

# KEY CLINICAL PERFORMANCE OBJECTIVES

“Cheat Sheet” for EHR Documentation and Data Entry for CRS Version 12.0

Last Updated January 2012

**Recommended use for this material:** Each facility should (1) identify their three or four key clinical problem areas; (2) review the attached information; (3) customize the provider documentation and data entry instructions, if necessary; (4) train staff on appropriate documentation; and (5) post the applicable pages of the Cheat Sheet in exam rooms.

This document is to provide information to both providers and to data entry on the *most appropriate* way to document key clinical procedures in the Electronic Health Record (EHR). It does not include all of the codes the Clinical Reporting System (CRS) checks when determining if a performance measure is met. To review that information, view the CRS short version logic at:

<http://www.ihs.gov/CIO/CRS/documents/crsv12/GPRA%20PART%20Measures%20V12.pdf>

See [Appendix A](#) for detailed instructions on how to enter information into EHR.

**Note: Government Performance and Results Act (GPRA) measures do not include refusals.**

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes Prevalence NOTE: This is not a GPRA measure; however, it is used in determining patients that have been diagnosed with diabetes.		<b>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</b> Date received Location Results	Diabetes Prevalence Diagnosis POV <a href="#">Visit Diagnosis Entry</a> <b>Purpose of Visit:</b> 250.00-250.93 <b>Provider Narrative:</b> <b>Modifier:</b> <b>Cause of DX:</b>
Diabetes: Glycemic Control	Active Clinical Patients DX with diabetes and with an A1c: <ul style="list-style-type: none"> <li>&gt; 9.5 (Poor Glycemic Control)</li> <li>&lt; 7 (Ideal Glycemic Control)</li> </ul>	<b>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</b> Date received Location Results	A1c Lab Test <a href="#">Lab Test Entry</a> <b>Enter Lab Test Type:</b> [Enter site’s defined A1c Lab Test] <b>Collect Sample/Specimen:</b> [Blood, Plasma] <b>Clinical Indication:</b>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Glycemic Control (cont)			CPT <a href="#">Visit Services Entry</a> (includes historical CPTs) Enter CPT: 83036, 83037, 3044F-3046F <b>Quantity:</b> <b>Modifier:</b> Modifier 2:
Diabetes: Blood Pressure Control	Active Clinical Patients DX with diabetes and with controlled blood pressure: <ul style="list-style-type: none"> <li>&lt; 130/80 (mean systolic &lt; 130, mean diastolic &lt; 80)</li> </ul>	<b>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</b> Date received Location Results	Blood Pressure Data Entry <a href="#">Vital Measurements Entry</a> (includes historical Vitals) <b>Value:</b> [Enter as Systolic/Diastolic (e.g., 130/80)] <b>Select Qualifier:</b> <b>Date/Time Vitals Taken:</b>
Diabetes: LDL Assessment	Active Clinical Patients DX with diabetes and a completed LDL test.	<b>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</b> Date received Location Results	LDL (Calculated) Lab Test <a href="#">Lab Test Entry</a> <b>Enter Lab Test Type:</b> [Enter site's defined LDL Lab Test] <b>Collect Sample/Specimen:</b> [Blood] <b>Clinical Indication:</b> LDL CPT <a href="#">Visit Services Entry</a> (includes historical CPTs) <b>Enter CPT Code:</b> 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F <b>Quantity:</b> <b>Modifier:</b> <b>Modifier 2:</b>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Nephropathy Assessment	Active Clinical Patients DX with diabetes with a Nephropathy assessment: <ul style="list-style-type: none"> <li>• <b>Estimated GFR with result during the Report Period</b></li> <li>• <b>Quantitative Urinary Protein Assessment during the Report Period</b></li> <li>• <b>End Stage Renal Disease diagnosis/treatment</b></li> </ul>	<b>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</b> <ul style="list-style-type: none"> <li>Date received</li> <li>Location</li> <li>Results</li> </ul>	Estimated GFR Lab Test <a href="#">Lab Test Entry</a> <b>Enter Lab Test Type:</b> [Enter site’s defined Est GFR Lab Test] Collect Sample/Specimen: <b>[Blood]</b> <b>Clinical Indication:</b> Quantitative Urinary Protein Assessment CPT <a href="#">Visit Services Entry</a> (includes historical CPTs) <b>Enter CPT: 82042, 82043, 84156</b> <b>Quantity:</b> <b>Modifier:</b> <b>Modifier 2:</b> ESRD CPT <a href="#">Visit Services Entry</a> (includes historical CPTs) <b>Enter CPT: 36145, 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, G0257, G0308-G0327, G0392, G0393, or S9339</b> <b>Quantity:</b> <b>Modifier:</b> <b>Modifier 2:</b>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Nephropathy Assessment (cont)			ESRD POV <a href="#">Visit Diagnosis Entry</a> <b>Purpose of Visit: 585.5, 585.6, V42.0, V45.11, V45.12, or V56.*</b> <b>Provider Narrative:</b> <b>Modifier:</b> <b>Cause of DX:</b> ESRD Procedure <a href="#">Procedure Entry</a> <b>Operation/Procedure: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6*</b> <b>Provider Narrative:</b> <b>Operating Provider:</b> Diagnosis: [Enter appropriate DX (ESRD)]

