tobacco Cessation	44.4%	45.7%	23.4%	45.7%	
Alcohol Screening (FAS Prevention)	60.3%	65.7%	20.5%	65.9%	
DV/IPV Screening	58.5%	62.4%	17.4%	64.1%	
Depression Screening	60.9%	65.1%	18.3%	66.9%	
Comp. CVD-related Assessment	44.2%	46.7%	7.1%	51.0%	
Prenatal HIV Screening	37.5%	87.7%	25.0%	89.1%	
Breastfeeding Rates	100.0%	29.0%	0.0%	29.0%	
Controlling High Blood Pressure: Million Hearts Measure	N/A	N/A	44.1%	Baseline	
Measures in red are GPRAMA measures					***Measures Met = 4*** ***Measures Not Met = 18***

vms - 071012

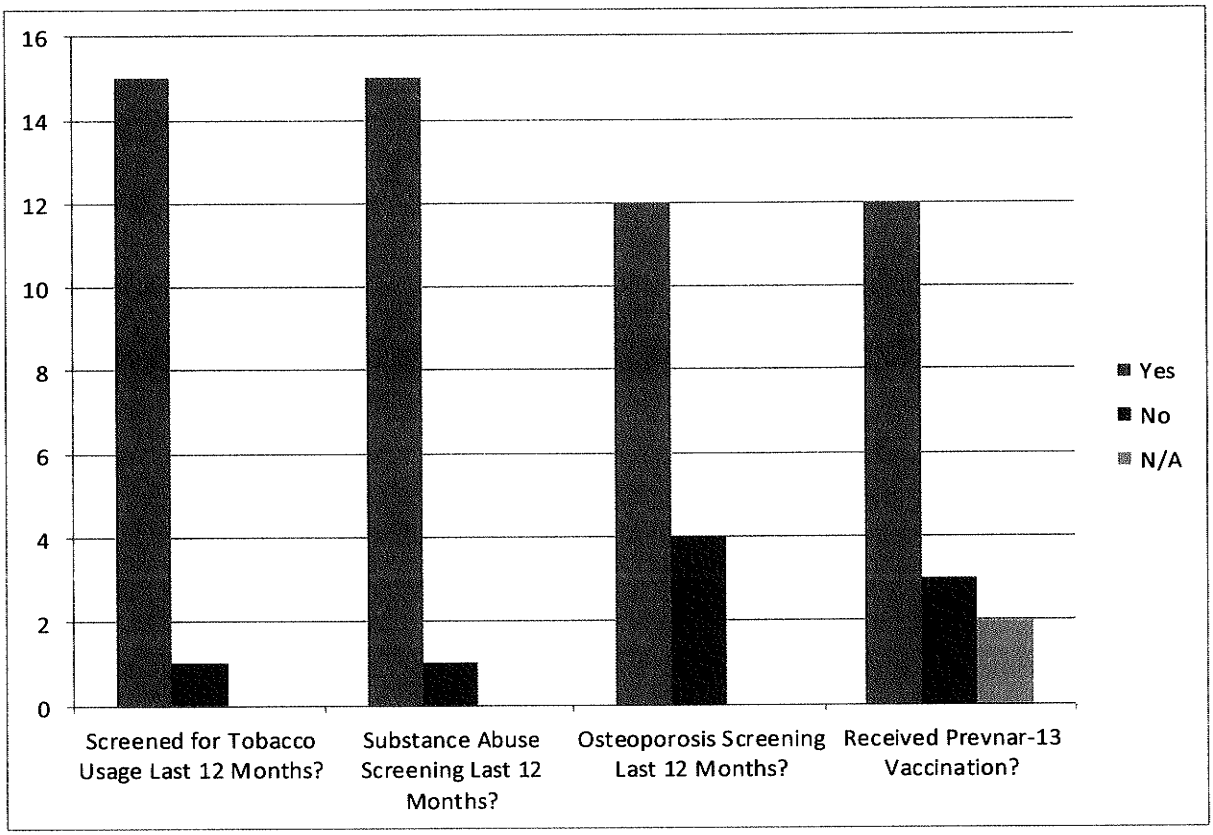
Plumas County HIV/AIDS Project
2nd Quarter CY 2013

For the 2nd quarter reporting period (4/1/13-7/31/13) the Karuk Medical Clinic had 16 active patients, 3 females, 12 males, and one transgender patient. That is one less than the previous quarter: one patient left care for a different provider, and two new patients registered. During the reporting period 8 patients were seen at least once. We currently have 4 patients who are non-compliant with therapy and have high HIV viral loads. 12 patients maintained excellent compliance, with low HIV viral loads and CD4 levels in the normal range.

Findings

Our monitoring of CD4 and HIV Viral Loads was completed for in 13 patients during this reporting period. The remaining 3 patients did not respond to repeated contacts requesting follow-up blood testing. Osteoporosis screening was done with Vitamin D levels in 8 patients during the reporting period, and Dexa scans were ordered for 4 others. We have found 6 of our patients are Vitamin D deficient, and we have begun therapy. 12 patients have received their PCV13 vaccines, 2 patients have not responded to requests to be vaccinated, and the vaccine is currently contraindicated for the remaining 2 patients.

Quality Improvement Measure Performance



KARUK COMMUNITY HEALTH CLINIC
HAPPY CAMP
CHDP REPORT FOR PAST 6 MONTHS (APRIL-SEPTEMBER-2013)

PURPOSE: Identify areas for improving the follow-up on CHDP's for patient's ages 0-18 years:

GOALS: To establish a follow-up system that will help us track patients who need CHDP's and to send notifications to parents along with an appointment date for patients to come in for their CHDP's and any immunizations that are due.

DATA: A list has been compiled of all patients meeting the criteria age as listed above; this list will be reviewed to see which patients are current with their CHDP's; patients that are past due; and patients that will have CHDP's coming up in the future.

RESULTS OF DATA:

Currently the data shows we have a total of 80 patients between the ages of 0-18 years

Twelve (12) of these patients have moved out of our area leaving us with a total of: 68 patients

Patients who are currently past due for CHDP's: 17 patients

Patients who are due for CHDP's in the next 3 months: 5 patients

Patients who are current on CHDP's and will need follow-up in the next two years: 25 patients

Patients who are current and will need follow up in the next 3-4 years: 21 patients

PROBLEMS: In the past there was no real system implemented to be sure that patients did not fall through the cracks and then fall behind in getting their CHDP's on time.

RESOULTION: A tickler file will be created for every month of the year. A copy of patients CHDP will be placed into the tickler file for the month preceding the next CHDP due; then a letter will be sent to patient's parents letting them know of appointment date for the next CHDP and any immunizations that the child may need. Parents will be asked to call the clinic immediately if the appointment date does not work for them, they will also be asked to bring in patient's immunization records if the child is receiving immunizations from another clinic.

Eligibility Report
ACQI Meeting
April - June 2013
September 11, 2013

During this period I have submitted a SSI/SSD application for 1 person, a reconsideration request for 1 person and follow-up actions for three people; I submitted 4 new on-line MediCal applications and one re-certification. All SSI applications are continuing.

I attended an excellent SSD/SSI training in Medford, Oregon on March 29th. To properly and completely provide appropriate advocacy for those applications would involve much more time than I have available. As it is I can guide and make suggestions to people about how to follow up on their applications

	April 2013	May 2013	June 2013	TOTALS
MediCal	2	1	1	4
CMSP	1	1	0	2
SSD/SSI	1	0	0	1
TOTALS				
Clients	8	4	2	14
Services Provided	11	4	**2**	17

Requests for services have declined each quarter. As I work with people I try to explain and teach them what to expect in follow-up paperwork and requirements so they can manage their own eligibility activities. They are always encouraged to come back in or call if they have questions or need help. One person had their SSI approved during this reporting period.

There are many changes coming through the Affordable Care Act, implemented in California as "Covered California" and many changes to MediCal. I am seeking information and training for these programs. I have attending a training on "Covered California" See separated report).

Nadine McElyea, Administrative Assistant/Patient Eligibility Worker
Child and Family Services, Happy Camp

Activity
Progress Report 2nd Quarter
April, May and June 2012

Title Eligibility Report

Purpose: To provide good service to all clients.

Problems: Had none in this quarter.

Data pulled from the number of clients that I had processed for the various programs, i.e.; Medi-Cal, CMSP for 2nd quarter.

Finding: Total applicants for 2nd quarter is (1)
April 2012 Total is (0)
May 2012 Total is (0)
June 2010 Total is (1) Denial Letter for excessive property.

Sharon Denz
Eligibility Worker for Yreka
08/10/2012

Karuk Tribal Health and Human Services Program

Performance Improvement Activity

October 9, 2013

Improve the Performance of Eye Exams for Karuk Diabetic Patients

I. **Purpose of the Study-** The purpose of this study is to improve the Best Practice we have chosen for our Diabetes Program, Grant, and Eye exams. The current eye exam rate per the last diabetes audit ended 12/31/2012 was 58%. Current to date the eye exam rate is 41%. It is important to improve these rates to screen and prevent Diabetic Retinopathy and to insure that all that are diagnosed with retinopathy are referred to a specialist for continuing care.

II. Our Electronic Health Record (EHR) provides a reliable way to document and follow the path of any diabetic for retinopathy. The EHR also contains reminders if the patient has not been screened over the previous year. The standard that we are following is the Indian Health Service (IHS) Special Diabetes Program for Indians (SDPI) which lists the eye exams goal as nationally at 58.6%

III. The data used comes through the EHR and we can only track accurate and consistent recording within the EHR. If we have patients in the EHR are currently not in our area or have had outside appointments and screenings and do not report hem to us for documentation, then our EHR reports are not accurate.

IV. If all those in our system that enter into EHR are not consistent in entering the current status of each patient, or if the direct care nursing staff do not follow through with both questioning the patient and entering the data, then our records are inaccurate. Additionally the Community Outreach staff must continue to call, visit and track the patients through questions and screening to insure we have all patient information.

V. **Corrective action:** Community Health Outreach staff will call all the patients on the diabetes register every three months, the direct care staff at all three clinics will be reminded to question each patient at each visit to ask if they have been screened for retinopathy, and continue to perform eye screening exam's while increasing the screening with monthly eye clinics at each facility. Additionally, Annie will call to UC Berkeley to find out the software issue with the translation of pictures taken with the camera in Happy Camp so we can make use of the camera in that clinic.

VI. This project will be re-measured in three months. Hopefully we will see an increase to 60% in our eye exams screenings of retinopathy by the next audit year end December 31, 2013.

KARUK TRIBAL HEALTH AND HUMAN SERVICES PROGRAM

2013

Create an Immunization Recall System

I. Purpose of the Study

The purpose of this study is to create an immunization recall system so that our childhood immunization rates for two year olds will increase by 2% or more per year from the 53% rate reported in 2008 on the UDS Report. It is time to review this CQI project and come up with a new plan and goals.

II. Identification of the Performance Goal

The Karuk **GPRA** 2008 immunization result (63%) for **Native American**, 19 to 35 month olds is low compared to the GPRA 2008 California Area Results (66%) and to the 2008 National Average Results (78%). The 2008 **UDS** for **all** two year olds was 53%. This low rate needs to be increased since it is important that children receive the appropriate vaccinations at an early age in order to prevent death and disability from transmissible and infectious childhood diseases. Low immunization rates can result in deadly epidemics that affect both the children who are patients of our clinics as well as children in the communities where our clinics are located.

In 2009 we considered an increase of 2% per year to be reasonable **and** achievable.

III. Description of the Data

The baseline data for this performance improvement project was taken from the 2008 UDS Report. This information came from results for both Native American and Non-Native American, two year old children. The UDS report now includes more vaccinations (increased by 3 in 2011) than the GPRA Report (see chart below). The GPRA report covers only Native American children, ages 19 to 35 months of age.

	4DTaP,3IPV,1MMR, 3Hib,3HepB	Plus 1VZV	Plus 4PCV	Plus 2HepA	Plus 2or3RV	Plus 2Flu
UDS	Yes	Yes	Yes	Yes	Yes	Yes
GPRA, past	Yes	No	No	No	No	No
GPRA, present	Yes	Yes	Yes	No	No	No

DTaP – Protects against diphtheria, tetanus, and pertussis (whooping cough)
IPV – Protects against polio
MMR – Protects against measles, mumps and rubella
Hib – Protects against *Haemophilus influenzae* type b.
HepB – Protects against Hepatitis B
VZV – Protects against chickenpox
PCV – Protects against pneumococcal disease
HepA- Protects against Hepatitis A
RV – Protects against rotavirus.
Flu – Protects against influenza.

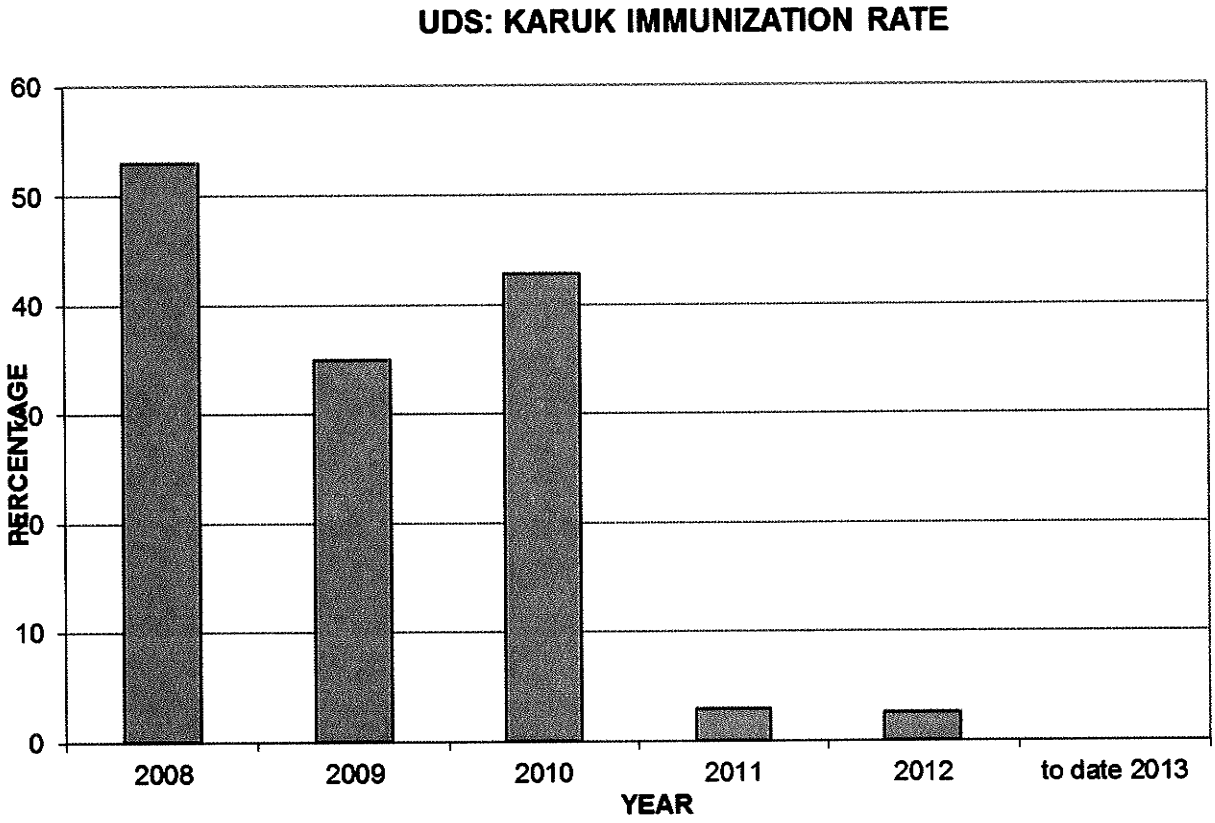
HRSA requires that the children be properly immunized by their 2nd year and GPRA by their 3rd.

