

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
			Length of Educ (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:
<b>Depression Screening</b>	<p><b>Adult patients 18 years of age and older should be screened for depression at least annually.</b>  <b>(Source: United States Preventive Services Task Force)</b></p> <p><b>Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</b></p>	<p><b>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</b></p> <ul style="list-style-type: none"> <li>Date received</li> <li>Location</li> <li>Results</li> </ul> <p><b>Medical Providers:</b>  <b>EXAM—Depression Screening</b></p> <ul style="list-style-type: none"> <li><b>Normal/Negative</b>—Denies symptoms of depression</li> <li><b>Abnormal/Positive</b>—Further evaluation indicated</li> <li><b>Refused</b>—Patient declined exam/screen</li> <li><b>Unable to screen</b>—Provider unable to screen</li> </ul> <p><b>Note: Refusals are not counted toward the GPRA measure, but should be documented.</b></p> <p><b>Mood Disorders:</b>  <b>Two or more visits with POV related to:</b></p> <ul style="list-style-type: none"> <li>Major Depressive Disorder</li> <li>Dysthymic Disorder</li> <li>Depressive Disorder NOS</li> <li>Bipolar I or II Disorder</li> </ul>	<p><b>Depression Screening Exam</b>  <a href="#">Exam Entry</a> (includes historical exams)            Select Exam: <b>36, DEP</b>            Result:            A—Abnormal            N—Normal/Negative            PR—Resent            PAP—Present and Past            PA—Past            PO—Positive            Comments: <b>PHQ-2 Scaled, PHQ9</b>            Provider Performing Exam:</p> <p><b>Depression Screen Diagnosis POV</b>  <a href="#">Visit Diagnosis Entry</a>            Purpose of Visit: <b>V79.0</b>            Provider Narrative:            Modifier:            Cause of DX:</p> <p><b>Mood Disorder Diagnosis POV</b>  <a href="#">Visit Diagnosis Entry</a>            Purpose of Visit: <b>296.*, 291.89,</b></p>

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		<p>Cyclothymic Disorder</p> <p>Bipolar Disorder NOS</p> <p>Mood Disorder Due to a General Medical Condition</p> <p>Substance-induced Mood Disorder</p> <p>Mood Disorder NOS</p> <p><b>Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</b></p> <p><b><u>Patient Health Questionnaire (PHQ-2 Scaled Version)</u></b></p> <p><b>Over the past 2 weeks, how often have you been bothered by any of the following problems?</b></p> <p><b>Little interest or pleasure in doing things</b></p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><b>Feeling down, depressed, or hopeless</b></p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><b>PHQ-2 Scaled Version (continued)</b></p> <p><b>Total Possible PHQ-2 Score: Range: 0-6</b></p> <p><b>0-2: Negative Depression Screening Exam:</b></p> <p><b>Code Result:</b> Normal or Negative</p>	<p><b>292.84, 293.83, 300.4, 301.13, 311</b></p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p>

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		<p><b>3-6: Positive; further evaluation indicated Depression Screening Exam</b>  <b>Code Result:</b> Abnormal or Positive</p> <p><b>The patient may decline the screen or “Refuse to answer” Depression Screening Exam</b>  <b>Code Result:</b> Refused</p> <p><b>The provider is unable to conduct the Screen Depression Screening Exam</b>  <b>Code Result:</b> Unable To Screen</p> <p><b>Provider should note the screening tool used was the PHQ-2 Scaled at the <i>Comment</i> Mnemonic for the Exam Code.</b></p> <p><b><u>PHQ9 Questionnaire Screening Tool</u></b></p> <p><b>Little interest or pleasure in doing things?</b></p> <ul style="list-style-type: none"> <li>a. Not at all Value: 0</li> <li>b. Several days Value: 1</li> <li>c. More than half the days Value: 2</li> <li>d. Nearly every day Value: 3</li> </ul> <p><b>Feeling down, depressed, or hopeless?</b></p> <ul style="list-style-type: none"> <li>a. Not at all Value: 0</li> <li>b. Several days Value: 1</li> <li>c. More than half the days Value: 2</li> <li>d. Nearly every day Value: 3</li> </ul> <p><b>Trouble falling or staying asleep, or sleeping too much?</b></p> <ul style="list-style-type: none"> <li>a. Not at all Value: 0</li> <li>b. Several days Value: 1</li> </ul>	

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		<p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><b>Feeling tired or having little energy?</b></p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><b>Poor appetite or overeating?</b></p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><b>Feeling bad about yourself—or that you are a failure or have let yourself or your family down?</b></p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><b>Trouble concentrating on things, such as reading the newspaper or watching television?</b></p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><b>Moving or speaking so slowly that other people could have noticed. Or the opposite—being so</b></p>	

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		<p><b>fidgety or restless that you have been moving around a lot more than usual?</b></p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><b>Thoughts that you would be better off dead, or of hurting yourself in some way?</b></p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><b><u>PHQ9 Questionnaire (Continued)</u></b></p> <p><b>Total Possible PHQ-2 Score: Range: 0–27</b></p> <p><b>0-4 Negative/None Depression Screening Exam:</b> <b>Code Result:</b> None</p> <p><b>5-9 Mild Depression Screening Exam:</b> <b>Code Result:</b> Mild depression</p> <p><b>10-14 Moderate Depression Screening Exam:</b> <b>Code Result:</b> Moderate depression</p> <p><b>15-19 Moderately Severe Depression Screening Exam:</b> <b>Code Result:</b> Moderately Severe depression</p> <p><b>20-27 Severe Depression Screening Exam:</b> <b>Code Result:</b> Severe depression</p> <p><b>Provider should note the screening tool used was the PHQ9 Scaled at the <i>Comment</i></b></p>	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
		<b>Mnemonic for the Exam Code.</b>	
<p><b>Obesity Assessment (Calculate Body Mass Index [BMI])</b></p> <p><b>NOTE: This is not a GPRA measure; however, it's displayed in GPRA report for reducing the incidence of obesity. The information is included here is to inform providers and data entry staff of how to collect, document, and enter the data.</b></p>	<p><b>Children (through age 18) must have both height and weight taken <u>on the same day</u> at least annually (at every visit is recommended).</b></p> <p><b>Adults 19-50, height and weight at least <u>every 5 years</u>, not required to be on same day.</b></p> <p><b>Adults over 50, height and weight taken <u>every 2 years</u>, not required to be on same day.</b></p>	<p><b>Standard EHR documentation. Obtain height and weight during visit and record information in EHR:</b></p> <p>Height</p> <p>Weight</p> <p>Date Recorded</p> <p><b>BMI is calculated using NHANES II.</b></p> <p><b>Obese is defined as:</b></p> <p>BMI of 30 or more for adults 19 and older.</p> <p>For ages 2–18, definitions based on standard tables.</p> <p><b>To document Refusals in EHR:</b></p> <p><a href="#">Refusal Entry in EHR</a></p> <p><b>For ages 18 and under, both the height and weight must be refused on the same visit at any time during the past year.</b></p> <p><b>For ages 19 and older, the height and weight must be refused during the past year and are not required to be on the same visit.</b></p>	<p><b>Height Measurement</b></p> <p><a href="#">Vital Measurements Entry</a> (includes historical Vitals)</p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Estimated</p> <p>Date/Time Vitals Taken:</p> <p><b>Weight Measurement</b></p> <p><a href="#">Vital Measurements Entry</a> (includes historical Vitals)</p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Bed</p> <p>Chair</p> <p>Dry</p> <p>Estimated</p> <p>Standing</p> <p>Date/Time Vitals Taken:</p>
<b>Childhood Weight Control</b>	<p><b>Patients ages 2–5 at the beginning of the report period whose BMI could be calculated and have a BMI =&gt; 95%.</b></p> <p><b>Height and weight taken on the same day.</b></p> <p><b>Patients that turn 6 years old during the report</b></p>	<p><b>Standard EHR documentation. obtain height and weight during visit and record information in EHR:</b></p> <p>Height</p> <p>Weight</p> <p>Date Recorded</p> <p><b>BMI is calculated using NHANES II</b></p> <p><b>Age in the age groups is calculated based on the</b></p>	<p><b>Height Measurement</b></p> <p><a href="#">Vital Measurements Entry</a> (includes historical Vitals)</p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Estimated</p> <p>Date/Time Vitals Taken:</p>

# Appendix A

Below you will find general instructions on how to enter the following information in EHR:

- [Clinic Codes](#)
- [Purpose of Visit / Diagnosis](#)
- [CPT codes](#)
- [Procedure Codes](#)
- [Exams](#)
- [Health Factors](#)
- [Immunizations](#), including [contraindications](#)
- [Vital Measurements](#)
- [Lab Tests](#)
- [Medications](#)
- [Infant Feeding](#)
- [Patient Education](#)
- [Refusals](#) (Note: GPRA measures do *not* include refusals, though refusals should still be documented.)

For many of these actions, you will need to have a visit chosen before you can enter data.

*Please note that EHR is highly configurable, so components may be found on tabs other than those listed here. Tabs may also be named differently.*

## Clinic Codes

Clinic codes are chosen when a visit is created.

**Encounter Settings for Current Activities**

17 OPHTHALMOLOGY 19-Aug-2010 12:12

**Encounter Location**

Appointments / Visits Hospital Admissions New Visit

Visit Location

- 17 OPHTHALMOLOGY
- 11 HOME CARE
- 12 IMMUNIZATION
- 13 INTERNAL MEDICINE
- 14 MENTAL HEALTH
- 16 OBSTETRICS
- 17 OPHTHALMOLOGY
- 18 OPTOMETRY

Date of Visit

Thursday , August 19, 2010

Time of Visit

12:12 PM

Type of Visit

Ambulatory

Create a Visit Now

**Encounter Providers**

All Providers

- POWERS,MEGAN
- POWERS,MEGAN
- REGA,ANN
- RICHARDS,SUSAN P
- ROBARDS,DARLENE G
- ROZSNYAI,DUANE
- SALMON,PHILLIP

OK Cancel

## Purpose of Visit/Diagnosis

The purpose of visit is entered in the Visit Diagnosis component, which may be found on the Prob/POV tab.

The screenshot displays the IHS-EHR Tucson Development System interface for patient POWERS, MEGAN. The interface includes several key components:

- Patient Information:** Patient name (POWERS, MEGAN), ID (900031), birth date (01-Jul-1958), gender (F), and visit date (19-Aug-2010).
- ICD Pick Lists:** A list of ICD codes and descriptions for selection, including Child Abuse and Neglect, Counseling, Family Disruption, and History of Abuse.
- Problem List:** A table of active problems, including a Dental Exam on 06/18/2003.
- Historical Diagnosis:** A table of past diagnoses, including Dental Exam, AMI, and STENOSIS.
- Visit Diagnosis:** A table for recording the purpose of the current visit, which is highlighted by a red circle.

