



Preventive Services

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Preventive Services

Overview: The purpose of the Preventive Services initiative is to coordinate patient care through Primary Care Physicians (PCPs) in a patient centered medical home (PCMH). Screening, active counseling, and outreach efforts will be used to inform and educate patients about preventive care.

These Blue Cross Blue Shield of Michigan criteria pertain to the preventive services initiative:

Criteria

Met 

- 9.1 Primary prevention program is in place that focuses on identifying and educating patient about personal health behaviors to reduce their risk of disease and injury
- 9.2 Systematic approach is in place to providing preventive services
- 9.3 Strategies are in place to promote ongoing well care visits and screenings for all populations
- 9.4 Practice has process in place to inquire about a patient's outside health encounters and has capability to incorporate information in patient tracking system or medical record
- 9.5 Practice has a systematic approach in place to ensure the provision / documentation of tobacco use assessment tools and advice regarding smoking cessation
- 9.6 Standing order protocols are in place allowing practice unit care team members to authorize and deliver preventive services according to physician-approved protocol without examination by a clinician
- 9.7 Secondary prevention program is in place to identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease, but in whom the disease itself has not become clinically apparent
- 9.8 Staff receives regular training and/or communications in health promotion and disease prevention and incorporates preventive-focused practices into ongoing administrative operations

9.0 Preventive Services

9.1

Primary prevention program is in place that focuses on identifying and educating patients about personal health behaviors to reduce their risk of disease and injury.

Guidelines:

- Primary prevention is defined as inhibiting the development of disease before it occurs. Secondary prevention, also called "screening," refers to measures that detect disease before it is symptomatic. Tertiary prevention efforts focus on people already affected by disease and attempt to reduce resultant disability and restore functionality.
- Patient questionnaire or other mechanism is used to elicit information about personal health behaviors that may be contributing to disease risk
 - o During well-visit exam and initial intake for new patients
 - o During other visits when behavior may be relevant to acute concern (e.g., tobacco use when patient presents with cough)
- Patient assessment addresses personal health behaviors and disease risk factors, based on age, gender, health issues
 - o Behaviors and risks assessed should include a majority of the following, as appropriate to the patient population: Alcohol and Drug Use, Breast Self-Examination, Awareness of Lead Exposure, Low Fat Diet and Exercise, Use of Sunscreen, Safe Sex, Testicular Self-Examination, and Tobacco Avoidance

9.2

A systematic approach is in place to providing preventive services

Guidelines:

- Preventive care guidelines are integrated into clinical practice (e.g., Michigan Quality Improvement Consortium - www.mqic.org/guid.htm). Examples of appropriate Guidelines include:
 - o Adult Preventive Services Guideline 18-49 Yrs
 - o Adult Preventive Services Guideline 50-65 Yrs
 - o Childhood Overweight Prevention Guideline
 - o Prevention of Unintended Pregnancy in Adults
 - o Preventive Service for Children & Adolescents Ages Birth – 24 Months
 - o Preventive Service for Children and Adolescents Ages 2-18 Yrs
 - o Tobacco Control Guideline
- Systematic appointment tracking system (implemented as part of Individual Care Management Initiative) is in place

9.3

Strategies are in place to promote and conduct outreach regarding ongoing well care visits and screenings for all populations, consistent with guidelines for such age and gender-appropriate services promulgated by credible national organizations

Guidelines:

- Systematic reminder system is in place and incorporates the following elements:
 - o Age appropriate health reminders (e.g., annual physicals).
 - o Age appropriate immunization information consistent with most current evidence-based guidelines
 - o If reminders are generated by PO, offices should have knowledge of the process/
- For children and adolescents from birth to 18 years of age examples of outreach strategies may include birthday reminders for well-visits, kindergarten round-up, flu vaccine reminders, health fairs, brochures, school physical fairs.
- For adults, examples of outreach strategies may include annual health maintenance examination reminders, and age and gender-appropriate reminders about recommended screenings (e.g., mammograms)
- Outreach should be systematic and consistent with evidence-based guidelines

9.4

Practice has process in place to inquire about a patient's outside health encounters and has capability to incorporate information in patient tracking system or medical record

Guidelines:

- "Outside health encounter information" includes services such as immunizations provided at health fairs
- Practice unit should include actual/estimated date of service in the medical record whenever possible
- Information may be included in historical section of record

9.5

Practice has a systematic approach in place to ensure the provision/documentation of tobacco use assessment tools and advice regarding smoking cessation

Guidelines:

- Examples may include yearly assessment sheet, tobacco use intervention programs

9.6

Written standing order protocols are in place allowing Practice Unit care team members to authorize and deliver preventive services according to physician-approved protocol without examination by a clinician

Guidelines:

- Examples include vaccinations, fecal occult blood tests and mammogram orders, medication intensification algorithm for patients with lipid disorder or high blood pressure

9.7

Secondary prevention program is in place to identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease, but in whom the disease itself has not become clinically apparent.

Guidelines:

- System with guideline-based reminders for age-appropriate risk assessment and screening tests is in place.
 - o Practice Unit may choose to implement tools such as checklists attached to the patient chart, tagged notes, computer generated encounter forms and prompting stickers.
- Mechanisms are established to identify asymptomatic at-risk patients and provide appropriate treatment
- Examples include metabolic syndrome, osteoporosis, coronary artery disease, depression, alcoholism, STDs, accelerated regimen for colon and breast cancer screening in high risk patients

9.8

Staff receives regular training and/or communications in health promotion and disease prevention and incorporates preventive-focused practices into ongoing administrative operations

Guidelines:

- Practice unit staff has received training or educational material has been posted or circulated regarding a full range of preventive services and health promotion issues
 - o New hires receive appropriate training
 - o Educational material is circulated or posted when guidelines change
 - For example, PO or practice unit staff person may be assigned to update clinical personnel on standards and guidelines such as AHRQ newsletter updates, the immunization schedule & standards issued by the Advisory Committee on Immunization Practices, Alliance of Immunization in Michigan, or Centers for Disease Control and Prevention.
 - For example, information may be provided to practice units educating them on appropriate billing and ICD-9 codes in order to ensure accurate reporting for preventive medicine services (including use of the correct ICD-9 code for a physical)
- Staff is trained (as appropriate to patient population) regarding consistently using and entering information into the Michigan Care Improvement Registry (MCIR)

<Practice Name>

Sample Test and Lab Tracking Policy and Procedure – Pending File Method

Issued by: <Practice Name>

Policy #: <Policy No.>

Prepared by: Clinical Staff

Revision: X/YYYY

Approved by: <Practice Name>

Effective Date: XX/XX/YYYY

Page 1 of 2

Purpose/Statement of Policy: Inform patients of test results including lab and x-ray. Ensure that:

- All test results are returned to the physician's office
 - The physician reviews the results, then dates and signs (or initials) them to verify that they have been reviewed
 - The patient is notified
 - Documentation is placed in the medical record to verify when and how the patient was notified, what was communicated, and any recommended follow-up
 - The results are filed in the patient's chart
 - Follow-up action(s) occurs (if recommended)
1. Patient phone number confirmed when appointment made. Patient address, phone and insurance checked upon sign-in. Patient photo ID is copied.
 2. Patient asked about flu shots or tests performed at other places like pharmacies, grocery stores or health fairs. Patients are asked to keep our office informed.

Test and Lab Tracking Policy and Procedure – Pending File Method procedure:

3. At the end of each day, the office administrative staff forwards all encounter forms to the designated clinical staff. The designated clinical staff reviews the encounter forms from the day and copies forms with lab tests ordered by the physician, and files the copy in a separate file entitled "PENDING." It is important that the office define what lab tests will be tracked. The designated clinical staff monitors the PENDING file weekly and takes the appropriate follow-up actions:
 - If results not received within one week of scheduled date, call lab for results and notify ordering physician.
 - If test not done or appointment not kept, call patient, determine reason for "no show" and make note on encounter form if test is rescheduled. May send email and voice messages to remind patients of tests which need to be done and record communication method on encounter form, date, and keep in PENDING file.
4. Test results are received into the Medical Records Department via fax or computer portal from provider. Medical Records Department forwards test results in clinical staff in-box. Clinical staff checks in-box daily for test results. Clinical staff reviews test results, removes encounter form from PENDING file, makes note of lab results in the patient's chart, attaches results to medical chart, and places in physician's in-box for review and initialing.

5. The physician reviews all test lab results in the “To BE REVIEWED” folder daily and initials, dates, and adds any comments or follow-up actions on the test result form. In addition, the physician also separates incoming abnormal and normal test results. It is important that the office establish a policy for how it will handle normal and abnormal test results. The method for handling normal and abnormal results may vary by office, for example:

A. Normal Results - After physician review, normal lab results are returned to the designated clinical staff who notifies the patient of results and inserts results in patient medical file. If the physician makes an additional order(s) on review, he/she records the order request on the lab report and returns to the designated clinical staff to carry out the orders.

Other methods of the designated clinical staff notifying patients of normal test results include:

- Copying the lab results and sending to the patient
- Develop and use a letter template (e.g., a cholesterol template, a bone-density template, etc.), and simply fill in the appropriate values and add comments.
- Mail the patient their normal lab results within a set time-frame (i.e. 3-5 days).

B. Abnormal Results - For *abnormal* or life-threatening results lab results, the physician contacts the patient immediately or within 24 hours of results being received. The physician records the date and time contact was made with the patient and any follow-up actions on the lab report. Document the conversation with the patient, and any resulting follow-up recommendations in the medical record. The physician forwards lab reports to clinical staff in-box for further processing and follow-up actions. Follow-up actions are documented in the medical record, including verification that the follow-up has occurred. If the patient cannot be reached by phone, the designated clinical staff sends a certified letter to the patient asking him/her to call the office as soon as possible to discuss the results with the physician.

6. It is the responsibility of the designated clinical staff to ensure that all patients are notified of their test results. Patients are also told to call the practice if they have not received their test results within a set-time frame (i.e., 5-10 days). Document all telephone calls in the patient’s medical record.



<Practice Name>

Sample Test and Lab Tracking Policy and Procedure – Logbook Method

Issued by: <Practice Name>

Policy #: <Policy No.>

Prepared by: Clinical Staff

Revision: X/YYYY

Approved by: <Practice Name>

Effective Date: XX/XX/YYYY

Page 1 of 3

Purpose/Statement of Policy: Inform patients of test and lab results. Ensure that:

- All test results are returned to the physician's office
 - The physician reviews the results, then date and sign (or initial) them to verify that they have been reviewed
 - The patient is notified
 - Documentation is placed in the medical record to verify when and how the patient was notified, what was communicated, and any recommended follow-up
 - The results are filed in the patient's chart
 - Follow-up action(s) occurs (if recommended)
1. Patient phone number confirmed when appointment made. Patient address, phone and insurance checked upon sign-in. Patient photo ID is copied.
 2. Patient asked about flu shots or tests performed at other places like pharmacies, grocery stores or health fairs. Patients are asked to keep our office informed.

Test and Lab Tracking Policy and Procedure – Logbook Method procedure:

3. Develop and Implement Tracking System

The clinical staff creates and maintains a logbook (paper or electronic) by physician to track diagnostic tests and consults. At the end of each day, the administrative staff forwards a copy of all encounter forms to the designated clinical staff that reviews and sorts the forms in two groups (one group with lab orders, second group without lab orders). The designated clinical staff takes the encounter forms with lab orders and records the information listed in 4 below in the logbook (paper or electronic) for each test ordered.

NOTE: Each office must define the type(s) of lab tests that should be recorded in the logbook.

4. Data Elements Collected

When ordering a test on a patient, the clinical staff tracks specific information throughout the process – from the time the test is ordered to the point the patient is notified.

Specific data to be tracked may include:

- Entry date
- Patient name or identifier

- Medical record number (if applicable)
- Initials of person entering information
- Test ordered
- Ordering physician
- Date test scheduled
- Lab or facility that conducted the test
- Date results received
- Date results reviewed by
- Patient notification date

5. Monitoring

The clinical staff reviews the logbook (paper or electronic) daily and monthly for completeness and takes appropriate action:

- If results not received within one week of scheduled date, call lab for results and notify ordering physician.
- If test not done or appointment not kept, call patient, determine reason for “no show” and make new entry in logbook if test is rescheduled. May send email and voice messages to remind patients of tests which need to be done-record communication method in logbook and date sent.

6. Test Results Received

Test results are received into the Medical Records Department via fax or computer portal from provider. Medical Records Department forwards test results in clinical staff in-box. Clinical staff checks in-box daily for test results. Clinical staff reviews test results, checks results off in the logbook, attaches results to medical chart, and places in physician’s in-box for review and initialing.

7. Physician Review of Lab Results

Physician checks in-box daily and reviews all lab test reports, adds comments, initials, and date of review. Physician also separates incoming abnormal test results from normal test results. It is important that the office establish a separate policy for how it will handle normal and abnormal lab results. The method for handling normal and abnormal results may vary by office, for example:

- A. **Normal Results** - After physician review, normal lab results are returned back to the designated clinical staff who notifies the patient of results, updates the logbook, and inserts in patient medical file. If the physician makes an additional order(s) on review, he/she records the order request on the lab report and returns to the designated clinical staff to carry out the orders. The designated clinical staff records additional order(s) in the logbook. Any physician reminders are entered into the patient registry or office system by the designated clinical staff.