IV. Evidence of Data Collection

We are able to pull quarterly results from RPMS' UDS section so, in the future, we will able to monitor improvement on a continuous basis. In addition, we can also pull GPRA results and monthly results for review.

V. Data Analysis

The 2008 **UDS** result for immunizations was 53%. The 2011 rate was 3%. This is drastically reduced from previous rates because HRSA increased the amount of required immunizations. The 2012 rate was 2.6 %. To date our UDS report indicates we are at 0%. Our GPRA Report requires fewer vaccines than HRSA so the results are higher. However the HRSA requirements may be fewer in the near future. At this point our GPRA immunization rate is at 47.8% at the end of June 2013.



Even with GPRA, our numbers are comparatively lower than other programs. If we compare our 2012 Karuk GPRA result (45.5%) to the 2012 California Area result (71.3%) and to the 2012 National result (76.8%) it shows substantial room for improvement.

VI. Comparison of Current Performance Against Performance Goal

Karuk had 53% compliance in 2009 and our goal was to improve by 2% per year. We did not meet this goal in 2009, but in 2010 we did improve. The 2011 rate was a dismal 3% so no improvement. The 2012 did not surpass 2011. Our problem area seems to be the lack of flu and Rota vaccines (short window of opportunity).

VII. Implementation of Corrective Action to Resolve Identified Problem

The following key steps will be initiated with the intended result that immunizations for **all** children who frequent our Karuk Clinics will be up to date by their 2nd birthday.

- Train clinic receptionists on how to open the schedule for recall appointments.
- Ensure that patients do not leave clinic without a follow-up appointment being made.

- Receptionists will make reminder calls the day before the appointment and also instruct the parent/guardian to bring current immunization card/record to appointment.
- A dynamic spreadsheet will be kept to track children's immunization needs using information gathered from RPMS.
- Reminder letters will be sent out to parents/guardians notifying them of the needed immunizations.
- Outreach workers will be sent out when parent/guardians do not respond.

VIII. Re-Measurement

Every three months (quarter) a UDS Table 6A Report or equivalent will be run for comparison with the last report. This is to determine whether the corrective actions have achieved the desired performance goal.

IX. Implementation of Additional Corrective Actions if Performance Goals Are Not Met

If the initial corrective actions did not achieve and/or sustain the desired improved performance, implement additional corrective actions and continue re-measurement until the problem is resolved.

X. Communication to Governing Bodies

Communicate findings of this quality improvement activity on a quarterly basis to the ACQI committee which in turn will report to the Tribal Health Board in the form of meeting minutes and report copies. In addition, these results will be posted on the ACQI bulletin board at each facility for review by clinic staff.

Respectfully Submitted by Vickie Simmons

Karuk Tribal Health & Human Services Program
ACQI Sign-In Sheet
Date: 10-9-2013

1. Patti White
2. Ronel Johnson
3. Nadine McElyea
4. Suzanna Hardenburger
5. Vicky Sam
6.
7. Dr. Brasseq
8. Vicki Walden
9. Mary Bruce
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.

Teleconferenced in from Yreka:

1. Michael Lynch
2. Dr. Ash
3. Sharon Denz
4. Dr. Milton
5. Annie Smith
6. Susan Beatty
7.
8.
9.
10.

Teleconferenced in from Orleans:

1.
2.
3.

Karuk Tribe

Karuk Tribal Health Board Report
For Meeting Date November 7, 2013

Dental Yreka Report as of October 31, 2013

1. ***Monthly meetings:*** The Dental Staff continue attending their monthly meetings as well as their providers are attending their additional meetings of Managed Care (CHS), Pharmacy and Therapeutics; (ACQI) Quality Improvement; Safety and Infection Control and the Executive Director Advisory Committee. We had an all dental staff meeting mid-October in Yreka and the meeting notes and agendas with supplemental materials reviewed are included from that gathering.

2. Skyler McNeal, (our front office receptionist in Yreka), left on the 18th of October and we have hired a replacement, Kayla Super. She has joined us and is working in the front office as of October 3rd. We welcome her and love her addition to our staff! She spent two weeks in training with Jessica Courts and has been doing a fantastic job!

3. We still do not have any information as to the proposals or timeline for the restoration of our heating and cooling here in Yreka. We look forward to the resolution of this ongoing and continued problem. With the cooler weather, we don't experience the heat as much but we will have to endure much colder temperatures, which are, additionally, as harmful to our supplies as heat. Not to mention the staff must wear three or four layers under our lab jackets to stay warm. We are also placing space heaters in some of the offices, but we cannot (OSHA) place space heaters in the operatories. We are providing blankets for the patients that are cold while undergoing treatment. Typically the temperature in the mornings are around 55-60 degrees but by the afternoon they have soared to 80. Clearly this has been a problem for some time, but I would really would like to get a resolution. It is an unhealthy and uncomfortable environment to work in and last week, I nearly passed out over a patient while in the middle of treatment. It will go beyond just getting a heating and cooling system resolution if something occurs to one of the staff that is of a physical nature e.g. passing out and injuring themselves or the patient or something more dire.

4. We will be visiting one of the local schools on November 6th and November 20th to do screenings and follow the IHS protocol for determining the need for additional dental programs and to discern the oral health of American Indian and Alaska Native youth in the 7th, 8th and 9th grades. The clinic here in Yreka will have only reception/billing staff unless it is requested that a dentist stay in the clinic for emergencies.

Dental Budget Report

Budget reports are not available this month per fiscal. They will be reported on next meeting. This was last meetings' budget information.

1. ***I.H.S. Budget 3000-41-*** **Yreka Dental** - Appropriations – $902,326.26 year to date Expenditures $860,722.99 Outstanding Encumbrances- $ 580.87 -Unencumbered Balance $ 41,022.40 Percent used 95.45

2. ***I.H.S. Budget 3000-42–*****HC Dental–** Appropriations - $593,071.50 - year to date Expenditures $547,185.94 Outstanding Encumbrances- $10.00 - Unencumbered Balance: $ 45,875.56 - Percent used 92.26

3. **HRSA Dental Supplies 3400-11-7500.03** Appropriations $25,000.00 - Year to Date Expenditures $27,507.34 - Unencumbered Balance: $ 4,752.63 - Percent Used 119.01 %

4. ***HRSA budget 3400-11-7502.00 – Dental Lab/Pedodontist Referrals*** – Appropriations $25,000.00 year to date Expenditures $ 4,291.11 – Outstanding E. $3,314.64– Unencumbered Balance - $17,394.25 – percent used 30.42.

5. ***Dental Lab Indian 3900-00-7600.00*** – Appropriations $ 85,000.00 –year to date Expenditures $101,892.20 – Outstanding E. $36,265.87 – Unencumbered Balance $ **53,158.07-** Percent used 162.54.

6. ***Dental Lab Non Indian*** *3900-00-7601.00* – Appropriations $10,000.00 – year to date Expenditures $ 9,757.09 Outstanding encumbrances $–3,880.51 - Unencumbered Balance -$3,637.60 – Percent **used 136.38**

7. ***Yreka Dental supplies*** *3900*-00-76.06- Appropriations $20.000.00 – year to date Expenditures $ **102,769.55 -** Outstanding encumbrances $ 7,944.57 – Unencumbered Balance **-$90,714.12 - Percent used 553.57 %**

8. ***HC Dental Supplies*** *3900-00-7600.07* **– Appropriations $10.000.00 – year to date Expenditures $ 5,999.04 Outstanding Encumbrances $ 2,814.20 - Unencumbered Balance $ 1,186.76 - Percent used 88.13 %**

Karuk Tribe

Karuk Tribal Health & Human Services Program

October 24, 2013 Dental Joint Staff Meeting Agenda
Yreka Clinic Conference Room

1. Vickie Walden – Call the Meeting to Order at _____
2. Meeting to start at 9:30 am and finish at 3:30 - With Lunch Break on your own from 11:45am to 1:10pm
3. Vickie Walden -Roll Call w/ Sign in Sheet
4. Vickie – Approve Meeting Minutes for last meeting.
5. **New Business-**
   a. Dr. Ash - Inputting from Dentrix to RPMS must be exactly the same.
   b. Dr. Ash - Scrubs and dress policy: discuss enforcement and when occurring
   c. Dr. Ash - Denta Quest falling away?
   d. Dr. Ash -Professional behavior and standards
   e. Vickie – Review and Sign the New MOA for Head Start, attached to agenda
   f. Debbie Whitman- Procedure Cassettes
   g. Vickie - Denti-Cal Training _____
   h. _____
   i. _____
   j. _____
6. **Old Business**
   a. Dr. Ash – Follow-up on revising dental forms - Pt.'s medical/Health History and etc.
   b. Dr. Ash – Update on removal of the carpet from the patient care areas in Yreka dental
   c. Dr. Ash - Dentrix – Training & Bridge – The date they planning on going live is November 1, 2013
   d. Vickie Walden - Follow-up on changing to new sharps containers.
   e. Vickie Walden – Follow-up on Dental Records Data Collection Audit Form
   f. Debbie W for Happy Camp and Jessica for Yreka– Update on Water treatment at the Main Source or use of Dental Units Water Bottle in the Clinics.
   g. **AAAHC Recommendations Corrective Actions**
      i. Debbie for HC and Jessica for Yreka - Dental X-ray Units Inspection and testing at least once a year.
      ii. Vickie Walden- Dental Consent forms needs witness line removed from the form.
      iii. Debbie & Jessica - Follow-up on Yreka and Happy Camp Dental Clinic need to monitoring high and low temps's and maintain a daily log. Dental refrigerator high and low temps' range needs to be posted on all refrigerators that contain dental items.
   h. _____
   i. _____
   j. **Billing - Vickie Walden**
      i. Request to remove the fees from codes OHI 1330 and Nutritional Counseling 1310.
      ii. FYI - For billing purposes only there is a fee of $289.00 attached code D0999. If the providers use that code for a visit they need to modify the fee based on what is done that visit. After December 31, 2013, we will only be billing Denta Quest for procedures done on or before that date.
      iii. FYI- Ongoing problem with some codes not crossing over to the billing package and Diana cannot see them when she is billing, they are 7140 extraction, 5820 acrylic partial, and endo codes 3310, 3320, and 3330.
      iv. Review of procedure codes for extractions D7111 and D7250. Agenda attachment with extraction information from the ADA Code Book
      v. Coding Exercises – Attachment
      vi. FYI – Coding Questions and Answers from the ADA Coding Made Simple Book- Attachment.
7. Additions-
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____

Vickie Walden

Subject: All Dental Staff joint Staff Meeting in Yreka today from 9:30 am to 3:30 PM

Start: Thu 10/24/2013 8:00 AM
End: Thu 10/24/2013 8:30 AM

Recurrence: (none)

Organizer: Rondi Johnson

Categories: Yellow Category

Attending the Meeting was:

Susan Beatty

Debbie Whitman
Shannon Jones
Kayla Super
Kayla Bridwell
Allison Ortiz
Dr. Walters
Dawn Mechling
Jessica Courts
Dr. Brassea
Nikki Hokanson
Tammy Rompon
Cheryl Tims
Vickie Walden
Meeting called to order at 9:40 am by Vickie Walden and roll call was done.
Meeting was held at the Siskiyou County Museum Meeting Room in Yreka, which we had to pay $70 dollars to rent from 9 am to 2:45 PM
Key points of the meeting were.

Additions to the agenda were Debbie Whitman re: scrubs and #5 h under new business added "the need to have a medical emergency in the dental clinics training/drill.
Tabled Dr. Ash's Items #5 b, d, Vickie Walden and Susan Beatty talked about Dr. Ash's agenda items #5 q,c,

Tabled Dr. Ash's follow-up on old business agenda item #6 a,b,c (Vickie Did talk a little about this item).

Some discussion on the changeover to new style of sharps container, which included where the clinics were at now, what kind of new containers were going to use. Also that Annie was not returning Jessica and Debbie calls when they had questions. Debbie said she order some new style sharps containers for HC Dental and will see how they work for them. It was decided that dental would use their existing inventory once that was gone they would start using the new system.

There was discussion on Waterline Treatment and in conclusion it was decided that we would wait on doing anything until we had to.

Debbie asked Yreka about their instrument setups and if they used cassettes for their exam packets and they said no. There was some discussion on using covers for the instrument trays in order to secure the instruments for transport to and from set-up, patient rooms and clean up areas. Yreka said they have tray covers that lock on to the trays.

