2022 ACO Quality Measures- Dr. Smith

Depression screening, fall risk, tobacco assessment, flu immunization, A1C, mammogram and colon cancer screening can be collected via telemedicine visit; requires date and physician signature

Patient:	**Screening for Falls and Fall Risk Management** Patients 65 years and older			
	Have you had 2 or more falls in the last 12 months?	YES	NO	
DOB:	Were you injured during a fall this year?	YES	NO	
Phone:	Do you use any of the following?	CANE	WALKER	WHEELCHAIR
Date Performed:	Is the patient a fall risk?	LOW	MODERATE	HIGH
PCP:	**Document appropriate level of FALL INTERVENTION PLANNING:**			

Alcohol and Health Assessment

Over the past year, Circle your answer	0	1	2	3	4
1. How often did you have a drink containing alcohol in the past year?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many drinks containing alcohol did you have on a typical day when you were drinking in the last year?	None, OR 1 to 2 drinks	3 or 4 drinks	5 or 6 drinks	7 to 9 drinks	10 or more drinks
3. How often did you have 6 or more drinks on one occasion in the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Total score of each column , then add across for grand total=					

Brief Counseling Indicated: YES / NO
> or = 7 assess further with Alcohol Symptom Checklist

Alcohol Symptom Checklist Completed YES/ NO # Symptoms = _____ Circle: Negative or Positive for AUD
Positive AUD = Counseling & Intervention using Decision Aid Completed YES/ NO

Tobacco Assessment

Never used tobacco _____Former User _____ Current User _____ Date_____/_____/_____

Type of Tobacco: (Cigarettes, chew, etc.) _____

Cessation Counseling (CC): _____

CC: includes brief counseling (3 minutes or less, can be longer duration and/or pharmacotherapy)

Immunization

Flu Vaccination: ___/___/___

Flu Vaccine Refusal Date: ___/___/___
***May be patient reported**

Pneumovax Vaccine: ___/____/_____

Refusal Date: ___/___/___

PHQ-9

Over the past 2 weeks, Circle how often have you been bothered by any of the following problems:	Not at all	Several Days	More than half the days	Nearly every Day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or staying asleep, or sleeping to much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor Appetite or overeating?	0	1	2	3
6. Feeling bad about yourself-or that you're a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Total score of each column , then add across for grand total=				

Circle: Negative or Positive for Depression Intervention or Counseling Required? YES / NO

Plan:
Office Use Only

Mammogram:
Date:___/____/____
Result:
_____
*May be patient reported

Diabetic A1c Result: _____%
A1c Date: ____/____/____
*May be patient reported

Microalbumin Results _____
Date:
Ordered: _____

Date of last Retinal Eye Exam:
_____

Colon Cancer Screening:
Date: ____/____/____
Procedure: _____
Result: _____
*May be patient reported
Colonoscopy: 2013-2022 | Sigmoidoscopy 2018-2022
Cologuard or FIT DNA: 2020-2022 | FOBT or FIT: 2022
CT of Colon 2018-2022

Blood Pressure:
_____/_____
Date: ____/____/____
DX: _____
DX: Essential HTN Req - I10
Prev-13
ASCVD Dx: _____
Date: _____
Statin: _____

M.A. Initials_____ **Clinicians Initial:** _____ **Date:** _____/_____/_____