Other methods the designated clinical staff may use include:

- Copying the lab results and sending to the patient
- Develop a letter template (e.g., a cholesterol template, a bone-density template, etc.), and simply fill in the appropriate values and add comments
- Mail the patient their normal lab results within a set time-frame (i.e. 3-5 days)

B. **Abnormal Lab Results** - For abnormal or life-threatening results, the physician contacts the patient immediately or within 24 hours of results being received. The physician records the date and time contact was made with the patient and any follow-up actions on the lab report. Document the conversation with the patient, and any resulting follow-up recommendations in the medical record. The physician forwards lab reports to designated clinical staff in-box for further processing and follow-up actions. Follow-up actions are documented in the medical record, including verification that the follow-up has occurred. If the patient cannot be reached by phone, the designated clinical staff sends a certified letter to the patient asking him/her to call the office as soon as possible to discuss the results with the physician.

8. Patient Notification of Lab Results

It is the responsibility of the clinical staff to ensure that all patients are notified of their test results. Patients are also told to call the practice if they have not received their test results within a set-time frame (i.e., 5-10 days). All telephone calls are documented in the patient's medical record.

Once the physician has reviewed the normal lab results, the designated clinical staff will notify the patient of their lab results. The clinical staff will make a copy of the lab results and place in patient's medical record.

9. Document Lab Results and Notification

The designated clinical staff documents lab results and notification of patient in the logbook.



Remember Home - Your Medical Home that is!

Did you get a flu shot at the pharmacy or grocery store?

Have you had tests or services performed at a health fair?

Have you received other health care services (pelvic exam, Pap test, retinal eye exam, diabetic foot exam)?

Tell the staff or doctor so we can keep your records up to date.

Name: _____

I had: _____ Date: _____



Remember Home - Your Medical Home that is!

Did you get a flu shot at the pharmacy or grocery store?

Have you had tests or services performed at a health fair?

Have you received other health care services (pelvic exam, Pap test, retinal eye exam, diabetic foot exam)?

Tell the staff or doctor so we can keep your records up to date.

Name: _____

I had: _____ Date: _____

Drug and alcohol screening questions

Do you drink alcohol?

Have you ever experimented with drugs?

If yes to drugs, give this instruction before asking the CAGE-AID questions:

“When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed”

Screen for alcohol and drug usage - CAGE-AID

C: Have you ever felt you ought to cut-down on your drinking *or drug use*?

A: Do you get annoyed when people talk about your drinking *or drug use*?

G: Do you feel bad or guilty about your drinking *or drug use*?

E: Have you ever had had a drink *or used drugs* first thing in the morning to steady your nerves or to get rid of a hangover?

*Two or more “yes” responses to CAGE-AID indicate a need for further screening and counseling.

Alcohol use disorder identification test (AUDIT)

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have six or more drinks on one occasion?
4. How often during the last year have you found that you were not able to stop drinking once you had started?
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been injured as a result of your drinking?
10. Has a relative, or friend, or doctor or other health worker been concerned about your drinking or suggested you cut down?

*The AUDIT is scored based on an answer range. Questions 1-8 are scored as follows: Never = 0; Less than monthly = 1; Monthly = 2; Weekly = 3; and, Daily or almost daily = 4. Questions 9-10 are scored based on yes/no responses: No = 0; Yes, but not in the past year = 2; and, Yes, during the past year = 4. A score of 8 or more is associated with risky drinking. Higher scores (13 or more for women and 15 or more for men) indicate the likelihood of alcohol dependence.

NIAAA screening questions for heavy drinking

1. Do you sometimes drink alcoholic beverages?
2. How many times in the past year have you had 5 or more drinks (if male) or 4 or more drinks (if female)?

*The NIAAA uses an algorithm to assess patient drinking consumption and patterns in primary healthcare settings. A “yes” response to both questions indicates the need to specifically assess alcohol consumption. To determine a weekly consumption level the average number of days per week of drinking is multiplied by the typical number of drinks consumed. Additional questions are used to assess for alcohol use disorders.

MAST-G: Alcohol screening for older adults

1. When talking with others, do you ever underestimate how much you actually drink?
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
3. Does having a few drinks help decrease your shakiness or tremors?
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?
5. Do you usually take a drink to relax or calm your nerves?
6. Do you drink to take your mind off your problems?
7. Have you ever increased your drinking after experiencing a loss in your life?
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?
9. Have you ever made rules to manage your drinking?
10. When you feel lonely, does having a drink help?

Scoring: If the person answered “yes” to two or more questions, encourage a talk with the doctor.

Geriatric Depression Scale – Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES/**NO**
2. Have you dropped many of your activities and interests? **YES**/NO
3. Do you feel that your life is empty? **YES**/NO
4. Do you often get bored? **YES**/NO
5. Are you in good spirits most of the time? YES/**NO**
6. Are you afraid that something bad is going to happen to you? **YES**/NO
7. Do you feel happy most of the time? YES/**NO**
8. Do you often feel helpless? **YES**/NO
9. Do you prefer to stay at home, rather than going out and doing new things?
YES/NO
10. Do you feel you have more problems with memory than most? **YES**/NO
11. Do you think it is wonderful to be alive now? YES/**NO**
12. Do you feel pretty worthless the way you are now? **YES**/NO
13. Do you feel full of energy? YES/**NO**
14. Do you feel that your situation is hopeless? **YES**/NO
15. Do you think that most people are better off than you are? **YES**/NO

Answers in bold indicate depression, and each answer counts as one point. For clinical purposes, a score greater than 5 suggests depression and warrants a follow-up interview. Scores greater than 10 are almost always depression.

Source: Sheikh, J.I., and Yesavage, J.A. Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical Gerontologist* 5(1&2):165-173, 1986.

Name: _____

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

	During the past week			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I did not feel like eating; my appetite was poor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt that I could not shake off the blues even with help from my family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I felt I was just as good as other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I had trouble keeping my mind on what I was doing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I felt depressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I felt that everything I did was an effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I felt hopeful about the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I thought my life had been a failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt fearful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. My sleep was restless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I was happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I talked less than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I felt lonely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. People were unfriendly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I enjoyed life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I had crying spells.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I felt sad.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I felt that people dislike me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I could not "get going".	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Physician Use:

Scoring: Item Weights	(less than 1 day)	(1-2 days)	(3-4 days)	(5-7 days)
Items 4, 8, 12 and 16:	3	2	1	0
All other items:	0	1	2	3

Score is the sum of the 20 item weights. Possible range is 0 to 60. If more than four questions are missing answers, do not score the CES-D. A score of 16 or more is considered depressed.

Center for Epidemiologic Studies Depression Scale (CES-D), (Radloff, 1977)

Child Preventive Care Flow Sheet

PATIENT NAME _____
 DOB ____/____/____

**Put Prevention
 Into Practice**

DATE																				
HEALTH GUIDELINES		NB	2M	4M	6M	9M	12M	15M	18M	2Y	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y
Abuse																				
Drugs/alcohol																				
Fluoride																				
HIV/AIDS																				
Injuries & poisons																				
Nutrition																				
Oral/dental health																				
Physical activity																				
Tobacco																				
UV exposure																				
Violence & guns																				
✓ = Discussed w/ patient																				

EXAMINATION & TESTS		NB	2M	4M	6M	9M	12M	15M	18M	2Y	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y
Height, weight, % on GC	Each visit																			
Head circ., % on GC	0, 2, 4, 6, 9, 12, 15, 18m, 2, 3y																			
Hearing/vision	0-3m, 6-12m, 3-5y																			
Hemoglobin or Hct	6-12m, 5y																			
Lead screen	12m, 5y, & high risk																			
Well visit with BP	3-6y (annual), 6-12y (q2y)																			
Urinalysis for bacteria	Once before 5y																			
Cholesterol/lipid profile	High risk																			
Tb skin test	12m, 5y, annual for high risk																			
T4/TSH, phenylalanine	3-6 days																			
Sickle cell screen	6m for high risk																			

IMMUNIZATIONS		NB	2M	4M	6M	9M	12M	15M	18M	2Y	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y
Polio	2, 4, 6-18m, 4-6y																			
DtaP	2, 4, 6, 15-18m, 4-6y																			
MMR	12-15m, 4-6y																			
Comvax	2, 4, 12m																			
Hib	2, 4, 6m, 12-15m																			
Hepatitis B	2, 4-6, 9-18m																			
Varicella	12-18m																			
Influenza	Annual for high risk																			
Pneumovax	High risk																			
dT	11-12y																			

O = Ordered, N = Normal, A = Abnormal Result, R = Refused, E = Done Elsewhere

Adult Female Age 13 to 30 Preventive Care Flow Sheet

PATIENT NAME _____
 DOB ____/____/____

**Put Prevention
 Into Practice**

DATE		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
HEALTH GUIDELINES																			
Abuse																			
Breast self-exam																			
Dental health																			
Drugs/alcohol																			
Folate																			
HIV/AIDS																			
Injuries																			
Mental health/depression																			
Nutrition																			
Occupational health																			
Physical activity																			
Sexual behavior																			
Tobacco																			
UV exposure																			
Violence & guns																			
✓ = Discussed w/ patient																			

EXAMINATION & TESTS		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Height, weight	Each visit																		
Blood pressure	Each visit, at least q2y																		
Skin, oral, thyroid exam	<40 q3y																		
Pelvic/PAP	Annual if sexually active																		
STD screening	Sexually active																		
Breast exam	Annual																		
Hemoglobin/hematocrit	Once before 20y																		
Cholesterol/lipid profile	q5y after 20y																		
Glucose, fasting	q5y after 20y																		
Tb skin test	High risk: annual																		

IMMUNIZATIONS		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
MMR	If not given before																		
dT	11-12y and q10y																		
Influenza	Annual for high risk																		
Pneumovax	High risk																		
Hepatitis B	High risk																		
Varicella	If not given																		

O = Ordered, N = Normal, A = Abnormal Result, R = Refused, E = Done Elsewhere

Adult Female Age 31 to 49 Preventive Care Flow Sheet

PATIENT NAME _____
 DOB ____/____/____

**Put Prevention
 Into Practice**

DATE		31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
HEALTH GUIDELINES																				
Abuse																				
Breast self-exam																				
Dental health																				
Drugs/alcohol																				
Estrogen																				
Folate																				
HIV/AIDS																				
Injuries																				
Mental health/depression																				
Nutrition																				
Occupational health																				
Physical activity																				
Sexual behavior																				
Tobacco																				
UV exposure																				
Violence & guns																				
✓ = Discussed w/ patient																				

EXAMINATION & TESTS		31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Height, weight	Each visit																			
Blood pressure	Each visit, at least q2y																			
Skin, oral, thyroid exam	<40y: q3y, >40y: annual																			
Pelvic/PAP	Annual																			
STD screening	Sexually active																			
Rectal exam	Low risk: annual >40y																			
Hemoccult of stool	Annual >50y																			
Breast exam	Annual																			
Mammogram	35-39y, >40 q2y																			
Flexible sigmoidoscopy	Low risk: >50y q5y																			
Cholesterol/lipid profile	q5y																			
Glucose, fasting	q5y																			
Urinalysis	q5y																			
Tb skin test	High risk: annual																			

IMMUNIZATIONS		31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
dT	q10y																			
Influenza	Annual for high risk or >65																			
Pneumovax	>65 or high risk																			
Hepatitis B	High risk																			

O = Ordered, N = Normal, A = Abnormal Result, R = Refused, E = Done Elsewhere

Adult Female Age 50 to 68 Preventive Care Flow Sheet

PATIENT NAME _____
 DOB ____/____/____

**Put Prevention
 Into Practice**

DATE		50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68
HEALTH GUIDELINES																				
Abuse																				
Advance directives																				
Breast self-exam																				
Calcium																				
Dental health																				
Drugs/alcohol																				
Estrogen																				
HIV/AIDS																				
Injuries																				
Mental health/depression																				
Nutrition																				
Occupational health																				
Physical activity																				
Sexual behavior																				
Tobacco																				
UV exposure																				
Violence & guns																				
✓ = Discussed w/ patient																				

EXAMINATION & TESTS		50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68
Height, weight	Each visit																			
Blood pressure	Each visit, at least q2y																			
Skin, oral, thyroid exam	<40y: q3y, >40y: annual																			
Pelvic/PAP	Annual if sexually active																			
STD screening	Sexually active																			
Rectal exam	Low risk: annual >40y																			
Hemoccult of stool	Annual >50y																			
Breast exam	Annual																			
Mammogram	Annual																			
Flexible sigmoidoscopy	Low risk: >50y q5y																			
Vision, glaucoma screen	<65: q4y; >65: q2y																			
Cholesterol/lipid profile	q5y																			
Glucose, fasting	q5y																			
Urinalysis	q5y																			
Tb skin test	High risk: annual																			

IMMUNIZATIONS		50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68
dT	q10y																			
Influenza	Annual for high risk or >65y																			
Pneumovax	>65y or high risk																			
Hepatitis B	High risk																			

O = Ordered, N = Normal, A = Abnormal Result, R = Refused, E = Done Elsewhere

Adult Male Age 13 to 30 Preventive Care Flow Sheet

PATIENT NAME _____
 DOB ____/____/____

**Put Prevention
 Into Practice**

DATE		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
HEALTH GUIDELINES																			
Abuse																			
Dental health																			
Drugs/alcohol																			
HIV/AIDS																			
Injuries																			
Mental health/depression																			
Nutrition																			
Occupational health																			
Physical activity																			
Sexual behavior																			
Testicular self-exam																			
Tobacco																			
UV exposure																			
Violence & guns																			
✓ = Discussed w/ patient																			

EXAMINATION & TESTS		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Height, weight	Each visit																		
Blood pressure	Each visit, at least q2y																		
Testicular exam	q3y																		
STD screening	Sexually active																		
Hemoglobin/hematocrit	Once before 20y																		
Cholesterol/lipid Profile	q5y after 20y																		
Glucose, fasting	q5y after 20y																		
Tb skin test	High risk: annual																		