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Diabetic Retinopathy	<p>Patients with diabetes will have a qualified* retinal examination during the report period.</p> <p>*Qualified retinal exam: The following methods are qualifying for this measure:</p> <ul style="list-style-type: none"> <li>• <b>Dilated retinal evaluation by an optometrist or ophthalmologist</b></li> <li>• <b>Seven standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist</b></li> <li>• <b>Any photographic method formally validated to seven standard fields (ETDRS).</b></li> </ul> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p><b>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Exams:</p> <p>Diabetic Retinal Exam</p> <p>Dilated retinal eye exam</p> <p>Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist</p> <p>Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos</p> <p>Routine ophthalmological examination including refraction (new or existing patient)</p> <p>Diabetic indicator; retinal eye exam, dilated, bilateral</p> <p>Other Eye Exams</p> <p>Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or validated tele-ophthalmology retinal evaluation clinics</p> <p>Non-DNKA visits to an optometrist or ophthalmologist</p>	<p>Diabetic Retinopathy Exam</p> <p><a href="#">Exam Entry</a> (includes historical exams)</p> <p><b>Select Exam: 03</b></p> <p><b>Result: [Enter Results]</b></p> <p><b>Comments:</b></p> <p><b>Provider Performing Exam:</b></p> <p>Retinal Exam CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT: 2022F, 2024F, 2026F, S0620, S0621, S3000</b></p> <p><b>Quantity:</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p> <p>Other Eye Exam CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT: 67028, 67038, 67039, 67040, 92002, 92004, 92012, 92014</b></p> <p><b>Quantity:</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetic Retinopathy (cont)			<p>Other Eye Exam POV  <a href="#">Visit Diagnosis Entry</a>  <b>Purpose of Visit: V72.0</b>  <b>Provider Narrative:</b>  <b>Modifier:</b>  <b>Cause of DX:</b></p> <p>Other Eye Exam Procedure  <a href="#">Procedure Entry</a>  <b>Operation/Procedure: 95.02</b>  <b>Provider Narrative:</b>  <b>Operating Provider:</b>  <b>Diagnosis: [Enter appropriate DX]</b></p> <p>Other Eye Exam Clinic  <a href="#">Clinic Entry</a>  <b>Clinic: A2, 17, 18, 64</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Access to Dental Service	<p>Patients should have annual dental exams.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p><b>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p>	<p>Dental Exam  <a href="#">Exam Entry</a> (includes historical exams)  <b>Select Exam: 30</b>  <b>Result: [Enter Results]</b>  <b>Comments:</b>  <b>Provider Performing Exam:</b></p> <p>Dental Exam (ADA code)  <i>ADA codes cannot be entered into EHR.</i></p> <p>Dental Exam POV  <a href="#">Visit Diagnosis Entry</a>  <b>Purpose of Visit: V72.2</b>  <b>Provider Narrative:</b>  <b>Modifier:</b>  <b>Cause of DX:</b></p>
Dental Sealants	<p>A maximum of two sealants per tooth are counted toward the GPRA measure.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p><b>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p>	<p>Dental Sealants (ADA)  <i>ADA codes cannot be entered into EHR.</i></p> <p>Dental Sealants CPT  <a href="#">Visit Services Entry</a> (includes historical CPTs)  <b>Enter CPT: D1351</b>  <b>Quantity:</b>  <b>Modifier:</b>  <b>Modifier 2:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Topical Fluoride	<p>A maximum of four topical fluoride application are counted toward the GPRA measure.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p><b>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p>	<p>Topical Fluoride (ADA code) <i>ADA codes cannot be entered into EHR.</i></p> <p>Topical Flouride CPT <b><u>Visit Services Entry</u></b> (includes historical CPTs) <b>Enter CPT: D1203, D1204, D1206, D5986</b></p> <p><b>Quantity:</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p> <p>Topical Flouride POV <b><u>Visit Diagnosis Entry</u></b></p> <p><b>Purpose of Visit: V07.31</b></p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Adult Immunizations: Influenza</p>	<p>All adults ages 65 and older should have an annual influenza (flu) shot.</p> <p>Adults 55-64 are strongly recommended to have annual influenza (flu) shot.</p> <p>All adult (18 and older) diabetic patients are strongly recommended to have annual influenza (flu) shot.</p> <p>Refusals should be documented. Note: Only Not Medically Indicated (NMI) refusals are counted toward the GPRA Measure.</p>	<p><b>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</b></p> <ul style="list-style-type: none"> <li>IZ type</li> <li>Date received</li> <li>Location</li> </ul> <p>Contraindications should be documented and are counted toward the GPRA Measure.</p> <p>Contraindications include:</p> <ul style="list-style-type: none"> <li>Immunization Package of "Egg Allergy" or "Anaphylaxis"</li> <li>NMI Refusal</li> </ul>	<p>Influenza Vaccine</p> <p><a href="#">Immunization Entry</a> (includes historical immunizations)</p> <p><b>Select Immunization Name: 140, 141 or 144 (other options are 111, 15, 16, 88)</b></p> <p><b>Lot:</b></p> <p><b>VFC Eligibility:</b></p> <p>Influenza Vaccine POV</p> <p><a href="#">Visit Diagnosis Entry</a></p> <p><b>Purpose of Visit: *V04.81, *V06.6</b></p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p> <p><b>* NOT documented with 90663, 90664, 90666-90668, 90470, G9141, G9142</b></p> <p>Influenza Vaccine CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT: 90654-90662, G0008, G8108</b></p> <p><b>Quantity:</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Adult Immunizations: Influenza (cont)			Influenza Procedure <a href="#">Procedure Entry</a> <b>Operation/Procedure: 99.52</b> <b>Provider Narrative:</b> <b>Operating Provider:</b> <b>Diagnosis: [Enter appropriate DX]</b>  NMI Refusal of Influenza <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i>  Contraindication Influenza <a href="#">Immunization Entry - Contraindications</a> <b>Vaccine: [See codes above]</b> <b>Reason: Egg Allergy, Anaphylaxis</b>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Adult Immunizations: Pneumovax</p>	<p>All adults ages 65 and older will have a pneumovax.</p> <p>All adult (18 and older) diabetic patients are strongly recommended to have a pneumovax.</p> <p>Refusals should be documented. Note: Only NMI refusals are counted toward the GPRA Measure.</p>	<p><b>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</b></p> <ul style="list-style-type: none"> <li>IZ type</li> <li>Date received</li> <li>Location</li> </ul> <p>Contraindications should be documented and are counted toward the GPRA Measure.</p> <p>Contraindications include:</p> <ul style="list-style-type: none"> <li>Immunization Package of "Egg Allergy" or "Anaphylaxis"</li> <li>NMI Refusal</li> </ul>	<p>Pneumovax Vaccine</p> <p><a href="#">Immunization Entry</a> (includes historical immunizations)</p> <p><b>Select Immunization Name: 33, 100, 109, 133</b></p> <p><b>Lot:</b></p> <p><b>VFC Eligibility:</b></p> <p>Pneumovax Vaccine POV</p> <p><a href="#">Visit Diagnosis Entry</a></p> <p><b>Purpose of Visit: V06.6, V03.82</b></p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p> <p>Pneumovax Vaccine CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT: 90669, 90670, 90732, G0009, G8115</b></p> <p><b>Quantity:</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p> <p>Pneumovax Procedure</p> <p><a href="#">Procedure Entry</a></p> <p><b>Operation/Procedure: 99.55</b></p> <p><b>Provider Narrative:</b></p> <p><b>Operating Provider:</b></p> <p><b>Diagnosis: [Enter appropriate DX]</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Adult Immunizations: Pneumovax			<p>NMI Refusal of Pneumovax <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p>Contraindication Pneumovax <a href="#"><u>Immunization Entry - Contraindications</u></a></p> <p><b>Vaccine:</b> [See codes above] <b>Reason:</b> <b>Egg Allergy, Anaphylaxis</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations	<p>Children age 19–35 months will be up-to-date for all ACIP recommended immunizations.</p> <p>This is the 4313314 combo:</p> <p>4 DTaP 3 IPV 1 MMR 3 Hepatitis B 3 Hib 1 Varicella 4 Pneumococcal</p> <p>Refusals should be documented.</p> <p>Note: Only NMI refusals are counted toward the GPRA Measure.</p>	<p><b>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</b></p> <p>IZ type Date received Location</p> <p><b>Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization</b></p> <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include Immunization Package of "Anaphylaxis" for all childhood immunizations. The following additional contraindications are also counted:</p> <p>IPV: Immunization Package: "Neomycin Allergy."</p> <p>MMR: Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</p> <p>Varicella: Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," <input type="checkbox"/> "Immune Deficient," or "Neomycin Allergy."