The Visit Diagnosis table is currently empty and has the following structure:

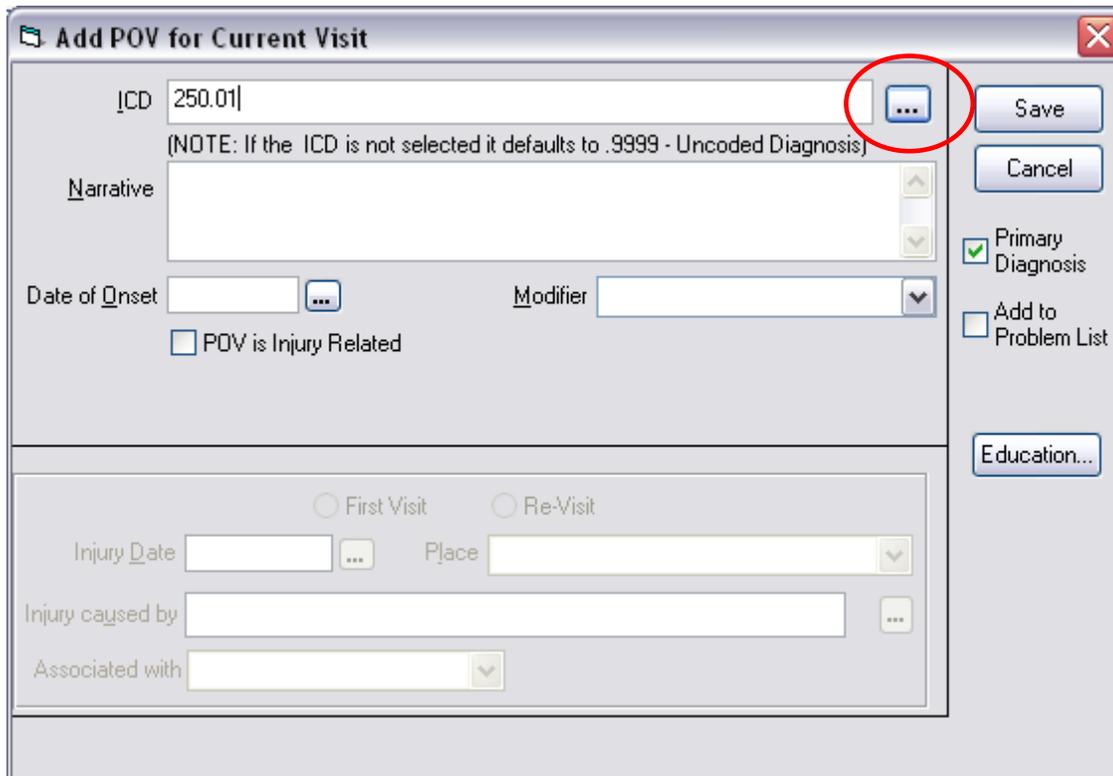
Provider Narrative	ICD	ICD Name	Priority	Cause	Injury Date

The interface also features a navigation bar at the bottom with tabs for various clinical functions, including Prob/POV, Services, Reports, and D/C Summ.

To enter a POV, click Add in the Visit Diagnosis component.



The Add POV for Current Visit dialog box displays. Type in the ICD code and click the ellipses (...) button.



Choose the ICD that you would like to enter and click OK.

**Diagnosis Lookup** ✖

Lookup Option  Lexicon  ICD

Search Value

Select from one of the following items

Code	Description
250.01	Diabetes Mellitus Without Mention Of Complication, Type I [juvenile Type], Not Stated As Uncontrolled

Return Search Text as Narrative

Enter in any other pertinent information and click Save.

**Add POV for Current Visit**
✖

ICD  ...

(NOTE: If the ICD is not selected it defaults to .9999 - Uncoded Diagnosis)

Narrative

Date of Onset  ...      Modifier

POV is Injury Related

First Visit       Re-Visit

Injury Date  ...      Place

Injury caused by

Associated with

Save

Cancel

Primary Diagnosis

Add to Problem List

Education...

Your newly added POV should display in the Visit Diagnosis component.

**Visit Diagnosis** i
Add   Edit   Delete

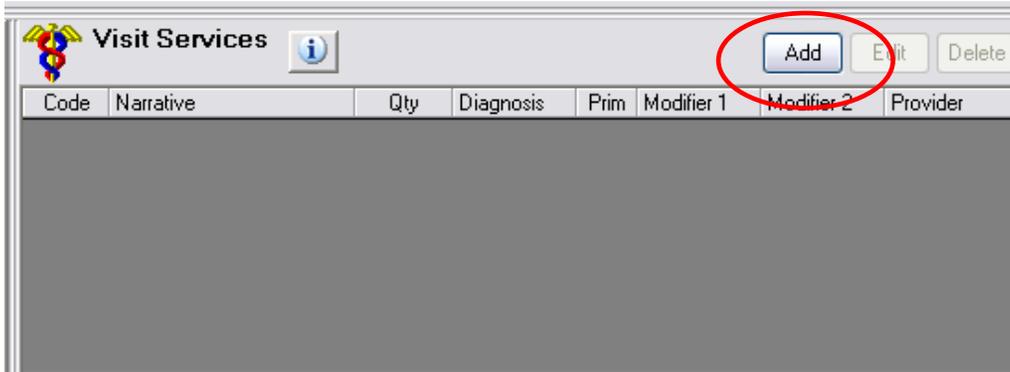
Provider Narrative	ICD	ICD Name	Priority	Cause	Injury Date	Injury Cause	Injury Place	Modifier
Diabetes Mellitus Without Mention Of Complication, Type I [juvenile Type], Not Stated As Uncontrolled	250.01	DIABETES I/JUV NOT UNCONTRL	Primary					

## CPT Codes

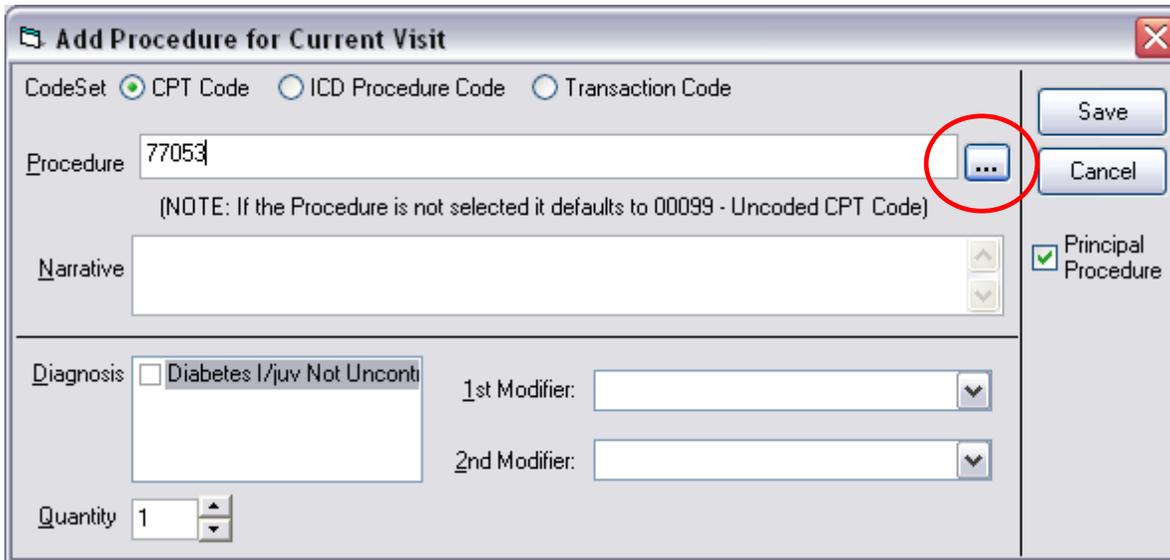
CPT codes are entered in the Visit Services component, which is located on the Services tab.

The screenshot displays the IHS-EHR Tucson Development System interface. The top navigation bar includes 'User', 'Patient', 'Tools', and 'Help'. Below this, there are tabs for 'Patient Chart', 'Communication', 'RPMS', 'CIHA Intranet', 'Micromedex', and 'E-Mail'. The patient information section shows 'Patient: Crsae', '900031', '01-Jul-1958 (52)', 'F', '01 GENERAL', 'POWERS, MEGAN', '19-Aug-2010 Am', and 'Primary Care Team Unassigned'. The 'Historical Services' section is set to 'Radiology' and includes an 'Add to Current Visit' button. A table of historical services is shown with columns for Visit Date, CPT Code, Description, Facility, Qty, Diagnosis, Prim, Modifier 1, and Modifier 2. The 'Super-Bills' section has checkboxes for 'Display', 'Freq. Rank', 'Code', and 'Description', and a 'Cols' dropdown set to 4. The 'Patient Education' section lists 'Pt Ed Ones', 'Diabetes', and 'Immunizations'. The 'Evaluation and Management' section has radio buttons for 'New Patient' and 'Established'. The 'Visit Services' section is highlighted with a red circle and contains a table with columns for Code, Narrative, Qty, Diagnosis, Prim, Modifier 1, Modifier 2, and Provider. The bottom navigation bar includes tabs for 'Notifications', 'Cover Sheet', 'Triage', 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prod/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Priority', and 'WCM'. The status bar at the bottom shows 'POWERS, MEGAN', 'DEMO.OKLAHOMA.IHS.GOV', 'DEMO INDIAN HOSPITAL', and '20-Aug-2010 15:51'.

To enter a CPT code, click Add button in the Visit Services component.



The Add Procedure for Current Visit dialog box displays. Type the CPT code and click the ellipses (...) button.



Choose the CPT you would like to enter and click OK. If you cannot find the CPT code, make sure that CPT is chosen in the Lookup Option. You may also need to check off more of the Included Code Sets.

Procedure Lookup

Lookup Option  Lexicon  CPT

Search Value 77053 Search

Included  Medical  Surgical  HCPCS  E & M  
Code Sets  Radiology  Laboratory  Anesthesia  Home Health

Select from one of the following items

Code	Narrative
77053	Mammary Ductogram Or Galactogram, Single Duct, Radiological Supervision And Interpretation

Return Search Text as Narrative OK Cancel

Enter any other pertinent information and click Save.

**Add Procedure for Current Visit**

CodeSet  CPT Code  ICD Procedure Code  Transaction Code

Procedure: Mammary Ductogram Or Galactogram, Single Duct, Radiological Supervision And Inter ...  
 (NOTE: If the Procedure is not selected it defaults to 00099 - Uncoded CPT Code)

Narrative: Mammary Ductogram Or Galactogram, Single Duct, Radiological Supervision And Interpretation

Diagnosis:  Diabetes I/juv Not Uncont... 1st Modifier: [ ] 2nd Modifier: [ ]

Quantity: 1

Principal Procedure

Save Cancel

Your newly added CPT code should display in the Visit Services component.

**Visit Services** Add Edit Delete

Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider	CPT Name	Visit Date
77053	Mammary Ductogram Or Galactogram, Single Duct, Radiological Supervision And Interpretation	1		Y			POWERS,MEGAN	X-ray Of Mammary Duct	08/19/2010

Historical CPT codes are entered in the Historical Services component, which is located on the Services tab.

The screenshot shows the IHS-EHR Tucson Development System interface. At the top, there are navigation tabs for Patient Chart, Communication, RPMS, CIHA Intranet, Micromedex, and E-Mail. The patient information bar shows Patient Crsae 900031, 01 Jul 1959 (92) F, 01 GENERAL POWERS, MEGAN, 19-Aug-2010, and Primary Care Team Unassigned. The Historical Services component is highlighted with a red circle and includes a dropdown menu for Radiology and an 'Add to Current Visit' button. Below this is a table with the following data:

Visit Date	CPT Code	Description	Facility	Qty	Diagnosis	Prim	Modifier 1	Modifier 2
07/05/2010	74280	Barium Enema	Cherokee Indian Hospital	1				

Below the table are sections for Super-Bills, Evaluation and Management, and Visit Services. The Visit Services component has an 'Add' button circled in red. At the bottom, there are tabs for Notifications, Cover Sheet, Triage, Wellness, Notes, Orders, Medications, Labs, Prob/POV, Services, Reports, D/C Summ, Consults, Privacy, and WCM. The status bar at the bottom shows POWERS, MEGAN, DEMO.OKLAHOMA.IHS.GOV, DEMO INDIAN HOSPITAL, and 20-Aug-2010 15:51.