There was discussion on the agenda item #6, e regarding the Data Collection Sheet for doing the Dental Records Audit. Susan talked about her process and asked Cheryl to send her a copy if the Happy Camp report so she can see how it's bring done. Susan reviewed some of the problem areas that she was finding with the Yreka records and there was discussion as to why the problem areas go up and down from quarter to quarter. There was also discussion on documentation the pain levels, Susan said that the pain level will always be at 0 if the assistant does not enter anything, once she sees the 0 she looks in the visit notes and sometimes the assistant notes patient report no pain today and sometimes there is nothing noted about the patients pain. There was discussion on this and no final discussion as made about how staff should document, asking the patient what their pain level was at the time of their visit. So Susan could confirm the 0 pain level score.

Agenda item 6 f – Debbie Whitman asked how Yreka was doing their water line treatment and Jessica said they have water bottles but they use the city water not the bottles. Debbie said she would like to start treating the water lines in Happy Camp, that we would have to buy a inline system to install in the main water line.
There was more discussion on whether treating the dental water lines was a law or a recommendation. Nikki said that they covered it in the training she went to and they said it was a recommendation but they were trying to make it law. The conclusion of the discussion was that we will wait until it becomes a law and we have to do it.

Agenda item 6 g I - AAAHC follow-up –
Item i. We are still trying to find a Physics to do our Annual Dental X-ray unit inspection and checks. Jessica, Debbie and Vickie said they have not been able to find a Physics to come here and do our machines. Jessica said she talked to Fair Child and got the person that dose their units and that contact did not work out. (After the Lunch Break Dr. Walters handed Vickie some contact information for a California Medical Physics Inc., she said they will come and do our x-rays units and I will share that information with Debbie and Jessica.)

Item ii - Vickie was to follow-up on a change to the Consent forms. Not done yet this task got lost on her task list, will do it at the next Medical Records Meeting.
Item iii – Debbie and Jessica Follow-up on recording the high and low temp and keeping a log. Debbie said that she has started this in Happy Camp and gave Jessica all the information so it can be started in Yreka.

Billing Agenda item J (which should be under New Business)

First item I – Removal of fees for codes 1330 and 1310 is was agreed that Vickie Walden would remove $25 fee from these codes and approved consensus of the staff present at this meeting.

ii. – just an FYI regarding use of preventive unspecified code D9990 for billing Denti-Quest.

iii – review of the codes that are not crossing over to the billing package and the billing clerks are not able to see when the following codes are used for a procedure done during a visit, codes D7140, D5820, D3310, D3320, and D3330. That billing could very easily miss billing for these procedures. That Susan and Vickie need to put the visit codes on the schedules they send to billing. Patti White and I.H.S are working in the problem.

iv – Vickie reviewed the use of ext codes D7111, D7140, D7250

v. – coding exercises were handed out and reviewed

vi. – the question and answer from the book coding made easy was handed out to staff.

Debbie Whitman wanted to talk about the up and coming dress policy re: the warring of scrubs. There was discussion on this subject.

Vickie Walden said with all the changes taking place this coming year, that there is a need to schedule a DentiCal Training to review their client benefits and the documentation needed in our charting to justify the procedures we do in our clinic. Also Vickie handed out DentiCal General Policies for Dental procedures and went over some of the highlights with staff.

Vickie Walden said that Patti White, Dentrix and Cimarron have been testing the bridge in our systems and their goal is to go live in November 1, 2013. There were questions and discussions, but no answers, Vickie will take the questions to Patti W and follow-up on this. We may have to wait until we go live before we get any answers to our questions.

Susan and Vickie did share with the rest of the staff what they knew about the phasing out of CMSP/Path 2 Health Program, it ends on December 31, 2013. They were being merged into the Medi-Cal/DentiCal State program and these patients would not have any coverage until May of next year. The patients that are in treatment past December 31 would have to go on to HRSA. That is possible we were to identify these patients and try to finish their treatment by December 31, 2013.

Susan and Vickie also went over the need to input the exact patient information into Dentrix just as it was in RPMS.

JOINT STAFF MEETING MINUTES
APRIL 25, 2013

approved Oct 24, 2013

1. Meeting called to order at 9:37 am in Yreka
2. Roll: Dr Ash DDS., Dr Shearer DDS., Dr Brassea DDS., Dr Walters DDS., Nichole Hokanson RDH.,Dawn Mechling, Tammy Rompon, Cheryl Tims, Debbie Whitman, Vickie Walden, Susan Beatty, Jessica Courts and Kayla Bridwell.
3. Meeting Minutes approved from last meeting January 2013.
4. Annie Smith – talked about needle sticks and sharps containers. When there is on incidents we are okay but since there has been two then according the AAAHC we must make changes. The changes will be that we will use up our Isolysers and then go to new sharps containers that are dry and have the flip top like medical side has.'
5. Old Business
   a. Dentrix Training- Nikki said that their was possible training on U-Tube and that some people in HC watched it and got some usefull information from it. At the I H S conference in Sacramento there will be Dentrix training there with Todd Greenway.
   b. Intake forms- Dr Ash will make the changes to the triage form and Susan will take it to the medical records meeting for approval.
   c. Carpets – Dr Ash says that it is still on going with Lessie.
   d. Code books – Vickie will order the new ADA code books for our clinics.
   e. Data Collection Audit –
   f. Dentrix Bridge -

Susan Beatty

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY — CDT-2013

Local anesthesia is usually considered to be part of Oral and Maxillofacial Surgical procedures.

For dental benefit reporting purposes a quadrant is defined as four or more contiguous teeth and/or teeth spaces distal to the midline.

EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE) — CDT-2013

D7111 EXTRACTION, CORONAL REMNANTS - DECIDUOUS TOOTH — CDT-2013

Removal of soft tissue-retained coronal remnants.

1. It is a common coding error to report extraction, *coronal remnants* – deciduous tooth (D7111), for *"routine"* deciduous (baby) tooth extractions. If any deciduous *root* structures remain, report the "routine" extraction (D7140) for a primary tooth. See D7140 for further details.

COMMENTS

1. A coronal remnant's removal is described using D7111. Be careful to bill primary tooth extractions using code D7140. Most dental plans reimburse D7140 for a primary tooth extraction at a higher rate than for extraction of coronal remnants (D7111). Most dental plans provide the same reimbursement for primary and permanent extractions. Note: some dentists charge a lower fee for primary extractions than for permanent extractions.
2. Report extraction, coronal remnants - deciduous tooth (D7111), for primary teeth that are held in by soft-tissue, *without roots*. Only the primary crown (or fragments of it) remains and is held in by soft tissue.
3. "Routine" primary tooth extractions with some root structure present should be reported as D7140.

LIMITATIONS

1. The reimbursement for D7111 is typically at 80% of the UCR fee.
2. Some payors have an exclusion for reimbursement of D7111 if an extraction is performed in conjunction with other surgery performed at the same site on the same day. For instance, when deciduous coronal remnants and an underlying permanent bicuspid are extracted on the same service date, some payors would reimburse the underlying permanent bicuspid tooth, but not the primary tooth remnant.

   If the extraction is for orthodontics, answer the question, "Is this for orthodontics?" on the claim form, "yes". If orthodontic benefits are available, orthodontic extractions for orthodontic reasons are generally reimbursed at 50% of the UCR fee, subject to the typical $1,500 lifetime orthodontic benefit. Sometimes an "orthodontic extraction" is reimbursed from the general dental benefits. If this is the case, reimbursement is usually made at 80% of the UCR fee. A deductible and other plan limitations may apply. Plan limitations are variable.

ORAL SURGERY

TIPS

1. Extraction, coronal remnants - deciduous tooth (D7111) could be used to report at a child's emergency visit. The primary tooth remnant is "hanging". The fee for extraction of a coronal remnant (D7111) may represent an "office visit" fee to remove the coronal remnant and consult with the parent.
2. When extracting several primary teeth on the same service date where some are classified as D7111 and others as D7140, (if you choose to "discount" the fee in these situations) report each extraction at a discounted fee. Do not charge the full fee for some of the extractions and not report some of the others. Always report "what you do."

D7140 EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL) — CDT-2013

Includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary.

CODING WATCH CORRECTION

1. It is a common coding error to report extraction, coronal remnants– deciduous tooth (D7111), for "routine" deciduous (baby) tooth extractions. If some primary deciduous root structures remain, report the "routine" extraction (D7140) for a primary tooth. See D7111 for further details regarding extraction of soft-tissue retained coronal remnants.
2. D7140 is used to describe a routine "exposed root" removal, where the coronal portion of the tooth has broken or decayed at or near the gumline. If the root remnant can be accessed without laying a flap, removing bone, or sectioning the root, report D7140.
3. If bone is removed and/or the exposed tooth root sectioned for removal, see surgical removal of erupted tooth (D7210). D7210 is a more complicated procedure than D7140 for removal of the exposed root and is reimbursed at a higher UCR fee.
4. See surgical removal of residual (not exposed root) tooth roots (D7250) to describe procedures where a flap is laid and bone removed in the extraction process.
5. If the extraction is a part of orthodontic treatment, answer the question, "Is this for orthodontics?" on the claim form, "yes". If orthodontic benefits are available, extractions for orthodontic reasons are generally reimbursed at 50% of the UCR fee, subject to the lifetime orthodontic benefit. Sometimes an "orthodontic extraction" is reimbursed from the general dental benefits. If this is the case, reimbursement is made at 80%of the UCR fee. A deductible and other plan limitations may apply.
6. Do not report surgical removal of residual tooth roots (D7250) for the routine extraction of exposed roots of an erupted tooth. See D7250 to report surgical removal of residual roots.

COMMENTS

1. Reimbursement for the extraction of an erupted tooth (D7140) is generally considered a "basic service" and paid at 80% of UCR.
2. D7140 is used to describe the "*routine*" removal of an erupted tooth (both primary *and* permanent) or *exposed roots* of an erupted tooth. Since this code may be used to report "multiple extractions" on the same service date, the D7140 code may be used to report each *additional* tooth or exposed root extraction extracted on the same date of service.
3. Payors typically reimburse the *same* UCR fee for primary *or* permanent tooth extraction.
4. For *Surgical* removal of an erupted tooth, requiring *removal of bone* and/or *sectioning of the tooth*, see D7210. To report D7210, laying a flap is optional.

LIMITATIONS

1. Most payors consider alveoloplasty in *conjunction* with extractions to be a part of the *global* extraction fee. D7140 may involve some *minor* removal/smoothing of bone. This incidental removal/smoothing of bone should not be reported as an alveoloplasty in addition to the extraction. If significant bony recontouring is required and involves *multiple adjacent* sites, see alveoloplasty (D7310/D7311).
2. Suture removal, minor smoothing of bone, closure, and follow up is included in the global fee for an erupted tooth extraction. The treatment of infection after extractions could be reported. See treatment of complications (post surgical) - unusual circumstances (D9930). The description of D9930 is generally used to report treatment of a dry socket or removal of a bony sequestrum. See D9930 for limitations.

TIPS

Some doctors, for multiple extractions, will charge for *fewer* extractions than were actually performed, when some extractions may have been "easy," and they want to provide the patient a discount. However, this approach is inappropriate. By reducing the true extraction count and then charging the full fee for fewer extractions than done, the overall reimbursement will be *less* when participating in a low UCR plan. For better reimbursement, charge the fee that is appropriate for *each* extraction, rather than reduce the true extraction count. The total fee charged is the same with either approach, but if the patient has a low UCR plan charging the appropriate fee on each extraction performed and reporting all the extractions will result in higher reimbursement. Always report the exact number of teeth extracted and the actual fee charged for each extraction.

SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE) CDT-2013

D7210 SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP, IF INDICATED CDT-2013

Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

1. When an *erupted* tooth is extracted and only a suture placed, it is misleading to report surgical removal of an erupted tooth. D7210 requires removal of bone and/or sectioning of tooth (D7210). When bone is not removed and/or the tooth is not sectioned, *do not* report D7210. Placing suture(s) does not elevate the routine extraction to the level of a *surgical* extraction of an erupted tooth (D7210). The removal of bone and/or "sectioning of tooth" are required to report D7210. Sectioning the tooth does elevate the service to that described by D7210. The elevation of mucoperiosteal flap is included as part of D7210, if indicated. Note: the elevation of mucoperiosteal flap is no longer required to report D7210.
2. Reporting D7210 is considered "upcoding" (a fraudulent act) when actually performing routine extractions.

COMMENTS If the extraction of an erupted tooth requires the removal of bone and/or sectioning of the tooth, report D7210, not D7140. D7210 is typically reimbursed at a level 150%-180% higher than D7140. The increased fee/reimbursement is justified by the fact that the surgical removal procedure requires increased time and because of the increased difficulty of the procedure. Some general practitioners do not utilize the surgical extraction code, D7210, although justified. The procedure counts for D7210 generally make up a *fraction* of the "routine" extraction (D7140) counts in a general dental office.

LIMITATIONS

1. Suture placement and removal, minor smoothing of bone, closure, and routine follow-up is included in the global surgical fee for D7210. Treatment for extensive infection after tooth removal could be a reimbursable service (see D9930). Aveoloplasty in conjunction with an extraction is generally considered a part of the extraction when performed on the same service date. Incidental bone removal during a single surgical extraction (D7210) is not considered a separate billable service. If multiple adjacent extractions are performed or if significant bony recontouring is required, see alveoloplasty (D7310/D7311).
2. D7210 is used to report a *surgical* extraction. Some payors require that the procedure be submitted to the patient's medical carrier before reimbursement is considered under the dental plan. If the claim has been submitted to the medical carrier, attach the medical explanation of benefits to the dental claim form with the dental claim.
3. The descriptor for D7210 indicates that either "removal of bone" *or* "section of tooth" is justification for reporting D7210. Note: some payors may require *both* removal of bone and sectioning the tooth to qualify for reimbursement. Some payors require that laying a mucoperiosteal flap be done to be considered for reimbursement even though the elevation of mucoperiosteal flap is no longer required to report D7210, according to the code descriptor.

NARRATIVES

1. D7210 should not be overutilized. Accurately describe the procedure in the clinical notes. A typical note might read: "elevated flap (if applicable) and removed bone and/or sectioned tooth. These procedures were necessary to extract the tooth." An intraoral camera photo of the sectioned tooth is recommended as proof that the procedure was provided and qualifies as a "surgical" extraction.
2. State if bone was removed during the extraction and why it was necessary - e.g., tooth was fractured off below bone level. "See attached image."
3. State if tooth was sectioned during extraction and why - e.g., tooth had curved roots, sectioning was necessary to remove tooth as atraumatically as possible. "See attached image."