</p>	<p>Childhood Immunizations</p> <p><a href="#">Immunization Entry</a> (includes historical immunizations)</p> <p><b>Select Immunization Name:</b> <i>DTaP: 20, 50, 106, 107, 110, 120, 130, 146; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113; Tetanus: 35, 112; Acellular Pertussis: 11; OPV: 2, 89; IPV: 10, 89, 110, 120, 130, 146; MMR: 3, 94; M/R: 4; R/M: 38 ; Measles: 5; Mumps: 7; Rubella: 6; Hepatitis B: 8, 42-45, 51, 102, 104, 110, 146; HIB: 17, 22, 46-49, 50, 51, 102, 120, 146; Varicella: 21, 94</i></p> <p><b>Lot:</b> <b>VFC Eligibility:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations (cont)		<p>Dosage and types of immunization definitions:</p> <p>Four doses of DTaP:  4 DTaP/DTP/Tdap  1 DTaP/DTP/Tdap and 3 DT/Td  1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus  4 DT and 4 Acellular Pertussis  4 Td and 4 Acellular Pertussis  4 each of Diphtheria, Tetanus, and Acellular Pertussis</p> <p>Three doses of IPV:  3 OPV  3 IPV  Combination of OPV and IPV totaling three doses</p> <p>One dose of MMR:  MMR  1 M/R and 1 Mumps  1 R/M and 1 Measles  1 each of Measles, Mumps, and Rubella</p> <p>Three doses of Hepatitis B  3 doses of Hep B</p> <p>Three doses of HIB</p> <p>One dose of Varicella</p>	<p>Childhood Immunizations POV  <a href="#">Visit Diagnosis Entry</a>  <b>Purpose of Visit: DTaP: V06.1; DTP: V06.1, V06.2, V06.3; DT: V06.5; Td: V06.5; Diphtheria: V03.5; Tetanus: V03.7; Acellular Pertussis: V03.6; OPV contraindication: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; IPV: V04.0, V06.3; IPV (evidence of disease): 730.70-730.79; MMR: V06.4; Measles: V04.2; Measles (evidence of disease): 055*; Mumps: V04.6; Mumps (evidence of disease): 072*; Rubella: V04.3; Rubella (evidence of disease): 056*, 771.0; Hepatitis B (evidence of disease): V02.61, 070.2, 070.3; HIB: V03.81; Varicella: V05.4; Varicella (evidence of disease): 052*, 053*; Varicella contraindication: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208</b></p> <p><b>Provider Narrative:</b>  <b>Modifier:</b>  <b>Cause of DX:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations (cont)		<p><b>IMPORTANT NOTE:</b></p> <p>The GPRA denominator is all User Population patients who are active in the Immunization Package. This means you must be using the Immunization Package and maintaining the active/inactive status field in order to have patients in your denominator for this GPRA measure. Immunization package v8.4 offers a scan function that searches the RPMS Patient Database for children who are less than 36 months old and reside in GPRA communities for the facility, and automatically enters them into the Register with a status of Active. Sites can run this scan at any time, and should run it upon loading 8.4. Children already in the Register or residing outside of the GPRA communities will not be affected.</p>	<p>Childhood Immunizations CPT <a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p>Enter CPT: <i>DTaP</i>: 90696, 90698, 90700, 90721, 90723; <i>DTP</i>: 90701, 90720; <i>Tdap</i>: 90715; <i>DT</i>: 90702; <i>Td</i>: 90714, 90718; <i>Diphtheria</i>: 90719; <i>Tetanus</i>: 90703; <i>OPV</i>: 90712; <i>IPV</i>: 90696, 90698, 90713, 90723; <i>MMR</i>: 90707, 90710; <i>M/R</i>: 90708; <i>Measles</i>: 90705; <i>Mumps</i>: 90704; <i>Rubella</i>: 90706; <i>Hepatitis B</i>: 90636, 90723, 90740, 90743-90748, G0010; <i>HIB</i>: 90645-90648, 90698, 90720-90721, 90748; <i>Varicella</i>: 90710, 90716</p> <p>Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations (cont)			<p>Childhood Immunizations Procedure</p> <p><a href="#">Procedure Entry</a></p> <p><b>Operation/Procedure: DTP: 99.39; Diphtheria: 99.36; Tetanus: 99.38; IPV: 99.41; MMR: 99.48; MMR contraindication: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; Measles: 99.45; Mumps: 99.46; Rubella: 99.47;</b></p> <p><b>Provider Narrative:</b></p> <p><b>Operating Provider:</b></p> <p><b>Diagnosis: [Enter appropriate DX]</b></p> <p>NMI Refusal of Childhood Immunizations</p> <p><i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p>Contraindication Childhood Immunizations</p> <p><a href="#">Immunization Entry - Contraindications</a></p> <p><b>Vaccine: [See codes above]</b></p> <p><b>Reason: [See Contraindications section under the Provider Documentation column]</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Cancer Screening: Pap Smear Rates	<p>Women ages 21–64 should have a Pap Smear every 3 years.</p> <p>Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.</p>	<p><b>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p>	<p>Pap Smear V Lab</p> <p><a href="#">Lab Test Entry</a></p> <p><b>Enter Lab Test Type:</b> [Enter site’s defined Pap Smear Lab Test]</p> <p><b>Clinical Indication:</b></p> <p>Pap Smear POV</p> <p><a href="#">Visit Diagnosis Entry</a></p> <p><b>Purpose of Visit:</b> V67.01, V76.2, V72.32, V72.3, V76.47, 795.0*, 795.10-16, 795.19</p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p> <p>Pap Smear CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT:</b> 88141-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091</p> <p><b>Quantity:</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p> <p>Pap Smear Procedure</p> <p><a href="#">Procedure Entry</a></p> <p><b>Operation/Procedure:</b> 91.46</p> <p><b>Provider Narrative:</b></p> <p><b>Operating Provider:</b></p> <p><b>Diagnosis:</b> [Enter appropriate DX]</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Cancer Screening: Mammogram Rates	<p>Women ages 52–64 should have a mammogram every 2 years</p> <p>Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.</p>	<p><b>Standard EHR documentation for Radiology performed at the facility. Ask and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Telephone visit with patient</p> <p>Verbal or written lab report</p> <p>Patient’s next visit</p>	<p>Mammogram POV</p> <p><a href="#">Visit Diagnosis Entry</a></p> <p><b>Purpose of Visit: V76.11, V76.12, 793.80, 793.81, 793.89</b></p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p> <p>Mammogram CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT: 77053-77059, G0206; G0204, G0202</b></p> <p><b>Quantity:</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p> <p>Mammogram Procedure</p> <p><a href="#">Procedure Entry</a></p> <p><b>Operation/Procedure: 87.36, 87.37</b></p> <p><b>Provider Narrative:</b></p> <p><b>Operating Provider:</b></p> <p><b>Diagnosis: [Enter appropriate DX]</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening	<p>Adults ages 50–75 should be screened for CRC (USPTF).</p> <p>For GPRA, IHS counts any of the following:</p> <ul style="list-style-type: none"> <li>• <b>Annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT)</b></li> <li>• <b>Flexible sigmoidoscopy or double contrast barium enema in the past 5 years</b></li> <li>• <b>Colonoscopy every 10 years.</b></li> </ul> <p>Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard EHR documentation for procedures performed at the facility (Radiology, Lab, provider).</p> <p>Guaiac cards returned by patients to providers should be sent to Lab for processing.</p> <p>Ask and <i>record historical information</i> in EHR:</p> <ul style="list-style-type: none"> <li>Date received</li> <li>Location</li> <li>Results</li> </ul> <p>Telephone visit with patient</p> <p>Verbal or written lab report</p> <p>Patient’s next visit</p>	<p>Colorectal Cancer POV</p> <p><a href="#">Visit Diagnosis Entry</a></p> <p><b>Purpose of Visit: 153.*, 154.0, 154.1, 197.5, V10.05</b></p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p> <p>Colorectal Cancer CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT: G0213-G0215, G0231</b></p> <p><b>Quantity:</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p> <p>Total Colectomy CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT: 44150-44151, 44155-44158, 44210-44212</b></p> <p><b>Quantity:</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening (cont)			FOBT or FIT CPT <a href="#">Visit Services Entry</a> (includes historical CPTs) <b>Enter CPT: 82270, 82274, G0328</b> <b>Quantity:</b> <b>Modifier:</b> <b>Modifier 2:</b>  Flexible Sigmoidoscopy CPT <a href="#">Visit Services Entry</a> (includes historical CPTs) <b>Enter CPT: 45330–45345, G0104</b> <b>Quantity:</b> <b>Modifier:</b> <b>Modifier 2:</b>  Flexible Sigmoidoscopy Procedure <a href="#">Procedure Entry</a> <b>Operation/Procedure: 45.24</b> <b>Provider Narrative:</b> <b>Operating Provider:</b> <b>Diagnosis: [Enter appropriate DX]</b>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening (cont)			<p>DBE CPT  <a href="#">Visit Services Entry</a> (includes historical CPTs)  <b>Enter CPT: 74280, G0106, G0120</b>  <b>Quantity:</b>  <b>Modifier:</b>  <b>Modifier 2:</b></p> <p>Colonoscopy POV  <a href="#">Visit Diagnosis Entry</a>  <b>Purpose of Visit: V76.51</b>  <b>Provider Narrative:</b>  <b>Modifier:</b>  <b>Cause of DX:</b></p> <p>Colon Screening CPT  <a href="#">Visit Services Entry</a> (includes historical CPTs)  <b>Enter CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121</b>  <b>Quantity:</b>  <b>Modifier:</b>  <b>Modifier 2:</b></p> <p>Colon Screening Procedure  <a href="#">Procedure Entry</a>  <b>Operation/Procedure: 45.22, 45.23, 45.25, 45.42, 45.43</b>  <b>Provider Narrative:</b>  <b>Operating Provider:</b>  <b>Diagnosis: [Enter appropriate DX]</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Tobacco Use and Exposure Assessment</p> <p>NOTE: This is not a GPRA measure; however, it will be used for reducing the incidence of Tobacco Use.