To enter a CPT code, click Add in the Visit Services component.

This close-up screenshot shows the Historical Services component with the 'Add' button circled in red. The table below it contains the same data as the previous screenshot:

Visit Date	CPT Code	Description	Facility	Qty	Diagnosis	Prim	Modifier 1	Modifier 2
07/05/2010	74280	Barium Enema	Cherokee Indian Hospital	1				

The Add Historical Service dialog box displays. You can either choose an item via Pick List or Procedure code.

Pick List:

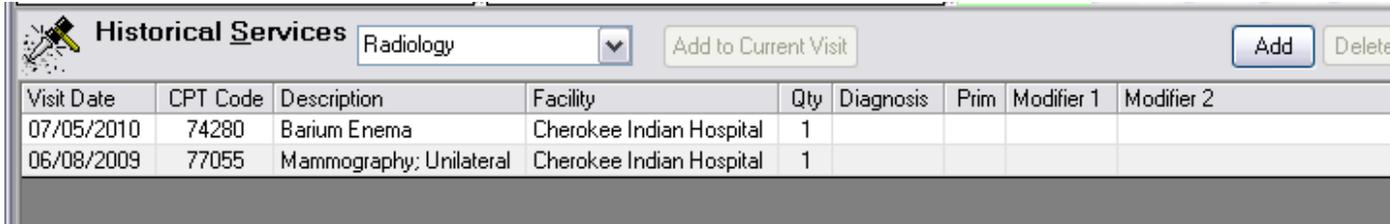
The screenshot shows the 'Add Historical Service' dialog box with the 'Pick List' tab selected. At the top, there is a dropdown menu labeled 'GPRA SERVICES'. Below it is a list of services with checkboxes: Barium Enema, Colonoscopy, Fobt (guaiac), Hiv-1, Hiv-1 And Hiv-2, Hiv-2, Mammography, Bilat, Mammography, Unilat, Pap Smear, and Sigmoidoscopy. At the bottom, there are fields for 'Date' and 'Location', and radio buttons for 'IHS/Tribal Facility' (selected) and 'Other'. On the right side, there are 'Save' and 'Cancel' buttons.

Procedure/CPT code:

The screenshot shows the 'Add Historical Service' dialog box with the 'Procedure' tab selected. At the top, there is a 'Procedure' text field with a dropdown arrow and a '...' button. Below it is a note: '(NOTE: If the Procedure is not selected it defaults to 00099 - Uncoded CPT Code)'. There is a 'Narrative' text area with up and down arrows. Below that are 'Quantity' (set to 1), '1st Modifier' (dropdown), and '2nd Modifier' (dropdown). At the bottom, there are fields for 'Date' and 'Location', and radio buttons for 'IHS/Tribal Facility' (selected) and 'Other'. On the right side, there are 'Save' and 'Cancel' buttons.

Enter the date and location of the service, and then enter the CPT in the same manner as listed above for a current CPT.

Your newly added CPT code should display in the Historical Services component.



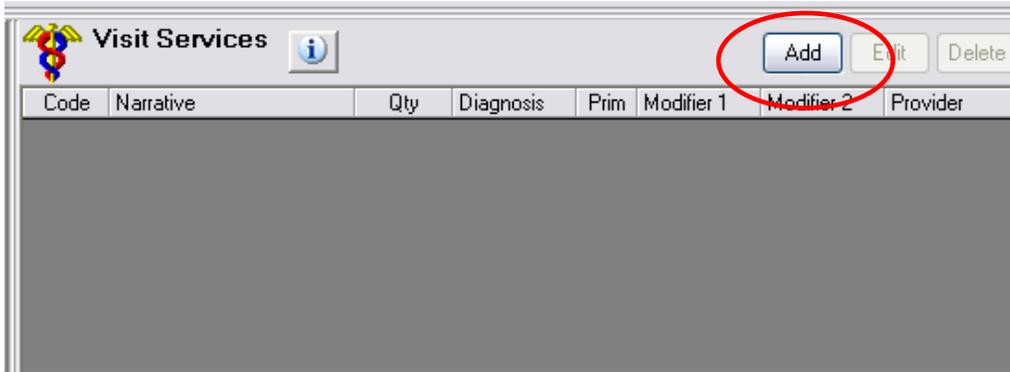
Visit Date	CPT Code	Description	Facility	Qty	Diagnosis	Prim	Modifier 1	Modifier 2
07/05/2010	74280	Barium Enema	Cherokee Indian Hospital	1				
06/08/2009	77055	Mammography: Unilateral	Cherokee Indian Hospital	1				

## Procedure Codes

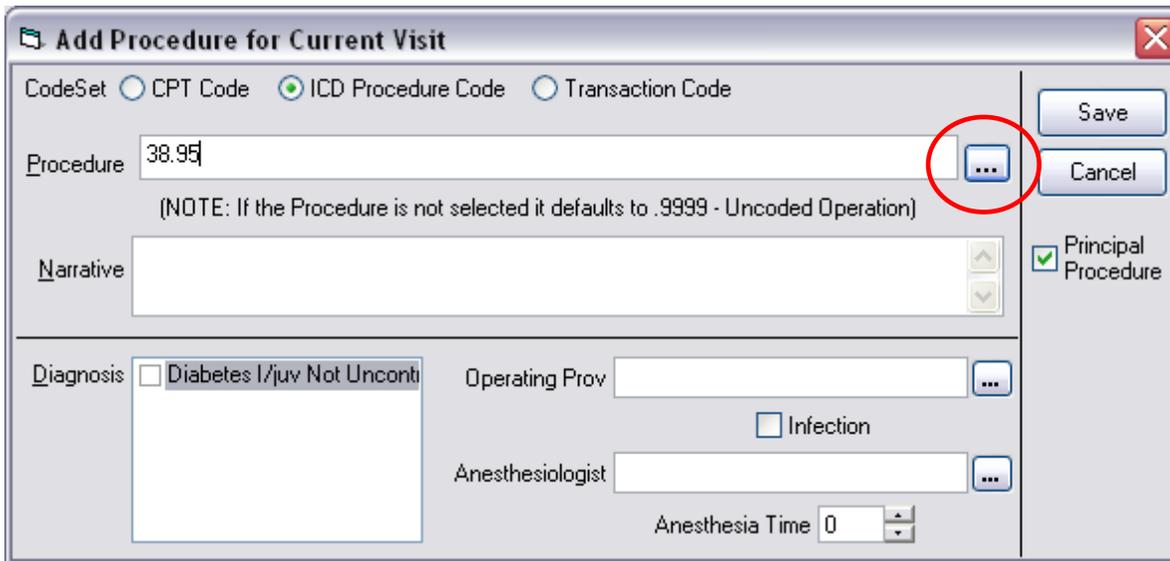
Procedure codes are entered in the Visit Services component, which is located on the Services tab.

The screenshot displays the IHS-EHR Tucson Development System interface. The top navigation bar includes 'User', 'Patient', 'Tools', and 'Help'. Below this, there are tabs for 'Patient Chart', 'Communication', 'RPMS', 'CIHA Intranet', 'Micromedex', and 'E-Mail'. The patient information section shows 'Patient, Crsae' with ID 900031, birth date 01-Jul-1958, and gender F. The primary care team is listed as '01 GENERAL POWERS, MEGAN' with a date of 19-Aug-2010. A green box highlights 'Primary Care Team Unassigned'. The 'Historical Services' section shows a table with one entry: a visit on 07/05/2010 with CPT code 74280 (Barium Enema) at Cherokee Indian Hospital. The 'Super-Bills' section has checkboxes for 'Freq. Rank', 'Code', and 'Description'. Below this are sections for 'Patient Education' and 'Immunizations' with a list of services including 'DIAGNOSTIC COLONOSCO...', 'PNEUMOCOCCAL VACC, 7 ...', 'DTAP VACCINE, < 7 YRS, IM', 'HEP A VACC, PED/ADOL, ...', 'IMMUNE ADMIN 1 INJ, < 8...', 'IMMUNE ADMIN ADDL INJ...', and 'IMMUNIZATION ADMIN'. The 'Evaluation and Management' section has radio buttons for 'New Patient' and 'Established'. The 'Visit Services' section is highlighted with a red circle and contains a table with columns: Code, Narrative, Qty, Diagnosis, Prim, Modifier 1, Modifier 2, and Provider. The bottom navigation bar includes tabs for 'Notifications', 'Cover Sheet', 'Triage', 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', and 'WCM'. The status bar at the bottom shows 'POWERS, MEGAN', 'DEMO.OKLAHOMA.IHS.GOV', 'DEMO INDIAN HOSPITAL', and '20-Aug-2010 15:51'.

To enter a Procedure code, click Add in the Visit Services component.



The Add Procedure for Current Visit dialog box will display. Make sure ICD Procedure Code is chosen for the CodeSet. Type in the Procedure code and click the ellipses (...) button.



Choose the Procedure that you would like to enter and click OK.

**Lookup ICD Procedure**

Search Value: 38.95

Buttons: Search, OK, Cancel

Code	Procedure
38.95	VENOUS CATHETERIZATION FOR RENAL DIALYSIS

Enter in any other pertinent information and click Save.

**Add Procedure for Current Visit**

CodeSet:  CPT Code  ICD Procedure Code  Transaction Code

Procedure: 38.95 - VENOUS CATHETERIZATION FOR RENAL DIALYSIS

(NOTE: If the Procedure is not selected it defaults to .9999 - Uncoded Operation)

Narrative: VENOUS CATHETERIZATION FOR RENAL DIALYSIS

Diagnosis:  Diabetes I/juv Not Uncont

Operating Prov: [Field]

Infection

Anesthesiologist: [Field]

Anesthesia Time: 0

Buttons: Save, Cancel

Principal Procedure

Your newly added CPT code should appear in the Visit Services component.