IMMUNIZATIONS		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
MMR	If not given before																		
dT	11-12y and q10y																		
Influenza	Annual for high risk																		
Pneumovax	High risk																		
Hepatitis B	High risk																		
Varicella	If not given																		

O = Ordered, N = Normal, A = Abnormal Result, R = Refused, E = Done Elsewhere

Adult Male Age 31 to 49 Preventive Care Flow Sheet

PATIENT NAME _____
 DOB ____/____/____

**Put Prevention
 Into Practice**

DATE		31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
HEALTH GUIDELINES																				
Abuse																				
Aspirin																				
Dental health																				
Drugs/alcohol																				
HIV/AIDS																				
Injuries																				
Mental health/depression																				
Nutrition																				
Occupational health																				
Physical activity																				
Sexual behavior																				
Testicular self-exam																				
Tobacco																				
UV exposure																				
Violence & guns																				
✓ = Discussed w/ patient																				

EXAMINATION & TESTS		31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Height, weight	Each visit																			
Blood pressure	Each visit, at least q2y																			
Skin, oral, thyroid exam	<40y: q3y, >40y: annual																			
Rectal/prostate exam	Low risk: annual >40y																			
Hemoccult of stool	Low risk: annual >50																			
Testicular exam	q3y																			
STD screening	Sexually active																			
Flexible sigmoidoscopy	Low risk: >50y q5y																			
Vision, glaucoma screen	<65y: q4y, >65y: q2y																			
Cholesterol/lipid profile	q5y																			
Glucose, fasting	q5y																			
Tb Skin Test	High risk: annual																			
PSA	FH-: qy >50, FH+: qy >40																			

IMMUNIZATIONS		31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
dT	q10y																			
Influenza	Annual for high risk or >65																			
Pneumovax	>65 or high risk																			
Hepatitis B	High risk																			

O = Ordered, N = Normal, A = Abnormal Result, R = Refused, E = Done Elsewhere

Adult Male Age 50 to 68 Preventive Care Flow Sheet

PATIENT NAME _____
 DOB ____/____/____

**Put Prevention
 Into Practice**

DATE		50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68
HEALTH GUIDELINES																				
Abuse																				
Advance directives																				
Aspirin																				
Dental health																				
Drugs/alcohol																				
HIV/AIDS																				
Injuries																				
Mental health/depression																				
Nutrition																				
Occupational health																				
Physical activity																				
Sexual behavior																				
Testicular self-exam																				
Tobacco																				
UV exposure																				
Violence & guns																				
✓ = Discussed w/ patient																				

EXAMINATION & TESTS		50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68
Height, weight	Each visit																			
Blood pressure	Each visit, at least q2y																			
Skin, oral, thyroid exam	<40y: q3y, >40y: annual																			
Rectal/prostate exam	Low risk: annual >40y																			
Hemoccult of stool	Low risk: annual >50																			
Testicular exam	q3y																			
STD screening	Sexually active																			
Flexible sigmoidoscopy	Low risk: >50y q5y																			
Vision, glaucoma screen	<65y: q4y, >65y: q2y																			
Cholesterol/lipid profile	q5y																			
Glucose, fasting	q5y																			
Tb skin test	High risk: annual																			
PSA	FH-: qy >50, FH+: qy >40																			

IMMUNIZATIONS		50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68
dT	q10y																			
Influenza	Annual for high risk or >65y																			
Pneumovax	>65 or high risk																			
Hepatitis B	High risk																			

O = Ordered, N = Normal, A = Abnormal Result, R = Refused, E = Done Elsewhere

Adult Male Over 65 Preventive Care Flow Sheet

PATIENT NAME _____
 DOB ____/____/____

**Put Prevention
 Into Practice**

DATE																				
HEALTH GUIDELINES	AGE																			
Abuse																				
Advance directives																				
Aspirin																				
Dental health																				
Drugs/alcohol																				
HIV/AIDS																				
Injuries																				
Mental health/depression																				
Nutrition																				
Occupational health																				
Physical activity																				
Sexual behavior																				
Testicular self-exam																				
Tobacco																				
UV exposure																				
Violence & guns																				
✓ = Discussed w/ patient																				

EXAMINATION & TESTS																				
Height, weight	Each visit																			
Blood pressure	Each visit, at least q2y																			
Skin, oral, thyroid exam	<40y: q3y, >40y: annual																			
Rectal/prostate exam	Low risk: annual >40y																			
Hemoccult of stool	Low risk: annual >50																			
Testicular exam	q3y																			
STD screening	Sexually active																			
Flexible sigmoidoscopy	Low risk: >50y q5y																			
Vision, glaucoma screen	<65y: q4y, >65y: q2y																			
Cholesterol/lipid profile	q5y																			
Glucose, fasting	q5y																			
Tb skin test	High risk: annual																			
PSA	FH-: qy >50: FH+: qy >40																			

IMMUNIZATIONS																				
dT	q10y																			
Influenza	Annual for >65y																			
Pneumovax	>65y																			
Hepatitis B	High risk																			

O = Ordered, N = Normal, A = Abnormal Result, R = Refused, E = Done Elsewhere

Moser SE, Goering TL. Implementing preventive care flow sheets. *Fam Pract Manage*. February 2001;51-53. Flow sheet developed by Wesley Medical Center, Wichita, Kan.; adapted from Put Prevention Into Practice, Office of Disease Prevention and Health Promotion, Public Health Service.

*Routine Preventive Services for Infants and Children
(Birth - 24 Months)*

The following guideline provides recommendations for routine preventive services for children birth to 24 months.

Recommendation	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months
Health, developmental and risk assessments	X	X	X	X	X	X	X	X	X
Parental education and counseling: <ul style="list-style-type: none"> ◆ Immunizations, nutrition, breast-feeding [A], physical activity, dental health, child abuse, depression, alcohol/drug abuse, anxiety, stress reduction, coping skills ◆ Motor vehicle safety - Rear facing car seat when riding in a motor vehicle until 1 year and 20 pounds [B]. ◆ Poison prevention - Keep National Poison Control numbers readily accessible; use child resistant containers ◆ Burn prevention - Install smoke detectors and test bi-annually; carbon monoxide detectors; water heater temperature and fire prevention ◆ Injury prevention - Use of gates; never leave infant unattended on changing table; water safety; CPR training ◆ SIDS and infant sleep positioning - Place infants on their back [B] 	X	X	X	X	X	X	X	X	X
Tobacco Use Screening: Establish tobacco use and secondhand exposure	X	X	X	X	X	X	X	X	X
Neonatal Screening: Newborn metabolic screening prior to hospital discharge > 24 hours of age [D]	X, > 24 hours of age								
Blood Lead Testing [B]						X			
Immunizations:									
<ul style="list-style-type: none"> ◆ Consult the Advisory Committee on Immunization Practices (ACIP) website (www.cdc.gov/nip/acip/) for most updated immunization schedules for routine and high risk populations. ◆ Use combination vaccines to minimize the number of injections ◆ Update the Michigan Care Improvement Registry (MCIR) 									
DTaP [A]			X	X	X		X		
IPV			X	X		X			
MMR (MMRV) [A]						X			
Varicella [A]						X			
Pneumococcal (PCV7)			X	X	X	X			
Hib [A]			X	X	X	X			
Rotavirus			X	X	X				
Hep B [A] - Schedule 1	X	X				X			
Hep B [A] - Schedule 2		X	X			X			
Hep A						X		X	
Influenza [B]						X, 6 - 59 months annually			

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources, including: Preventive Services for Children and Adolescents, Institute for Clinical Systems Improvement, 2006 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline

Routine Preventive Services for Children and Adolescents

(Ages 2 - 18)

The following guideline provides recommendations for routine preventive services for children and adolescents ages 2 - 18 years.

Recommendation	2-6 years	7-12 years	13-18 years
Health, developmental and risk assessments	X	X	X
Parent/Child education and counseling: <ul style="list-style-type: none"> ◆ Nutrition, physical activity, dental health, violence and abuse, sexually transmitted infection (STI) prevention, depression, suicide threats, alcohol/drug abuse, anxiety, stress reduction, coping skills, immunizations ◆ Bicycle safety - helmet use when riding bicycle [B] ◆ Motor vehicle safety - Car seat/booster seat/seat belt use [B] ◆ Poison prevention - Keep National Poison Control numbers readily accessible; use child resistant containers; dispose expired/unused medications ◆ Burn prevention - Install smoke detectors and test bi-annually; carbon monoxide detectors; water heater temperature and fire prevention ◆ Injury prevention - Firearm safety; water safety; CPR training 	X	X	X
Tobacco Use Screening: Establish tobacco use and secondhand exposure	X	X	X
Screening for overweight	Record height, weight and BMI annually		
Cholesterol Screening [A]	Over age 2 if increased risk for genetic forms of hypercholesterolemia		
Chlamydia Screening - sexually transmitted infection (STI) [B]			All sexually active women 25 years and younger
Cervical Cancer Screening (Pap Smear) [B]			Beginning at age 21 or within three years after first sexual intercourse, whichever is earlier; every 3 years after 3 consecutive normal Pap smears over 5 years.
Preconception and Pregnancy Prevention Counseling		Preventive counseling beginning at age 12, or earlier if sexually active	
Vision Screening [A]	Children 4 years old and younger. By age 5, should be performed as part of preschool screening.		
Immunizations: <ul style="list-style-type: none"> ◆ Consult the Advisory Committee on Immunization Practices (ACIP) website (www.cdc.gov/nip/acip/) for most updated immunization schedules for routine and high risk populations. ◆ Use combination vaccines to minimize the number of injections ◆ Update the Michigan Care Improvement Registry (MCIR) 	4-6 years	11-12 years	15-18 years
DTaP [A]	X	Tdap	
IPV	X		
MMR (MMRV) [A]	X		
Varicella [A]	X		
Meningococcal		X	
Influenza [B]	X 6 - 59 months annually		
Human Papilloma Virus (females 9 - 26 years)		X 3-dose series	X 3-dose series

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources, including: Preventive Services for Children and Adolescents, Institute for Clinical Systems Improvement, 2006 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Prevention and Identification of Childhood Overweight

The following guideline recommends specific interventions for prevention and identification of childhood overweight and obesity.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Parents of children younger than 2 years old	Education of parents regarding obesity and prevention of risk	<p>Prevention to promote healthy weight:</p> <ul style="list-style-type: none"> ◆ Encourage breastfeeding; discourage overfeeding of bottle fed infants [A]. ◆ Avoid premature introduction of solids and base timing for introduction of solids on child's development, usually between 4 months and 6 months of age. ◆ Preserve natural satiety by respecting a child's appetite. ◆ Educate caregivers on the importance of age-specific meals and snacks, consistent mealtimes, appropriate snacking, serving sizes, reading nutritional labeling and daily physical activity. ◆ Educate parents about the importance of parental role modeling for healthy lifestyle behaviors and of parental controls [D]. ◆ Avoid high-calorie, nutrient-poor beverages (e.g., soda, fruit punch or any juice drink less than 100% juice). ◆ Limit intake of 100% juice to < 6 oz per day; may offer in a cup, starting at 6 months of age. ◆ Evaluate general comorbidities, including but not limited to cardiovascular disease of parents. ◆ No television or computer screen time [D]. 	At each periodic health exam
Children 2 years or older	Assessment of body mass index, risk factors for overweight and excessive weight gain relative to linear growth	<p>General assessment:</p> <ul style="list-style-type: none"> ◆ History (including focused family history) and physical exam ◆ Measure and record weight and height on CDC BMI-for-age growth chart, calculate and plot patients' BMI [weight (kg)/height squared (m²) or (pounds x 703)/inches²]¹ ◆ Dietary patterns (e.g. frequency of eating outside the home, consumption of breakfast, adequate fruits and vegetables, excessive portion sizes, etc.) ◆ Risk factors for overweight² including pattern of weight change [C]. Watch for increases of 3-4 BMI units/year 	
Children 2 years or older, BMI for age < 85th percentile	Prevention to promote healthy weight	<p>Age specific prevention messages:</p> <p>Preschool:</p> <ul style="list-style-type: none"> ◆ Limit television and computer screen time to 1-2 hours per day; remove television and computer screens from primary sleeping area. ◆ Replace whole milk with skim, avoid high-calorie, nutrient-poor beverages (soda, fruit punch, juice drinks); limit intake of 100% juice. ◆ Eat breakfast daily; limit eating out and portion sizes, particularly fast foods. ◆ Promote a healthy diet (include fruit and vegetables and low-fat dairy) that encourages family mealtimes, regular eating times and minimizes nutritionally poor food prepared outside the home. ◆ Respect the child's appetite and allow him or her to self-regulate food intake. ◆ Provide structure and boundaries around healthy eating with adult supervision. ◆ Promote physical activity including unstructured play at home, during child care and in the community. <p>School-aged, the above plus:</p> <ul style="list-style-type: none"> ◆ Accumulate at least 60 minutes, and up to several hours, of age-appropriate physical activity on all or most days of the week (emphasize lifestyle exercise, i.e., outdoor play, yard work, and household chores). ◆ Consider barriers (e.g., social support, unsafe neighborhoods or lack of school-based physical education) and explore individualized solutions. ◆ Reinforce making healthy food and physical activity choices at home and outside of parental influence. 	

¹ See <http://apps.nccd.cdc.gov/dnpabmi/calculator.aspx>

² Low or high birth weight, low income, minority, television or computer screen time > 2 hrs, low physical activity, poor eating, depression

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources, including the American Medical Association 2007 Expert Committee Recommendations on the Treatment of Pediatric Obesity (www.ama-assn.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

The following guideline recommends clinical preventive services for adults.