</p>	<p><b>Ask all patients age five and over about tobacco use at least annually.</b></p>	<p><b>Standard EHR documentation for tests performed at the facility, ask and <i>record historical information</i> in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Document on designated Health Factors section of form:</p> <p>HF–Current Smoker, every day</p> <p>HF–Current Smoker, some day</p> <p>HF–Current Smoker, status unknown</p> <p>HF–Current Smokeless</p> <p>HF–Previous (Former) Smoker [or -Smokeless] (quit &gt; 6 months)</p> <p>HF–Cessation-Smoker [or -Smokeless] (quit or actively trying &lt; 6 months)</p> <p>HF–Smoker in Home</p> <p>HF–Ceremonial Use Only</p> <p>HF–Exp to ETS (Second Hand Smoke)</p> <p>HF–Smoke Free Home</p> <p>NOTE: If your site uses other expressions (e.g.,” Chew” instead of “Smokeless;” “Past” instead of “Previous”), be sure Data Entry staff knows how to “translate”</p> <p>Tobacco Patient Education Codes: Codes will contain "TO-", "-TO", "-SHS"</p>	<p>Tobacco Screening Health Factor</p> <p><a href="#">Health Factor Entry</a></p> <p><b>Select V Health Factor: [Enter HF (See the Provider Documentation column)]</b></p> <p><b>Level/Severity:</b></p> <p><b>Provider:</b></p> <p><b>Quantity:</b></p> <p>Tobacco Screening PED–Topic</p> <p><a href="#">Patient Education Entry</a> (includes historical patient education)</p> <p><b>Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]</b></p> <p><b>Readiness to Learn:</b></p> <p><b>Level of Understanding:</b></p> <p><b>Provider:</b></p> <p><b>Length of Educ (Minutes):</b></p> <p><b>Comment</b></p> <p><b>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</b></p> <p><b>Goal Comment:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Use and Exposure Assessment (cont)		<p><b>NOTE:</b> Ensure you update the patient’s health factors as they enter a cessation program and eventually become non-tobacco users. Patients who are in a tobacco cessation program should have their health factor changed from “Smoker” or “Smokeless” to “Cessation-Smoker” or “Cessation-Smokeless” until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to “Previous Smoker” or “Previous Smokeless.”</p>	<p>Tobacco Users Health Factor <a href="#">Health Factor Entry</a> <b>Select V Health Factor: Current Smoker (every day, some day, or status unknown), Current Smokeless, Cessation-Smoker, Cessation-Smokeless</b> <b>Level/Severity:</b> <b>Provider:</b> <b>Quantity:</b></p> <p>Smokers Health Factor <a href="#">Health Factor Entry</a> <b>Select V Health Factor: Current Smoker (every day, some day, or status unknown), or Cessation-Smoker</b> <b>Level/Severity:</b> <b>Provider:</b> <b>Quantity:</b></p> <p>Smokeless Health Factor <a href="#">Health Factor Entry</a> <b>Select V Health Factor: Current Smokeless or Cessation-Smokeless</b> <b>Level/Severity:</b> <b>Provider:</b> <b>Quantity:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Use and Exposure Assessment (cont)			ETS Health Factor <a href="#">Health Factor Entry</a> <b>Select V Health Factor: Exp to ETS</b> <b>Level/Severity:</b> <b>Provider:</b> <b>Quantity:</b>
Tobacco Cessation	Active clinical patients identified as current tobacco users prior to report period and who have received tobacco cessation counseling or a Rx for smoking cessation aid.  Note: Refusals are not counted toward the GPRA measure, but should still be documented.	<b>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</b> Date received Location Results  Current tobacco users are defined by having any of the following documented prior to the report period: Last documented Tobacco Health Factor Last documented Tobacco related POV Last documented Tobacco related CPT  Health factors considered to be a tobacco user: HF–Current Smoker, every day HF–Current Smoker, some day HF–Current Smoker, status unknown HF–Current Smokeless HF–Cessation-Smoker [or -Smokeless] (quit or actively trying < 6 months)  Tobacco Patient Education Codes: Codes will contain "TO-", "-TO", "-SHS"	Tobacco Cessation PED - Topic <a href="#">Patient Education Entry</a> (includes historical patient education) <b>Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]</b> <b>Readiness to Learn:</b> <b>Level of Understanding:</b> <b>Provider:</b> <b>Length of Educ (Minutes):</b> <b>Comment</b> <b>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</b> <b>Goal Comment:</b>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Cessation (cont)		<p>Prescribe Tobacco Cessation Aids:            Predefined Site-Populated Smoking Cessation Meds</p> <p>Meds containing:            “Nicotine Patch”            “Nicotine Polacrilex”            “Nicotine Inhaler”            “Nicotine Nasal Spray”</p> <p>NOTE:            Ensure you update the patient’s health factors as they enter a cessation program and eventually become nontobacco users. Patients who are in a tobacco cessation program should have their health factor changed from “Smoker” or “Smokeless” to “Cessation-Smoker” or “Cessation-Smokeless” until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to “Previous Smoker” or “Previous Smokeless.”</p>	<p>Tobacco Cessation PED–            Diagnosis  <a href="#">Patient Education Entry</a>  <b>(includes historical patient education)</b>  <b>Select ICD Diagnosis Code Number: 649.00-649.04</b>  <b>Category:</b>  <b>Readiness to Learn:</b>  <b>Level of Understanding:</b>  <b>Provider:</b>  <b>Length of Educ (Minutes):</b>  <b>Comment</b>  <b>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</b>  <b>Goal Comment:</b>  <b>Provider’s Narrative:</b>            Tobacco Cessation PED - CPT  <i>Mnemonic PED enter</i>  <b>Select CPT Code Number:</b>  <b>D1320, 99406, 99407, G0375 (old code), G0376 (old code), 4000F, G8402 or G8453</b>  <b>Category:</b>  <b>Readiness to Learn:</b>  <b>Level of Understanding:</b>  <b>Provider:</b>  <b>Length of Educ (Minutes):</b>  <b>Comment</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Cessation (cont)			<p><b>Goal Code:</b> [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p><b>Goal Comment:</b></p> <p><b>Provider’s Narrative:</b></p> <p>Tobacco Cessation Clinic</p> <p><a href="#">Clinic Entry</a></p> <p><b>Clinic: 94</b></p> <p>Tobacco Cessation Dental (ADA)</p> <p><i>ADA codes cannot be entered into EHR.</i></p> <p>Tobacco Cessation CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT Code: D1320, 99406, 99407, 4000F, G8402 or G8453</b></p> <p><b>Quantity</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p> <p>Tobacco Cessation Medication</p> <p><a href="#">Medication Entry</a></p> <p><b>Select Medication:</b> [Enter Tobacco Cessation Prescribed Medication]</p> <p><b>Outside Drug Name (Optional):</b> [Enter any additional name for the drug]</p> <p><b>SIG</b></p> <p><b>Quantity:</b></p> <p><b>Day Prescribed:</b></p> <p><b>Event Date&amp;Time:</b></p> <p><b>Ordering Provider:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Cessation (cont)			Tobacco Cessation Prescription CPT <u><a href="#">Visit Services Entry</a></u> (includes <b>historical CPTs</b> ) <b>Enter CPT Code: 4001F</b> <b>Quantity</b> <b>Modifier:</b> <b>Modifier 2:</b>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (FAS Prevention)	<p>Pregnant women should be screened for alcohol use at least on their first visit; education and follow-up provided as appropriate.</p> <p>Women of childbearing age should be screened at least annually.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p><b>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Alcohol screening may be documented with either an exam code or the CAGE health factor in EHR.</p> <p>Medical Providers: EXAM—Alcohol Screening</p> <p><b>Negative</b>—Patient’s screening exam does not indicate risky alcohol use.</p> <p><b>Positive</b>—Patient’s screening exam indicates potential risky alcohol use.</p> <p><b>Refused</b>—Patient declined exam/screen</p> <p><b>Unable to screen</b> - Provider unable to screen</p> <p>Note: Recommended Brief Screening Tool: SASQ (below).</p> <p><u>Single Alcohol Screening Question (SASQ)</u></p> <p><u>For Women:</u></p> <p>When was the last time you had more than 4 drinks in one day?</p> <p><u>For Men:</u></p> <p>When was the last time you had more than 5 drinks in one day?