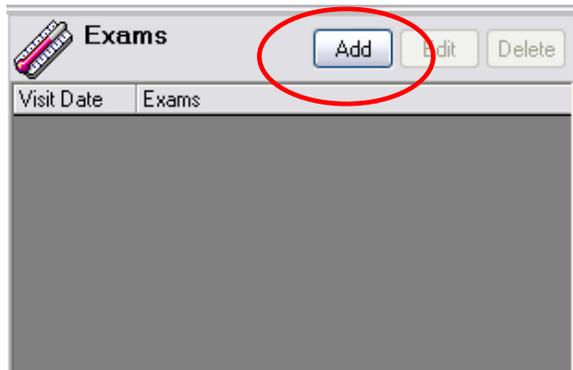
Visit Services 									
Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider	CPT Name	Visit Date
38.95	Venous Catheterization For Renal Dialysis						POWERS,MEGAN	Venous Catheterization For Dialysis	08/19/2010

# Exams

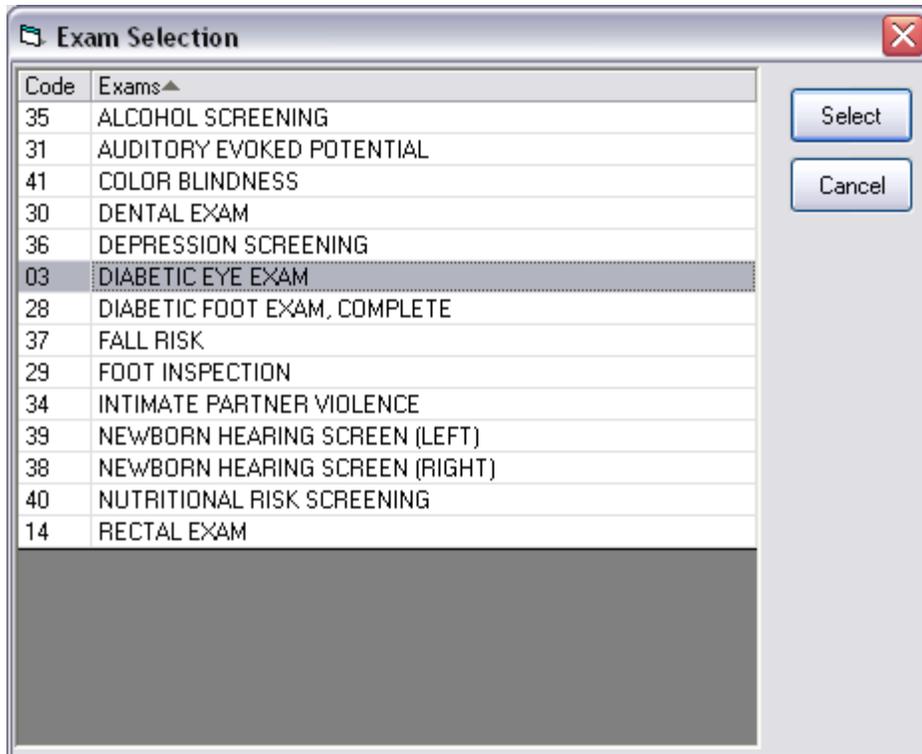
Exam codes are entered in the Exams component, which is located on the Wellness tab.

The screenshot displays the IHS-EHR Tucson Development System interface. At the top, the patient information bar shows 'Patient\_Crsae' with ID 900031, birth date 01-Jul-1958, gender F, and name '01 GENERAL POWERS,MEGAN'. The date is 19-Aug-2010. Below this, the 'Education' section is visible. The main area contains three panels: 'Health Factors', 'Exams', and 'Skin Test History'. The 'Exams' panel is highlighted with a red circle. Below these panels is the 'Immunization Record' section, which includes a 'Forecast' table with one entry: 'Tdap past due'. The 'Contraindications' section lists 'PNEUMO-PS Egg Allergy' dated 19-Aug-2010. At the bottom, a navigation bar includes tabs for 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', and 'WCM'. The status bar at the very bottom shows the user 'POWERS,MEGAN', the system 'DEMO.OKLAHOMA.IHS.GOV', the location 'DEMO INDIAN HOSPITAL', and the time '20-Aug-2010 16:06'.

To enter an Exam code, click Add in the Exams component.



Select the Exam you would like to enter and click OK.



Enter in the result and any comments and click Save.

The screenshot shows the 'Document an Exam' dialog box. The 'Exam' field contains 'DIABETIC EYE EXAM'. The 'Result' dropdown is set to 'NORMAL/NEGATIVE'. The 'Comment' field is empty. The 'Provider' field contains 'POWERS,MEGAN'. On the right side, the 'Current' radio button is selected, and the 'Add' and 'Cancel' buttons are visible.

If this is a historical exam, select the Historical radio button and enter the date and location of the exam.

The screenshot shows the 'Document an Exam' dialog box with the 'Historical' radio button selected. The 'Exam' field contains 'DIABETIC EYE EXAM', 'Result' is 'NORMAL/NEGATIVE', and 'Provider' is 'POWERS,MEGAN'. A new 'Historical' section is expanded, containing 'Event Date' (06/02/2010) and 'Location' (CHEROKEE INDIAN HOSPITAL). Below the location field, the 'IHS/Tribal Facility' radio button is selected. The 'Add' and 'Cancel' buttons are also present.

Your newly added Exam code should appear in the Exams component.

Exams					
Visit Date	Exams	Result	Comments	Provider	Location
08/19/2010	DIABETIC EYE EXAM	NORMAL/NEGATIVE		POWERS,MEGAN	DEMO INDIAN HOSPITAL

## Health Factors

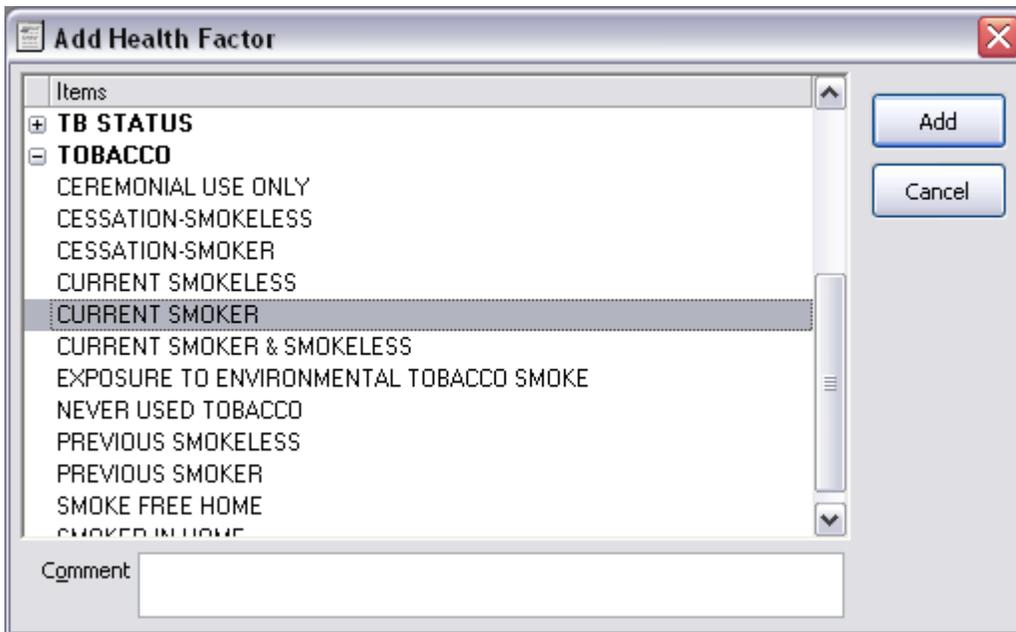
Health Factors are entered in the Health Factors component, which is located on the Wellness tab.

The screenshot displays the IHS-EHR Tucson Development System interface. At the top, the patient information is shown: Patient\_Crsae, ID 900031, DOB 01-Jul-1958 (52), F. The patient's name is POWERS, MEGAN, and the primary care team is unassigned. The interface includes tabs for Patient Chart, Communication, RPMS, CIHA Intranet, Micromedex, and E-Mail. Below the patient information, there are sections for Education, Health Factors, Exams, and Skin Test History. The Health Factors section is highlighted with a red circle and has a red 'X' over its icon. The Immunization Record section is also visible, showing a forecast for Tdap (past due) and contraindications for PNEUMO-PS (Egg Allergy) on 19-Aug-2010. The bottom of the screen shows a navigation bar with tabs for Notifications, Cover Sheet, Triage, Wellness, Notes, Orders, Medications, Labs, Prob/POV, Services, Reports, D/C Summ, Consults, Privacy, and WCM. The bottom status bar displays the user name POWERS, MEGAN, the system name DEMO.OKLAHOMA.IHS.GOV, the location DEMO INDIAN HOSPITAL, and the time 20-Aug-2010 16:06.

To enter a Health Factor, click Add in the Health Factors component.



Choose the Health Factor you would like to enter and click Add.



Your newly added Health Factor should appear in the Health Factors component.



The screenshot shows a window titled "Health Factors" with a "No" icon in the top-left corner. To the right of the title are three buttons: "Add", "Edit", and "Delete". Below the title bar is a table with four columns: "Visit Date", "Health Factor", "Category", and "Comment". The first row of the table contains the following data: "08/19/2010", "Current Smoker", "Tobacco", and an empty "Comment" cell. The rest of the table area is shaded grey.

Visit Date	Health Factor	Category	Comment
08/19/2010	Current Smoker	Tobacco	

## Immunizations

Immunizations are entered in the Immunization Record component, which is located on the Wellness tab.

The screenshot displays the IHS-EHR Tucson Development System interface. The patient information at the top includes Patient ID 900031, name Patient.Crsae, and date of birth 01-Jul-1958. The primary care team is listed as Unassigned. The Immunization Record component is highlighted with a red circle and contains the following sections:

- Forecast:** Tdap past due
- Contraindications:** PNEUMO-PS, Egg Allergy (19-Aug-2010)
- Vaccinations:** Includes buttons for Print Record, Due Letter, Profile, Case Data, Add, Edit, and Delete.

The Vaccinations table below the buttons is empty:

Vaccine	Visit Date	Age@Visit	Location	Reaction	Volume	Inj. Site	Lot	VIS Date	Administered By	VFC Eligibility
---------	------------	-----------	----------	----------	--------	-----------	-----	----------	-----------------	-----------------

The bottom of the screen shows a navigation bar with tabs for Notifications, Cover Sheet, Triage, Wellness, Notes, Orders, Medications, Labs, Prob/POV, Services, Reports, D/C Summ, Consults, Privacy, and WCM. The current user is POWERS,MEGAN, and the system is running on DEMO.OKLAHOMA.IHS.GOV at DEMO INDIAN HOSPITAL.

To enter an Immunization, click Add in the Vaccinations section of the Immunization Record component.

The screenshot shows the 'Immunization Record' window. It has a 'Forecast' section with 'Tdap past due' and a 'Contraindications' section with one entry: 'PNEUMO-PS Egg Allergy 19-Aug-2010'. Below these is the 'Vaccinations' section, which contains buttons for 'Print Record', 'Due Letter', 'Profile', 'Case Data', 'Add', 'Edit', and 'Delete'. The 'Add' button is circled in red. Below the buttons is a table header with columns: Vaccine, Visit Date, Age@Visit, Location, Reaction, Volume, Inj. Site, Lot, VIS Date, Administered By, and VFC Eligibility.

Choose the Immunization that you would like to enter and click OK.

The 'Vaccine Selection' dialog box is shown. It has a 'Search Criteria' section with a search value of 'influ' and a 'Search' button. There are 'OK' and 'Cancel' buttons. Below the search criteria are two radio buttons: 'Show All Active Vaccines' (selected) and 'Show Only active Vaccines with a Lot Number'. Below that is the text 'Select one of the following Records'. A list of immunization records is displayed with two columns: 'Immunization' and 'Description'. The record 'INFLUENZA, SPLIT (INCL. PURIFIED)' is highlighted.

Immunization	Description
INFLUENZA, H5N1	Influenza virus vaccine, H5N1, A/Vietnam/120
INFLUENZA, HIGH DOSE SEASONAL	INFLUENZA, HIGH DOSE SEASONAL, PRESI
INFLUENZA, INTRANASAL	Influenza virus vaccine, live, attenuated, for intr
INFLUENZA, NOS	Influenza virus vaccine, NOS
INFLUENZA, SPLIT (INCL. PURIFIED)	Influenza virus vaccine, split virus (incl. Purified
INFLUENZA, WHOLE	Influenza virus vaccine, whole virus
IPV	Poliovirus vaccine, inactivated
JAPANESE ENCEPHALITIS	Japanese Encephalitis virus vaccine
Japanese Encephalitis-IM	Japanese Encephalitis vaccine for intramuscul
JUNIN VIRUS	Junin virus vaccine
LEISHMANIASIS	Leishmaniasis vaccine
LEPROSY	Leprosy vaccine
LYME DISEASE	Lyme Disease Vaccine

Enter in any other pertinent information and click Save.