Recommendation	18 - 39 Years	40 - 49 Years
Health Assessment Screening, History & Counseling	One health maintenance exam (HME) every 1 - 5 years [D] according to risk status. Each HME should include: <ul style="list-style-type: none"> ♦ Height, weight and Body Mass Index (BMI) ♦ Risk evaluation and counseling (Nutrition, obesity, physical activity, dental health, tobacco use [A], immunizations, HIV prevention [B], sexually transmitted infections prevention [B] and sexual health, sexual abuse, preconception counseling for all women of reproductive age [B], polypharmacy including over-the-counter and herbal preparations when appropriate, sun exposure) ♦ Safety (Domestic violence, seat belts [B], helmets, firearms, smoke and carbon monoxide detectors) ♦ Behavioral Assessment (Depression, suicide threats, alcohol/drug use, anxiety, stress reduction, coping skills) 	
Blood Pressure Monitoring [A]	At every office visit and at minimum every 2 years. If BP 120 -139/80-89 or higher and/or presence of risk factors, more frequent monitoring is recommended.	
Cholesterol and Lipid Screening [B]	Measure a complete fasting lipoprotein profile, (i.e. total cholesterol, LDL-C, HDL-C) in men 35 years and older and women 45 years and older without other risk factors. Screen younger adults for lipid disorders if other risk factors for coronary heart disease (CHD) (i.e. diabetes, family history cardiovascular disease before age 50 in male relatives or age 60 in female relatives), multiple CHD risk factor [e.g. tobacco use, hypertension). Once screening begins, repeat every 5 years for low risk adults if initial test normal; consider more frequent screening in individuals at increased risk.	
Diabetes Mellitus Screening [D]	Screening may be indicated in patients with risk factors for diabetes (e.g. obesity, family history, high-risk ethnic groups [African Americans, Native Americans, Hispanics and Pacific Islanders], previously identified impaired fasting plasma glucose [FPG] or impaired glucose tolerance; history gestational diabetes, hypertension, HDL-C < 35 mg/dL and/or triglyceride > 250 mg/dL, polycystic ovarian disease, or history of vascular disease)	FPG every 3 years (especially if BMI > 25) starting at age 45.
Colorectal Cancer Screening [B] for average risk adults	No requirement unless high risk (e.g. family history, history of colorectal polyps, chronic inflammatory bowel disease)	
Glaucoma Screening [C]	No requirement unless high risk (e.g. increased intraocular pressure, family history, African Americans, people who have diabetes, myopia, regular/long-term steroid use, previous eye injury)	Begin screening high risk patients annually at age 45
Cervical Cancer Screening [A] Pap Smear	At least every 3 years, more frequently if high risk (i.e. history of abnormal Pap results, sexually transmitted diseases or HIV; sexual activity before age 18 or multiple partners; vaginal spotting or bleeding between periods, after intercourse or after menopause; tobacco use) [Consider discontinuation for patients with surgical removal of cervix for benign conditions]	
Chlamydia Screening [B]	Recommended for all sexually active women age 24 and younger, and sexually active women age 25 and older if high risk (i.e. new or multiple sexual partners, history of sexually transmitted diseases, not using condoms consistently or correctly)	
Mammography with or without Clinical Breast Examination [B]	No requirement, unless high risk	Every 1-2 years
Immunizations (Consult ACIP website, www.cdc.gov/vaccines/recs/acip/ for up-to-date recommendations):		
Tdap/Td [A]	Tdap once after age 11, then Td every 10 years	
HPV [D]	All females 26 years and younger should have full three vaccine series if not previously completed	
MMR [C], Varicella [C]	Ages 19 - 49 years: MMR 2 doses; Varicella as indicated by ACIP guidelines	
Influenza [B]	Every year if high risk; Optional for those who wish to avoid getting the flu	

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources, including: The Guide to Clinical Preventive Services 2007, Recommendations of the U.S. Preventive Services Task Force (www.preventiveservices.ahrq.gov) and the Advisory Committee on Immunization Practices (ACIP) 2006 Immunization Recommendations (www.cdc.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Adult Preventive Services (Ages 50 - 65+)

The following guideline recommends clinical preventive services for adults.

Recommendation	50 - 64 Years	65+ Years
Health Assessment Screening, History and Counseling	One health maintenance exam (HME) every 1 - 3 years according to risk status [D] Each HME should include: <ul style="list-style-type: none"> Height, weight and Body Mass Index (BMI) Risk evaluation and counseling (Nutrition, obesity, physical activity, dental health, tobacco use [A], immunizations, HIV prevention [B], sexually transmitted infections prevention [B] and sexual health, sexual abuse, polypharmacy including over-the-counter and herbal preparations when appropriate, sun exposure) Safety (Domestic violence, seat belts, helmets, firearms, smoke and carbon monoxide detectors) Behavioral Assessment (Depression, suicide threats, alcohol/drug use, anxiety, stress reduction, coping skills) 	One HME at least every 2 years
Blood Pressure Monitoring [A]	At every office visit and at minimum, every 2 years. If BP 120 -139/80-89 or higher and/or presence of risk factors, more frequent monitoring is recommended.	
Cholesterol and Lipid Screening [B]	Measure a complete fasting lipoprotein profile (i.e. total cholesterol, LDL-C, HDL-C and triglycerides every 5 years if initial test is normal in low risk adults). If multiple risk factors are present, more frequent measurements are recommended.	
Diabetes Mellitus Screening	Fasting plasma glucose (FPG) every 3 years beginning at age 45. FPG may be performed earlier in patients at increased risk of diabetes (e.g., those with BMI ≥ 25, family history and high-risk ethnic groups - African Americans, Native Americans, Hispanics and Pacific Islanders)	
Colorectal Cancer Screening [A] for average risk adults	FOBT annually and/or sigmoidoscopy every 5 years; or colonoscopy every 10 years. Stop routine screening at age 75; use individual consideration.	
Glaucoma Screening [C]	No requirement unless high risk (e.g. increased intraocular pressure, family history, African Americans, people who have diabetes, myopia, regular/long-term steroid use, previous eye injury)	Every 2 years; Screen annually if high risk
Osteoporosis Screening [C]	<ul style="list-style-type: none"> Men or women on chronic glucocorticosteroids (prednisone > 7.5 mg/d, or equivalent, for > 6 months) and those who have received a solid organ transplant > 2 years ago should be screened. Post-menopausal women with any of the following: personal history of fracture without substantial trauma ≥ age 40; family history of fracture (hip, wrist or spine in first-degree relative ≥ age 50); current smoking; weight in lowest quartile (< 127 lbs); and frailty. Bone Mineral Density (BMD) test once for initial diagnosis. Do not repeat test more frequently than every 2 years (per MQIC Osteoporosis guideline). 	Women > age 65 regardless of risk factors
Cervical Cancer Screening [A] Pap Smear	At least every 3 years, unless high risk (i.e. history of abnormal Pap results, sexually transmitted diseases or HIV; sexual activity before age 18 or multiple partners; vaginal spotting or bleeding between periods, after intercourse or after menopause; tobacco use) [Consider discontinuation for patients with surgical removal of cervix for benign conditions]	May discontinue after age 65, based on clinical judgement according to risk status
Mammography [A] with or without Clinical Breast Exam [B]	Every 1 - 2 years	Shared decision-making after age 70
Prostate Cancer Screening [D]	Age 50 - 65 years, shared decision-making for digital rectal examination (DRE) and/or prostate specific antigen (PSA) testing	
Immunizations (Consult ACIP website, www.cdc.gov/vaccines/recs/acip/ for up-to-date recommendations):		
Tdap/Td [A]	Tdap once after age 11, then Td every 10 years	Td every 10 years
Varicella [C]; Zoster [C]	Varicella as indicated by ACIP guidelines. Single dose zoster vaccine aged ≥ 60 years	
Influenza [B]	Annually	
Pneumococcal vaccine [B]	No requirement, unless high risk	Once at age 65; booster may be needed after 5

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources, including: The Guide to Clinical Preventive Services 2007, Recommendations of the U.S. Preventive Services Task Force (www.preventiveservices.ahrq.gov) and the Advisory Committee on Immunization Practices (ACIP) 2006 Immunization Recommendations (www.cdc.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Michigan Quality Improvement Consortium Guideline

Prevention of Unintended Pregnancy in Adults 18 Years and Older

The following guideline recommends specific interventions for assessing and counseling to lower the risk of unintended pregnancies.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Males and Females	Assessment for risk of unintended pregnancy	<p>Ask about:</p> <ul style="list-style-type: none"> ◆ Sexual activity/involvement, past pregnancy and outcome ◆ Abuse (e.g. Were you pressured or forced to have sex when you did not want to?) ◆ Consistent use of birth control or protection (e.g. Does it ever happen that you have sex without using birth control or protection?) <ul style="list-style-type: none"> - If contraception is used, assess type ◆ Intent to become pregnant or father a child (e.g. Are you trying to get pregnant? Are you trying to father a child?) <p>If currently pregnant discuss postpartum contraception.</p>	At annual health exam; more frequently at the discretion of the health care provider [D]
	Interventions to prevent unintended pregnancies	<p>Advise and discuss:</p> <ul style="list-style-type: none"> ◆ Patient's risk of pregnancy or contributing to an unintended pregnancy ◆ Risks and adverse outcomes associated with unintended pregnancies <p>Assess:</p> <ul style="list-style-type: none"> ◆ Patient's understanding of risks and readiness to make behavior changes. <p>Assist patients in preventing unintended pregnancy by:</p> <ul style="list-style-type: none"> ◆ Discussing all contraceptive methods [B] ◆ Offering prescriptions ◆ Encouraging consistent latex condom use for sexually transmitted infection prevention [B] ◆ Referring to primary care provider, local health department, family planning clinic, Plan First, federally qualified health center or hotline <p>Arrange follow-up</p>	

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources including the Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report: Recommendations to Improve Preconception Health and Health Care - United States, 06-Apr-2006; 55 (RR-6), (www.cdc.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Tobacco Control

The following guideline recommends specific interventions for cessation services for current smokers and tobacco users.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
All patients 12 years of age and older (regardless of prior use status)	Identification of tobacco use and exposure status (never, former, current) and type (all forms, including smokeless tobacco, pipe, snuff, cigars, hookah [water pipe] and second-hand smoke)	<ul style="list-style-type: none"> ♦ Ask and document tobacco use status in the medical record and/or problem list [A] 	At each outpatient visit and inpatient admission
All patients identified as current smokers/tobacco users	Intervention to promote cessation of tobacco use	<ul style="list-style-type: none"> ♦ Advise to quit [A]/avoid second-hand smoke ♦ Assess patient willingness to attempt to quit [C] ♦ Assist patients who are ready to quit by: <ul style="list-style-type: none"> - Establishing a quit date - Providing self-help materials (e.g. free Quit Kits; see www.michigan.gov/tobacco) - Offering nicotine replacement therapy (adults only) and/or withdrawal medications e.g., sustained release bupropion [A] (adolescents and adults) - Offering referral into smoking cessation program (e.g. MI Quit Line 1-800-480-7848) - The combination of nicotine replacement therapy and/or withdrawal medications plus a smoking cessation program is more effective than either alone ♦ Arrange follow-up contact, either in person or by telephone [D]: <ul style="list-style-type: none"> First week after quit date First month after quit date 	At each periodic health exam, more frequently at the discretion of the physician

SPECIAL CIRCUMSTANCES

- ♦ **Pregnant Smokers:** Due to the serious risks to the mother and fetus, pregnant smokers should be offered interventions such as referral to a smoking cessation program.
- ♦ **Hospitalized Smokers:** Clinicians should provide appropriate pharmacotherapy and counseling during hospitalization to reduce nicotine withdrawal symptoms and assist smokers in quitting.
- ♦ **Smokers with Psychiatric Comorbidity:** Nicotine withdrawal symptoms may exacerbate depression among patients with a prior history of affective disorder. Stopping smoking may affect the pharmacokinetics of certain psychiatric agents. Clinicians should monitor closely the actions or side effects of psychiatric medications in smokers/tobacco users who are attempting to quit.