D7220 REMOVAL OF IMPACTED TOOTH - SOFT TISSUE CDT-2013

Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

COMMENTS Suture removal and follow up is considered a part of the global surgical fee for removal of an impacted tooth - soft tissue (D7220). Extensive infection after an impacted tooth removal, could be reported separately on a subsequent service date. See D9930 to report treatment of complicated (post-surgical) situations. Most payors consider D9930 (by the same office) to be a part of the global extraction fee.

LIMITATIONS

1. Reimbursement of D7220 is typically based on the payor's assessment of the narrative and the anatomical position of the impacted tooth from submitted diagnostic films. The surgical technique necessary for removal is not considered. This procedure requires the elevation of a mucoperiosteal flap for access as the tooth is located beneath soft tissue. When reporting D7220 the tooth is not submerged in bone.
2. Some payors require that the medical plan be billed *before* consideration of the service under the dental plan. If medical billing is required, attach the medical explanation of benefits to the subsequent dental claim.
3. Sectioning the tooth is not a requirement to submit this procedure (D7220) for payment, but it does require mucoperiosteal flap elevation.
4. In some cases, D7220 may be subject to age limitations. Some plans limit coverage for patients fifteen to thirty years of age.

NARRATIVES

1. The narrative should describe the anatomical position of the tooth and the remarks should indicate that the occlusal surface of the tooth was obstructed by soft tissue.
2. The narrative should explain that a mucoperiosteal flap was elevated.
3. A photograph of the pre treatment area is recommended as part of the documentation. "See attached x-ray(s) and operative notes."

D7230 REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY CDT-2013

Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

COMMENTS Suture removal and follow up is considered a part of the global surgical fee for removal of an impacted tooth - partially bony (D7230). Extensive infection after an impacted tooth removal could be reported separately. See D9930 to report treatment of complicated (post-surgical) situations. Most payors consider D9930 (by the same office) to be a part of the global extraction fee.

LIMITATIONS

1. D7230 reports removal of impacted tooth – partially bony where "part of" the crown is submerged in bone. "Part of" the crown covered by bone implies that less than 50% of the crown is covered by bone. The ADA CDT 2011/2012 manual's Q&A section on page 173 indicates the observed clinical condition in conjunction with the descriptors for D7230 and D7240 would be used by the dentist to determine the appropriate procedure code as to "part" or "most." Page 173 further states "radiographic images may not provide enough visual information to determine the extent of bony coverage. Reimbursement of D7230 is based on the payor's assessment of the narrative and the anatomical position suggested from submitted diagnostic films. The surgical technique necessary for removal is not considered for reimbursement. This code requires that both mucoperiosteal flap be elevated and that the pericoronal bone be removed in order to access the tooth for extraction.
2. Some payors require that the medical plan be billed *before* consideration of the service under the dental plan. If medical billing is required, attach the medical explanation of benefits to the subsequent dental claim.
3. Sectioning the tooth is not a requirement to submit this procedure (D7230) for payment, but it does require mucoperiosteal flap elevation and bone removal to access the tooth.
4. In some cases, D7230 may be subject to age limitations. Some plans limit coverage for patients fifteen to thirty years of age.

NARRATIVES

1. The narrative should describe the anatomical position of the tooth and the remarks should indicate that a portion of the crown was obstructed by soft tissue and bone and that there was some bone removed to allow access.
2. The narrative should explain that a mucoperiosteal flap was elevated and that pericoronal bone was removed.
3. A photograph of the pre treatment area is recommended as part of the documentation. "See attached image(s) and operative notes."

D7240 REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY CDT-2013

Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

COMMENTS Suture removal and follow up is considered a part of the global surgical fee for removal of an impacted tooth - completely bony (D7240). Extensive infection after an impacted tooth removal, could be reported separately. See D9930 to report treatment of complicated (post-surgical) situations. Most payors consider D9930 (by the same office) to be a part of the global extraction fee.

LIMITATIONS

1. D7240 reports removal of impacted tooth – completely bony where "most or all" of the crown is covered by bone. "Most" of the crown covered by bone implies that more than 50% of the crown is covered by bone. The ADA CDT 2011/2012 manual's Q&A section on page 173 indicates the observed clinical condition in conjunction with the descriptors for D7230 and D7240 would be used by the dentist to determine the appropriate procedure code as to "part" or "most." Page 173 further states "radiographic images may not provide enough visual information to determine the extent of bony coverage. Reimbursement of D7240 is based on the payor's assessment of the narrative and the anatomical position suggested from submitted diagnostic films. The surgical technique necessary for removal is not considered for reimbursement. This code requires that both mucoperiosteal flap be elevated and that the pericoronal bone be removed in order to access the tooth for extraction.
2. Some payors require that the medical plan be billed *before* consideration of the service under the dental plan. If medical billing is required, attach the medical explanation of benefits to the subsequent dental claim.
3. Sectioning the tooth is not a requirement to submit this procedure (D7240) for payment, but it does require mucoperiosteal flap elevation and bone removal to access the tooth.
4. In some cases, D7240 may be subject to age limitations. Some plans limit coverage for patients fifteen to thirty years of age.

NARRATIVES

1. The narrative should describe the anatomical position of the tooth and the remarks should indicate that a portion of the crown was obstructed by soft tissue and that more than 50% of the crown was obstructed by bone.
2. The narrative should explain that a mucoperiosteal flap was elevated and that pericoronal bone was removed.
3. A current diagnostic radiograph of the pre treatment area is recommended as part of the documentation. See attached image(s) and operative notes.

D7241 REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS CDT-2013

Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.

COMMENTS

1. This code is used to describe the removal of a completely bony impaction which is "unusually difficult or complicated. Factors that may justify the use of this code may be: nerve dissection required, separate closure of maxillary sinus, or difficult access due to aberrant tooth position". The reimbursement for this service is higher than for a "routine" complete bony impaction. This code is used infrequently and is designed to describe particularly exceptional circumstances.
2. Suture removal and follow up is considered a part of the global surgical fee for removal of an impacted tooth - completely bony with unusual surgical complication (D7241). Extensive infection after an impacted tooth removal, could be reported separately. See D9930 to report treatment of complicated (post-surgical) situations. Most payors consider D9930 (by the same office) to be a part of the global extraction fee.

LIMITATIONS

1. D7241 reports removal of impacted tooth – completely bony where "most or all" of the crown is covered by bone and the procedure was unusually complicated. "Most" is defined as more than 50% of the crown is covered by bone. ADA CDT-4 manual's Q&A section describes this scenario on page 94. Reimbursement of D7241 is based on the payor's assessment of the narrative and the anatomical position suggested from submitted diagnostic films. The surgical technique necessary for removal is not considered for reimbursement. This code requires that both mucoperiosteal flap be elevated and that the pericoronal bone be removed in order to access the tooth for extraction.
2. Some payors require that the medical plan be billed *before* consideration of the service under the dental plan. If medical billing is required, attach the medical explanation of benefits to the subsequent dental claim.
3. Sectioning the tooth is not a requirement to submit this procedure (D7241) for payment.
4. In some cases, D7241 may be subject to age limitations. Some plans limit coverage for patients fifteen to thirty.

NARRATIVES

1. The narrative should describe the anatomical position of the tooth and the remarks should indicate that a portion of the crown was obstructed by soft tissue and more than 50% of the crown obstructed by bone.
2. The narrative should explain that a mucoperiosteal flap was elevated and that pericoronal bone was removed and how the procedure was unusually complicated.
3. A current diagnostic radiograph of the pre treatment area is recommended as part of the documentation. «See attached image(s) and operative notes.»

D7250 SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) CDT-2013

Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

1. D7250, surgical removal of residual tooth roots (cutting procedure) does not describe "difficult" extractions of an erupted tooth (D7140) or the removal of the exposed root (D7140). If removing bone or sectioning the erupted tooth or exposed root is required to extract the erupted tooth/root, report D7210.
2. "Residual tooth roots" refers to roots left after an extraction. D7250 should not be used to describe the removal of a root fractured at the extraction appointment. D7250 does describe the removal of a root at a subsequent appointment, on a different treatment date, or by a different provider. The initial extraction occurred sometime before removal of the *residual* root. In this case, reporting D7250 might evoke the "missing tooth" clause. The tooth was "extracted" (although partially) at an earlier appointment. The missing tooth clause might limit the reimbursement for a new bridge, implant or partial if the initial extraction was done before the patient was covered under the existing dental plan.
3. If a retained root is *exposed* (visible in the mouth), then the routine removal of the root should be reported as extraction of *exposed roots*, D7140. If the exposed root requires removal of bone or sectioning to remove, report

LIMITATIONS

1. D7250 describes the "cutting of the soft tissue and *bone*, removal of tooth structure, and closure". This code is appropriate to use when removing *residual* root fragments remaining in the bone left from a previous *incomplete* extraction. Some payors require a diagnostic film to confirm that the residual root is completely embedded in bone.
2. D7250 would be used to describe the situation where a general practitioner attempts the extraction of a tooth, cannot remove all the root structure and refers the patient for completion of the procedure (removal of the residual tooth root(s)) to an oral surgeon. The oral surgeon would use D7250 to describe the procedure. The GP would report a partial extraction, D7999, by report.
3. Suture removal and follow up is included in the global fee for D7250. Extensive infection after third molar removal would be reported separately. See D9930 to report treatment of complications (post-surgical) - unusual circumstances. However, most payors consider D9930 to be in the global extraction fee.
4. The reporting of surgical removal of residual tooth roots (D7250) may invoke the "missing tooth" limitation. Consider using D7140 or D7210 to report the erupted tooth/root extraction procedure if it reports "what you did."
5. Some payors require that the medical plan be billed *before* consideration of this service under the dental plan. If medical billing is required, attach the medical explanation of benefits to the subsequent dental claim.

NARRATIVES The narrative should describe the position of the *residual* tooth roots, the required cutting of soft tissue and bone, removal of the tooth structure, and closure.

Chapter 2. Coding Exercises – Day-to-Day CDT Code Use

This chapter contains a number of exercises designed to help you practice your coding skills and are based on "real life" situations. These exercises have been devised to illustrate varied aspects of the CDT Code. Answers are intended to demonstrate possible coding solutions for the situations described. The scenarios and solutions have been developed to reflect common and accepted practices, but may not reflect the way your office would manage a given situation. The dentist who treats a patient is the person who can best determine appropriate treatment and what codes will best describe it.

These exercises and their solutions are not to be considered legal advice or a guarantee that individual payer contracts will follow this assistance.

Use these exercises to get a better understanding of the principles of reporting using the CDT Code. Since the exercises cover subjects from many different aspects of the CDT Code it is likely that some exercises will be more applicable to your particular situation than others. All the exercises, including those that involve procedures you may not usually report, may be of value since the principles that are demonstrated can often be applied to other areas of the CDT Code.

Space has been provided for you to record your own answers to each question. Please compare your solutions to those provided. Remember,

- "Code for what you do" is the fundamental rule to apply in all coding situations.
- After reading the full nomenclature and descriptor, select the code that matches the procedure delivered to the patient.
- If there is no applicable code, document the service using an unspecified, by report ('999') code.
- The existence of a procedure code does not mean that the procedure is a covered or reimbursed benefit in a dental benefit plan.
- Treatment planning is based on clinical need, not covered services.

The exercises are organized in order of increasing complexity; however, whether an individual finds a particular exercise difficult will depend upon scope of their experience using the CDT Code.

Keep in mind that the terminology the dental team and others use to describe various procedures may depend on when and where they practice or went to school. In many cases, these terms are used interchangeably, for example:

- Maryland Bridge = Bonded Bridge
- Bridge or Bridgework = Fixed Partial Denture (FPD)
- Abutment = Fixed or Removable Partial Denture Retainer
- Abutment = Implant-supported intermediary component of some implant restorative systems
- Retainer =Teeth that serve as support for a fixed partial denture
- Retainer = orthodontic treatment maintenance appliance
- "Flipper" = Interim Partial Denture

If you have difficulty finding a code, consider whether there may be another way to describe the procedure. The CDT Manual's alphabetic index, and the glossary of dental terms posted on ADA.org are likely to be helpful in these situations.

Dental procedure codes vs. medical procedure codes

The CDT Code is the source for procedure codes used when submitting claims to dental benefit plans on either the ADA Dental Claim Form or the HIPAA standard electronic dental claim transaction. There may be times when a dentist's services are submitted to a patient's medical benefit plan. When this happens not only is there a different claim form, there are also different procedure codes that must be used.

Medical procedure codes come from two sources, the American Medical Association's Current Procedure Terminology (CPT) code set and the federal government's Healthcare Common Procedure Code Set (HCPCS). When selecting a medical procedure code the rule of thumb is to first look at the CPT code set to determine if there is an appropriate code to use. If there is none, a HCPCS code may be used.

Two of the following coding exercises, #8 and #15, illustrate how medical procedure codes may be used. There is more information about medical claim submission in Chapter 9.

Coding Exercise #1

Topical fluoride treatments – preventive; sensitivity; caries risk

Three friends decided to visit their dentist together. They all had their teeth cleaned and checked and each one had fluoride varnish applied to their teeth at the end of the visit. When they compared their statements afterward, the dentist had used a different code for each one.

Can you match the code with the appropriate application?

1. ***Bob*** had never had a cavity, which he attributed to the great preventive care he had always received. This included regular cleanings and topical fluoride treatments.

2. ***Bill*** had not had a cavity in many years, but since his last visit there were a number of teeth that had become sensitive. The doctor had applied varnish to each of those teeth to make them less sensitive.

3. ***Ben*** had gone for years without a cavity, but this visit he had decay on the roots of two teeth and there were others that looked suspicious. He had recently started taking an anti-depressant medication that left his mouth dry, and found that sucking on candy made him feel more comfortable. The dentist suggested that he might need to have the varnish applied again in a few weeks.

Coding Exercise #2

Patient age 11 – evaluation and preventive services

A new patient, age 11, was seen for a first exam, cleaning, and fluoride application. During the exam the dentist noted that the erupting tooth #4 was impinging on the band loop spacer cemented to #3 and decided to remove it.

1. How might this visit be coded?

2. What if the same patient was not new and the doctor had placed the space maintainer two years ago. How would this encounter be coded?