**Add Immunization**

Vaccine: INFLUENZA, SPLIT (INCL. PURIFIED)

Administered By: POWERS, MEGAN

Lot: U1293AA

Injection Site: Intranasal

Volume: .5 ml

Vac. Info. Sheet: 08/11/2009

Given: 08/20/2010 4:30 PM

Patient/Family Counseled by Provider

Current  
 Historical  
 Refusal

OK  
Cancel

If this is a historical immunization, select the Historical radio button and enter the date and location of the immunization.

**Add Historical Immunization**

Vaccine: INFLUENZA, SPLIT (INCL. PURIFIED)

Documented By: POWERS, MEGAN

Event Date: 06/02/2010

Location: CHEROKEE INDIAN HOSPITAL

IHS/Tribal Facility  
 Other

Current  
 Historical  
 Refusal

OK  
Cancel

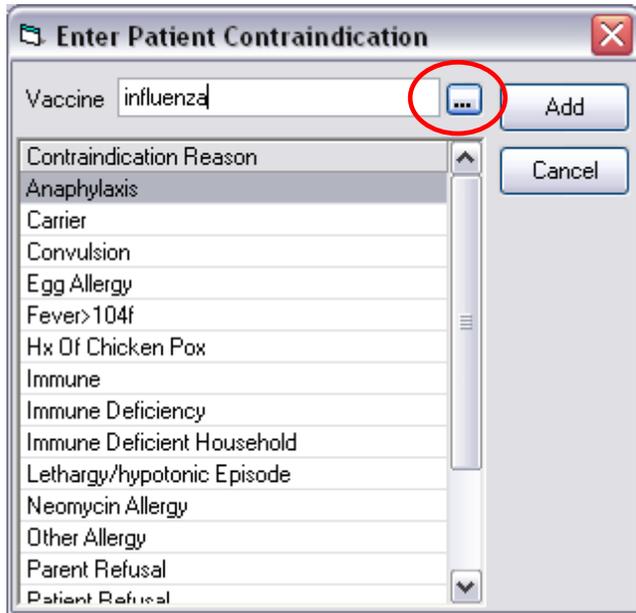
Your newly added Immunization should appear in the Immunization Record component.

The screenshot shows the 'Immunization Record' interface. It features three main sections: 'Forecast', 'Contraindications', and 'Vaccinations'. The 'Forecast' section contains the text 'Tdap past due'. The 'Contraindications' section lists 'PNEUMO-PS Egg Allergy 19-Aug-2010' with 'Add' and 'Delete' buttons. The 'Vaccinations' section includes buttons for 'Print Record', 'Due Letter', 'Profile', 'Case Data', 'Add', 'Edit', and 'Delete'. Below these is a table with columns: Vaccine, Visit Date, Age@Visit, Location, Reaction, Volume, Inj. Site, Lot, VIS Date, and Administered By. A single row is visible with the following data: FLU-TIV, 08/19/2010, 52 yrs, DEMO INDIAN HOSPITAL, .5, Intranasal, U1293AA, 08/11/2009, POWERS,MEGAN.

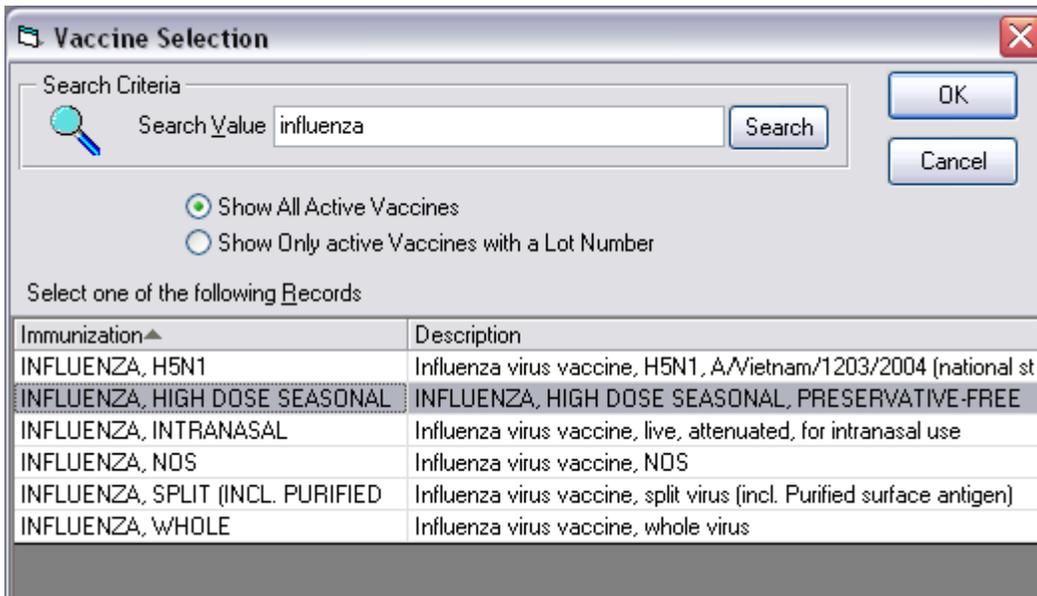
**Contraindications:** To enter a contraindication for an immunization, click Add in the Contraindications section of the Immunization Record component.

This screenshot is identical to the one above, but the 'Add' button in the 'Contraindications' section is circled in red to highlight it.

Choose the contraindication reason, type in the vaccine, and click the ellipses (...) button.



Select the immunization and click OK.



Click Add.

**Enter Patient Contraindication**

Vaccine: INFLUENZA, HIGH DOSE SEAS

Contraindication Reason:

- Anaphylaxis
- Carrier
- Convulsion
- Egg Allergy
- Fever > 104f
- Hx Of Chicken Pox
- Immune
- Immune Deficiency
- Immune Deficient Household
- Lethargy/hypotonic Episode
- Neomycin Allergy
- Other Allergy
- Parent Refusal
- Patient Refusal

Buttons: Add, Cancel

Your newly added contraindication should appear in the Immunization Record component.

**Immunization Record**

**Forecast**

Tdap past due

**Contraindications**

PNEUMO-PS	Egg Allergy	19-Aug-2010
FLU-HIGH	Anaphylaxis	19-Aug-2010

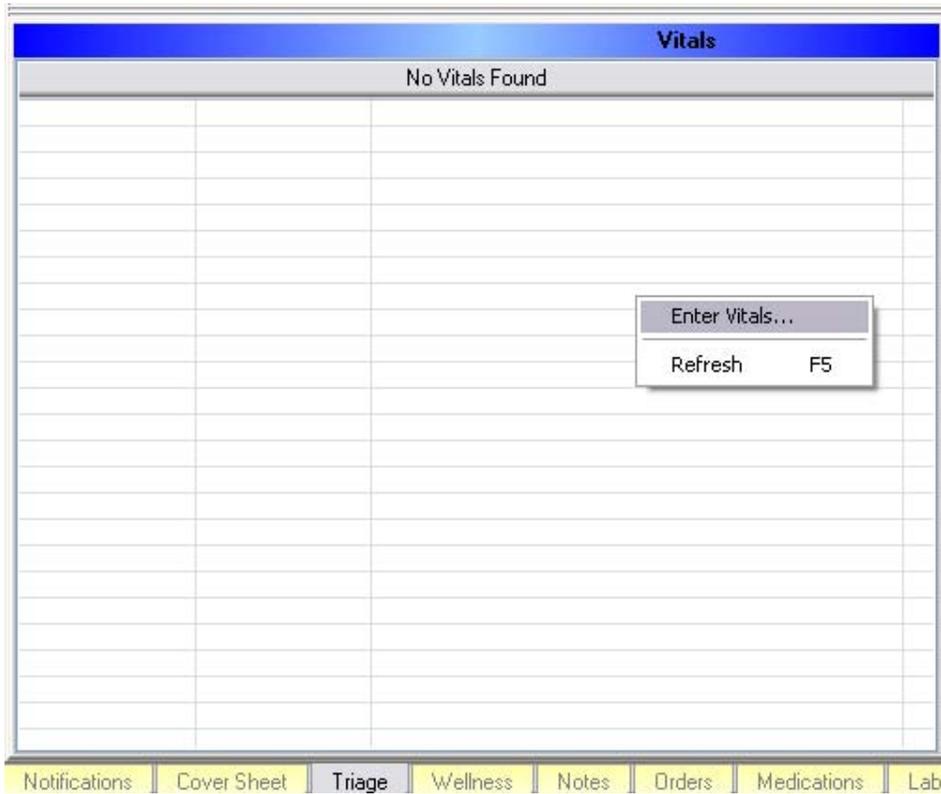
Buttons: Add, Delete

## Vital Measurements

Vital Measurements are entered in the Vitals component, which is located on the Triage tab.

The screenshot displays the IHS-EHR Tucson Development System interface. The top navigation bar includes 'User', 'Patient', 'Tools', and 'Help'. Below this, there are tabs for 'Patient Chart', 'Communication', 'RPMS', 'CIHA Intranet', 'Micromedex', and 'E-Mail'. The patient information section shows 'Patient.Crsae' with ID 900031, birth date 01-Jul-1958 (52), and gender F. The encounter is labeled '01 GENERAL POWERS.MEGAN' on '19-Aug-2011 Am', with a status of 'Primary Care Team Unassigned'. A 'No Postings' button is visible. The 'Chief Complaint' section is currently empty. The 'Vitals' section, highlighted with a red circle, shows 'No Vitals Found'. To the right of the vitals table is an 'Activity Time' section for 'POWERS.MEGAN' with input fields for 'Encounter Time' (0 minutes), 'Travel Time' (0 minutes), and a 'Total' of 0 minutes. The bottom navigation bar includes tabs for 'Notifications', 'Cover Sheet', 'Triage', 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', and 'WCM'. The status bar at the bottom shows 'POWERS.MEGAN', 'DEMO.OKLAHOMA.IHS.GOV', 'DEMO INDIAN HOSPITAL', and the time '20-Aug-2010 16:41'.

To enter Vital Measurements, right-click on the Vitals component and select Enter Vitals.



If you wish to enter historical vitals, click on the date and time in the column header, and then click the ellipses (...) button.

Default Units		20-Aug-2010 16:45	...	Range	Units
<input checked="" type="radio"/>	Temperature				F
	Pulse			60 - 100	/min
	Respirations				/min
	Blood Pressure			90 - 150	mmHg
	Height				in
	Weight				lb
	Pain				
	PHQ2				
	PHQ9				
	Crafft				
	Audit				
	Audiometry				
	Asq - Questionnaire (Mos)				
	Asq - Fine Motor				
	Asq - Gross Motor				
	Asq - Language				
	Asq - Problem Solving				
	Asq - Social				

New Date/Time    OK    Cancel

Choose the historical date and click OK.

The dialog box titled "Select Date/Time" features a calendar grid for August 2010. The date August 3, 2010, is selected. To the right of the calendar, the time is set to 10:00. Below the calendar is a "Today" button. Below the time selection is a vertical scroll bar and buttons for "Now" and "Midnight". On the right side of the dialog are "OK" and "Cancel" buttons.

Enter the Vital Measurements you would like to add and click OK.

The "Vital Measurement Entry" dialog box contains a table with the following data:

Default Units	20-Aug-2010 16:44	Range	Units
Temperature	98.8		F
Pulse	75	60 - 100	/min
Respirations			/min
Blood Pressure	128/80	90 - 150	mmHg
Height	72		in
Weight	203		lb
Pain			
<input checked="" type="radio"/> PHQ2			
PHQ9			
Crafft			
Audit			
Audiometry			
Asq - Questionnaire (Mos)			
Asq - Fine Motor			
Asq - Gross Motor			
Asq - Language			
Asq - Problem Solving			
Asq - Social			

At the bottom of the dialog are buttons for "New Date/Time", "OK", and "Cancel".

