PROTECT PI CME Chart Review Form

Immunizations in High-Risk Adults

Patient ID _____ Chart Review Date: _____

(for clinician's use only; not entered into online form) Chart Reviewer: _____

Elibility Criteria

_____ years Patient's age at last office visit ☞ *Must be age 19 or older to be eligible*

___ Yes† ____ No Has the patient been established in your practice for at least 12 months?

___ Yes† ____ No Within the past 3 months, was this patient seen for preventive care or follow-up of a chronic condition?

___ Yes† ____ No Is patient at high-risk for vaccine-preventable infections?*

**Patient is high-risk if one or more of the following are present: Age 65 or older; current smoker; diabetes; chronic respiratory illness (i.e. COPD or asthma); chronic cardiac, liver, or kidney disease; sickle cell disease; cancer; HIV/AIDS; chronic alcoholism; weakened immune system (removed or dysfunctional spleen; receiving immunosuppresive chemotherapy or systemic corticosteroids)*

† *Response must = YES for patient chart to be eligible*

Immunization Status

PPSV

___ Yes ____ No Has the patient ever received a **pneumoccal polysaccharid vaccine (PPSV)**?

If YES, skip to Zoster Question Set

___ Yes ____ No Does the patient have a medical contraindication to PPSV or this vaccine's components?

If YES, skip to Zoster Question Set

___ Yes _____ No During the past 12 months, did you recommend PPSV to this patient?

Zoster

___ Yes ___ No Has the patient ever received a **Zoster (shingles)** vaccine?

If YES, skip to Td/Tdap Question Set

☞ ***Zoster vaccine is recommended for all persons aged ≥60 years who have no contraindications. There are currently no vaccine reccommendations for persons aged <60***

___ Yes ___ No Does the patient have a medical contraindication to the zoster vaccine or this vaccine's components?

IfYES, skip to Td/Tdap Question Set

____ Yes ____ No During the past 12 months, did you recommend zoster vaccine to this patient?

Td/Tdap

____ Yes ____ No Within the past 10 years, has the patient received a **tetanus, diphtheria toxoid and acellular pertussis vaccine (Tdap)**?

____ Yes ____ No Within the past 10 years, has the patient received a **tetanus and diphtheria toxoid vaccine (Td)**?

If YES for Td or Tdap, skip to Influenza Question Set

____ Yes ____ No Does the patient have a medical contraindication to Td, Tdap or one of these vaccine's components?

If YES, skip to influenza Question Set

____ Yes _____ No During the past 12 months, did you recommend a Td or Tdap vaccine to this patient?

Influenza

____ Yes ____ No Within the past 12 months, has the patient received an **influenza vaccine**?

If YES, skip to Contributing Factors section

____ Yes ____ No Does the patient have a medical contraindication to influenza vaccine or this vaccine's components?

If YES, skip to Contributing Factors section

____ Yes _____ No During the past 12 months, did you recommend an influenza vaccine to this patient?

Factors Contributing to Lack of Immunization

Complete only if one or more of the above vaccines NOT received

Which of the following contributed significantly to this patient's lack of immunization?

___ Yes ___ No Immunization deferred due to illness or injury

___ Yes ___ No Immunization records missing or incomplete

___ Yes ___ No Insurance coverage or cost issues

___ Yes ___ No Patient declined ***(If YES, indicate which vaccines were declined)***

_____ PPSV _____ Zoster _____ Td/Tdap _____ Influenza

___ Yes ___ No Patient uncertain of immunization status

___ Yes ___ No Vaccine not available in practice

___ Yes ___ No Vaccine not considered indicated for this patient at this time (***If YES, specify vaccines not considered indicated)***

_____ PPSV _____ Zoster _____ Td/Tdap _____ Influenza

___ Yes ___ No Other factors contributing to this patient's lack of immunization: (please describe)

PROTECT PI CME Chart Review Form

Adolescent Immunization

Patient Name _____ Patient ID_____ Chart Review Date: _____

(for clinician's use only; not entered online) *(Patient ID issued when chart data entered in PIM)* Chart Reviewer: _____

Elibility Criteria

___ Yes† ____ No Does this patient meet the age criteria?

- ***For Stage A: Must have had 13th birthday within the past 24 months***
- ***For Stage C: Must have had 13th birthday since you began Stage B of this PI-CME program***