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources including, the Clinical Practice Guideline for the Management of Tobacco Use, Veterans Health Administration/Department of Defense, 2004 (www.oqp.med.va.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Insurers Tobacco Cessation Benefits

As of 9/2007	<i>Pharmacy (Members must have drug benefit)</i>							<i>Cessation Programs</i>		
Health Plan	Patch	Gum	Lozenge	Inhaler	Nasal Spray	Bupropion or Wellbutrin	Chantix/ Varenicline	Group Classes	Telephone Counseling	Resources on Plan Website
Blue Care Network	RX-PA <i>must enroll in Quit the Nic</i>	RX-PA <i>must enroll in Quit the Nic</i>	RX- <i>must enroll in Quit the Nic</i>	RX- <i>must enroll in Quit the Nic</i>	RX- <i>must enroll in Quit the Nic</i>	RX-PA	RX-PA <i>may require Step Therapy</i>	Not Available	Quit the Nic 800-775-2583	www.MiBCN.com
Blue Cross Blue Shield of Michigan (Traditional) Refer to number on card	Based on individual contract benefits	Based on individual contract benefits	Based on individual contract benefits	Based on individual contract benefits	Based on individual contract benefits	Based on individual contract benefits	Based on individual contract benefits	Not Available	Quit the Nic 800-775-2583	www.bcbsm.com/member/ managing_your_health/sm oking_cessation.shtml
Blue Cross Blue Shield of Michigan (PPO) Refer to number on card	Based on individual contract benefits	Based on individual contract benefits	Based on individual contract benefits	Based on individual contract benefits	Based on individual contract benefits	Based on individual contract benefits	Based on individual contract benefits	Not Available	Quit the Nic 800-775-2583	www.bcbsm.com/member/ managing_your_health/sm oking_cessation.shtml
Community Choice	Generic only-QL	Generic only-QL	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Available	1-866-206-0488	Not Available
Great Lakes Health Plan	RX-OTC-QL	Not Covered	Not Covered	Not Covered	Not Covered	RX-QL Generic only	RX-PA	Not Available	800-480-7848	http://www.glhp.com/Memb ers/PDF/MyHealth/Smokin g.pdf
Health Alliance Plan	RX-PA <i>Quantity Limits</i>	RX-PA <i>Quantity Limits</i>	RX	RX	RX-PA <i>Quantity Limit</i>	RX	RX <i>Tier 2 Co-Pay</i>	Coverage for approved classes	Smoking Intervention Program 1-888-427-7587	http://www.hap.org/healthy _living/indx_smoking.php
Health Plan of Michigan	RX-QL <i>must start with 21 mg for 2 weeks</i>	RX -QL	Not Covered	Not Covered	RX-QL	RX-PA	RX-QL	Not Available	1-800-480-7848	Not Available
HealthPlus of Michigan Commercial	OTC RX requires ST	OTC Not covered	Not Covered	RX	RX	RX	RX-Tier 2 Co-pay	Not Available	1-810-230-2118	www.healthplus.org
HealthPlus of Michigan Medicaid	RX	Not Covered	Not Covered	Not Covered	Not Covered	RX	RX	Will Reimburse	1-800-480-7848	www.healthplus.org

McLaren Health Plan-Medicaid	OTC-QL Generic only	OTC-QL Generic only	Not Covered	RX-QL	RX	RX-QL Generic only	Not Covered	Not Available	1-866-800-0135	Not Available
Medicaid Fee for Service (Straight Medicaid)	RX	RX	Not Covered	Not Covered	Not Covered	RX	RX	Not Available	1-800-480-7848	Not Available
Midwest Health Plan	OTC- Covered with RX	OTC- Covered with RX	Not Covered	Not Covered	Not Covered	RX-PA	RX-PA	Not Available	1-888-654-2200	Not Available
Molina Healthcare of Michigan	RX <i>OTC covered with RX 3 mo supply</i>	RX-PA	Not Covered	RX-PA	RX-PA	RX-PA	RX-PA	Not Available	1-800-480-7848	Not Available
Physician' Health Plan of Mid-MI	50% Co-pay	50% Co-pay				RX	Not Covered	Not Available	1-877-330-2746	Not Available
Priority Health Commercial	RX	RX	Not Covered	RX	RX	RX-PA	RX-ST	Not Available	1-800-446-5674	www.priorityhealth.com
Priority Health Medicaid	RX	RX	Not Covered	RX-ST	RX-ST	Not Covered	Not Covered	Not Available	1-800-446-5674	www.priorityhealth.com
Total Health Care	Not Covered	RX-OTC- QL	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Available	1-800-480-7848	Not Available
	RX = Prescription required for coverage						PA = Prior Authorization		QL = Quantity Limit	
							ST = Step Program			
	<i>In some cases, the member may obtain the brand name drug, but may incur an additional charge (higher co-pay).</i>									
	<i>Benefits are subject to change at each insurer's discretion.</i>					<i>Check with your insurer to confirm coverage eligibility.</i>				

Michigan Quality Improvement Consortium Guideline

Screening, Diagnosis and Referral for Substance Use Disorders



The following guideline recommends detection, diagnosis and referral considerations for substance use disorders.

Eligible Population	Key Components	Recommendation and Level of Evidence
Adolescents and adults	Detection/Screening	<ul style="list-style-type: none"> ■ Screen by history for substance use at every health maintenance exam or initial pregnancy visit (repeat as indicated), using a validated screening tool (improves accuracy of detecting alcohol abuse or dependence)¹ [D] ■ Maintain high index of concern for substance use in persons with: <ul style="list-style-type: none"> ◆ Family history of substance use disorder [B] ◆ Recent stressful life events and lack of social supports ◆ Chronic pain or illness, trauma ◆ Mental illness (e.g. depression, bipolar disorder, etc.) ◆ Drug seeking behaviors ◆ Physical and cognitive disabilities ◆ Started alcohol use before age 15 ◆ Medical condition associated with substance use <p>Substance dependence or abuse indicates a maladaptive pattern of substance use resulting in clinically significant impairment or distress. Relevant issues include:</p> <ul style="list-style-type: none"> ◆ Recurrent substance use resulting in a failure to fulfill major role obligations ◆ Recurrent substance use in situations that are physically hazardous ◆ Recurrent substance-related legal problems ◆ Substance use despite having persistent or recurrent social or interpersonal problems ◆ Tolerance, withdrawal, use in larger amounts or over a longer period than intended ◆ Persistent desire or unsuccessful efforts to cut down ◆ Great deal of time spent in obtaining, using or recovering from use of the substance ◆ Reduction in social, occupational or recreational activities because of substance use ◆ Substance use continues despite knowledge of problems
Patients with Substance Use Disorder	Patient Education and Brief Intervention by PCP or Trained Staff (e.g. RN, MSW, etc.) [A] Referral Considerations	<ul style="list-style-type: none"> ◆ Assess patient's risk, understanding and readiness to change ◆ Discuss the relationship of substance use to presenting medical concerns or psychosocial problems ◆ Negotiate goals and strategies for reducing consumption and other change ◆ Involve family members as appropriate ◆ Consider referral to community-based services (e.g., Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) or Employee Assistance Program, or (especially if substance dependent) a substance abuse or behavioral health specialist. [D] ◆ Pharmacologic management should be conducted by or in collaboration with physicians who have expertise in the area of substance use disorders. [D] ◆ Schedule appropriate follow-up within 30 days to re-assess and support behavior change

¹ Validated tools include: Alcohol Use Disorders Identification Test (AUDIT), TWEAC (for pregnant women), Michigan Alcohol Screening Test (MAST, MAST-G), CAGE Survey, Substance Abuse Subtle Screening Inventory (SASSI)

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel
 This guideline lists core management steps for non-behavioral health specialists. It is based on several sources including, Practice Guideline for the Treatment of Patients With Substance Use Disorders, American Psychiatric Association, August 2006 (www.psych.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Highlights of MCIR version 7

MCIR Home Screen

All users will notice newly organized menus.

- All types of reports (Reminder/Recall, Import/Export, Profile, Batch, etc.) are now accessed under the **Reports** menu.
- New links:
 - Site Administrators will click the **Administration**→**Site Users** link to maintain their list of staff authorized to use MCIR. *Please note that User Role names have changed slightly. Any role ending in “Administrator” is a Site Administrator. “Limited Access User” is a restricted view-only role.*
 - Local Health Department roles: LHD Administrator, Provider User, Childcare User, Childcare Administrator, LHD User, School Administrator, School User, Limited Access User
 - Provider Site roles: Provider User, Provider Administrator, Limited Access User
 - School Site roles: School Administrator, School User
 - Childcare Site roles: Childcare User, Childcare Administrator
 - WIC Site roles: WIC Administrator, WIC User, Limited Access User
 - Healthcare Organization roles: General Administrator, General User, Limited Access User
 - Schools and Childcares will see that the **Build Roster** and **IP Status** are now found under the **School/Childcare** menu.
 - Doses Administered and Provider Profile Data reports are available under **Reports**→**Vaccine** (this link used to be named VFC).
 - To find which patients received specific vaccines at your office, click the **Vaccine Management**→**Vaccines Administered** link (this link used to be named Doses Administered).

Adding new Persons to MCIR

A complete mailing address is required to add a new Person to MCIR.

For all users: a security information popup may appear when on the General Information or Site Information page. To prevent this, a Security Setting must be updated in your browser.

- Internet Explorer: click Tools→Internet Options, Security tab, Custom Level button. On the “Display Mixed Content” setting select “Disable”

Correcting an Invalid Primary Contact

When logging on, users may notice a message at the top of the Home screen saying “Invalid Primary Contact”. The Site Administrator must go in and update the Primary Contact information. The Primary Contact is the person who signed your site’s MCIR User/Usage Agreement.

- Click the [Edit My Site](#) link (under the My Site menu)
- Click the [Site Contacts](#) tab
- Click the underlined name beginning with “Unknown...”
 - Choose the Type (for provider sites this must be a Doctor)
 - Type the First Name and Last Name of the Primary Contact
 - If the Primary Contact is a Doctor or Nurse, the license number and licensing state are required

Click the Submit button

The screenshot shows the MCIR home page with a blue header containing the MDCH logo and the text "Michigan Care Improvement Registry" and "michigan.gov". Below the header, a message states: "This site has the following incorrect or missing information and needs to be updated. Please correct the following before proceeding:" followed by a bullet point: "• Invalid primary contact". Below this message, it says: "Please correct the above issues by clicking 'Edit My Site' from the menu and making the necessary changes." The main content area is divided into several menu sections: "Person", "Reminder/Recall", "Vaccine Mgmt", "My Site", "Administration", "Reports", and "Other". The "My Site" menu is highlighted, and the "Edit My Site" link is circled in red. Other links in the "My Site" menu include Site Preferences, User Preferences, View My Site List, and Go to New Site. The "Administration" menu includes Add/Find User and Site Users. The "Reports" menu includes Batch, Inventory, Profile, Reminder/Recall, Retrieve Results, Roster, Vaccine, and VAERS. The "Other" menu includes Get News, View Usage Agreement, MCIR Training Course, MCIR.org, VIS, IVEN, and Exit Application.

Business Hours	Shipping Hours	Principal Storage	Alternate Storage
Contact Information	MCIR Users	Site Contacts	VFC Enrollment
Emergency Response Plan			
Name	Phone	Email	Lic#/State
Type			
Add New Contact			
Frank Buddy, MD			asdfasdfasef/MI
Doctor			
Jamie Daniels		jdaniels@provider.com	
Other			
Dr. Diedra Garrison, MD			asdfasdfasdfasd/MI
Doctor			
Unknown U20000007233			
Change Me			

Contact Information

Edit Contact

Contact Information

Type*

Title First Name* MI Last Name* Suffix

License # License State

NPI Medicaid Prov. ID

Phone Numbers

Office () - Ext

Fax () - Ext

Cell/Pgr () -

Email Address

Email

General Information screen

1. Integration tabs

Program screening results from other Michigan Department of Community Health (MDCH) databases are viewable to authorized MCIR users.

Tab	Description	Which Facility Types may view this information	Who to contact with questions
Immunization (Figure 1)	Summary view of immunizations (detail is available on Status and History links)	All (except Schools and Childcares)	Regional MCIR Helpdesk (see last page for contact information)
Lead (Figure 2)	Blood lead screening	Childcares, Providers, Local Health Departments, MDCH	MDCH Lead Program 517-335-8885
NBS (Figure 3)	Newborn Screening	Providers, Local Health Departments, MDCH	MDCH Newborn Screening 866-673-9939
Other (Figure 4)	Identifying information & MCIR Options (click the Edit link to update)	All (except Schools and Childcares)	Regional MCIR Helpdesk (see last page for contact information)
EPSDT (Figure 5)	Early Periodic Screening Diagnostic Treatment	Providers, MDCH	MDCH Medicaid
EHDI (Figure 6)	Early Hearing Detection & Intervention	Providers, Local Health Departments, MDCH	MDCH EHDI Program 517-335-8878

Figure 1: General Information Page.

Person: Michigander, Little [Print](#) [Print Help](#)
 Birth Date: 01/01/2008 [Home](#) [Exit](#)
 Provider: **Overdue** [View](#)

Person Rem/Rcl VIM My Site Admin Reports Other
 Add/Find Roster Add Imm Add Event Information Status History

If this is not the correct person you may [Search Again](#).