Your newly added Vital Measurements should display in the Vitals component.

Vitals		
Vital	Value	Date ▼
TMP	98.8 F (37.11 C)	20-Aug-2010 16:44
PU	75 /min	20-Aug-2010 16:44
BP	128/80 mmHg	20-Aug-2010 16:44
HT	72 in (182.88 cm)	20-Aug-2010 16:44
WT	203 lb (92.08 kg)	20-Aug-2010 16:44
BMI	27.53	20-Aug-2010 16:44

## Lab Tests

Lab tests are entered in the Orders component, which is located on the Orders tab.

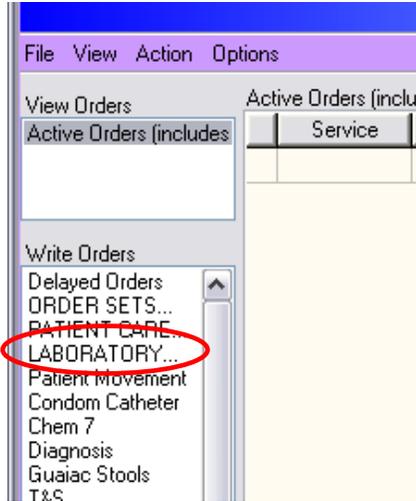
The screenshot displays the IHS EHR Tucson Development System interface. At the top, the window title is "IHS EHR TUCSON DEVELOPMENT SYSTEM". Below the title bar, there are menu options: "User", "Patient", "Tools", and "Help". A secondary menu bar includes "Patient Chart", "Communication", "RPMS", "CIHA Intranet", "Micromedex", and "E-Mail".

The main content area is titled "Orders" and features a sub-menu with "File", "View", "Action", and "Options". Below this, there is a section for "View Orders" and "Active Orders (includes Pending & Recent Activity) - ALL SERVICES". A table with columns for "Service", "Order", "Duration", "Provider", "Nurse", "Clerk", "Chart", and "Status" is present but currently empty.

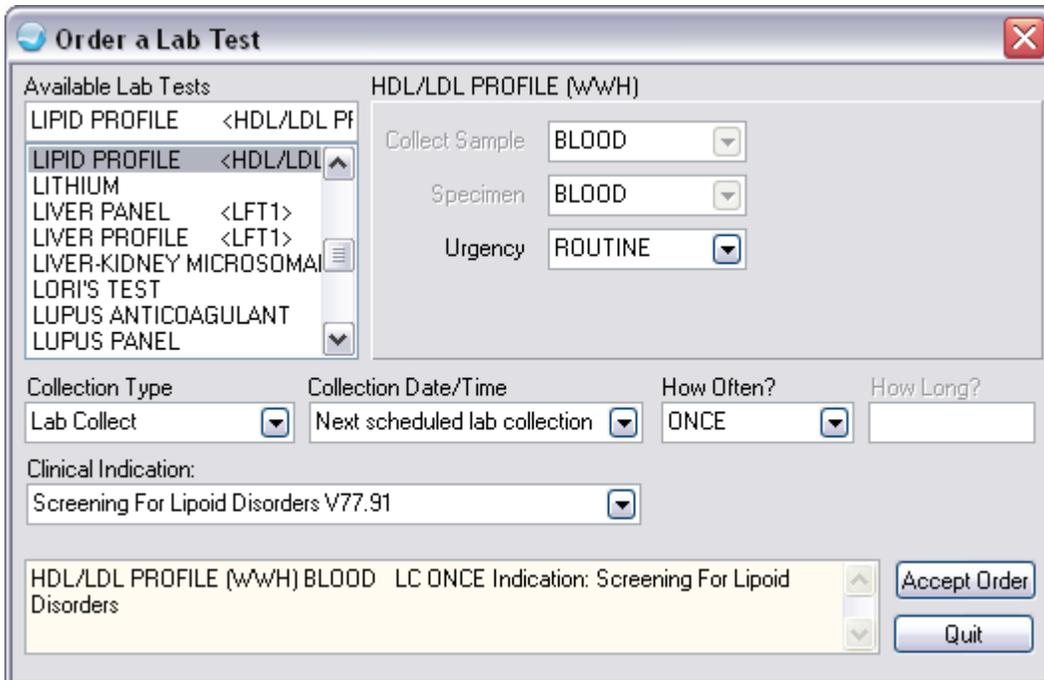
On the left side, there is a "Write Orders" menu with a scrollable list of services including: "Delayed Orders", "ORDER SETS...", "PATIENT CARE...", "LABORATORY...", "Patient Movement", "Condom Catheter", "Chem 7", "Diagnosis", "Guaiac Stools", "T&S", "Condition", "Incentive Spiromete", "Glucose", "Allergies", "Dressing Change", "CBC w/Diff", "PT", "PARAMETERS...", "DIETETICS...", "PTT", "TPR B/P", "Regular Diet", "CPK", "Weight", "Tubefeeding", "CPK", "I & O", "NPO at Midnight", "LDH", "Call HO on", and "Urinalysis".

At the bottom of the interface, there is a navigation bar with tabs for "Notifications", "Cover Sheet", "Triage", "Wellness", "Notes", "Orders", "Medications", "Labs", "Prob/POV", "Services", "Reports", "D/C Summ", "Consults", "Privacy", and "WCM". Below this, there are buttons for "ASU" and "Suicide". At the very bottom, there are three buttons: "POWERS,MEGAN", "DEMO.OKLAHOMA.IHS.GOV", and "DEMO INDIAN HOSPITAL".

To enter a Lab test, select the Laboratory option in the Write Orders section of the Orders component. Note: this may be named differently at your site.



The Order a Lab Test dialog box displays. Select the appropriate lab test, enter any other pertinent information, and click Accept Order.



Your newly added Lab test should display in the Active Orders section of the Orders component.

Orders							
Active Orders (includes Pending & Recent Activity) - ALL SERVICES							
Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
Lab	HDL/LDL PROFILE (w/WH) BLOOD LC ONCE Indication: Screening For Lipoid Disorders *UNSIGNED*	Start: NEXT	Powers,M				unreleased

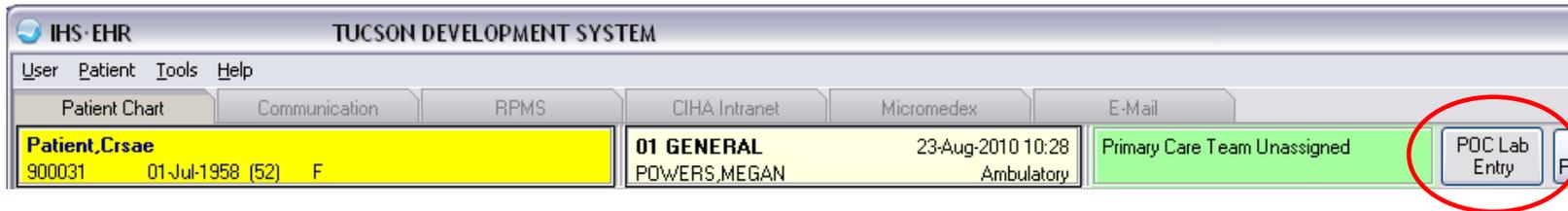
You will need to sign the order before it is released.

Once the Lab test has been completed, results can be viewed in the Laboratory Results component, which is located on the Labs tab.

The screenshot shows the IHS EHR Tucson Development System interface. At the top, the patient information is displayed: Patient ID 900031, name CSRAE, and provider POWERS, MEGAN. The Laboratory Results section is currently empty, displaying "No Lab Results Collected". The interface includes a navigation menu on the left and a bottom toolbar with various clinical tabs like Orders, Medications, and Labs.

Please note that most laboratory results must be entered via the Lab Package or sent over electronically from a reference laboratory. These results cannot be entered through EHR. However, point of care laboratory tests and results can be entered through EHR.

To enter Point of Care Lab tests and results, click POC Lab Entry. If this button is not visible, speak with your Clinical Applications Coordinator to see if it can be added.



The Lab Point of Care Data Entry Form displays. Choose the appropriate laboratory test, enter the test results and any other pertinent information, and click Save.

The screenshot shows the Lab Point of Care Data Entry Form. The form contains the following fields and data:

- Patient: PATIENT,CRSAE
- Hospital Location: 01 GENERAL
- Ordering Provider: POWERS,MEGAN
- Nature of Order/Change: WRITTEN
- Test: GLUCOSE
- Sample Type: BLOOD
- Collection Date and Time: 08/23/2010 09:55 AM
- Sign or Symptom: 714.0 Rheumatoid Arthritis
- Comment/Lab Description: (Empty text area)
- Add Canned Comment (Button)
- TEST RESULTS (Section Header)
- Test Results Table:

Test Name	Result	Result Range	Units
GLUCOSE	92	>70 to 105	mg/dL

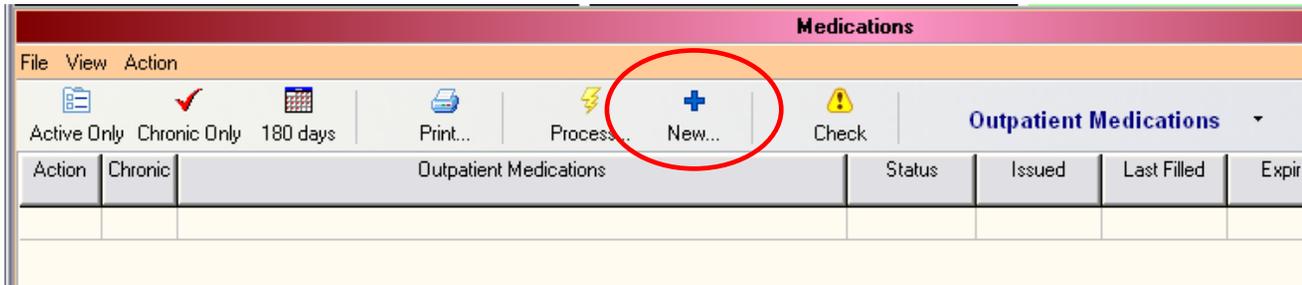
Save (Button) Cancel (Button)

## Medications

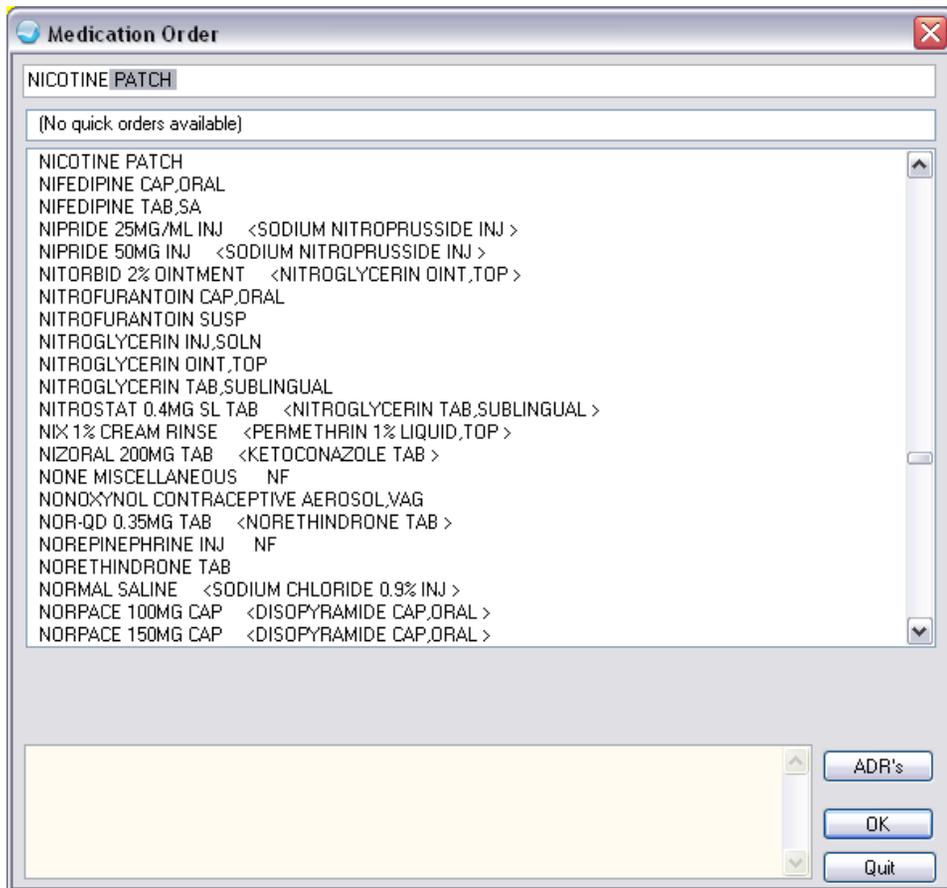
Medications are entered in the Medications component, which is located on the Medications tab.