___ Female ____ Male Gender (***if patient is male do not complete HPV question set)***

___ Yes† ____ No Was this patient seen in your practice on or before the 12th birthday?

___ Yes† ____ No Was this patient seen in your practice at least once during the year before the 13th birthday?

† ***Response must = YES for patient chart to be eligible***

Immunization Status

MCV4

___ Yes ____ No **Meningococcal vaccine (MCV)** received on or between the 11th and 13th birthday

If YES, Skip to Td/Tdap Question Set

___ Yes ____ No History of anaphylactic reaction to MCV4 or any of this vaccine's components?

___ Yes ____ No Other medical contraindications to MCV4?

Please describe contraindication to MCV: _____

If YES to either, Skip to Td/Tdap section

___ Yes ____ No MCV4 recommended to patient during 12 months before 13th birthday? (If unsure, choose "No")

Tdap or Td

___ Yes ___ No **Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap)** received on or between the patient's 10th and 13th birthday?

___ Yes ___ No **Tetanus, diphtheria toxoids vaccine (Td)** received on or between the patient's 10th and 13th birthday?

If YES to Tdap or Td, Skip to HPV Question Set

___ Yes ____ No History of anaphylactic reaction to Tdap, Td, or any of these vaccines' components?

___ Yes ____ No Other medical contraindications to Tdap or Td?

Please describe contraindication to Tdap or Td: _____

If YES, Skip to HPV Question Set

___ Yes ____ No Td or Tdap recommended to patient during 12 months before 13th birthday? (If unsure, choose "No")

HPV *(Female Patients Only)*

Human papillomavirus vaccine (HPV) doses received between 9th and 13th birthday

____0 ____1 ____2 ____3 or more

If 1 or more HPV doses received, Skip to Influenza question Set

___ Yes ____ No Pregnant on or before the 13th birthday?

___ Yes ____ No History of anaphylactic reaction to HPV or any of this vaccine's components?

___ Yes ____ No Other medical contraindications to HPV ?

Please describe contraindication to MCV: _____

If YES to any of these, Skip to Influenza question set

____ Yes _____ No HPV recommended to patient during the 12 months before the 13th birthday? (If unsure, choose "No")

Influenza

____ Yes ____ No Within the past 12 months, has the patient received an **influenza vaccine**?

If YES, Skip to Catch-up Planning section

___ Yes ____ No History of anaphylactic reaction to Influenza vaccine or any of this vaccine's components?

___ Yes ____ No Other medical contraindications to Influenza vaccine?

Please describe contraindication to influenza vaccine: _____

If YES, Skip to Catch-up Planning section

____ Yes _____ No

Influenza vaccine recommended to this patient during the 12 months before the 13th birthday?

Catch-up Planning

Complete only if one or more of the above vaccines were NOT received (with no contraindication or anaphylactic reaction recorded)

___ Yes ___ No Has patient had at least 1 office visit since the 13th birthday?

If No, Skip to Contributing Factors section

___ Yes ___ No Were any vaccines given at this first 13-year-old visit?

___ Yes ___ No Had patient received all indicated vaccines by the end of this visit?

If YES - All Vaccines Received at Visit End, Skip to Contributing Factors section

___ Yes ___ No Was a plan for getting vaccines caught up established and reviewed with the family?

Factors Contributing to Lack of Immunization

Complete only if one or more of the above vaccines were NOT received (with no contraindication or anaphylactic reaction recorded)

Which of the following contributed significantly to this patient's delayed immunizations?

___ Yes ___ No Deferral due to illness or injury

___ Yes ___ No Incomplete or missing immunization records

___ Yes ___ No Insurance coverage or cost issues

___ Yes ___ No National vaccine shortage

___ Yes ___ No Patient/Parent declined (If **YES**, please indicate reason)

___ Fear of autism ___ Religious beliefs ___ Other concerns or beliefs

___ Yes ___ No Parent or guardian not present to provide consent

___ Yes ___ No Recommended well child care/immunization visits missed or not scheduled

___ Yes ___ No Vaccine not available in practice

___ Yes ___ No Other factors: (please describe below)

PROTECT PI CME Chart Review Form
Early Childhood Immunization

Patient Name _____ Patient ID_____ Chart Review Date: _____

(for clinician's use only; not entered online) *(Patient ID issued when chart data entered in PIM)* Chart Reviewer: _____

Eligibility Criteria *(Must answer YES to all 3 questions for patient chart to be eligible)*

___ Yes ____ No Does this patient meet the age criteria?

- ☞ ***For Stage A: Must have had 2nd birthday within the past 24 months***
- ☞ ***For Stage C: Must have had 2nd birthday after the Index Date***

1st Stage C Chart Review: Index Date = Date on or after you began Stage B of the PI-CME program

2nd Stage C Chart Review: Index Date = Day you submitted your initial Stage C chart review data

___ Yes ____ No Was this patient seen in your practice on or before age 12 months?

___ Yes ____ No Was this patient seen in your practice at least once between the ages of 12 and 24 months?

HEDIS Childhood Immunization Status

How many of the following vaccines did the patient receive ON or BEFORE their 2nd birthday?