</p>	<p>Alcohol Screening Exam</p> <p><a href="#">Exam Entry</a> (includes historical exams)</p> <p><b>Select Exam: 35, ALC</b></p> <p><b>Result:</b></p> <p><b>A</b>—Abnormal</p> <p><b>N</b>—Normal/Negative</p> <p><b>PR</b>—Resent</p> <p><b>PAP</b>—Present and Past</p> <p><b>PA</b>—Past</p> <p><b>PO</b>—Positive</p> <p><b>Comments: SASQ</b></p> <p><b>Provider Performing Exam:</b></p> <p>Cage Health Factor</p> <p><a href="#">Health Factor Entry</a></p> <p><b>Select Health Factor: CAGE</b></p> <p><b>1 CAGE 0/4 (all No answers)</b></p> <p><b>2 CAGE 1/4</b></p> <p><b>3 CAGE 2/4</b></p> <p><b>4 CAGE 3/4</b></p> <p><b>5 CAGE 4/4</b></p> <p><b>Choose 1-5: [Number from above]</b></p> <p><b>Level/Severity:</b></p> <p><b>Provider:</b></p> <p><b>Quantity:</b></p> <p>Alcohol Screening POV</p> <p><a href="#">Visit Diagnosis Entry</a></p> <p><b>Purpose of Visit: V11.3, V79.1</b></p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (FAS Prevention) (cont)		<p>Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen:</p> <p style="padding-left: 40px;"><b>Alcohol Screening Exam Code Result: Positive</b></p> <p>The patient may decline the screen or “Refuse to answer”:</p> <p style="padding-left: 40px;"><b>Alcohol Screening Exam Code Result: Refused</b></p> <p>The provider is unable to conduct the screen:</p> <p style="padding-left: 40px;"><b>Alcohol Screening Exam Code Result: Unable To Screen</b></p> <p><b>Note: Provider should note the screening tool used was the SASQ at the <i>Comment</i> Mnemonic for the Exam code.</b></p> <p>All Providers: Use the CAGE questionnaire:</p> <p>Have you ever felt the need to Cut down on your drinking?</p> <p>Have people Annoyed you by criticizing your drinking?</p> <p>Have you ever felt bad or Guilty about your drinking?</p> <p>Have you ever needed an Eye-opener the first thing in the morning to steady your nerves or get rid of a hangover?</p> <p>Tolerance: How many drinks does it take you to get high?</p>	<p>Alcohol Screening CPT <a href="#">Visit Services Entry</a> (includes historical CPTs) <b>Enter CPT Code: 99408, 99409, G0396, G0397, H0049, H0050</b> <b>Quantity</b> <b>Modifier:</b> <b>Modifier 2:</b> Alcohol-Related Diagnosis POV <a href="#">Visit Diagnosis Entry</a> <b>Purpose of Visit: 303.*, 305.0*, 291.*, 357.5*</b> <b>Provider Narrative:</b> <b>Modifier:</b> <b>Cause of DX:</b> Alcohol-Related Procedure <a href="#">Procedure Entry</a> <b>Operation/Procedure: 94.46, 94.53, 94.61-94.63, 94.67-94.69</b> <b>Provider Narrative:</b> <b>Operating Provider:</b> <b>Diagnosis: [Enter appropriate DX]</b> Alcohol-Related PED - Topic <a href="#">Patient Education Entry</a> (includes historical patient education) <b>Enter Education Topic: [Enter Alcohol-Related Education Code (See the Provider Documentation column)]</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (FAS Prevention) (cont)		<p><b>Based on how many YES answers were received, document Health Factor in EHR:</b></p> <p>HF-CAGE 0/4 (all No answers)</p> <p>HF-CAGE 1/4</p> <p>HF-CAGE 2/4</p> <p>HF-CAGE 3/4</p> <p>HF-CAGE 4/4</p> <p>Optional values:</p> <p>Level/Severity: Minimal, Moderate, or Heavy/Severe</p> <p>Quantity: # of drinks daily OR T (Tolerance) -- # drinks to get high (e.g. T-4)</p> <p>Comment: used to capture other relevant clinical info e.g. "Non-drinker"</p> <p>Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-"</p> <p>AUDIT Measurements:</p> <p><b>Zone I:</b> Score 0–7 Low risk drinking or abstinence</p> <p><b>Zone II:</b> Score 8–15 Alcohol use in excess of low-risk guidelines</p> <p><b>Zone III:</b> Score 16–19 Harmful and hazardous drinking</p> <p><b>Zone IV:</b> Score 20–40 Referral to Specialist for Diagnostic Evaluation and Treatment</p>	<p><b>Readiness to Learn:</b></p> <p><b>Level of Understanding:</b></p> <p><b>Provider:</b></p> <p><b>Length of Educ (Minutes):</b></p> <p><b>Comment</b></p> <p><b>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</b></p> <p><b>Goal Comment:</b></p> <p>Alcohol-Related PED - Diagnosis</p> <p><a href="#"><u>Patient Education Entry</u></a> (includes historical patient education)</p> <p><b>Select ICD Diagnosis Code Number: V11.3, V79.1, 303.*, 305.0*, 291.* or 357.5*</b></p> <p><b>Category:</b></p> <p><b>Readiness to Learn:</b></p> <p><b>Level of Understanding:</b></p> <p><b>Provider:</b></p> <p><b>Length of Educ (Minutes):</b></p> <p><b>Comment</b></p> <p><b>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</b></p> <p><b>Goal Comment:</b></p> <p><b>Provider’s Narrative:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (FAS Prevention) (cont)		<p>AUDIT-C Measurements:</p> <p>How often do you have a drink containing alcohol?</p> <ul style="list-style-type: none"> <li>(0) Never (Skip to Questions 9-10)</li> <li>(1) Monthly or less</li> <li>(2) 2 to 4 times a month</li> <li>(3) 2 to 3 times a week</li> <li>(4) 4 or more times a week</li> </ul> <p>How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <ul style="list-style-type: none"> <li>(0) 1 or 2</li> <li>(1) 3 or 4</li> <li>(2) 5 or 6</li> <li>(3) 7, 8, or 9</li> <li>(4) 10 or more</li> </ul> <p>How often do you have six or more drinks on one occasion?</p> <ul style="list-style-type: none"> <li>(0) Never</li> <li>(1) Less than monthly</li> <li>(2) Monthly</li> <li>(3) Weekly</li> <li>(4) Daily or almost daily</li> </ul>	<p>Alcohol-Related PED - CPT  <a href="#">Patient Education Entry</a>  (includes historical patient education)  <b>Select CPT Code Number: 99408, 99409, G0396, G0397, H0049, or H0050</b>  <b>Category:</b>  <b>Readiness to Learn:</b>  <b>Level of Understanding:</b>  <b>Provider:</b>  <b>Length of Educ (Minutes):</b>  <b>Comment</b>  <b>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</b>  <b>Goal Comment:</b>  <b>Provider’s Narrative:</b>  Alcohol Screen AUDIT Measurement  <a href="#">Vital Measurements Entry</a>  (includes historical Vitals)  <b>Value: [Enter 0-40]</b>  <b>Select Qualifier:</b>  <b>Date/Time Vitals Taken:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (FAS Prevention) (cont)		<p>The AUDIT-C (the first three AUDIT questions which focus on alcohol consumption) is scored on a scale of 0–12 (scores of 0 reflect no alcohol use).</p> <p>In men, a score of 4 or more is considered positive</p> <p>In women, a score of 3 or more is considered positive.</p> <p>A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence.</p> <p>CRAFFT Measurements:</p> <p>C–Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?</p> <p>R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?</p> <p>A–Do you ever use alcohol/drugs while you are by yourself, ALONE?</p> <p>F–Do you ever FORGET things you did while using alcohol or drugs?</p> <p>F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?</p> <p>T–Have you gotten into TROUBLE while you were using alcohol or drugs?</p> <p><b>Total CRAFFT score (Range: 0–6). Positive answers to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated.</b></p>	<p>Alcohol Screen AUDIT-C Measurement  <a href="#">Vital Measurements Entry</a>  <b>(includes historical Vitals)</b>  <b>Value: [Enter 0-40]</b>  <b>Select Qualifier:</b>  <b>Date/Time Vitals Taken:</b></p> <p>Alcohol Screen CRAFFT Measurement  <a href="#">Vital Measurements Entry</a>  <b>(includes historical Vitals)</b>  <b>Value: [Enter 0-6]</b>  <b>Select Qualifier:</b>  <b>Date/Time Vitals Taken:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Intimate Partner (Domestic) Violence Screening (IPV/DV)</p>	<p><b>Adult females should be screened for domestic violence at new encounter and at least annually Prenatal once each trimester</b> (Source: Family Violence Prevention Fund National Consensus Guidelines)</p> <p>Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</p>	<p><b>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Medical and Behavioral Health Providers: EXAM—IPV/DV Screening</p> <p><b>Negative</b>—Denies being a current or past victim of IPV/DV</p> <p><b>Past</b>—Denies being a current victim, but discloses being a past victim of IPV/DV</p> <p><b>Present</b>—Discloses current IPV/DV</p> <p><b>Present and Past</b>—Discloses past victimization and current IPV/DV victimization</p> <p><b>Refused</b>—Patient declined exam/screen</p> <p><b>Unable to screen</b>—Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.)