3. What would change if the patient was 12 years old?

4. What if the patient only had permanent teeth?

Coding Exercise #3

Child under three – evaluation and parent counseling, and preventive services

Dr. Thomas had been preparing himself for something new, but much of what he did at 10-month-old Katie's appointment, he had been doing routinely. He knew that the American Academy of Pediatric Dentistry and the ADA advise that children should have their first dental visit within six months of the eruption of the first primary tooth. However, he had a hard time thinking of children Katie's age, as patients.

In the past, Dr. Thomas had given new parents education regarding diet, proper use of bottles, and cleaning those new "baby" teeth, but had never really counted that as "billable" time. Recently however, Dr. Thomas attended a workshop where he learned about the significance of early prevention and a procedure code to report these early childhood encounters.

Dr. Thomas performed an intraoral examination while mom restrained Katie's forehead in her lap. The dentist was able to determine that Katie had maxillary and mandibular primary central incisors and that they were free of decay. He also removed plaque using an ultra-soft toothbrush and applied fluoride varnish. Dr. Thomas explained to Katie's mother how to use a wash cloth or soft brush to remove plaque each day and the importance of getting Katie to go to sleep without a bottle. They discussed foods that can lead to decay and recommended that she return in a year for an exam after most of the primary teeth have erupted.

To summarize, this is what occurred during the office visit:

- Oral examination
- Toothbrush deplaquing
- Fluoride varnish
- Discussion of diet and preventive care with her mother

1. How would you code this visit? _____

2. How could you code on Katie's next visit? _____

3. Is there more than one possibility for coding the fluoride varnish? _____

Coding Exercise #4

Radiographs – What constitutes a full mouth series?

Here are three radiographic scenarios: How would you code them?

1. ***Betty*** is missing all second and third molars. The office takes ten periapical x-rays: three upper anterior, three lower anterior and one posterior in each quadrant.

2. ***Barbara*** has all her teeth and has impacted partially erupted third molars. The office takes a panoramic x-ray and four posterior bitewings.

3. ***Becky*** has a maxillary full denture and fourteen mandibular teeth. The office takes four periapicals of the upper edentulous ridge, seven periapicals of the lower arch and four posterior bitewings.

CDT Code Questions & Answers

Diagnostic Services (D0100 – D0999)

Clinical Oral Evaluations

1. **When is it appropriate to report a consultation versus an evaluation procedure?**

   Typically, a consultation (D9310) is reported when one dentist refers a patient to another dentist for an opinion or advice on a particular problem encountered by the patient.

2. **Should a specialist who sees patients referred by a general dentist for an evaluation of a specific problem report code D0140, D0160 or D9310 for the evaluation? Does it matter if the specialist initiates treatment for the patient on the same visit?**

   Code D9310 may be used when a patient is referred to another dentist for evaluation of a specific problem. The dentist who is consulted may initiate therapeutic services for the patient.

   Code D0140 and D0160 are both problem focused evaluations. D0160 should be used when the evaluation is detailed and extensive and based on the findings of a comprehensive evaluation.

3. **What are the codes for an initial exam and an emergency exam?**

   A series of clinical evaluation codes exist that recognize the cognitive skills necessary for patient evaluation. Codes D0120 through D0180 are available to report patient evaluations, depending on the nature of the service provided. Please refer to the code's nomenclature and descriptor to assist your decision making process.

   The initial examination for a new patient may be reported using "D0150 comprehensive oral evaluation – new or established patient" or by "D0180 comprehensive periodontal evaluation – new or established patient." An examination of a patient who presents with a dental emergency may be reported using "D0140 limited oral evaluation – problem focused."

4. **Can I submit a periodic evaluation (D0120) on the same day as a full mouth debridement to enable comprehensive periodontal evaluation and diagnosis (D4355)?**

   There is nothing in the descriptors of the oral evaluation code or D4355 that preclude reporting on the same day. Some benefit plans have limitations or exclusions about paying for both of these procedures on the same day.

5. **May I submit a 'limited oral evaluation' (D0140) and another procedure on the same day?**

   There is no language in the descriptor of D0140 that precludes the reporting of other procedures on the same date of service. However, some benefit plans have limitations or exclusions about paying for certain combinations of codes performed on the same day.

6. **May I report "D0170 re-evaluation – limited, problem focused (established patient; not post-operative visit)" for a periodontal re-evaluation?**

   There is no code for a periodontal re-evaluation. Procedure code D0170 may be reported when not monitoring post-operative tissue healing. Code "D4999 unspecified periodontal procedure, by report" is also an available code to report a periodontal re-evaluation.

7. **We recently had a patient come in for a periodic oral evaluation. The doctor found signs and symptoms of periodontal disease and performed a complete periodontal evaluation. May I report both the periodic and periodontal evaluations, since these are two separate procedures?**

   The comprehensive periodontal procedure includes all of the components of a periodic evaluation, and adds additional requirements for periodontal charting and the evaluation of periodontal conditions. When a patient presents with signs or symptoms of periodontal disease, and all of these components were performed, D0180 would be reported.

8. **Is reporting the 'comprehensive periodontal evaluation' (D0180) limited to Periodontists?**

   D0180 is not limited to Periodontists. All dental procedure codes are available to any practitioner providing service within the scope of her or his license.

9. **I have read the descriptors of the evaluation codes, but am confused as to which code should be reported when a very young child is evaluated in the office. None of them seem to apply. What should be reported?**

   The procedure code for the evaluation of a child under age three and including counseling of the child's primary caregiver may be reported. This code is: "D0145 oral evaluation for a patient under three years of age and counseling with primary caregiver."

10. **Can code D0145 be reported every time the child comes into the office for an evaluation, or should we report a recall evaluation for subsequent visits?**

    A separate evaluation code was added because of the unique procedures that are necessary when evaluating a very young child. Depending on the nature of the evaluation, a periodic evaluation (D0120) or an oral evaluation for a patient under three years of age (D0145) would be appropriate choices to consider.

Diagnostic Imaging

11. **Are bitewings and a panoramic radiographic image considered a full mouth series of radiographs?**

    No, these images are not the same as the "D0210 intraoral, complete series..." procedure. According to the FDA's "The Selection of Patients for Dental Radiographic Examinations," published in 2005, a full mouth series is defined as "A set of intraoral radiographs usually consisting of 14 to 22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone crest." Effective January 1, 2009 this definition was incorporated into the D0210 descriptor.

Further, a panoramic radiographic image cannot be considered a full mouth series as it is an extraoral film and it does not reflect the FDA definition of a full mouth series. Different procedure codes are available to report a full mouth series of radiographs (D0210) and a panoramic radiograph (D0330). Please note that bitewings taken as part of a full mouth series are not reported separately.

12. There are procedure codes for one, two and four bitewings, but no code for three bitewings. How do I report three bitewing x-rays?

A procedure code to report three bitewing images was added to the CDT Code effective January 1, 2007 – "D0273 bitewings, three radiographic images."

13. Our office has begun to use new technology that provides 3-D or 2-D images of a patient that are generated from a CT-like scan. How do we code this?

Several procedure codes (e.g., D0364-D0368) are available to document "cone beam CT..." diagnostic images taken in the dentist's office. There are separate codes based on the field of view. For example, an initial scan that yields coronal, sagittal, and panoramic views would be documented with:

D0367 cone beam CT capture and interpretation with field of view of both jaws, with or without cranium

The entire "cone beam..." nomenclature must be read to determine which describes the diagnostic image.

Tests and Examinations

14. Is a caries susceptibility test (D0425) the same as a caries detectibility test?

No, they are different procedures. A caries susceptibility test is a diagnostic test for determining a patient's propensity for caries. There is no procedure code for a caries detectibility test, which aids in determining the presence of caries. "D0999 unspecified diagnostic procedure, by report" may be used to report a caries detectibility test.

15. Can I submit a code for pulp vitality tests or is this considered to be included in all endodontic procedures?

Yes, you may submit this as a separate service (D0460) as it is a stand-alone code. It includes multiple teeth and contra lateral comparison(s), as indicated.

16. Our office recently purchased a VelScope and was wondering if there was a procedure code available?

Procedure codes in the CDT Manual are not product or brand-name specific. Devices such as the VelScope may be used in the delivery of procedures such as: "D0431 adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures."

Preventive Services (D1000 – D1999)

Dental Prophylaxis

1. **What is the definition of prophylaxis?**

   A prophylaxis is removal of plaque, calculus and stains from the tooth structures. It is intended to control local irritational factors.

2. **Does the patient's age dictate whether a child or adult prophylaxis is reported?**

   The prophylaxis codes are dentition specific rather than age specific.

   However, third-party payers may have age restrictions in their contracts that determine the level of benefits available. The ADA's House of Delegates has adopted a policy concerning this question:

   Age of "Child" (1991:635)

   Resolved, that when dental plans differentiate coverage based on the child or adult status of the patient, this determination be based on clinical development of the patient's dentition, and be it further

   Resolved, that where administrative constraints of a dental plan preclude the use of clinical development so that chronological age must be used to determine child or adult status, the plan defines a patient as an adult beginning at age 12 with the exclusion of treatment for orthodontics and sealants.

3. **What code do I utilize for a difficult prophylaxis?**

   There is no separate procedure code that reflects the degree of difficulty of a dental prophylaxis. The available prophylaxis codes are "D1110 prophylaxis – adult" and "D1120 prophylaxis – child".

4. **How do I document cleaning a complete fixed denture or a removable partial prosthesis?**

   According to third-party payer members of the Code Revision Committee "D1110 prophylaxis – adult" would be used to document and report this service.

5. **What code do I use to report a cleaning in the presence of gingival inflammation?**

   The descriptors of the prophylaxis codes ("D1110 prophylaxis – adult" and "D1120 prophylaxis – child") include removal of factors that cause local irritations. When bone loss is present, other procedures may be appropriate to control disease factors.

6. **Can "D1110 prophylaxis-adult" and "D4342 scaling and root planing one to three teeth per quadrant" be reported on the same date of service?**

   There is no language in the descriptor of an adult prophylaxis that precludes the reporting of any other procedure. Some benefit plans have limitations or exclusions about paying for both these procedures on the same day.

7. **Our office has received EOBs from insurance companies indicating that the combination prophy/fluoride codes (D1201-child, D1205-adult) are no longer valid. What are the new combination codes?**

The CDT Code does not contain combination prophy/fluoride procedure codes. A prophylaxis and a fluoride treatment are reported as two separate procedures. On January 1, 2013 the CDT Code eliminated separate topical fluoride application codes for children and for adults – all are now documented using "D1208 application of topical fluoride." The separate prophylaxis codes continue – "D1120 prophylaxis – child" and "D1110 prophylaxis – adult."

Topical Fluoride Treatment

8. **I see that there is a code for placing fluoride varnish. May I use this code when applying varnish to desensitize a tooth?**

When fluoride varnish is utilized to desensitize a tooth, you may report "D9910 application of desensitizing medicament". Procedure code "D1206 application of topical fluoride varnish" is used for therapeutic purposes.

9. **If our office uses fluoride varnish as part of our recall visit protocol should I report codes D1203 or D1204 as we have done in the past, or should I use the new fluoride varnish code?**

Procedure codes you have used in the past for preventive topical fluoride do not specify the formulation or technique used for application. On January 1, 2013 the CDT Code eliminated separate topical fluoride application codes for children and for adults – all are now documented using "D1208 application of topical fluoride." The formulation and technique used for application continue not to be specified. Procedure code "D1206 application of topical fluoride varnish" is used when more detailed documentation is necessary.

10. **Is it necessary to use trays to deliver fluoride treatment in the office?**

The CDT Code does not specify delivery mechanisms for topical fluoride materials. This aspect of the procedure is best determined by the practitioner at the time of service.

11. **What is meant by delivery of a fluoride treatment "...under the direct supervision of a dental professional?"**

All dental professionals should deliver services according to applicable state laws and within the scope of their licensure. "Direct supervision..." would be defined by state law; contact your constituent or component dental society for such information.

Other Preventive Services

12. **What code do I use to report a fissurotomy?**

The term "fissurotomy" is actually a trademarked name and applies to a particular type of dental bur. However, "fissurotomy" is sometimes used to describe a technique utilizing the mechanical enlargement of occlusal pits and fissures. In that situation you could use "D9971 odontoplasty 1-2 teeth; includes removal of enamel projections."

13. **When using resin, what distinguishes a sealant from a preventive resin restoration?**

The CDT Code was revised effective January 1, 2011 to enable separate reporting of these distinct procedures. Resin used as a sealant in a pit and fissure area, limited to the enamel, would be documented using D1351. When resin is used in a pit and fissure area where there is an active cavitated lesion that does not extend into the dentin, the available procedure code is D1352 (added effective January 1, 2011). Should the lesion extend into the dentin, the procedure code for one surface composite resin restoration (D2391) would be used to document the service.

As always, the full procedure code nomenclature and descriptor must be used to determine which CDT Code entry is applicable.

D1351 **sealant - per tooth**
Mechanically and/or chemically prepared enamel surface sealed to prevent decay.

D1352 **preventive resin restoration in a moderate to high caries risk patient – permanent tooth**
Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits.

D2391 **resin-based composite – one surface, posterior**
Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.

Restorative Services (D2000 – D2999)

1. **How may I report local anesthesia as a separate procedure?**

"D9215 local anesthesia in conjunction with operative or surgical procedures" is an available procedure code if you wish to report it separately. Benefit plan limitations may preclude separate reimbursement for local anesthesia.

2. **I know there are no differences between primary teeth and permanent teeth for most indirect restorations. Are there direct restorative codes for primary teeth?**

The codes listed under the direct restorative category of service include both the primary and permanent dentitions.

3. **How do I report two separate 2-surface restorations on the same tooth? Carriers advise me to report a MO amalgam and a DO amalgam as a MOD restoration. Is this correct?**

Dentists should report the procedures performed, and reporting these restorations separately as a MO and a DO is appropriate. Dental plans may have clauses that restrict coverage on the same surface twice on the same date of service. This is why some carriers may apply an alternate benefit provision that recodes the two separate restorations as a single restoration.

4. **I recently purchased a laser and have been unable to find any "laser" codes in the *Code on Dental Procedures and Nomenclature*.**

   The codes are procedure based rather then instrument based. You would report the appropriate code based on the actual procedure that was performed.