Person Information : Edit MCIR ID : 10218597326

Name: Michigander, Little Birthdate: 01/01/2008 Gender: Female
 Age: 1 Year 4 Months
 Address: 12345 Anywhere Street
 Detroit, MI 48202
 As of 03/23/2009 Resp. Party: TEST, PARENT
 Phone: (123) 555-1212

High Risk Conditions : Edit

Influenza Screening Notification

Series	Immunizations						Status
	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6+	
DTP/DTaP/ DT/Td/Tdap	03/06/2008 DTaP-Daptacel 2mos 5dys	10/21/2008 DTaP 9mos 20dys	12/02/2008 DTaP 11mos 1dy	03/23/2009 DTaP- Daptacel 1yr 2mos			Up-to-date Next Due 01/01/2012
Polio	10/08/2008 IPV 9mos 7dys	01/27/2009 DTaP-Hep B- IPV 1yr					DUE NOW
MMR							Eligible Next Due 05/25/2009
Hib	05/03/2008 Hib- ActHib/OmniHib 4mos 2dys	10/21/2008 Hib- ActHib/OmniHib 9mos 20dys					DUE NOW
Hepatitis B	01/01/2008 Hep B (ped/adol)	01/25/2008 Hep B (ped/adol) 24dys	06/18/2008 Hep B (ped/adol) 5mos 17dys	08/22/2008 Hep B (ped/adol) 7mos 21dys	01/27/2009 DTaP-Hep B- IPV 1yr		Series Complete
Varicella	03/23/2009 Varicella 1yr 2mos						Immune
Pneumococcal Conjugate							DUE NOW
Hepatitis A	03/10/2009 Hep A (ped/hist) 1yr 2mos						Up-to-date Next Due 09/10/2009
Influenza							DUE NOW

Other Administrations

Series	Status
Various Immune Globulins 01/02/2008 HBIG: Hep B globulin 1dy	Not Available
Other 01/25/2008 Mumps 24dys	Not Available

Non-Administered Doses/Positive Immunity

Series/Antigen	Date	Reason	Entered by
Hib	07/14/2008	Other	MDCH LHD ADMIN
Pneumococcal Conjugate	08/06/2008	Other	MDCH LHD ADMIN
MMR	02/21/2009	Other	MCIR VIM LHD Site
Varicella	07/01/2008	Immunity	MDCH LHD ADMIN

Invalid Doses

Series/Dose #	Vaccine	Date	Age	Reason
DTaP 1	DTaP	01/01/2008		Does not meet minimum age
Hepatitis B 3	Hep B (ped/adol)	02/20/2008	1 Month 19 Days	Does not meet minimum age
Hepatitis B 3	Hep B (ped/adol)	05/05/2008	4 Months 4 Days	Does not meet minimum age
Hepatitis B 3	Hep B (ped/adol)	08/04/2008	7 Months 3 Days	Does not meet minimum interval
MMR 1	MMR	08/17/2008	7 Months 16 Days	Does not meet minimum age
Hepatitis A 1	Hep A (ped)	09/19/2008	8 Months 18 Days	Does not meet minimum age
Polio 2	IPV	10/13/2008	9 Months 12 Days	Does not meet minimum interval
Hepatitis A 1	Hep A (ped)	11/10/2008	10 Months 9 Days	Does not meet minimum age
DTaP 4	DTaP-Hep B-IPV	01/27/2009	1 Year	Does not meet minimum interval
Polio 3	IPV	01/29/2009	1 Year	Does not meet minimum interval
Polio 3	IPV	02/03/2009	1 Year 1 Month	Does not meet minimum interval
DTaP 4	DTaP-Daptacel	02/04/2009	1 Year 1 Month	Does not meet minimum interval
DTaP 4	DTaP-Daptacel	02/21/2009	1 Year 1 Month	Does not meet minimum interval
DTaP 4	DTaP	03/09/2009	1 Year 2 Months	Does not meet minimum interval
DTaP 4	DTaP-Daptacel	03/13/2009	1 Year 2 Months	Does not meet minimum interval
DTaP 5	DTaP	03/24/2009	1 Year 2 Months	Does not meet minimum age
MMR 1	MMR	03/25/2009	1 Year 2 Months	Live dose given within 28 days of another live vaccine product

[Unlock Person](#) [Take off Roster](#)

To view Accelerated, Recommended, and Overdue dates for each series click the Status link.

To view and/or edit immunization history, click the History link.

General Information Screen will show the Primary Series and the most recent vaccine received. To view the entire history of more than 6 doses Click the "More ..." link.

Note that Non-Administered Doses, Positive Immunity & Invalid doses are listed at the bottom of the page.

Figure 4: Other tab

Contains Medicaid ID, Health Plan, Patient ID, Birth Facility Information, MCIR Options, and Additional Information (Alias Name, Mother's Maiden Name). Some of these items may be updated by clicking on the Edit link (see next page).

Immunizations <input type="checkbox"/>		Other <input checked="" type="checkbox"/>	
Medicaid:	Health Plan:		
Patient ID:	123463		
Birth Facility Information			
Name:	St Joseph Hospital	State:	MI
		County:	Washtenaw
MCIR Options Edit			
<input type="checkbox"/>	Person does not receive medical care in Michigan		<input type="checkbox"/>
			Person is deceased
<input type="checkbox"/>	Person is migrant		<input type="checkbox"/>
			Person has moved or gone elsewhere
Additional Information			
Alias Name:	Number, Two		Mother's Maiden Name:

Figure 5: EPSDT tab

Immunizations <input type="checkbox"/>		NBS Mailers <input type="checkbox"/>		Other <input type="checkbox"/>		EPSDT <input checked="" type="checkbox"/>		EHDI <input type="checkbox"/>	
Age:	1 Year		Months Between Visits:		3		Last Notified:		
Date	Code	Description							
10/06/2008	99391	Per pm reeval, est pat, inf							
	V040	VACCIN FOR POLIOMYELITIS							
	V061	VACCIN FOR DTP							
	V202	ROUTIN CHILD HEALTH EXAM							
09/11/2008	99391	Per pm reeval, est pat, inf							
	V038	VACCIN FOR BACT DIS NEC							
	V0382	STREP PNEUMONIA (PNEUMOCOCCUS)							
	V202	ROUTIN CHILD HEALTH EXAM							
04/13/2008	7746	FETAL/NEONATAL JAUND NOS							
	99431	Initial care, normal newborn							
	V3000	DELIVERED W/O MENTION OF CESAR							

Figure 6: EHDI tab

Immunizations <input type="checkbox"/>		NBS Mailers <input type="checkbox"/>		Other <input type="checkbox"/>		EPSDT <input checked="" type="checkbox"/>		EHDI <input checked="" type="checkbox"/>	
Kit Number:								Follow-Up	
Initial and Rescreen Results									
Date Screened	Test Method	Left Ear	Right Ear	Incomplete Reason					
04/15/2008	DPOAE	PASS	PASS						
Diagnostic Results									
Date Diagnosed	Left Ear			Right Ear					
<i>No Diagnostic Results Found</i>									

2. Click the Edit link to change demographic information

The General Information screen is read-only (exception: schools and childcares). To edit items on this screen or on the Other tab, click the Edit link. Here is what may be updated on the Edit Person screen:

- Gender, Multiple Birth
- Influenza Screening Notification: check the box if the patient is at high risk for influenza
- Notification information: this is the current responsible party to which reminder/recall notices would be sent.
 - Notifications: choose 'Don't Send' in the dropdown if the patient does not wish to receive immunization reminder or recall notices from MCIR
 - Street, City, State, ZIP , Country, Phone
 - County is automatically assigned based on the person's address. If no ZIP code is recorded then there will be no county affiliation
- Responsible Party Last name, First name, Middle name, Suffix name: this is the current person to which reminder or recall notices would be addressed
 - To add a new responsible party address information, click the Add New link
 - Alternate contacts: these were previous responsible parties. To make one of these the current responsible party, click on the desired underlined name, then click the Make Current Contact button. Click OK to confirm.
- Identifiers: Patient ID (Medicaid ID is only entered by MDCH Medicaid)
- Birth facility information: Birth facility name, State, County
- MCIR Options: Person does not receive medical care in Michigan, Person is migrant, Person is deceased, Person has moved or gone elsewhere
- Additional information: previous names/nicknames of the person (check Default box to make this name appear on reports), person's mother's maiden name

Click the **Submit** button after making any changes on the Edit Person screen.

Site Information screen (Site Administrators, Regions, MDCH)

New tabs have been added to incorporate provider enrollment in the Vaccines For Children (VFC) program. Administrators may edit their site's address, phone number, and email address.

Tab name	Function	Who may edit
Contact information	Physical & mailing address, Email, Phone, Fax, View Primary Contact	Provider, Regions, MDCH
MCIR Users	Staff authorized to use MCIR. Site Administrators remove departing staff by clicking the trash can icon to the right of their name (there is no more "Invalid User" role)	All Site Administrators of Childcare, School, WIC, LHD and Provider sites; also Regions and MDCH
Site contacts	Primary contact is the person who signed the MCIR User Agreement for the site. License number is required to add any additional medical personnel.	Provider, Regions, MDCH
VFC enrollment	VFC PIN, Status, VFC contact, Enroll/renewal dates, last site visit, Additional program certifications	MDCH
Emergency response plan	Contacts, Dry ice location, Refrigerator company & phone number, Outage notification	Regions, MDCH
Business hours	Hours the office is open	Provider, MDCH
Shipping hours	Hours the office will accept vaccine shipments, Shipping instructions	Regions (instructions only), MDCH
Principal storage	List of vaccine storage devices at the office	Regions, MDCH
Alternate storage	Name, Address, Phone of 2 alternate storage locations	Regions, MDCH

VIM Transactions Report (Provider Transfer Sites)

This report is for provider sites that:

- Upload immunization data to MCIR from an approved Electronic Health Record (EHR), **and**
- Are also using the MCIR Vaccine Inventory Module (VIM).

All Provider Transfer Sites must check (at the **Import/Export** → **Retrieve Results** link) the day after their upload for any Edits or System Errors that occurred with their transfer file.

- Edits may be corrected and resubmitted online
- System errors appear in their Transfer Summary Report and must be fixed manually in the MCIR

A new report will appear for Provider Transfer Sites: the VIM Transactions Report.

- This report lists any immunizations from the transfer file that did not deduct from inventory in MCIR. See below for an example.

All of these errors must be fixed by Provider Transfer Sites so that their complete immunization data is loaded into MCIR.

Import/Export Requests [Print Help](#)
[Home](#) [Exit](#)

Person Rem/Rec Sch/CC **VIM** Imp/Exp My Site Admin Reports Other

Submit File Retrieve Results

Note: Please press the Refresh button to update the status. Refresh

Description	User	Date	
TFR 20090331 Tuesday	LastnameF2009	03/31/2009	Delete
Status: Transfer run has completed.			Summary Report: VIM Trans Report

05/08/2009

Transferred Vim Transactions

Page 1

Your provider site name

Failed/Unprocessed transactions

Admin Date	Product - Lot	Eligibility	Inv.
05/23/2006	Td (adult) Pres. Free (sanofi) - U1596CA Status: No lot in inventory.	MI VRP	UNK
04/14/1998	Hep B (adult) (Glaxo) - 2133A1 Status: No lot in inventory.	Private Pay/Insurance	UNK
03/21/2001	PPV23 (Wyeth (WAL)) - 465-898 Status: No lot in inventory.	Private Pay/Insurance	UNK
04/14/1998	Td (adult): Teta-Diph (Connaught) - 7C91550 Status: No lot in inventory.	Private Pay/Insurance	UNK

Lastname, Firstname - Birthdate - MCIR ID

Regional MCIR helpdesk contact information

REGION 1

City of Detroit; Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw, and Wayne Counties

- 1-888-217-3900

REGION 2

Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Ionia, Jackson, Kalamazoo, Kent, Lenawee, Muskegon, Ottawa, St. Joseph, and Van Buren Counties

- 1-888-217-3901

REGION 3

Barry, Clinton, Eaton, Gratiot, Ingham, and Montcalm Counties

- 1-888-217-3902

REGION 4

Bay, Genesee, Huron, Lapeer, Midland, Saginaw, Sanilac, Shiawassee, and Tuscola Counties

- 1-888-217-3903

REGION 5

Alcona, Alpena, Antrim, Arenac, Benzie, Charlevoix, Cheboygan, Clare, Crawford, Emmet, Gladwin, Grand Traverse, Iosco, Isabella, Kalkaska, Lake, Leelanau, Manistee, Mason, Mecosta, Missaukee, Montmorency, Newaygo, Oceana, Ogemaw, Oscoda, Osceola, Otsego, Presque Isle, Roscommon, and Wexford Counties

- 1-888-217-3904

REGION 6

Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft Counties

- 1-888-217-3905

MCIR

Web Guide





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MCIR User ID, Password and Single Sign On

To enter the MCIR system, you must have a user ID and password. With the new HIPAA security guidelines, it is important that you do not share your Single Sign-On user ID and password. With your user ID and password, anyone can make modifications in the MCIR under your name.



HIPAA security standards are mandated for all health care providers, health plans, and health care clearinghouses that utilize computers to store or transmit patient information electronically.



How to search for a child in the MCIR

To find a child in the MCIR, identifying information must be entered in the text boxes. At a minimum, you must enter two items. We strongly recommend the following information:

- Last name
- MCIR ID number
- Date of Birth (mm/dd/yyyy)



During the first attempt to find a child, it is recommended that you enter the minimum amount

of information to avoid receiving multiple results.

When entering the child's first or last name, use their full name as stated on their birth certificate to be accurate with spelling. Using child IDs are recommended since they help uniquely identify a child. The MCIR system searches faster using numeric child ID fields such as birth date and MCIR ID.

To find a child use the **Find Child** screen.

There are two ways to access the **Find Child** screen:

1. From the home Page under the **Child** column, select **Find**
2. From the MCIR menu bar, select **Find**

Click on the **Submit** button to search for the child in the MCIR.

- *A specific match to a child's information must be made or the child's MCIR record will not be displayed.*

Find Child	
Please enter two or three pieces of information on the government - It is recommended that you use more than one of the fields to narrow the search information.	
This information identifies the child (parenting for deviant treatment)	
MCIR ID	<input type="text"/>
Last Name	<input type="text"/>
First Name	<input type="text"/>
Birthdate	<input type="text"/>
Mother's Maiden Name	<input type="text"/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Multiple/Other Child

Last Name	Smith	First Name	Joseph
Birthdate	04-12-2000		

Child found/not found

Child found

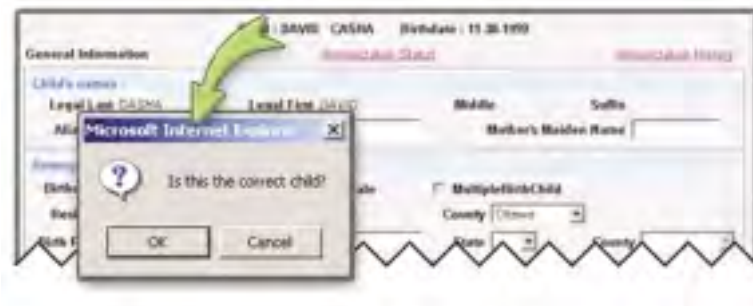
The verify **Correct Child** found screen will appear once the system finds a match to the data you entered.



As prompted by the message on the screen, you should always review the child's information to verify the correct child has been found.