</p> <p>IPV/DV Patient Education Codes: Codes will contain "DV-" or "-DV"</p>	<p>IPV/DV Screening Exam</p> <p><a href="#">Exam Entry</a> (includes historical exams)</p> <p><b>Select Exam: 34, INT</b></p> <p><b>Result:</b></p> <p><b>A</b>—Abnormal</p> <p><b>N</b>—Normal/Negative</p> <p><b>PR</b>—Resent</p> <p><b>PAP</b>—Present and Past</p> <p><b>PA</b>—Past</p> <p><b>PO</b>—Positive</p> <p><b>Comments:</b></p> <p><b>Provider Performing Exam:</b></p> <p>IPV/DV Diagnosis POV</p> <p><a href="#">Visit Diagnosis Entry</a></p> <p><b>Purpose of Visit: 995.80-83, 995.85, V15.41, V15.42, V15.49, V61.11 (IPV/DV Counseling)</b></p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p> <p>IPV/DV—Topic</p> <p><a href="#">Patient Education Entry</a> (includes historical patient education)</p> <p><b>Enter Education Topic: [Enter IPV/DV Patient Education Code (See the Provider Documentation column)]</b></p> <p><b>Readiness to Learn:</b></p> <p><b>Level of Understanding:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont)			<p><b>Provider:</b>  <b>Length of Educ (Minutes):</b>  <b>Comment</b>  <b>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</b>  <b>Goal Comment:</b>            IPV/DV PED–Diagnosis  <a href="#">Patient Education Entry</a>            (includes historical patient education)  <b>Select ICD Diagnosis Code Number: 995.80-83, 995.85, V15.41, V15.42, V15.49</b>  <b>Category:</b>  <b>Readiness to Learn:</b>  <b>Level of Understanding:</b>  <b>Provider:</b>  <b>Length of Educ (Minutes):</b>  <b>Comment</b>  <b>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</b>  <b>Goal Comment:</b>            Provider’s Narrative:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening	<p><b>Adult patients 18 years of age and older should be screened for depression at least annually.</b> (Source: United States Preventive Services Task Force)</p> <p>Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</p>	<p><b>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Medical Providers:</p> <p>EXAM—Depression Screening</p> <p><b>Normal/Negative</b>—Denies symptoms of depression</p> <p>Abnormal/Positive—Further evaluation indicated</p> <p><b>Refused</b>—Patient declined exam/screen</p> <p>Unable to screen—Provider unable to screen</p> <p>Note: Refusals are <i>not</i> counted toward the GPRA measure, but should be documented.</p> <p>Mood Disorders:</p> <p>Two or more visits with POV related to:</p> <p>Major Depressive Disorder</p> <p>Dysthymic Disorder</p> <p>Depressive Disorder NOS</p> <p>Bipolar I or II Disorder</p> <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>Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</p>	<p>Depression Screening Exam</p> <p><a href="#">Exam Entry</a> (includes historical exams)</p> <p><b>Select Exam: 36, DEP</b></p> <p><b>Result:</b></p> <p><b>A—Abnormal</b></p> <p><b>N—Normal/Negative</b></p> <p><b>PR—Resent</b></p> <p><b>PAP—Present and Past</b></p> <p><b>PA—Past</b></p> <p><b>PO—Positive</b></p> <p><b>Comments: PHQ-2 Scaled, PHQ9</b></p> <p><b>Provider Performing Exam:</b></p> <p>Depression Screen Diagnosis POV</p> <p><a href="#">Visit Diagnosis Entry</a></p> <p><b>Purpose of Visit: V79.0</b></p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p> <p>Depression Screening CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT Code: 1220F</b></p> <p><b>Quantity</b></p> <p><b>Modifier:</b></p> <p><b>Modifier 2:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont)		<p><u>Patient Health Questionnaire (PHQ-2 Scaled Version)</u></p> <p>Over the past 2 weeks, how often have you been bothered by any of the following problems?</p> <p>Little interest or pleasure in doing things</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>Feeling down, depressed, or hopeless</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>PHQ-2 Scaled Version (continued)</p> <p>Total Possible PHQ-2 Score: Range: 0-6</p> <p>0-2: Negative <b>Depression Screening Exam:</b> Code Result: Normal or Negative</p> <p>3-6: Positive; further evaluation indicated Depression Screening Exam Code Result: Abnormal or Positive</p> <p>The patient may decline the screen or “Refuse to answer” Depression Screening Exam Code Result: Refused</p> <p>The provider is unable to conduct the Screen Depression Screening Exam <b>Code Result:</b> Unable To Screen</p>	<p>Mood Disorder Diagnosis POV <a href="#">Visit Diagnosis Entry</a></p> <p><b>Purpose of Visit: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311</b></p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont)		<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><u>PHQ9 Questionnaire Screening Tool</u></p> <p>Little interest or pleasure in doing things?</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>Feeling down, depressed, or hopeless?</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>Trouble falling or staying asleep, or sleeping too much?</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>Feeling tired or having little energy?</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>	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont)		<p>Poor appetite or overeating?</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>Feeling bad about yourself—or that you are a failure or have let yourself or your family down?</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>Trouble concentrating on things, such as reading the newspaper or watching television?</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>Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?</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>	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont)		<p>Thoughts that you would be better off dead, or of hurting yourself in some way?</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><u>PHQ9 Questionnaire (Continued)</u></p> <p>Total Possible PHQ-2 Score: Range: 0–27</p> <p>0-4 Negative/None Depression Screening Exam: <b>Code Result:</b> None</p> <p>5-9 Mild Depression Screening Exam: <b>Code Result:</b> Mild depression</p> <p>10-14 Moderate Depression Screening Exam: <b>Code Result:</b> Moderate depression</p> <p>15-19 Moderately Severe Depression Screening Exam: <b>Code Result:</b> Moderately Severe depression</p> <p>20-27 Severe Depression Screening Exam: <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> Mnemonic for the Exam Code.</b></p>	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Obesity Assessment (Calculate Body Mass Index [BMI])</p> <p>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.</p>	<p>Children (through age 18) must have both height and weight taken <b><u>on the same day</u></b> at least annually (at every visit is recommended).</p> <p>Adults 19-50, height and weight at least <b><u>every 5 years</u></b>, not required to be on same day.</p> <p>Adults over 50, height and weight taken <b><u>every 2 years</u></b>, not required to be on same day.</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>BMI is calculated using NHANES II.</p> <p>Obese is defined as:</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>To document Refusals in EHR: <b><u>Refusal Entry in EHR</u></b></p> <p>For ages 18 and under, both the height and weight must be refused on the same visit at any time during the past year.</p> <p>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.</p> <p>Patients whose BMI either is greater or less than the Data Check Limit range shown in the BMI Standard Reference Data Table in PCC will not be included in the report counts for Overweight or Obese.</p>	<p>Height Measurement <b><u>Vital Measurements Entry</u></b> (includes historical Vitals)</p> <p><b>Value:</b></p> <p><b>Select Qualifier:</b></p> <p><b>Actual</b></p> <p><b>Estimated</b></p> <p><b>Date/Time Vitals Taken:</b></p> <p>Weight Measurement <b><u>Vital Measurements Entry</u></b> (includes historical Vitals)</p> <p><b>Value:</b></p> <p><b>Select Qualifier:</b></p> <p><b>Actual</b></p> <p><b>Bed</b></p> <p><b>Chair</b></p> <p><b>Dry</b></p> <p><b>Estimated</b></p> <p><b>Standing</b></p> <p><b>Date/Time Vitals Taken:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Weight Control	<p>Patients ages 2–5 at the beginning of the report period whose BMI could be calculated and have a BMI =&gt; 95%.</p> <p>Height and weight taken on the same day.</p> <p>Patients that turn 6 years old during the report period are not included in the GPRA measure.</p>	<p><b>Standard EHR documentation. obtain height and weight during visit and record information in EHR:</b></p> <ul style="list-style-type: none"> <li>Height</li> <li>Weight</li> <li>Date Recorded</li> </ul> <p>BMI is calculated using NHANES II</p> <p>Age in the age groups is calculated based on the date of the most current BMI found.</p> <p><b>Example, a patient may be 2 at the beginning of the time period but is 3 at the time of the most current BMI found, patient will fall into the age 3 group.</b></p> <p><b>The BMI values for this measure are reported differently than in the Obesity Assessment measure as they are Age-Dependent. The BMI values are categorized as Overweight for patients with a BMI in the 85th to 94th percentile and Obese for patients with a BMI at or above the 95th percentile (GPRA).</b></p>	<p>Height Measurement  <a href="#">Vital Measurements Entry</a>  (includes historical Vitals)  <b>Value:</b>  <b>Select Qualifier:</b>  <b>Actual</b>  <b>Estimated</b>  <b>Date/Time Vitals Taken:</b></p> <p>Weight Measurement  <a href="#">Vital Measurements Entry</a>  (includes historical Vitals)  <b>Value:</b>  <b>Select Qualifier:</b>  <b>Actual</b>  <b>Bed</b>  <b>Chair</b>  <b>Dry</b>  <b>Estimated</b>  <b>Standing</b>  <b>Date/Time Vitals Taken:</b></p>