The screenshot shows the 'Medications' component in the IHS-EHR Tucson Development System. At the top, the patient information is displayed: Patient ID 900031, Name POWERS, MEGAN, Date of Birth 01-Jul-1958, and Gender F. The system is currently displaying 'Outpatient Medications'. The interface includes a menu bar with 'File', 'View', and 'Action', and a toolbar with icons for 'Active Only', 'Chronic Only', '180 days', 'Print...', 'Process...', 'New...', and 'Check'. Below the toolbar is a table with columns for 'Action', 'Chronic', 'Outpatient Medications', 'Status', 'Issued', 'Last Filled', 'Expires', 'Refills Remaining', 'Rx #', and 'Provider'. The table is currently empty. At the bottom of the screen, there is a navigation bar with tabs for 'Notifications', 'Cover Sheet', 'Triage', 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', and 'WCM'. The 'Medications' tab is currently selected. The bottom status bar shows the user 'POWERS, MEGAN', the system 'DEMO.OKLAHOMA.IHS.GOV', the location 'DEMO INDIAN HOSPITAL', and the time '23-Aug-2010 12:54'.

To enter a prescription for a medication, click New.....



You will then see the Medication Order dialog. Choose the appropriate medication.



You will then be able to enter more information about the prescription.

**Medication Order**

NICOTINE PATCH Change

**Dosage** Complex

Dosage	Route	Schedule
1 patch	TRANSDERMAL	DAILY <input type="checkbox"/> PRN
	TRANSDERMAL	BID (INSULIN) CONTINUOUSLY DAILY FIVE TIMES/DAY FR FR-SA US

Comments:

Days Supply: 90    Quantity: 1    Refills: 1    Clinical Indication: Personal History of Tobacco Use  Chronic Med    Priority: ROUTINE  Dispense as Written

**Pick Up**  
 Clinic     Mail     Window

NICOTINE PATCH  
APPLY ONE (1) PATCH TO SKIN DAILY  
Quantity: 1 Refills: 1 Chronic Med: NO Dispense as Written: NO Indication: Personal History of Tobacco Use

ADR's Accept Order Quit

Your newly added medication should display in the Medications component.

Medications										
File View Action										
Active Only Chronic Only 180 days Print... Process... New... Check Outpatient Medications										
Action	Chronic	Outpatient Medications	Status	Issued	Last Filled	Expires	Refills Remaining	Rx #	Provider	
New		<b>NICOTINE PATCH</b> APPLY ONE (1) PATCH TO SKIN DAILY Quantity: 1 Refills: 1 Dispense as Written: NO Indication: Personal History of Tobacco Use *UNSIGNED*								

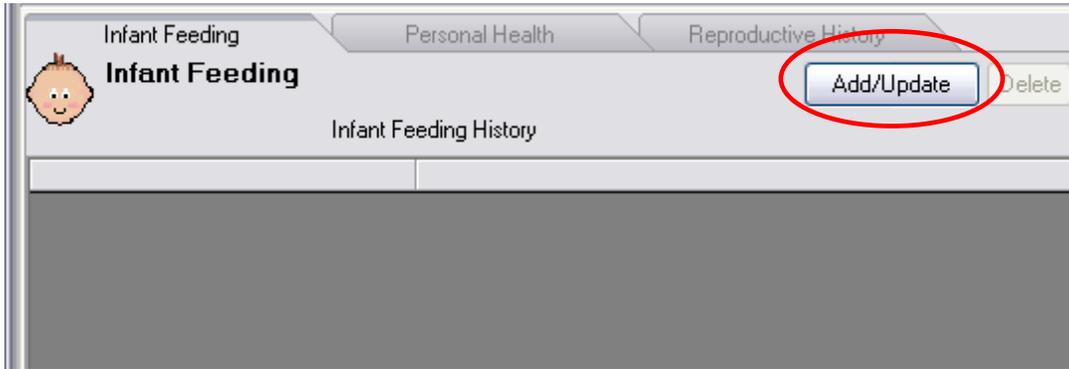
You will need to sign the medication before it is released.

## Infant Feeding

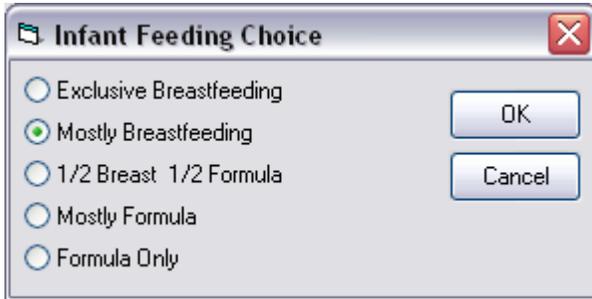
Infant Feeding choices are entered in the Infant Feeding component (new in EHR v1.1 patch 6), which is located on the Wellness tab.

The screenshot displays the IHS EHR Tucson Development System interface. The patient information at the top includes: Patient, Udsbq, 519357, 12-Feb-2010 (6 months), F, 20 PEDIATRIC, POWERS, MEGAN, 23-Aug-2010 11:07, Ambulatory, Primary Care Team Unassigned, POC Lab Entry, No Postings. The main content area is divided into several sections: Education, Health Factors, Exams, Skin Test History, Infant Feeding, and Immunization Record. The Infant Feeding section is highlighted with a red circle. It contains an 'Infant Feeding History' table and an 'Add/Update' button. The Immunization Record section includes a 'Forecast' table with columns for vaccine name and status (e.g., HEV B PED, DTaP, HIB, IPV, all 'past due'), a 'Contraindications' section, and a 'Vaccinations' table with columns for vaccine, visit date, age, location, reaction, volume, injection site, lot, visit date, and administered by. The bottom navigation bar includes tabs for Notifications, Cover Sheet, Triage, Wellness, Orders, Medications, Labs, Prob/POV, Services, Reports, D/C Summ, Consults, Privacy, WCM, ASQ, and Suicide. The bottom status bar shows the user POWERS, MEGAN, the system DEMO.OKLAHOMA.IHS.GOV, the location DEMO INDIAN HOSPITAL, and the time 23-Aug-2010 11:13.

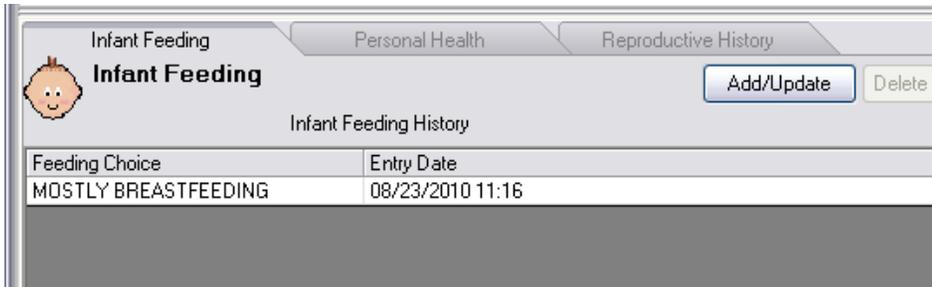
To enter Infant Feeding, click Add/Update in the Infant Feeding component.



Select the Infant Feeding choice you would like to enter and click OK.



Your newly added Infant Feeding choice should display in the Infant Feeding component.

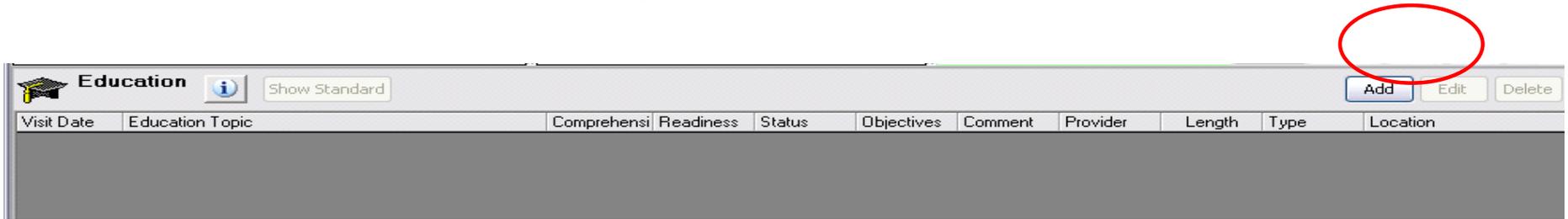


## Patient Education

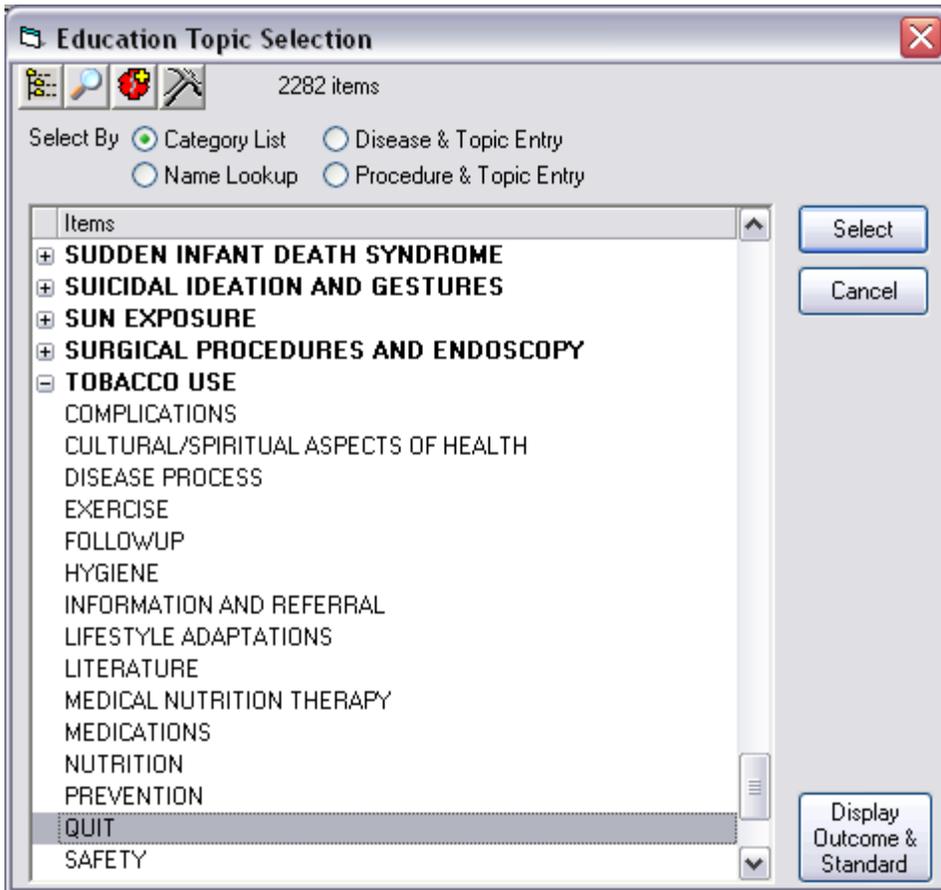
Patient Education can be entered several ways. The most common method is through the Education component, which is located on the Wellness tab.