1. If the correct child has been found, click **OK** to view the child's MCIR information.
2. If the correct child is not found, click **Cancel**. Your next step depends on if the wrong child or no child was found in your search.

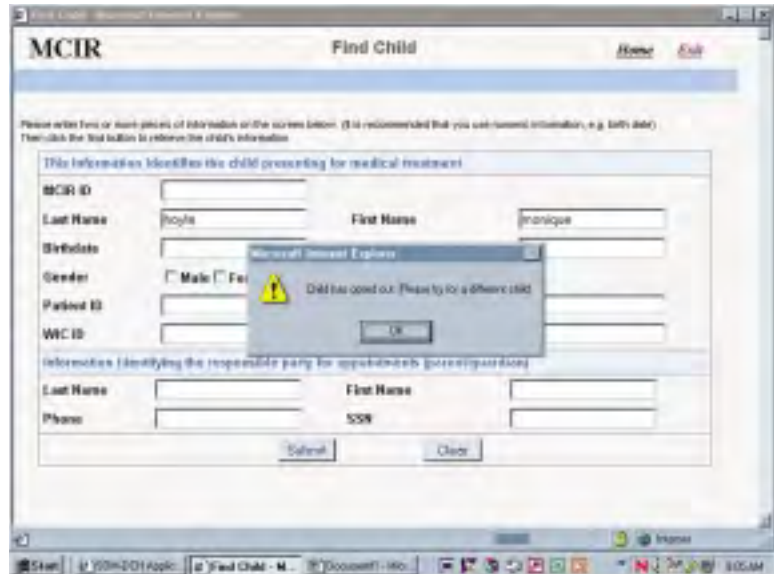
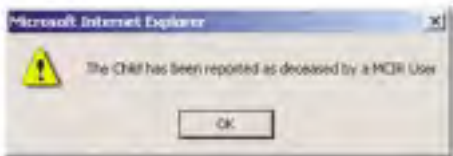
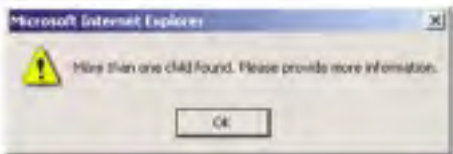
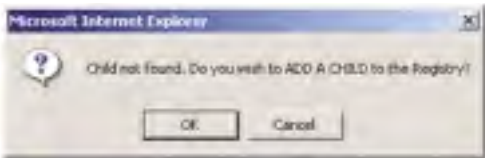
**Gender and Multiple Birth Status of a child are not good search criteria. These pieces of information are too vague to result in a specific child match.*



Child not found

If the child is not found in the MCIR database, one of the following messages will appear:

- Child not found
- More than one child found
- Child not participating in MCIR (“opted out”)
- Child has been reported as deceased.



If you cannot find a MCIR record for a child born in Michigan on or after January 1, 1994:

1. Confirm that you are searching for the child by their legal name (the name as it appears on the birth certificate)
2. Confirm that the child was born in a Michigan hospital
3. Wait 2-3 weeks after the child's date of birth. If you still cannot find the child in the MCIR, DO NOT ADD the child. Contact your MCIR regional office for assistance.

More than One Child Found

More than one child in the MCIR database meets the criteria you have entered into your **Find a Child** search. Click the **OK** button and enter additional pieces of search criteria to narrow your search in an attempt to locate the exact child you are looking for.

Child not participating in the MCIR/Opt-Out

The child has been "opted-out" of the MCIR and is not included in MCIR reporting. The child may be opted-out for several reasons:

- The parent or guardian has opted the child out of the system
- The child is not a Michigan resident

Click the **OK** button. If you believe this information is incorrect or if you need to opt a child out of the MCIR, please notify your regional MCIR office.

**A parent may later choose to rescind their decision to have opted their child's record out of the MCIR.*

Child has been reported as deceased/Recording a child as deceased in the MCIR

Click the **OK** button. If you believe this information is incorrect, please notify your regional MCIR office.

To record a child as deceased in the MCIR database, go to the **General Information** screen. In the MCIR Options at the bottom of the General Information screen, click on the **Child is deceased** check box, then click the **Update Child** button to save the changes.

**It is necessary to report this information to prevent a MCIR Reminder/Recall notice from being sent to the responsible party of a deceased child.*



Adding a child

After a detailed search has yielded no MCIR record for the child you are attempting to find, a new child may be added to the MCIR without contacting the regional office only if:

- The child was born outside of Michigan, or
- The child was born prior to January 1, 1994

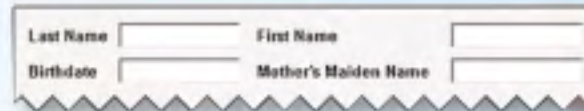
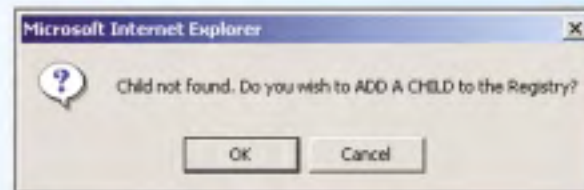
**In all other circumstance, please contact your regional MCIR office before adding a child to the database.*

***In the case of a legal name change or adoption, notify your MCIR regional office to review the original record prior to adding a new one.*

To add a new child to the MCIR:

1. If the **Child Find** screen is not visible on your screen, click the **Find** link on the toolbar.
2. Type in the minimum information required to search for a child. (It is important that you enter the child's name correctly. Once accepted, it cannot be changed. Always use the child's full name.)
3. Click the **Find** button to search for the child in the system.
4. When a record is not found matching the criteria you have entered, the **Child Not Found** message will be displayed.
5. Click **OK** to **Add a Child** to the MCIR
6. The **Add New Child** screen will appear after clicking **Yes** to add a child.

**In the Add New Child screen, text boxes marked with the asterisk (*) must be filled in before a child can be added. The remaining fields are not required, however, you should enter as much information as possible.*

A screenshot of a search form. It has a white background with a blue border and a blue header bar. Below the header bar, there are four text input fields arranged in a 2x2 grid. The fields are labeled 'Last Name', 'First Name', 'Birthdate', and 'Mother's Maiden Name'. Each field has a small blue asterisk icon to its left, indicating it is a required field.

MCIR - Add New Child [Home](#) [Exit](#)

Find Patient Entry Child Reports Options Admin

Child's names

Legal Last * Legal First * Middle Suffix
 Alias Last Alias First Middle's Middle Name

Demographics

Birthdate * Gender * Male Female Multiple-Birth-Child
 Residence Information: State * County *
 Birth Facility Information: Name State County

Child's IDs

Patient ID Medicaid ID SSN

Responsible Party Information (for Reminder and Recall Notices)

Last Name * First Name Middle Name Suffix
 Address
 City State Zipcode
 Country Phone SSN
 This person wishes to get immunization notices in

All fields marked with * are mandatory



Ziddling a Child

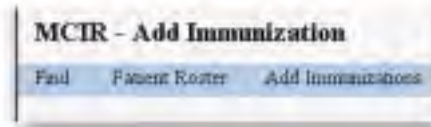
Adding Immunizations

To update a child's immunization record, you must first find the child. (See the *How to Search for a Child* section of this booklet.)

After finding a child click on the **Add Immunizations** option on the menu bar. The **Add Immunization** screen will appear. Choose the correct administrating party for the vaccine administration you will be documenting in the **Vaccine Administered By** drop down menu. (Only change the **Vaccine Administered By** to **Other Provider Administered Vaccine** if your office did not administer the vaccine you are documenting in the child's MCIR record.)

Vaccines administered by your office and another office cannot be combined. You must add the vaccinations for one office, click **Submit, and then add the other vaccinations under the appropriate drop-down selection.*

Also, in the **Vaccine Administered By** area, you have the option to select the **Wish to be point of contact** check box. Checking this box identifies your office as the point of contact for MCIR generated reminder/recall notices for the child. If you do not wish to check this box, the MCIR will associate the child to the last provider identified as the "point of contact" for reminder/recall.



The screenshot shows the "MCTR - Add Immunization" form. At the top, there are tabs for "Find", "Parent Roster", "Add Immunizations", "Child", "Inventory", "Reports", and "Options". Below the tabs, there is a dropdown menu for "Vaccines administered by" with "Training User" selected. A checkbox labeled "Wish to be point of contact for MCTR reminder/recall" is checked. Below this is a table with columns: "Date*", "CPT", "Vaccine*", "Vaccine Efficacy*", "Mmr1/2/3/4/5", and "Quantity". The table has 10 rows, each with a dropdown arrow in the "Vaccine*" column. At the bottom, there are buttons for "Submit", "Add More", "Clear", and "Cancel". A note at the bottom left states "All fields marked with * are mandatory".

The screenshot shows the "Add Immunizations" form with the following information: "Child: 88 874 0885A" and "Status: 05 12 2009". Below this, there is a dropdown menu for "Vaccines administered by" with "Training User" selected. A checkbox labeled "Wish to be point of contact" is checked. At the bottom, there are buttons for "Submit", "CPT", "Search", and "Add More".

The screenshot shows the "Add Immunizations" form with the following information: "Select whether the immunizations were administered by this office in particular. CPT code. Click on 'Add More' to record more immunizations for the same child." Below this, there is a dropdown menu for "Vaccines administered by" with "Training User" selected. A checkbox labeled "Wish to be point of contact for MCTR reminder/recall" is checked. Below this is a table with columns: "Date*", "CPT", and "Vaccine*". The table has one row with the following values: "05-08-2002", "90700", and "DTaP".

Non-Administered Vaccines

At the bottom of the **Immunization Status** and **Immunization History** screens, the **Non-Administered Vaccine** area lists the vaccines that were not given. The area also shows the date the information was recorded and the reason why the vaccine was not administered.

To add a non-administered vaccine to a child's MCIR record follow the steps outlined in the *Adding Immunizations* section of this booklet. Add the date, vaccine type and click the **Non Adm** check box at the far right of the **Add Immunization** screen. In the **Non Administered Reason** pop-up box, select the reason for the non-administration:

Documented Immunity – Child has documented immunity to disease

Parent/Guardian Waiver – Parent/Guardian waives immunizations for child.



Other than documented immunity for Varicella, choosing a non-administered code does not affect the immunization assessment of the child in the MCIR.

MCIR Eligibility Field

Vaccine eligibility is recorded after the vaccine name on the **Add Immunization** screen. Select the appropriate vaccine eligibility from the drop-down menu:

- **Medicaid**
- **Native or Alaskan American**
- **Uninsured**
- **Underinsured** – Insurance does not cover any reimbursement for the cost of vaccine.
- **Private Insurance/Fully Insured** - (not VFC Eligible) Insurance pays for all or part of the cost of the vaccine. As with underinsured, office co-pays or administration fees may still be charged.

**Mandatory elements of the Vaccine for Children (VFC) Program include screening the child's eligibility status on each visit and keeping a record of each VFC dose administered (tally sheet). The resulting data serves a tri-fold purpose:*

- *Children are not denied immunizations because of the inability to pay, while those who have complete insurance coverage receive vaccines from a purchased supply*
- *The data allows the state to forecast vaccine needs to keep adequate supplies in stock*
- *Vaccine funds are provided through separate state and federal programs. The purchase of vaccines must be attributed to the appropriate funding source to ensure the continuation of this valuable program.*

Editing a MCIR Record

Review the list below to see what information you can and cannot edit on the **General Information** screen:

Edit

Alias Last (name), Alias First (name), Mother's Maiden Name, Residence Information, Birth Facility Information, Patient ID, Responsible Party Information, all MCIR Options

Cannot Edit

Legal Last (name), Legal First (name), Middle (name), Suffix (name), Date of Birth, Multiple Birth Status, MCIR ID, WIC ID, Medicaid ID, Health Plan Name

Editing Immunization Data

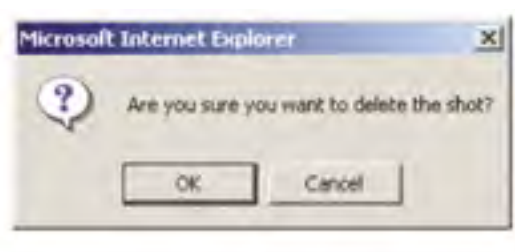
To edit a record, click on the hyperlink under the vaccination you want to edit. The **Edit Immunization History** screen will appear. On this screen you are able to modify the following text boxes: date administered, manufacturer, lot number, site on body, vaccine eligibility, dose, initials, route, non-administration, and provider/other provider. Once the modifications have been made, click the **Submit** button to save the changes.

To delete a vaccine you must be on the **Immunization History** screen. Click on the **Delete** check box on the same row as the vaccine you which to delete. A pop-up box will open stating, "Are you sure you want to delete the shot?" Click the **Yes** button and the record will be deleted.

You will only be allowed to edit/delete those vaccinations that your office entered into the MCIR. These vaccines will have hyperlinks under them. On the **Add Immunization screen, you can add or change information, prior to clicking the **Submit** button. Once submitted, the immunization record becomes part of the immunization history and can only be edited or deleted on the **Immunization History** screen. Care should be taken when entering the vaccine information to ensure you are documenting the appropriate information relating to the vaccines administered.*

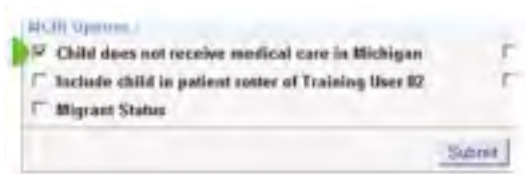


Any shot deleted from the MCIR CANNOT be recovered!