Performance Measure	Standard	Provider Documentation						How to Enter Data in EHR
Childhood Weight Control (cont)		<p><b>Patients whose BMI either is greater or less than the Data Check Limit range shown below will not be included in the report counts for Overweight or Obese.</b></p>						
		<b>Low-High</b>		<b>BMI &gt;= 85</b>	<b>BMI &gt;= 95</b>	<b>Data Check Limits</b>		
		Ages	Sex	Over Weight	Obese	BMI >	BMI <	
		2-2	M F	17.7 17.5	18.7 18.6	36.8 37.0	7.2 7.1	
		3-3	M F	17.1 17.0	18.0 18.1	35.6 35.4	7.1 6.8	
		4-4	M F	16.8 16.7	17.8 18.1	36.2 36.0	7.0 6.9	
		5-5	M F	16.9 16.9	18.1 18.5	36.0 39.2	6.9 6.8	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment	<p>Active Clinical Patients ages 22 and older diagnosed with Ischemic Heart Disease (IHD) prior to the Report Period, <i>and</i> at least 2 visits during the Report Period, <i>and</i> 2 IHD-related visits ever who had the following tests documented:</p> <ul style="list-style-type: none"> <li>• <b>Blood Pressure</b></li> <li>• <b>LDL Assessment</b></li> <li>• <b>Tobacco Use Assessment</b></li> <li>• <b>BMI Calculated</b></li> <li>• <b>Lifestyle Counseling</b></li> </ul> <p>Note: This does <i>not</i> include depression screening and does <i>not</i> include refusals of BMI.</p> <p>Note: Refusals of any or all of the above are not counted toward the GPRA measure, but should still be documented.</p>	<p><b>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Note: See related individual measures above for recording historical information.</p> <p>Blood Pressure Control</p> <p>LDL Assessment</p> <p>Tobacco Use and Assessment</p> <p>BMI (Obesity)</p> <p>Tobacco Use Health Factors:</p> <p>HF–Current Smoker, every day</p> <p>HF–Current Smoker, some day</p> <p>HF–Current Smoker, status unknown</p> <p>HF–Current Smokeless</p> <p>HF–Previous (Former) Smoker [or -Smokeless] (quit &gt; 6 months)</p> <p>HF–Cessation-Smoker [or -Smokeless] (quit or actively trying &lt; 6 months)</p> <p>HF–Smoker in Home</p> <p>HF–Ceremonial Use Only</p> <p>HF–Exp to ETS (Second Hand Smoke)</p> <p>HF–Smoke Free HomeNOTE: If your site uses other expressions (e.g.,” Chew” instead of “Smokeless;” “Past” instead of “Previous”), be sure Data Entry staff knows how to “translate”</p> <p>Tobacco Patient Education Codes:</p> <p>Codes will contain "TO-", "-TO", "-SHS"</p>	<p>IHD Diagnosis POV (Prior to the report period)</p> <p><a href="#">Visit Diagnosis Entry</a></p> <p><b>Purpose of Visit: 410.0-412.*, 414.0-414.9, 428.* 429.2</b></p> <p><b>Provider Narrative:</b></p> <p><b>Modifier:</b></p> <p><b>Cause of DX:</b></p> <p>Blood Pressure Data Entry</p> <p><a href="#">Vital Measurements Entry</a> (includes historical Vitals)</p> <p><b>Value: [Enter as Systolic/Diastolic (e.g., 130/80)]</b></p> <p><b>Select Qualifier:</b></p> <p><b>Date/Time Vitals Taken:</b></p> <p>LDL (Calculated) Lab Test</p> <p><a href="#">Lab Test Entry</a></p> <p><b>Enter Lab Test Type: LDL</b></p> <p><b>Collect Sample/Specimen:</b> [Blood]</p> <p><b>Clinical Indication:</b></p> <p>LDL CPT</p> <p><a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p><b>Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F</b></p> <p><b>Quantity :</b></p> <p><b>Modifier:</b></p> <p>Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)		<p>BMI is calculated using NHANES II.</p> <p>Adults 19–50, height and weight at least every 5 years, not required to be on same day.</p> <p>Adults over 50, height and weight taken every 2 years, not required to be on same day.</p> <p>Nutrition, dietary surveillance and counseling Patient Education Codes: Codes will contain "-N" (Nutrition) or "-MNT"</p> <p>Exercise Patient Education Codes: Codes will contain "-EX"</p> <p>Lifestyle Patient Education Codes: Codes will contain "-LA"</p> <p>Other Related Nutrition and Exercise Patient Educations Codes: Codes will contain "-OBS" (Obesity)</p> <p>Lifestyle Counseling includes: Lifestyle adaptation counseling Medical nutrition therapy Nutrition counseling Exercise counseling Other lifestyle education</p>	<p>Tobacco Use Assessment <a href="#">Health Factor Entry</a> <b>Select V Health Factor: [Enter HF (See the Provider Documentation column)]</b> <b>Level/Severity:</b> <b>Provider:</b> <b>Quantity:</b></p> <p>Tobacco Use Dental (ADA) <i>ADA codes cannot be entered into EHR.</i></p> <p>Tobacco Screening CPT <a href="#">Visit Services Entry</a> (includes historical CPTs) <b>Enter CPT Code: D1320, 99406, 99407, 1034F, 1035F, 1036F, 1000, G8455, G8456, G8457, G8402, G8453</b> <b>Quantity</b> <b>Modifier:</b> <b>Modifier 2:</b></p> <p>Tobacco Related Diagnoses POV <a href="#">Visit Diagnosis Entry</a> <b>Purpose of Visit: 305.1, 649.00-649.04, V15.82</b> <b>Provider Narrative:</b> <b>Modifier:</b> <b>Cause of DX:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)			<p>Tobacco Screening PED - Topic  <a href="#">Patient Education Entry</a>  (includes historical patient education)  Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]  Readiness to Learn:  Level of Understanding:  Provider:  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:  Tobacco Screening PED–  Diagnosis  <a href="#">Patient Education Entry</a>  (includes historical patient education)  Select ICD Diagnosis Code Number: 305.1, 649.00-649.04, V15.82  Category:  Readiness to Learn:  Level of Understanding:  Provider:  Length of Educ (Minutes):  Comment</p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)			<p><b>Goal Code:</b> [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p><b>Goal Comment:</b></p> <p><b>Provider’s Narrative:</b></p> <p>Tobacco Screening PED–CPT  <a href="#">Patient Education Entry</a>  (includes historical patient education)</p> <p><b>Select CPT Code Number:</b>  D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455, G8456, G8457, G8402 or G8453</p> <p><b>Category:</b></p> <p><b>Readiness to Learn:</b></p> <p><b>Level of Understanding:</b></p> <p><b>Provider:</b></p> <p><b>Length of Educ (Minutes):</b></p> <p><b>Comment</b></p> <p><b>Goal Code:</b> [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p><b>Goal Comment:</b></p> <p><b>Provider’s Narrative:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)			BMI Data Entry Height Measurement <a href="#">Vital Measurements Entry</a> (includes historical Vitals) <b>Value:</b> <b>Select Qualifier:</b> <b>Actual</b> <b>Estimated</b> <b>Date/Time Vitals Taken:</b> Weight Measurement <a href="#">Vital Measurements Entry</a> (includes historical Vitals) <b>Value:</b> <b>Select Qualifier:</b> <b>Actual</b> <b>Bed</b> <b>Chair</b> <b>Dry</b> <b>Estimated</b> <b>Standing</b> <b>Date/Time Vitals Taken:</b> Lifestyle Counseling Data Entry Medical Nutrition Therapy CPT <a href="#">Visit Services Entry</a> (includes historical CPTs) <b>Enter CPT Code: 97802-97804, G0270, G0271</b> <b>Quantity</b> <b>Modifier:</b> <b>Modifier 2:</b>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)			<p>Medical Nutrition Therapy Clinic  <a href="#">Clinic Entry</a>  <b>Clinic: 67, 36</b></p> <p>Nutrition Education POV  <a href="#">Visit Diagnosis Entry</a>  <b>Purpose of Visit: V65.3</b>  <b>Provider Narrative:</b>  <b>Modifier:</b>  <b>Cause of DX:</b></p> <p>Nutrition/Exercise/Lifestyle Adaption PED-Topic  <a href="#">Patient Education Entry</a>  (includes historical patient education)  <b>Enter Education Topic: [Enter Nutrition/Exercise/Lifestyle Adaption Patient Education Code (See the Provider Documentation column)]</b>  <b>Readiness to Learn:</b>  <b>Level of Understanding:</b>  <b>Provider:</b>  <b>Length of Educ (Minutes):</b>  <b>Comment</b>  <b>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</b>  <b>Goal Comment:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Comprehensive CVD-Related Assessment (cont)			Nutrition/Exercise/Lifestyle Adaption PED–Diagnosis <a href="#"><u>Patient Education Entry</u></a> <b>(includes historical patient education)</b> <b>Select ICD Diagnosis Code Number: V65.3 (Nutrition), V65.41 (Exercise), 278.00 or 278.01 (Obesity)</b> <b>Category:</b> <b>Readiness to Learn:</b> <b>Level of Understanding:</b> <b>Provider:</b> <b>Length of Educ (Minutes):</b> <b>Comment:</b> <b>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</b> <b>Goal Comment:</b> <b>Provider’s Narrative:</b>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
HIV Screening	<p>Pregnant women should be tested for HIV at least on their first visit; education and follow-up provided as appropriate.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p><b>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</b></p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>NOTE: The timeframe for screening for the pregnant patient's denominator is anytime during the past 20 months.</p> <p>Pregnant patients are any patients with at least two non-pharmacy only visits with a pregnancy POV code with no recorded abortion or miscarriage in this timeframe.</p>	<p>HIV Screen CPT  <a href="#">Visit Services Entry</a> (includes historical CPTs)  <b>Enter CPT Code: 86689, 86701-86703, 87390, 87391, 87534-87539</b>  <b>Quantity</b>  <b>Modifier:</b>  <b>Modifier 2:</b>  HIV Diagnoses POV  <a href="#">Visit Diagnosis Entry</a>  <b>Purpose of Visit: 042, 079.53, V08, 795.71</b>  <b>Provider Narrative:</b>  <b>Modifier:</b>  <b>Cause of DX:</b>  HIV Lab Test  <a href="#">Lab Test Entry</a>  <b>Enter Lab Test Type:</b> [Enter site's defined HIV Screen Lab Test]  <b>Collect Sample/Specimen:</b> [Blood, Serum]  <b>Clinical Indication:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Breastfeeding Rates</p> <p>NOTE: This is not a GPRA measure; however, it will be used in conjunction with the Childhood Weight Control measure for reducing the incidence of childhood obesity. The information is included here to inform providers and data entry staff of how to collect, document, and enter the data.</p>	<p><b>All providers</b> should assess the feeding practices of all newborns through age 1 year at all well-child visits.</p>	<p>Definitions for Infant Feeding Choice Options:</p> <p><b>Exclusive Breastfeeding</b>–Breastfed or expressed breast milk only, no formula</p> <p><b>Mostly Breastfeeding</b>–Mostly breastfed or expressed breast milk, with some formula feeding (1X per week or more, but less than half the time formula feeding.)</p> <p><b>½ Breastfeeding, ½ Formula Feeding</b>–Half the time breastfeeding/expressed breast milk, half formula feeding</p> <p><b>Mostly Formula</b>–The baby is mostly formula fed, but breastfeeds at least once a week</p> <p><b>Formula Only</b>–Baby receives only formula</p> <p>The additional one-time data fields, e.g., birth weight, formula started, and breast stopped, may also be collected and may be entered using the data entry Mnemonic PIF. However, this information is not used or counted in the CRS logic for Breastfeeding Rates.</p>	<p>Infant Breastfeeding</p> <p><a href="#">Infant Feeding Choice Entry</a></p> <p><b>Enter Feeding Choice:</b></p> <p><b>Exclusive Breastfeeding</b></p> <p><b>Mostly Breastfeeding</b></p> <p><b>1/2 &amp; 1/2 Breast and Formula</b></p> <p><b>Mostly Formula</b></p> <p><b>Formula Only</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Patient Education Measures (Patient Education Report)</p> <p>NOTE: This is not a GPRA measure; however, the information is being provided because there are several GPRA measures that do include patient education as meeting the numerator (e.g. alcohol screening). Providers and data entry staff need to know they need to collect and enter <i>all</i> components of patient education.</p>	<p>N/A</p>	<p><u>All providers should document all 5 patient education elements and elements #6–7 below if a goal was set for the patient:</u></p> <ol style="list-style-type: none"> <li>1. Education Topic/Diagnosis</li> <li>2. Readiness to Learn</li> <li>3. Level of Understanding (see below)</li> <li>4. Initials of Who Taught</li> <li>5. Time spent (in minutes)</li> <li>6. Goal Not Set, Goal Set, Goal Met, Goal Not Met</li> <li>7. Text relating to the goal or its status</li> </ol> <p>Readiness to Learn:</p> <ul style="list-style-type: none"> <li>Distraction</li> <li>Eager To Learn</li> <li>Intoxication</li> <li>Not Ready</li> <li>Pain</li> <li>Receptive</li> <li>Severity of Illness</li> <li>Unreceptive</li> </ul> <p>Levels of Understanding:</p> <ul style="list-style-type: none"> <li>P–Poor</li> <li>F–Fair</li> <li>G–Good</li> <li>GR–Group-No Assessment</li> <li>R–Refused</li> </ul>	<p>Patient Education Topic <b><u>Patient Education Entry</u></b> (includes historical patient education) <b>Topic:</b> [Enter Topic] <b>Readiness to Learn:</b> D, E, I, N, P, R, S, U <b>Level of Understanding:</b> P, F, G, GR, R <b>Provider:</b> <b>Length of Educ (minutes):</b> <b>Comment:</b> <b>Goal Code:</b> GS, GM, GNM, GNS <b>Goal Comment:</b></p> <p>Patient Education Diagnosis <b><u>Patient Education Entry</u></b> (includes historical patient education) <b>Select ICD Diagnosis Code Number:</b> <b>Category:</b> [Enter Category] <b>Readiness to Learn:</b> D, E, I, N, P, R, S, U <b>Level of Understanding:</b> P, F, G, GR, R <b>Provider:</b> <b>Length of Educ (Minutes):</b> <b>Comment:</b> <b>Goal Code:</b> [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] <b>Goal Comment:</b></p>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Patient Education Measures (Patient Education Report) (cont)		Goal Codes: GS–Goal Set GM–Goal Met GNM–Goal Not Met GNS–Goal Not Set  Diagnosis Categories: Anatomy and Physiology Complications Disease Process Equipment Exercise Follow-up Home Management Hygiene Lifestyle Adaptation Literature Medical Nutrition Therapy Medications Nutrition Prevention Procedures Safety Tests Treatment	<b>Provider’s Narrative:</b>