The screenshot displays the IHS EHR Tucson Development System interface. At the top, the patient information is shown: Patient Chart, Communication, RPMS, CINA Internet, Micromedex, and E-Mail. The patient details include Patient.Crsae (900031), 01-Jul-1958 (52), F, 01 GENERAL POWERS,MEGAN, 19-Aug-2010 Am, and Primary Care Team Unassigned. The Education component is highlighted with a red circle and contains a table with the following columns: Visit Date, Education Topic, Comprehensi, Readiness, Status, Objectives, Comment, Provider, Length, Type, and Location. Below the Education table are sections for Health Factors, Exams, and Skin Test History, each with an Add, Edit, and Delete button. The Immunization Record section is also visible, showing a Forecast (Tdap past due) and Contraindications (PNEUMO-PS Egg Allergy 19-Aug-2010). The bottom of the screen shows a navigation bar with tabs for Notifications, Cover Sheet, Triage, Wellness, Notes, Orders, Medications, Labs, Prob/POV, Services, Reports, D/C Summ, Consults, Privacy, and WCM. The status bar at the very bottom displays POWERS,MEGAN, DEMO.OKLAHOMA.IHS.GOV, DEMO INDIAN HOSPITAL, and 20-Aug-2010 16:06.

To enter Patient Education, click Add in the Education component.



Choose the Education you would like to enter and click Select. To expand a topic, click the plus sign (+) next to the topic.



To enter Patient Education by disease, select the Disease & Topic Entry radio button. (Note: Patient Education can be entered using any of the radio buttons.) Select the Disease/Illness and Topic Selection and click OK.

**Education Topic Selection**

Select By  Category List  Disease & Topic Entry  Pick List  
 Name Lookup  Procedure & Topic Entry

**Enter both the Disease/Condition/Illness and the Topic for the Education activity.**

Disease/Condition/Illness Selection

Disease/Illness: Tobacco Use Disorder ...

POV: SCREENING FOR LIPOID DISORDERS  
RHEUMATOID ARTHRITIS

Topic Selection

- ANATOMY AND PHYSIOLOGY
- COMPLICATIONS
- DISEASE PROCESS
- EQUIPMENT
- EXERCISE
- FOLLOW UP
- HOME MANAGEMENT
- HYGIENE
- LIFESTYLE ADAPTATION
- LITERATURE
- MEDICATIONS
- NUTRITION

OK  
Cancel

The Add Patient Education Event dialog box displays. Type in any pertinent information and click Add.

**Add Patient Education Event**

Education Topic: Tobacco Use-Quit  
(Tobacco Use)

Type of Training:  Individual  Group

Comprehension Level: GOOD

Length: 10 (min)

Comment:

Provided By: POWERS, MEGAN

Readiness to Learn: RECEPTIVE

Status/Outcome:  
 Goal Set  Goal Met  Goal Not Met

Buttons: Add, Cancel, Historical, Display Outcome & Standard, Patient's Learning Health Factors

If this is historical education, select the Historical check box and enter the date and location of the education.

Your newly added Patient Education should display in the Education component.

Visit Date	Education Topic	Comprehension	Readiness To Learn	Status	Objectives	Comment	Provider	Length	Type	Location
08/23/2010	Tobacco Use-Quit	GOOD	RECEPTIVE				POWERS, MEGAN	10	Individual	DEMO INDIAN HOSPITAL

Patient Education can also be entered when the Visit Diagnosis is entered. After entering the POV, click Education....

**Add POV for Current Visit**

ICD:  ...

(NOTE: If the ICD is not selected it defaults to .9999 - Uncoded Diagnosis)

Narrative:

Date of Onset:  ... Modifier:

POV is Injury Related

Primary Diagnosis

Add to Problem List

First Visit  Re-Visit

Injury Date:  ... Place:

Injury caused by:  ...

Associated with:

The Document Patient Education dialog box displays. Type in any pertinent information and click Save.

**Document Patient Education**

Disease/Illness: Tobacco Use Disorder

Topic Selection:

- ANATOMY AND PHYSIOLOGY
- COMPLICATIONS
- DISEASE PROCESS
- EQUIPMENT
- EXERCISE
- FOLLOW UP

Type of Training:  Individual  Group

Comprehension Level: GOOD

Length: 10 (min)

Comment:

Provided By: POWERS, MEGAN

Readiness to Learn: RECEPTIVE

Status/Outcome:

Goal Set  Goal Met  Goal Not Met

Buttons: Save, Cancel, Patient's Learning Health Factors, Historical

## Refusals

Refusals are entered in the Personal Health component, which is located on the Wellness tab. *Note: refusals are not counted toward the GPRA measure, but should still be documented.*

The screenshot displays the IHS-EHR Tucson Development System interface. The top navigation bar includes 'User', 'Patient', 'Tools', and 'Help'. Below this, there are tabs for 'Patient Chart', 'Communication', 'RPMS', 'CIHA Intranet', 'Micromedex', and 'E-Mail'. The patient information section shows 'Patient: Crsae', ID '900031', birth date '01-Jul-1958 (52)', gender 'F', and '01 GENERAL POWERS,MEGAN' with a visit date of '23-Aug-2010 10:28' and location 'Ambulatory'. A green box indicates 'Primary Care Team Unassigned'. The 'Education' section contains a table with one entry: '08/23/2010 Tobacco Use-Quit GOOD RECEPTIVE' by provider 'POWERS,MEGAN' at 'DEMO INDIAN HOSPITAL'. The 'Health Factors' section shows '08/19/2010 Current Smoker Tobacco'. The 'Exams' section lists '08/19/2010 DIABETIC EYE EXAM NORMAL/N' and '06/02/2010 ALCOHOL SCREENING NORMAL/N'. The 'Skin Test History' section is empty. The 'Personal Health' section is highlighted with a red circle and shows a 'Refusal' dropdown menu. The 'Immunization Record' section includes a 'Forecast' table with 'Tdap past due', 'Contraindications' table with 'PNEUMO-PS Egg Allergy 19-Aug-2010' and 'FLU-HIGH Anaphylaxis 19-Aug-2010', and 'Vaccinations' buttons. The bottom status bar shows 'POWERS,MEGAN', 'DEMO.OKLAHOMA.IHS.GOV', 'DEMO INDIAN HOSPITAL', and '24-Aug-2010 15:41'.

Visit Date	Education Topic	Comprehension	Readiness To Learn	Status	Objectives	Comment	Provider	Length	Type	Location
08/23/2010	Tobacco Use-Quit	GOOD	RECEPTIVE				POWERS,MEGAN	10	Individual	DEMO INDIAN HOSPITAL

Visit Date	Health Factor	Category	Comment
08/19/2010	Current Smoker	Tobacco	

Visit Date	Exams	Result
08/19/2010	DIABETIC EYE EXAM	NORMAL/N
06/02/2010	ALCOHOL SCREENING	NORMAL/N

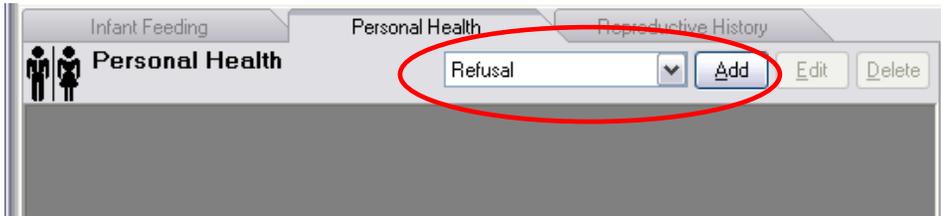
Visit Date	Skin Test	Location	Age@Visit	F
------------	-----------	----------	-----------	---

Forecast
Tdap past due

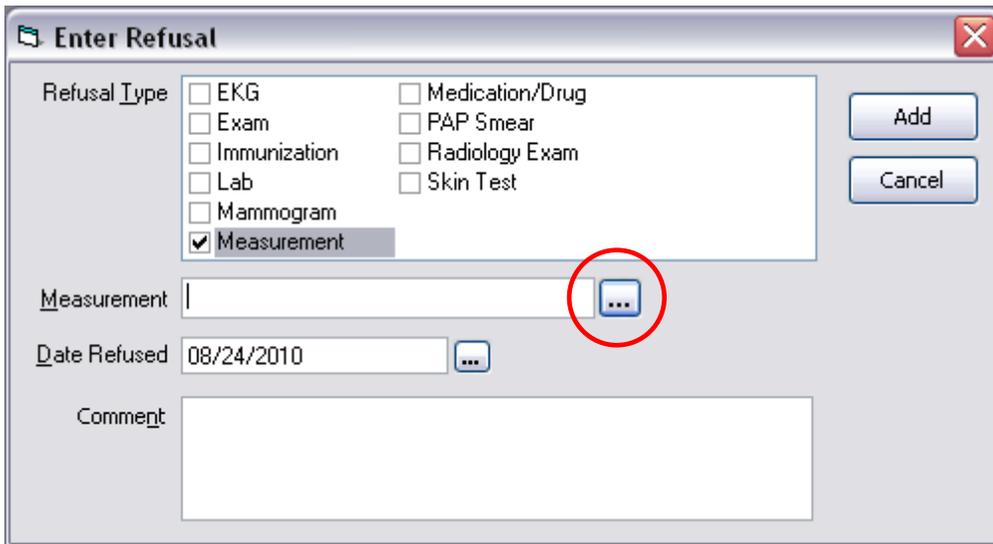
Contraindications
PNEUMO-PS Egg Allergy 19-Aug-2010
FLU-HIGH Anaphylaxis 19-Aug-2010

Vaccinations
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To enter a Refusal, select Refusal in the drop-down box and click Add in the Personal Health component.



Select the Refusal Type you would like to enter and click the ellipses (...) button.



Search for the item you would like to add a refusal for and click OK.

Lookup Measurement

Search Value: H

Search

OK

Cancel

Select one of the following records

Measurement ▲

- HEAD CIRCUMFERENCE
- HEARING
- HEIGHT

Enter in a comment (if applicable) and click Add.

Enter Refusal

Refusal Type

- EKG
- Exam
- Immunization
- Lab
- Mammogram
- Measurement
- Medication/Drug
- PAP Smear
- Radiology Exam
- Skin Test

Add

Cancel

Measurement: HEIGHT

Date Refused: 08/24/2010

Comment:

Your newly added Refusal should display in the Personal Health component.