Change Medical Status of Child

If a child receives medical care outside of Michigan, you can record this information to prevent reminder/recall notices from being generated for the child. To indicate a child's change in medical status, go to the **General Information** screen. In the **MCIR Options** at the bottom section of the **General Information** screen, click on the **Child does not receive medical care in Michigan** check box. Then click the **Update Child** button to save the changes.



Petition for Modification to a MCIR Record

A MCIR user or a child's responsible party may petition the Michigan Department of Community Health (MDCH) to have a MCIR record changed. The completed Petition for Modification form should be submitted to your regional MCIR office.

**Contact your regional MCIR office for Petition for Modification forms and instructions.*

Printing a Child's MCIR Record

At the top left of the **Immunization History** screen is a **View Immunization Report** hyperlink. Clicking this hyperlink allows you to see the child's immunization status and history in a printable format. To print out a copy of the record, click on the **File** drop-down menu and choose **Print**.

There are three available formats for printing a MCIR record. All three of the formats are considered to be Official State of Michigan Records, which may replace the Green Card immunization record.

- One page print-out with responsible party information
- One page print-out without responsible party information
- Two to three page print-out detailing the manufacturer and lot number

To choose one of the above print formats from the **Immunization History** screen click on **Reports**.

You may also set your computer's default to automatically print in one of the three formats by choosing **Options, then **User Preferences**.*

Patient Roster

The **Patient Roster** can be used to save time in retrieving your patient's immunization record. It is highly recommended that you include your patients in your *Patient Roster*. The *Patient Roster* is a quick way to access a current patient, especially if the patient was previously hard to locate in the MCIR.

To add a child to your Patient Roster

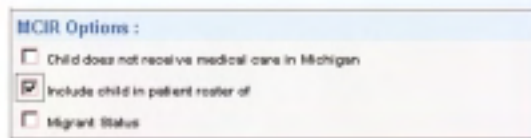
On the **General Information** screen check the box in the MCIR Options to **Include child in patient roster**.

To delete child from your Patient Roster

In your *Patient Roster*, click on the **Delete** check box which appears on the same line as the name of the child that you wish to remove from your **Patient Roster**. Then click on the **Delete Checked** box.

You may choose to check all children in your roster by clicking on the **Check All hyperlink.*

By clicking on the column titles, you can sort patients by the various column headings.



MCIR Options :

- Child does not receive medical care in Michigan
- Include child in patient roster of
- Migrant Status

MCIR Reports

The MCIR System generates reports by combining and organizing individual immunization information according to your requested report parameters. These MCIR Reports help organize and track immunization data at the provider, regional, and state level.

**Since a report is created from individual immunization information, it is important that the child's information is accurate and current in the MCIR.*

To access MCIR Reports, click on the **Reports** link on the menu bar, or choose the appropriate report category from the **Reports** column of the **MCIR Web Home Page**. Once the report is open, you will have the ability to view the report on the computer or print a paper copy of the report.

1. Official State of Michigan Immunization Record –

This report gives the provider a two to three page printout of a child's immunization record that can be used for school/daycare/camp. The report provides demographical information regarding the child. The report shows the status of the child based on the date printed. In addition, this report provides a list of vaccinations given by series, displays the child's current immunization status and indicates needed vaccines, provides a place to write in shots given today, provides more detailed information on vaccines by the date of administration, and displays a non-administered vaccine section.

2. 1-Page Official State of Michigan Immunization

Record with Address – This is the same report as the *Official State of Michigan Immunization Record*.

In addition, this report provides a list of vaccinations given by series, displays the child's current immunization status, and indicates needed vaccines. The signature and date line is to be signed by the health care professional that administered the vaccines. Signature and date are optional.

3. 1-Page Official State of Michigan Immunization

Record without Address – This is the same report as the 1-Page *Official State of Michigan Immunization Record with Address*. But on this report only the child's MCIR ID, Gender, Patient ID, Name, Age and Date of Birth are viewable. (The child's address is excluded from this report.)

4. Current Immunization Profile by Provider ID

This report is designed to give the user statistics for their immunization practice based on their MCIR User ID number. Parameters for this report can be changed at the discretion of the user. Parameters include: age range and a minimum number of doses for a particular vaccine. Once the report is generated, it will provide the user with the number and percentage of the clients that meet the selected criteria, the number of clients not meeting the selected criteria, and the total number of clients evaluated.

5. Current Immunization Profile by Patient Roster

This report is the same as the *Current Immunization Profile by Provider ID*. The only difference is that this report is based on clients in the user's patient Roster, rather than those clients attached to the user's MCIR ID.

6. Immunization Profile Listing by Provider ID

This report goes hand-in-hand with the Current Immunization Profile by Provider ID and provides the user with a list of clients in their practice who do not meet the minimum doses for specific vaccines. Parameters for this report can be set and changed at the discretion of the user. Parameters include: age range and a minimum number of doses for a particular vaccine. Once this report is generated, it will provide the user with the MCIR IDs for each client not meeting the report criteria. In addition, the report lists the clients' names, birth dates, and responsible party phone numbers (if listed on the individual clients' MCIR

records). This report can be used to contact children who are overdue for immunizations and/or to flag records for clients needing immunizations.

7. Immunization Profile Listing by Patient Roster

This report is the same as the *Immunization Profile Listing by Provider ID*. The only difference is that this report is based on clients in the user's Patient Roster, rather than those clients attached to the user's MCIR ID.

8. Doses Admin – Single User – This report is designed for participants in the Michigan Vaccine for Children (VFC) program. The Vaccine Eligibility field must be used when adding all immunizations into the MCIR in order for this report to generate accurately. In order to run this report, the user must select a starting and ending month/year and vaccine purchase type (funding type) for the report. The Doses Admin- Single User report provides the user with a detailed list of each vaccine series type, along with the number of doses of each vaccine type administered within the chosen time frame and administered to clients in the selected vaccine purchase type category.

Vaccine Purchase/Funding Types:

- MI-VFC – Medicaid, Native American, uninsured, and under insured
- Private Funds – private insurance
- Other Public Funds – other public purchase types
- All – Summary of all vaccine eligibility types combined into one report

9. Provider Profile Report – This report generates a projection for the number of vaccines that will be administered in the user's medical practice for the following year. This report is broken down by the individual Vaccine Purchase Types (see list of Vaccine Purchase Types above). The user must use the vaccine eligibility field when adding all immunization to the MCIR in order for this report to function properly. This report may be ran by a one month, three month, six month or twelve month increment. *Vaccine Eligibility must have been used in the MCIR for the total period of time the user is choosing to generate the report.*

Vaccine Inventory Module

The Vaccine Inventory Module (VIM) is a vaccine tracking system for providers. The VIM automatically deducts the appropriate dose amounts from the provider's inventory balances as the immunizations are added to a child's MCIR record.

VIM Tips

1. When entering vaccines given, always use the pull-down menu to access the correct lot number used. The **lot number and manufacturer must be accurate** for inventory to run smoothly. If you don't see the lot number you want to choose, this means something is wrong with the vaccine type, the lot number, or the manufacturer chosen. Using the pull-down menu to access the correct lot number is the best way to avoid error.
2. **You need to add vaccines received to the VIM in a timely manner.** If vaccines with a new lot number are typed in during routine data entry, before they are entered into VIM, VIM will not take the vaccine out of inventory.
3. If you typed in a lot number and inventory and saved it, and then realized that you made an error, you will not be able to edit the lot number. You must "inactivate" the lot number and enter the correct number into inventory as a new vaccine lot. If this error is not discovered immediately and the incorrect lot number has been selected during data entry, you have two choices for correction:

- **Add** the correct lot number to inventory and then edit each of the records for those children documented as having received the vaccine. Once this is complete, inactivate the invalid lot number.
- **Inactivate** the incorrect lot number immediately and enter the correct one into the inventory.

Note: In order to run an accurate end-of-the-month "Ending Inventory Report" you will have to re-activate the inactivated lot number long enough to generate the report.

4. Provider *Vaccine for Children (VFC)* logs cannot be done from VIM at this time. The State of Michigan currently requests that all Michigan health departments collect their providers' logs and tally the totals together, recording totals on one form with the specific county name written on the top of the report.

Options

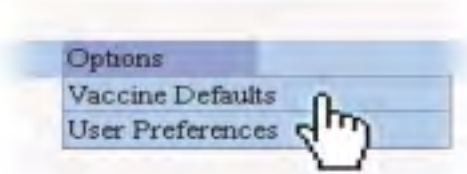
User Preferences

This option allows you to customize those MCIR options you use frequently:

- Automatically add the CPT-4 Codes to vaccines entered
- Automatically add a child to your **Patient Roster**
- Default your **Immunization History** screen view format
- Specify the view and print format for MCIR records
- Specify default demographics to be used when adding a child to MCIR (city, zip code, county or phone area code)

Vaccine Defaults

This option allows you to customize the vaccine settings your office frequently uses to add immunizations and associated information to the MCIR. To see the Vaccine Default information, click on **Options** and then **Vaccine Defaults**, or click directly on **Vaccine Defaults** from the **Options** column on the Home Page. Click **Add New**, fill in the necessary information, and click **Submit**.





General Tips and Troubleshooting

Reminders for Adding Immunization to the MCIR

Combination Vaccines are uniquely assessed in the MCIR:

- Pedvax HIB is a three-dose series vaccine. If you administered Pedvax HIB, select **Hib-Pedvax HIB**. Do not select Hib (unspecified), ActHib/OmniHib, or Hibtiter when entering the immunization encounter into the MCIR. Hib (unspecified) and Hib-hibtiter are both assessed as four-dose series vaccines. Selecting **Hib-Pedvax HIB** will prevent a child from being assessed as needing a fourth dose.
- **DTaP-Hib (Trihibit)** combination vaccine is only licensed for the fourth dose of the DTP and HIB series. The dose will be considered invalid if recorded for any dose other than the fourth. Do not record DTaP-Hib unless the combination vaccine was actually given.
- **Hib-Hep B (Comvax)** is a three-dose series. If you administered Comvax, select Hib-Hep B when adding the encounter. A child will be assessed as needing another Hib if the vaccine is recorded separately under Hib and Hep B.

**Do not document vaccines as combination vaccines in the MCIR unless combination vaccines were actually administered. This does not save time! It will only cause invalid assessments on a child's MCIR record!*

Are you sure what kind of DTP, Hib or Polio some children have received? If not, please consider the following tips when entering this data into the MCIR:

- Select DTaP over DTP if the administration date is after 1-1-2000 (DTP is no longer manufactured)
- Select Hib (unspecified) if the specific type of Hib is not documented on the immunization record
- Select Polio (unspecified) if the specific type of Polio is not documented on the immunization record

***Please contact your regional MCIR office for any technical issues or concerns.**

MCIR Web Data Entry Shortcuts

Vaccine to enter	Key stroke	Tips and Trade Names
DTaP	D	Licensed in 1996
DTP	D, then down arrow key three times	
DTaP-HIB <i>Licensed for fourth dose ONLY!</i>	D, then down arrow key once	TriHibit (Do not enter DTaP and Hib together unless these shots were actually given in the combination DTaP-Hib vaccine. This does not save time. It causes data quality and MCIR immunization assessment errors.)
Hib (unspecified)	H, then down arrow three times	4 dose series
PedvaxHIB <i>Select Hib-Pedvax HIB</i>	H, then down arrow twice	Pedvax 3 dose series
Hib - HibTiter	H	4 dose series
Hib-Hep B	H, then down arrow four times	Comvax (Select Hib-Hep B if the Comvax combination vaccine was given. If accidentally documented separately, the child's MCIR assessment will call for a fourth and unnecessary dose.)
ActHIB	H, then down arrow once	ActHib 4 dose series
Polio (unspecified)	P	If the immunization record does not indicate Oral or Intravenous Polio, then the Polio should be documented as <i>Unspecified</i>
IPV	I	Licensed in 1999 as primary series, but available prior to 1999 upon request
OPV	O	Administered prior to 1999
MMR	M	
Hepatitis B (pediatric or adolescent)	H, then down arrow five times	
Varicella	V	Licensed in 1995
Documenting Immunity to Chickenpox	V (for Varicella)	Check the <i>No Admin</i> box. Select Documented Immunity
Pneumocacal Conjugate	P, then down arrow three times	PCV 7 or Prevnar Licensed in 2000
Non Administered Vaccines	<i>Key in appropriate vaccine</i>	Check the <i>No Admin</i> box. Then choose proper non-administration reason in the <i>Non Administered</i> pop-up box.

Regional MCIR Help Desks

Listed by Michigan County, unless otherwise noted

- Region 1:** City of Detroit; Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw & Wayne Counties
1-888-217-3900
- Region 2:** Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Ionia, Jackson, Kalamazoo, Kent, Lenawee, Muskegon, Ottawa, St. Joseph & Van Buren Counties
1-888-217-3901
- Region 3:** Barry, Clinton, Eaton, Gratiot, Ingham and Montcalm Counties
1-888-217-3902
- Region 4:** Bay, Genesee, Huron, Lapeer, Midland, Saginaw, Sanilac, Shiawassee & Tuscola Counties
1-888-217-3903
- Region 5:** Alcona, Alpena, Antrim, Arenac, Benzie, Charlevoix, Cheboygan, Clare, Crawford, Emmet, Gladwin, Grand Traverse, Iosco, Isabella, Kalkaska, Lake, Leelanau, Manistee, Mason, Mecosta, Missaukee, Montmorency, Newaygo, Oceana, Ogemaw, Osocoda, Oseola, Ostego, Presque Isle, Roscommon & Wexford Counties
1-888-217-3904
- Region 6:** The entire U.P. (Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, & Schoolcraft Counties)
1-888-217-3905

Visit Michigan Virtual University's *free* MCIR Training Module, at www.healthcare.mivu.org. *CEUs are available for this course.