DTaP	___ 0	___1	___ 2	___ 3	___ 4 or more
IPV	___ 0	___1	___ 2	___ 3 or more	
MMR	___ 0	___1 or more			
Hib	___ 0	___1	___ 2	___ 3	___ 4 or more
HepB	___ 0	___1	___ 2	___ 3 or more	
Varicella	___ 0	___1 or more			
PCV	___ 0	___1	___ 2	___ 3	___ 4 or more
HepA	___ 0	___1	___ 2 or more		
Rotavirus (2-dose vaccine)	___ 0	___1	___ 2	___ 3 or more	
Rotavirus (3-dose vaccine)	___ 0	___1	___ 2	___ 3 or more	
Influenza	___ 0	___1	___ 2	___ 3 or more	

Did the patient have a seropositive test result or a documented history of illness for the following ON or BEFORE the 2nd birthday?

Measles	___ Yes	____ No	Hepatitis A	___ Yes	____ No
Mumps	___ Yes	____ No	Hepatitis B	___ Yes	____ No
Rubella	___ Yes	____ No	Varicella	___ Yes	____ No

Does the patient have a medical contraindication to any of the following vaccines? (select all that apply)

___ No contraindication

If NO, skip to "Catch-up Planning" section

___ DTaP	___ HepB	___ Rotavirus (2-dose vaccine)
___ IPV	___ Varicella	___ Rotavirus (3-dose vaccine)
___ MMR	___ PCV	___ Influenza
___ Hib	___ HepA	

Which of the following medical contraindications to immunization does the patient have? (select all that apply)

___ Anaphylactic reaction to common baker's yeast
___ Anaphylactic reaction to a prior vaccine
___ Anaphylactic reaction to streptomycin, polymixin B or neomycin
___ Cancer - including leukemia, lymphoma, multiple myeloma
___ Encephalopathy
___ HIV infection
___ Immunodeficiency
___ Progressive neurologic disorder including infantile spasm, uncontrolled seizures
___ Other contraindications: (please describe below)

Catch-up Planning

Complete ONLY if this patient is not up-to-date for 1 or more recommended vaccines and does not have contraindications for those vaccines

___ Yes ___ No Has patient had at least 1 office visit since the 2nd birthday?

If No, Skip to Contributing Factors Section

___ Yes ___ No Were any vaccines given at this first 2-year-old visit?

___ Yes ___ No Had patient received all indicated vaccines by the end of this visit?

If YES - All Vaccines Received at Visit End, Skip to Contributing Factors section

___ Yes ___ No Was a plan for getting vaccines caught up established and reviewed with the family?

Factors Contributing to Lack of Immunization

Complete if one or more of indicated vaccines was NOT received OR any vaccine series was abbreviated

Which of the following contributed significantly to this patient's delayed or reduced number of immunizations?

___ Yes ___ No Too delayed to give standard number of pneumococcus vaccine doses
___ Yes ___ No Too delayed to give standard number of rotavirus vaccine doses
___ Yes ___ No Too delayed to give standard number of Hib vaccine doses
___ Yes ___ No Deferral due to illness or injury
___ Yes ___ No Incomplete or missing immunization records
___ Yes ___ No Insurance coverage or cost issues
___ Yes ___ No National vaccine shortage
___ Yes ___ No Parent declined (If **YES**, please indicate reason)
___ Fear of autism ___ Religious beliefs ___ Other concerns or beliefs
___ Yes ___ No Parent or guardian not present to provide consent
___ Yes ___ No Recommended well child care/immunization visits missed or not scheduled
___ Yes ___ No Vaccine not available in practice
___ Yes ___ No Other factors: (please describe below)

This data collection form can help you find and record all needed chart data before entering your chart data online.
Although the paper and online forms are quite similar, the online question sets may be slightly different from those on this form.