Resin-based Composite Restorations

5. **What code do I report for an incisal restoration?**

   If the restoration involves the incisal angle, code "D2335 resin-based composite – four or more surfaces or involving incisal angle (anterior)" may be reported. If the incisal surface restored does not involve the incisal angle, report with the appropriate anterior procedure code that describes the number of surfaces restored.

Crowns - Single Restorations Only

6. **Should single crowns that are splinted together be coded as single crowns (in the D27xx series of codes) or as a bridge (in the D67xx series)?**

   Single crowns that are splinted together are appropriately reported as single crowns, D27xx. There is no coding mechanism to report splinting the crowns. Prosthodontic retainers are parts of a fixed partial denture that attach a pontic to the abutment tooth, implant abutment, or implant and should be used in conjunction with a pontic code.

7. **What procedure code should I report for a porcelain fused to a zirconium substrate crown?**

   The available procedure code is "D2740 crown – porcelain/ceramic substrate."

8. **How do I code a porcelain fused to titanium crown? I only see a code for titanium code D2794 crown - titanium.**

   "D2794 crown – titanium" is the only titanium crown procedure available.

Other Restorative Services

9. **Is there a code for retrofitting a new crown to an existing partial denture?**

   The code is "D2971 additional procedures to construct new crown under existing partial denture framework" and should be reported in addition to the crown.

10. **Is there a procedure code for recementing an onlay?**

    Code "D2910 recement inlay, onlay, or partial coverage restoration" includes the recementation of an inlay, onlay or any other partial coverage restorations such as a veneer.

11. **If I place an IRM (Intermediate Restorative Material) restoration, do I report this as sedative restoration or a palliative procedure?**

    Both a protective restoration (D2940) and palliative (emergency) treatment of dental pain (D9110) may be applicable depending on the dentist's clinical judgment. However, one would not code both simultaneously for the same procedure.

12. **How is the doctor to report a situation where a restorative (or any other) procedure is started but not finished?**

    The current version of the CDT Code does not contain a code for procedures that are started but not completed (with the exception of D3332 incomplete endodontic therapy; inoperable, unrestorable or fractured tooth). When services rendered are not addressed by a specific code, an unspecified procedure, by report code (e.g., D2999 unspecified restorative procedure, by report) may be used.

13. **The patient's treatment plan includes placement of a prefabricated post and core under an existing crown. What procedure code would be used to report this procedure?**

    There is no code that specifically refers to placement of a prefabricated post and core under an existing crown. When there is no procedure code whose nomenclature and descriptor reflect the service provided, an "unspecified...procedure, by report" code may be considered (e.g., D2999 unspecified restorative procedure, by report).

14. **The patient's treatment plan includes placement of a prefabricated post without a core. What procedure code would be used to report this procedure?**

    There is no code that specifically refers to placement of a prefabricated post without a core. When there is no procedure code whose nomenclature and descriptor reflect the service provided, an "unspecified...procedure, by report" code may be considered (e.g., D2999 unspecified restorative procedure, by report).

15. **An access cavity was made through a crown for endodontic treatment. What procedure code is appropriate to report sealing an endodontic access cavity?**

    There is no code that specifically refers to placement of a restoration to seal an endodontic access cavity. When there is no procedure code whose nomenclature and descriptor reflect the service provided, an "unspecified...procedure, by report" code may be considered (e.g., D2999 unspecified restorative procedure, by report). Restorative codes may also be used to report sealing an access cavity.

16. **I placed a temporary restoration to protect my patient's tooth structure and surrounding tissues. Would "D2940 protective restoration" be appropriate for reporting this procedure?**

    Yes, as the D2940 descriptor reads as follows:

    Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under restoration.

Endodontics (D3000 – D3999)

Pulpotomy

1. **What is the code for apexogenesis?**

   Apexogenesis is vital pulp therapy performed to encourage continued physiological formation and development of the tooth root. To report this procedure, use procedure code "D3222 partial pulpotomy for apexogenesis..." that was added to the CDT Code effective January 1, 2009.

Endodontic Therapy

2. **Should I report a root canal procedure on the date the tooth is opened, or the final fill date?**

   For clinical record keeping purposes, the initiation date should be recorded. Some third-party payers require the completion date as the date of service for an endodontic procedure.

3. **If I see a patient on an emergency basis to relieve pain and begin a root canal procedure on tooth # 31, but do not finish it on the same day, may I code D3221 on the initial visit and later code the root canal procedure (D3330)?**

   Language in the descriptor of pulpal debridement (D3221) precludes the same provider from reporting this procedure on the same date as an endodontic procedure. Since the date of completion of the root canal is different from the date of initiation of the procedure, and the patient presented with an emergency, both codes may be reported.

4. **What code do I use to report root canal therapy on a molar with 4 canals since it requires more work than a typical molar with three roots?**

   Endodontic therapy is reported based on the anatomic type of the tooth, not number of canals. Code "D3330 endodontic therapy, molar (excluding final restoration)" should be reported for a molar root canal therapy.

5. **May I report code "D3331 treatment of root canal obstruction; non-surgical access" and D3330 (root canal therapy on a molar) on the same day?**

   There is nothing in either codes' nomenclature or descriptor that says these two cannot be reported on the same day.

6. **May I report "D3331 treatment of root canal obstruction..." and "D3348 retreatment of previous root canal therapy - molar" when an endodontic molar retreatment involves removing separated instruments or carriers for filling material?**

   There is no language in the descriptor of D3331 that precludes the reporting of any initial or retreatment endodontic codes on the same date of service.

7. **Does an endodontic procedure include an exam and diagnostic X-rays?**

   The descriptor for the Endodontic Therapy subcategory of service that contains endodontic procedures D3310, D3320, and D3330 states that these procedures do not include diagnostic evaluation and necessary diagnostic radiographs/images. It is appropriate to report an evaluation or diagnostic radiographs/images when clinical circumstances dictate these procedures are necessary.

Apicoectomy/Periradicular Services

8. **How can I report a procedure performed to determine if a root was fractured?**

   Codes in the Endodontics subcategory "Apicoectomy/Periradicular Services" can be used to report this procedure. The codes are differentiated by type of tooth and number of roots involved in the surgical service.

9. **If I perform an apicoectomy and submit tissue for a biopsy on tooth #10, how do I code for these procedures?**

   Submission of tissue for biopsy is not included in the subcategory descriptor as a component of an apicoectomy procedure. There are no biopsy codes available to report tissue collection during an apicoectomy procedure. The descriptor of "D7286 biopsy of oral tissue – soft" prohibits its use at the same time as codes for apicoectomy/periradiucular surgery. An available code is "D9999 unspecified adjunctive procedure, by report." Plan limitations may exclude or not recognize certain combinations of codes performed on the same day.

Other Endodontic Procedures

10. **I am a dentist in general practice and my patient has a tooth that needs endodontic retreatment, which will be provided by an endodontist after I remove the post. What procedure code is appropriate to report only removal of the post?**

    "D2955 post removal" is applicable to the service described.

16. What is occlusal equilibration, and how would it be documented?

Occlusal equilibration, also known as occlusal adjustment, refers to the reshaping of the occlusal surfaces of teeth to create a harmonious contact relationship between the upper and lower teeth.

Available procedure codes:

D9951 occlusal adjustment – limited
May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamalplasty. Typically reported on a "per visit" basis. This should not be reported when the procedure only involves bite adjustment in the routine post-delivery care for a direct/indirect restoration or fixed/removable prosthodontics.

D9952 occlusal adjustment – complete
Occlusal adjustment may require several appointments of varying length, and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be utilized for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma when indicated. Occlusal adjustment enhances the healing potential of tissues affected by lesions of occlusal trauma.

17. What is a dry socket and how would treatment be coded?

A dry socket is localized inflammation of the tooth socket following extraction due to loss of the blood clot with resultant osteitis.

Available procedure codes are:

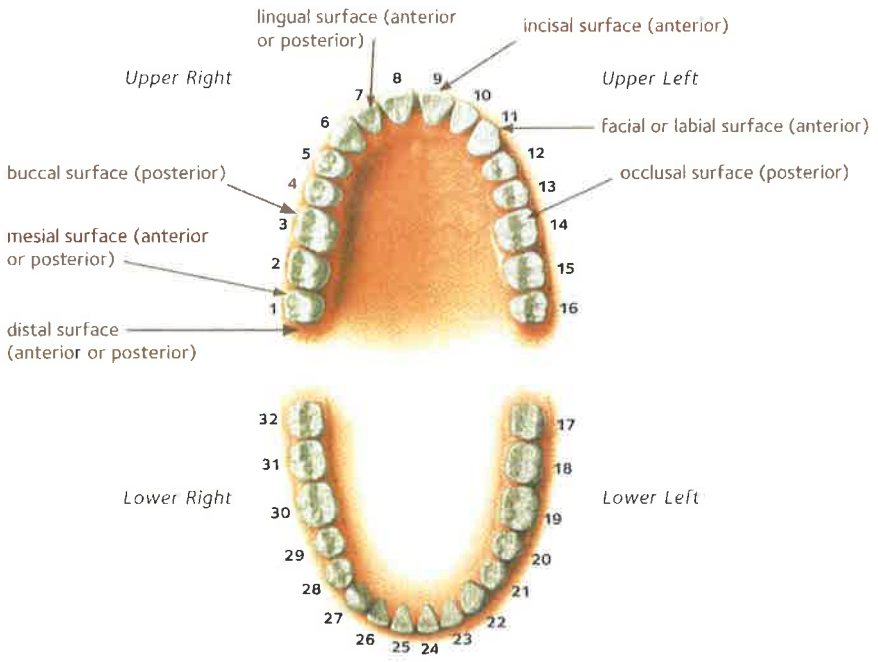
D9930 treatment of complications (post surgical) – unusual circumstances, by report
For example, treatment of a dry socket following extraction or removal of bony sequestrum.

D9110 palliative (emergency) treatment of dental pain – minor procedure
This is typically reported on a "per visit" basis for emergency treatment of dental pain.

Illustrations of the Oral Cavity

The following pages contain illustrations of the oral cavity that portray primary dentition and permanent dentition. Individual teeth are identified by name and by number, using the Universal/ National Tooth Designation System. The perspective is facing the patient, which means that tooth number 1 (upper right primary third molar) is to the upper left side of the illustration.

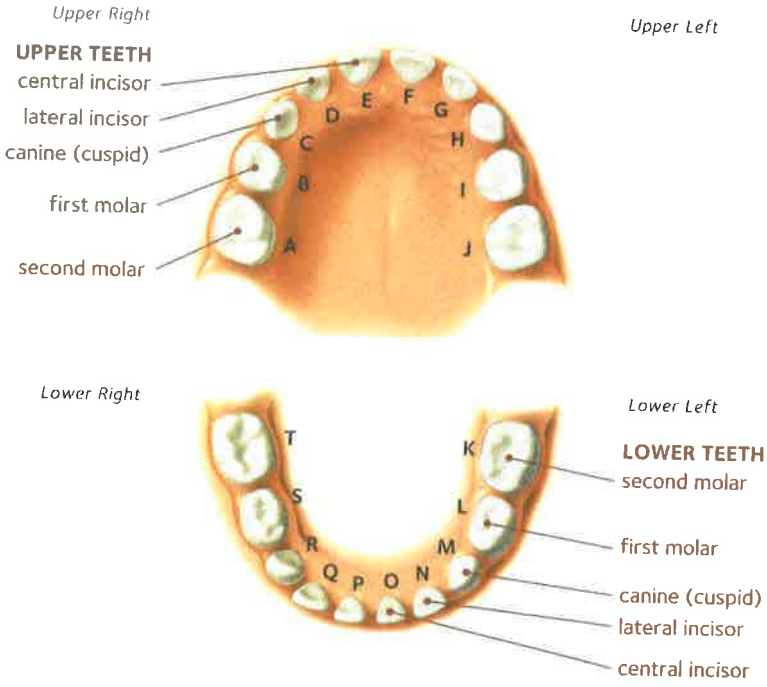
Permanent Teeth



1. 3rd molar (wisdom tooth)
2. 2nd molar (12-yr. molar)
3. 1st molar (6-yr. molar)
4. 2nd bicuspid (2nd premolar)
5. 1st bicuspid (1st premolar)
6. cuspid (canine/eye tooth)
7. lateral incisor
8. central incisor
9. central incisor
10. lateral incisor
11. cuspid (canine/eye tooth)
12. 1st bicuspid (1st premolar)
13. 2nd bicuspid (2nd premolar)
14. 1st molar (6-yr. molar)
15. 2nd molar (12-yr. molar)
16. 3rd molar (wisdom tooth)
17. 3rd molar (wisdom tooth)
18. 2nd molar (12-yr. molar)
19. 1st molar (6-yr. molar)
20. 2nd bicuspid (2nd premolar)
21. 1st bicuspid (1st premolar)
22. cuspid (canine/eye tooth)
23. lateral incisor
24. central incisor
25. central incisor
26. lateral incisor
27. cuspid (canine/eye tooth)
28. 1st bicuspid (1st premolar)
29. 2nd bicuspid (2nd premolar)
30. 1st molar (6-yr. molar)
31. 2nd molar (12-yr. molar)
32. 3rd molar (wisdom tooth)

Primary Teeth

UPPER TEETH	ERUPT	SHED
central incisor	8-12 mos.	6-7 yrs.
lateral incisor	9-13 mos.	7-8 yrs.
canine (cuspid)	16-22 mos.	10-12 yrs.
first molar	13-19 mos.	9-11 yrs.
second molar	25-33 mos.	10-12 yrs.



LOWER TEETH	ERUPT	SHED
second molar	23-31 mos.	10-12 yrs.
first molar	14-18 mos.	9-11 yrs.
canine (cuspid)	17-23 mos.	9-12 yrs.
lateral incisor	10-16 mos.	7-8 yrs.
central incisor	6-10 mos.	6-7 yrs.

ANSI/ADA/ISO Specification No. 3950

This system (ANSI/ADA/ISO Specification No. 3950 – 1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity) is designed to identify areas of the oral cavity as well as uniquely number permanent and primary dentition. This code set does not yet identify supernumerary teeth. It is used in many countries outside the USA, as well as being a component of developing electronic dental transactions, such as the 'dental laboratory prescription'.

The ISO System is also identified as code set "JO" in references found on the ADA Dental Claim form and on HIPAA standard electronic dental claim transactions. Each component of this numbering system, starting with 'Areas of the Oral Cavity' and followed by 'Designation of Teeth', is described below.

Areas of the Oral Cavity

The areas of the oral cavity are designated by a two-digit code, where at least one of the two digits is zero, as follows:

00 designates the whole of the oral cavity
01 designates the maxillary area
02 designates the mandibular area

10 designates the upper right quadrant
20 designates the upper left quadrant
30 designates the lower left quadrant
40 designates the lower right quadrant

03 designates the upper right sextant
04 designates the upper anterior sextant
05 designates the upper left sextant
06 designates the lower left sextant

07 designates the lower anterior sextant
08 designates the lower right sextant

Karuk Tribe

Karuk Tribal Health & Human Services Program

October 24, 2013 Dental Joint Staff Meeting Agenda
Yreka Clinic Conference Room

1. Vickie Walden – Call the Meeting to Order at _____
2. Meeting to start at 9:30 am and finish at 3:30 - With Lunch Break on your own from 11:45am to 1:10pm
3. Vickie Walden _Roll Call w/ Sign in Sheet
4. Vickie – Approve Meeting Minutes for last meeting.
5. **New Business-**
   a. Dr. Ash - Inputting from Dentrix to RPMS must be exactly the same.
   b. Dr. Ash - Scrubs and dress policy: discuss enforcement and when occurring
   c. Dr. Ash - Denta Quest falling away?
   d. Dr. Ash -Professional behavior and standards
   e. Vickie – Review and Sign the New MOA for Head Start, attached to agenda
   f. Debbie Whitman- Procedure Cassettes
   g. _____
   h. _____
6. **Old Business**
   a. Dr. Ash – Follow-up on revising dental forms - Pt.'s medical/Health History and etc.
   b. Dr. Ash – Update on removal of the carpet from the patient care areas in Yreka dental
   c. Dr. Ash - Dentrix Bridge – The date they planning on going live is November 1, 2013
   d. Vickie Walden - Follow-up on changing to new sharps containers.
   e. Vickie Walden – Follow-up on Dental Records Data Collection Audit Form
   f. Debbie W for Happy Camp and Jessica for Yreka– Update on Water treatment at the Main Source or use of Dental Units Water Bottle in the Clinics.
   g. **AAAHC Recommendations Corrective Actions**
      i. Debbie for HC and Jessica for Yreka - Dental X-ray Units Inspection and testing at least once a year.
      ii. Vickie Walden- Dental Consent forms needs witness line removed from the form.
      iii. Debbie & Jessica - Follow-up on Yreka and Happy Camp Dental Clinic need to monitoring high and low temps's and maintain a daily log. Dental refrigerator high and low temps' range needs to be posted on all refrigerators that contain dental items.
   h. _____
   i. _____

   j. **Billing - Vickie Walden**
      i. Request to remove the fees from codes OHI 1330 and Nutritional Counseling 1310.
      ii. FYI - For billing purposes only there is a fee of $289.00 attached code D0999. If the providers use that code for a visit they need to modify the fee based on what is done that visit. After December 31, 2013, we will only be billing Denta Quest for procedures done on or before that date.
      iii. FYI- Ongoing problem with some codes not crossing over to the billing package and Diana cannot see them when she is billing, they are 7140 extraction, 5820 acrylic partial, and endo codes 3310, 3320, and 3330.
      iv. Review of procedure codes for extractions D7111 and D7250. Agenda attachment with extraction information from the ADA Code Book
      v. Coding Exercises – Attachment
      vi. FYI – Coding Questions and Answers from the ADA Coding Made Simple Book- Attachment.
7. Additions-
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____

Executive Director Of Health and Human Services

Board Report November 7, 2013 Lessie Aubrey, EDHHS

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Orleans Clinic Provider

A locums PA will begin working on Monday November 4, 2013. he will receive orientation on Monday in Happy Camp before going down to Orleans. He is assigned to us through March unless we find a permanent placement.

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Follow-up from Last Months Meeting Question: "They are leaving us out".

The insurance companies in the healthcare marketplace will require preferred providers for clinics or hospitals serving their patients. The fact is that they won't/don't have to accept us as their preferred provider. Seeing their patients then would be without getting paid. There is NO law stating they have to accept us. I do believe that this refers to all healthcare organizations not just Indian Tribes.

We are working with Partnership Health Plan for our managed care. However, they may also be an insurance company listed in the marketplace. Even though we contract with them they might not accept us as their preferred providers.

We need to look good so that they will all want to select us.

The government was shut down so Margo didn't travel to Lake Tahoe for the CRIHB meeting. So I've yet to find out what she meant.

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Emergency Fund

I received a letter that we have been approved for $78, 125.00 from IHS for the recent fire emergency.

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Psychiatry Services

Pat Hobbs, Suzanna Hardenburger and I have been working out a contract for psychiatry services. We are in the process of making a counter offer and hope to have a contract ready for Board approval soon.

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After Hours Care

After hours care as defined by HRSA will begin December 1, 2013. That's the goal Amy Coapman has selected to begin the service.

I need to complete my HRSA report on after-hours care now so it will be ready when they want it. Rondi has developed a brochure and a poster for the clinics. I have written a plan and now I must complete the policy and get it approved. Amy has found providers for the service and ahs developed a schedule. When this is all complete then the report will be finished.

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Three Enrollment and Education Counselors for Covered CA

Debbie Bickford, Sharon Denz, and Nadine will be certified enrollment, and education counselors who will enroll people in Health Insurance through the Market Place. They are both scheduled for two training programs that will be taking place in November. Rondi is Debbie Beckford's supervisor. Sharon and Nadine are our current eligibility clerks, who will also help patients enroll.

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HANC Round Table

Rondi and I attended the HANC Round Table on October 24 and 25, at Bodega Bay. The scenery was beautiful, but there was nothing to do there outside the meeting, and we had not planned on going fishing.

The Round Table is where clinics in our area come together to network and discuss problems we are encountering,

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or discuss new projects or services. Problems with Partnership seem to be common among us. Much of the problems may stem from just getting use to each other. These are also HRSA clinics so they share the same problems and discuss solutions. I enjoy this group.

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Annual CRIHB Meeting

The retirement party went well and I could see that Jim Crouch was truly enjoying it. Many people came out to pay tribute to him; he is really respected and he received many nice gifts.

It seemed the theme of the meeting was the past to the present, of years gone by and the growth made at CRIHB.

The program director's talked about Covered California and had a very long discussion of being left out by the insurance companies. We shared problems we were having with Managed Care and most importantly the need for them to have passwords to our computer systems. Susan Dahl ruled it a HIPAA violation. Regardless, Andy said we need to realize that these people have a lot of power over us now. I hope this is a democracy and we can do business as usual with a few changes.

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IT Department

Our IT Department needs to be congratulated on the large grant they received to place Broad Ban down river.

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OPUS Solutions

I am reviewing an agreement I received for OPUS Solutions a new company that sells diabetic supplies supposedly at a reduced rate. The Chairman of this company is Molin Malicay and I would like to see him do well but his prices need to be comparable. In addition, he has a line of diabetic shoes for sale and I think Medicare may pay for them. Look for this agreement sometime soon.

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Luke's Pharmacy

Luke's pharmacy would like to contract with us. I am working on their contract now, but it isn't ready for the Council. Medical center Pharmacy is our other pharmacy working with Capture RX. We haven't had much luck with Raley's. They were already to go but someone held them up. I'm going to have to write their supervisor and try to get things straightened out.

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KARUK TRIBAL HEATLH PROGRAM

BUSINESS OFFICE HEALTH BOARD REPORT

MEETING DATE NOVEMBER 7, 2013

The month has been more complex then expected and will continue into the next few months I am sure.

The staff is learning how to bill our medi-cal in the new Partnership Healthplan of California (PHC) format. This first couple of months the clinic front desk staff are having some issues collecting all the information we need for billing purposes, so the billers must do quite a bit of back tracking and figuring out patient's valid eligibility. It is far more complex than regular medi-cal. Then they must turn around and bill it to our regular Medi-cal for the newly negotiated rates again. Double the amount of claims and work. As well as slightly different regulations. David Arwood is just beginning to handle the first round of medi-cal EOBs which again will be effected by PHC to a degree. Some patients are under the PHC format, but some, by new regulations, are not. At this point he is checking each that looks suspicious to be sure it was billed and paid correctly. Progress within the department is very slow and stress is running very high as people attempt to work through their frustrations.

We have progressed with CRIHB Options and have been able to submit claims, but it takes a couple of months to be paid and we are looking forward to our first payment on this program. Eileen has taken a great deal of the CRIHB stress off of me by handling most of it on her own and guiding the billers through that format. And is now working with the billers and the PHC billing issues.

I have begun the process of getting Dr Vasquez enrolled with each of our payers. Medicare has a "Revalidation" program. This is just their way of updating everyones records. This is done approximately every 5 years and usually it is for one clinic site or one provider at a time. But this time they are requiring all three of our sites be done at once and also Elizabeth Rugg FNP. This along with Everything else is difficult. So, I will be extending my hours again to accomplish it by our deadlines. But it will work.

ICD-10 training that most of us were going to attend was cancelled due to the government shut down in November. It is my understanding it will be rescheduled in early spring. Sheila Super is studying hard at this time and will attempt her AAPC coders certification test on November 9th and we hope she does well. April Spence, AAPC certified coder at the Karuk Community Health Clinic, is beginning to bring herself up to speed and she and I are beginning to work on some method to assist the Providers with their documentation needs in preparation for ICD 10. It will need to be more precise and informative then ever before. If the Provider does not accurately complete very accurate information and terminology as is called for in ICD 10 we will not be able to code accurately or specifically. Dr. Vasquez will help us encourage the providers in this endeavor.

Attached is the financial reports, with a change you will notice. We receive small HPSA & HSIP incentive payments from Medicare Jul/Aug visits. It is primarily because we are in a Physician Shortage area. And the other items I added to the medical revenue section is the new monthly capitation paid by Partnership Healthplan of Calfornia (PHC). It is varying amounts paid per patient per month dependent upon our PHC patient enrollment. I will be including these 2 items from now on for your better understanding of what the health program earns.

Suzanna Hardenburger CCS-

	MONTHLY REVENUE REPORT		
	October-13	**Happy Camp**	**Yreka**
	Revenue Medical	$43,041.39	$60,492.50
	PHC Capitation	$3,578.22	$4,370.35
	HPSA Quarterly Incentive	$571.12	$1,463.73
	Revenue Dental	$37,860.56	$86,126.15
	Revenue Mental Health	$774.16	$619.96
	Revenue Total	**$85,825.45**	**$153,072.69**
		Happy Camp	**Yreka**
	Billing Oct Medical		
	Billing Oct Dental	**NOT**	**AVAILABLE**
	Billing Oct Mental Health		
	Billed Grand Total		

BUSINESS OFFICE		
Orleans	**KTHP**	
$4,916.26	$110,274.14	
$1,618.97	$9,567.54	
$193.01	$2,227.86	
0	$123,986.71	
$0.00	$1,394.12	
$6,728.24	**$247,450.37**	
Orleans	**KTHP**	
AT THIS	**TIME**	

OPERATIONS SUMMARY FOR KARUK TRB HP Service Unit
FOR SEP 2013
Prepared for November 7, 2012 Health Board Meeting

(Note: In parentheses following each statistic is the percent increase or decrease from the same time period in the previous year. '**' indicates no data is present for one of the two time periods.)

PATIENT REGISTRATION

There are 17,955 (+4.9) living patients registered at this SU. This number does not represent the 'Active User Population' which is found elsewhere in PCC Reports. There were 71 (-11.3) new patients, 1 (-80.0) births, and 3 (+0.0) death(s) during this period. Data is based on the Patient Registration File.

THIRD PARTY ELIGIBILITY

There were 2,699 (-0.2) patients enrolled in Medicare Part A and 2,580 (-0.1) patients enrolled in Part B at the end of this time period.

There were 93 (+14.8) patients enrolled in Medicare Part D.

There were also 6,048 (+1.4) patients enrolled in Medicaid and 4,763 (+10.6) patients with an active private insurance policy as of that date.

CONTRACT HEALTH SERVICES

Total CHS expenditures (obligations adjusted by payments) for this period were 74,707.09 (+102.6). The number and dollar amount of authorizations by type were:

57 - DENTAL	13	11504.25
64 - NON-HOSPITAL SERVICE	926	63202.84

DIRECT INPATIENT

[NO DIRECT INPATIENT DATA TO REPORT]

AMBULATORY CARE VISITS

There were a total of 1,851 ambulatory visits (+13.6) during the period for all visit types except CHS.

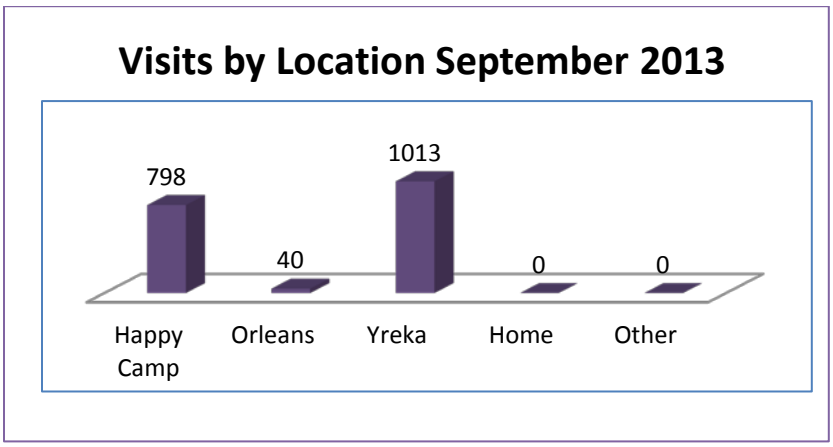
They are broken down below by Type, Location, Service Category, Clinic, Provider Discipline and leading Diagnoses. These do not equate to 'official' APC Visits which are identified in other PCC Reports.

By Type:

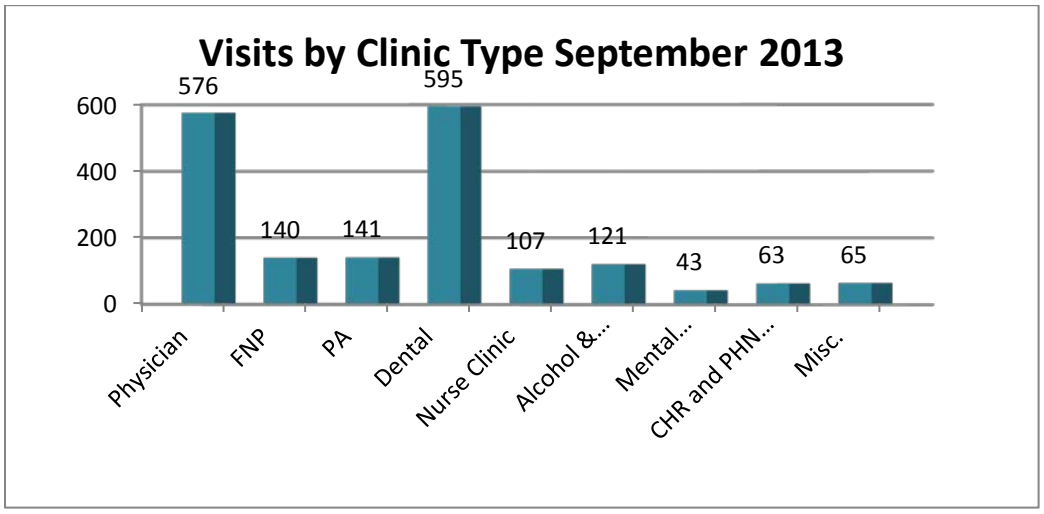
TRIBE-638 PROGRAM	1,851	(+13.6)

By Location:

YREKA	1,013	(+6.7)
KARUK COMM HEALTH CLINIC	798	(+35.7)
ORLEANS	40	(-57.0)

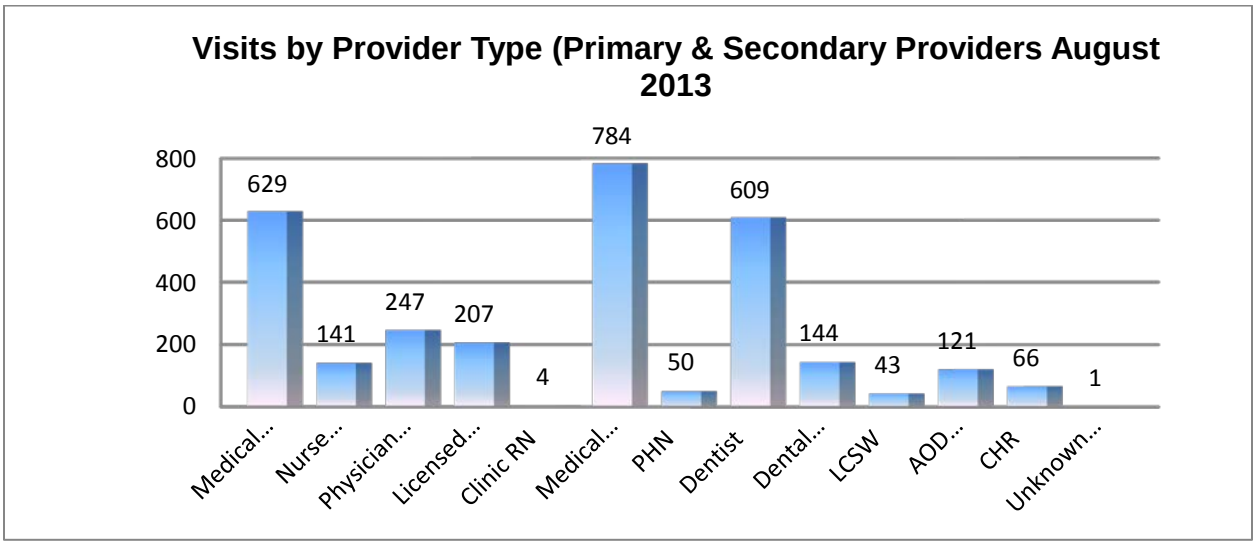


By Service Category:		
AMBULATORY	1,830	(+14.3)
TELECOMMUNICATIONS	20	(-31.0)
NOT FOUND	1	(**)
By Clinic Type:		
DENTAL	595	(+29.3)
PHYSICIAN	576	(+46.6)
PHYSICIAN ASSISTANT	141	(-0.7)
FAMILY NURSE PRACTITIONER	140	(-49.5)
ALCOHOL AND SUBSTANCE	121	(+28.7)
NURSE CLINIC	107	(+59.7)
TRANSPORT	53	(+65.6)
PHN CLINIC VISIT	49	(+104.2)
MENTAL HEALTH	43	(-40.3)
CHR	14	(-51.7)
TELEPHONE CALL	6	(-60.0)
CHART REV/REC MOD	3	(-62.5)
LABORATORY SERVICES	1	(**)
PHARMACY	1	(-91.7)
TELEMEDICINE	1	(**)



By Provider Type (Primary and Secondary Providers):

MD	629	(+49.1)
DENTIST	609	(+31.5)
HEALTH AIDE	594	(+14.9)
PHYSICIAN ASSISTANT	247	(+26.0)
LICENSED PRACTICAL NURSE	207	(-11.5)
MEDICAL ASSISTANT	190	(+81.0)
DENTAL HYGIENIST	144	(+188.0)
NURSE PRACTITIONER	141	(-51.7)
ALCOHOLISM/SUB ABUSE COUNSELOR	121	(+26.0)
COMMUNITY HEALTH REP	66	(+8.2)
PUBLIC HEALTH NURSE	50	(+66.7)
LICENSED CLINICAL SOCIAL WORK	43	(-44.2)
CLINIC RN	4	(+0.0)
UNKNOWN	1	(**)



The ten leading purposes of ambulatory visits by individual ICD Code are listed below. Both primary and secondary diagnoses are included in the counts.

By ICD Diagnosis		
1). DENTAL EXAMINATION	595	(+29.3)
2). VACCIN FOR INFLUENZA	337	(+51.8)
3). OBESITY NOS	99	(+421.1)
4). HYPERTENSION NOS	83	(-23.9)
5). ALCOHOL ABUSE-UNSPEC	81	(+22.7)
6). OTHER SPECFD COUNSELING	72	(+100.0)
7). LUMBAGO	67	(+4.7)
8). SCREENING FOR ALCOHOLISM	67	(**)
9). HYPERLIPIDEMIA NEC/NOS	59	(+37.2)
10). DIETARY SURVEIL/COUNSEL	58	(**)

CHART REVIEWS

There were 1,145 (+1.1) chart reviews performed during this time period.

INJURIES

There were 93 visits for injuries (+38.8) reported during this period. Of these, 21 were new injuries (+40.0). The five leading causes were:

1).	ACC-POWER HOUSE APPLIANC	2	(**)
2).	LOSS CONTROL MV-MOCYCL	1	(**)
3).	RIDDEN ANIMAL ACC-RIDER	1	(**)
4).	FALL ON STAIR/STEP NEC	1	(+0.0)
5).	FALL ON LEVEL NEC/NOS	1	(**)

EMERGENCY ROOM

[NO EMERGENCY ROOM VISITS TO REPORT]

DENTAL

There were 462 patients (+26.9) seen for Dental Care. They accounted for 595 visits (+29.3). The seven leading service categories were:

1).	PATIENT REVISIT	495	(+27.2)
2).	HYPERTENSION SCREENING	226	(+56.9)
3).	LOCAL ANESTHESIA IN CONJUNCTION WIT	172	(+38.7)
4).	PREVENTIVE PLAN AND INSTRUCTION	132	(+100.0)
5).	INTRAORAL - PERIAPICAL FIRST RADIOG	123	(+5.1)
6).	TOPICAL APPLICATION OF FLUORIDE VAR	108	(+80.0)
7).	FIRST VISIT OF FISCAL YEAR	104	(+33.3)

PHARMACY

There were 1,520 new prescriptions (+6.8) and 0 refills (**) during this period.

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KTHHSP Tribal Statistics for September 2013

	Registered Indian Patients	Indian Patients Receiving Services August 2013	APC Visits by Indian Patients August 2013
Karuk	2061	452	547
Descendants residing in CA	1864	239	319
All other Tribes	2128	116	132
Total	6053	807	998

CPCA Annual Conference
Training Report
October 2-4, 2013

Along with Rondi Johnson, I attended the 2013 CPCA Conference October 2-4, 2013. We attended a preconference event on October 2, 2013 and the Annual Conference on October 3-4, 2013.

October 2, 2013
Pre Conference
NCQA (National Committee for Quality Assurance) Advanced Topics In Patient Centered Medical Home (PCMH)-Mastering PCMH Recognition.

The patient centered medical home is a team base model of care in which patients are at the center of their health care. A chosen provider provides comprehensive and continuous medical care to the patients with a goal of obtaining maximized health outcomes. Regulations and payment systems are rewarding practices for transforming into medical homes. This all day event was about the National Committee for Quality Assurance method and certification process. The day's program covered the PCMH certification and how to achieve certification through NCQA. They reviewed the standards, identified acceptable documentation and how a practice can create and maintain a continuous quality improvement program. The information will help us achieve PCMH whether or not we use their model or go with another certification process.

October 3-4, 2013
CPCA 2013 Conference-"Leading the Way"

The conference this year was to highlight the work that Community Clinics and Health Centers in California are doing in health care reform implementation. There was a panel presentation on implementing the Affordable Care Act (ACA) in California and how Community Clinics throughout the State are leading the way.

During the next day and a half I attended sessions that were related to the ACA:

- ***iCARE: Using Data to Improve Quality-***The results of a study conducted on using medical assistants and community health workers as part of diabetes care interventions.
- ***Putting Experience to Work: Resources to Address Changing Business Models.-***How using retired or nearing retirement business professionals have impacted health organizations. *Encore Fellows* is a program to place corporate professionals in community health centers to boost financial management, strategic planning, IT systems, and operations. The panel spoke on the experiences and accomplishments they had while hosting a fellow. I found this is not available in our area at this time.
- ***Maximizing care coordination for increase new patient access:***-A health center in Merced, CA, had a quality improvement project aimed at getting new diabetic and hypertensive patients seen in a timely manner. They used a team approach for these new patients. The patients were usually seen by a provider within one day of meeting with a care coordinator. This improved the patient flow process as much of the patient information was in their system before the patient saw the provider for the first time. Health history done, medication lists completed and a risk assessment done by care coordinator.
- ***Payment reform-*** This covered innovative models of payment and reimbursement for community clinics in California. It did not apply to Tribal Organizations, so I left the session after 30 minutes. There were no other sessions at this time that applied to us.

There was much that did not apply to us as a Tribal organization, but there are requirements that we must meet for Health Care Reform and ACA. The conference gave insight into these things.

Respectfully submitted,

Patricia White
RPMS Site Manager

RPMS
Karuk Tribal Health and Human Services Program
Health Board Meeting
November 7, 2013
Patricia White, RPMS Site Manager

Action Items

I have no action items for this month.

User Assistance and Requests

There were a total of 43 new documented requests for HHS users in October: 20 were assigned to Amy and 23 assigned to me. 40 are closed. There are 7 items not completed that include 4 from previous months.

Workload reports

Attached is the September 2013 *Operations Summary* along with Tribal Statistics. During September we had 1,851 visits at all locations. This is down by only 22 visits over August. 998 of these visits were for Native American patients (54%). Graphs are also included with this report. Orleans is down by over 50% due to Fabian leaving.

Meeting / Conference Calls and other Activities – October 2013

- October 2-4 - CPCA Conference in Sacramento-Report attached
- October 9 – ACQI Committee Meeting
- October 10 - RPMS/EHR Office Hours Conference Call
- October 11 - Online Recorded RPMS training
    - Referred Care 20 minutes
    - Immunization Manager 2 hours
- October 14 – HL7 Interface Conference Call with Henry Schein and Cimarron Medical Informatics.
- October 15 – HL7 Interface Conference Call with Henry Schein
- October 17 – EHR Office Hours Conference Call
- October 22 – Monthly VistA Imaging Conference Call
- October 29 – ED Advisory Committee Meeting

RPMS – EHR – EDR

- Security Risk Analysis:

We are continuing to work on this document. We are scheduled to phone conference with Infogard on November 4th for the follow up on the site visit. This assessment needs to be completed this quarter in order to meet the requirement for stage one of meaningful use.

- VistA Imaging:

I have been invited to participate in the monthly conference calls for VistA Imaging. I logged into the October 22nd call. Sites in California that are using or preparing to use the program are able to bring problems, questions, and successes to the call.

- Bi-Directional Lab Interface:

On October 16, we discovered that labs were not coming into RPMS from Quest. After investigating we found that the labs were making it to *Ensemble,* (the platform for the health database/program), but were not flowing into RPMS. I worked with Gary Mosier from CAO/IHS and we were unable to get them to RPMS. Gary started a heat ticket with OIT.

It was discovered that a new tech at IHS, who was building labs for us, had ran an option that changed all of the setting in RPMS for the inbound messages. They were able to correct the settings. Karen Mundy from Cimarron Medical Informatics has been working this past week on retransmitting the labs that had not crossed over into RPMS.

This did not affect patient care, because we also receive paper copies of all labs, so providers were able to see them, just not in RPMS/EHR.

- RPMS Dentrix Interface:

The interface is installed and tested. On October 14 and 15 I had conference calls with Henry Schein and Cimarron Medical Informatics. We tested the program by loading patient registration from RPMS into the Dentrix Test database. We were able to identify those that created duplicate accounts. When a new patient is entered in dental they must match what is in RPMS. I corrected the ones that I could identify. I am scheduled for another conference call on October 31 to work on unresolved issues. We were hoping to go live with the interface on November 1, but due to a number of duplicate accounts that I could not fix, we may delay by 1 week. This has been a long anticipated fix to the program since we began using Dentrix in September 2012. The data entry clerks will not have to do double data entry to get the information into RPMS.

Budget: For period ending September 30, 2013 (End of Fiscal Year). We ended the year under budget.

Program	RPMS
Budget Code	3000-75
Program Year	2012-2013
Appropriation	$235,220.84
Expenses to Date	$205,003.85
Balance	$29.226.99
Percent used	87.57%

Respectfully Submitted,

Patricia C White, RPMS Site Manager