# 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.

The screenshot shows a software dialog box titled "Encounter Settings for Current Activities". At the top, it displays "17 OPHTHALMOLOGY 19-Aug-2010 12:12". Below this, there are three tabs: "Appointments / Visits", "Hospital Admissions", and "New Visit". The "New Visit" tab is active. Under "Visit Location", a dropdown menu is open, showing a list of clinic codes: 11 HOME CARE, 12 IMMUNIZATION, 13 INTERNAL MEDICINE, 14 MENTAL HEALTH, 16 OBSTETRICS, 17 OPHTHALMOLOGY (highlighted with a red circle), and 18 OPTOMETRY. To the right of this list, there are fields for "Date of Visit" (Thursday, August 19, 2010), "Time of Visit" (12:12 PM), and "Type of Visit" (Ambulatory). There is also a checkbox labeled "Create a Visit Now". Below the "Visit Location" section is the "Encounter Providers" section, which lists several providers: POWERS, MEGAN (highlighted), REGA, ANN, RICHARDS, SUSAN P, ROBARDS, DARLENE G, ROZSNYAI, DUANE, and SALMON, PHILLIP. At the bottom of the dialog are "OK" and "Cancel" buttons.

## Purpose of Visit/Diagnosis

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

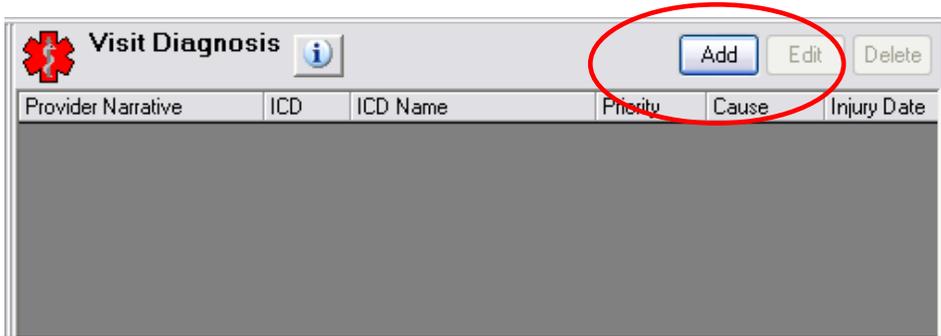
The screenshot displays the IHS-EHR Tucson Development System interface. The patient information at the top includes Patient: Crsae, 900031, 01-Jul-1958 (52), F. The primary care team is unassigned. The ICD Pick Lists section shows various categories of child abuse and neglect. The Problem List shows a single active problem: Dental Exam (V72.2). The Historical Diagnosis section lists three past diagnoses: Dental Exam (V72.2), AMI (410.21), and STENOSIS (395.0). The Visit Diagnosis section is highlighted with a red circle and is currently empty.

ID	Provider Narrative	Status	Modified	Priority	Notes	Class	Onset	ICD	ICD Name	Classification
WW-1	Dental Exam	Active	06/18/2003					V72.2	DENTAL EXAMINATION	

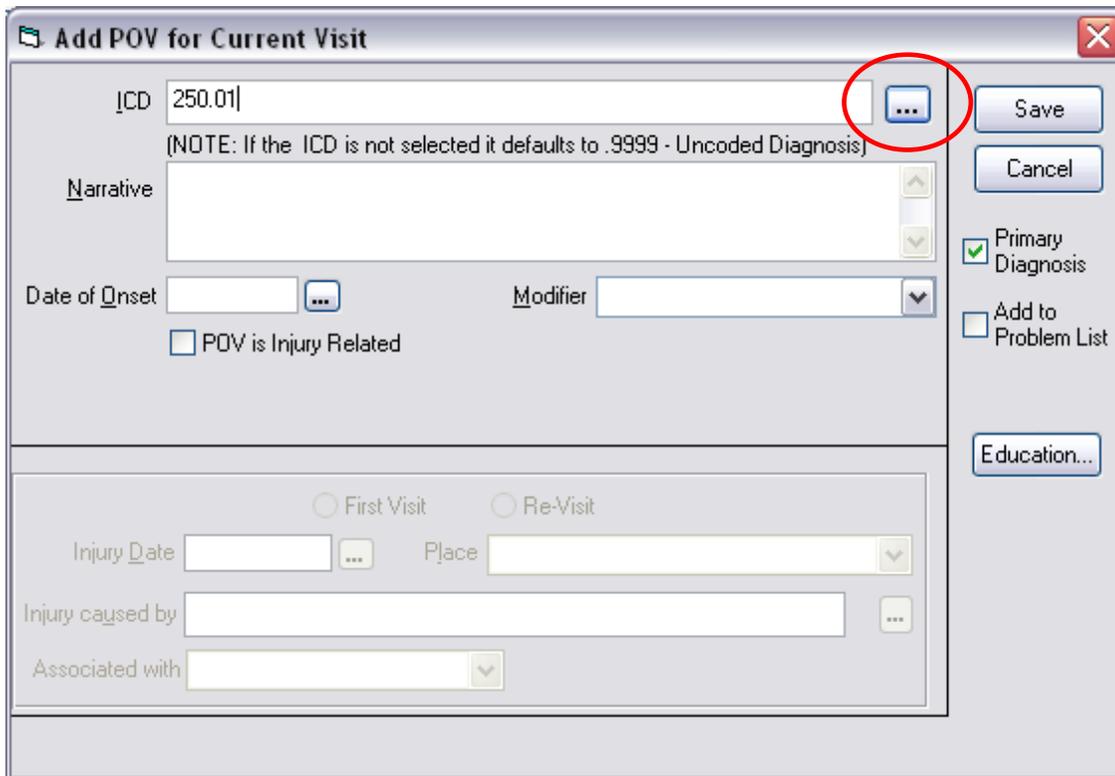
Visit Date	POV Narrative	ICD	ICD Name	Facility
06/18/2003	Dental Exam	V72.2	Dental Examination	Demo Indian Hospital
06/01/2003	AMI	410.21	Ami Inferolat,init Care	Demo Indian Hospital
05/01/2002	STENOSIS	395.0	Rheumat Aortic Stenosis	Demo Indian Hospital

Provider Narrative	ICD	ICD Name	Priority	Cause	Injury Date

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

Primary Diagnosis

Add to Problem List

Education...

First Visit  Re-Visit

Injury Date  ... Place

Injury caused by  ...

Associated with

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

**Visit Diagnosis** Info 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.

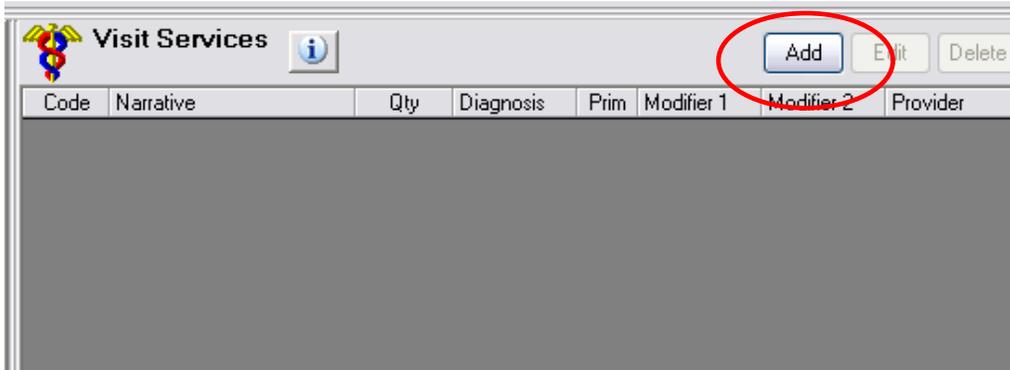
The screenshot displays the IHS-EHR Tucson Development System interface. The top navigation bar includes 'User', 'Patient', 'Tools', and 'Help'. Below this, there are tabs for 'Patient Chart', 'Communication', 'RPMS', 'CIHA Intranet', 'Micromedex', and 'E-Mail'. The patient information section shows 'Patient: Crsae', ID '900031', birth date '01-Jul-1958', gender 'F', and '01 GENERAL POWERS.MEGAN' with a visit date of '19-Aug-2011'. The 'Historical Services' section shows a table with one entry: '07/05/2010', CPT Code '74280', Description 'Barium Enema', Facility 'Cherokee Indian Hospital', Qty '1'. The 'Super-Bills' section has a 'Display' button and checkboxes for 'Freq. Rank', 'Code', and 'Description'. The 'Evaluation and Management' section shows a table with columns for 'Type of Service', 'Level of Service', 'Complexity', 'Approx. Time', and 'CPT Code'. 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 'Notifications', 'Cover Sheet', 'Triage', 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Proc/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'.

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

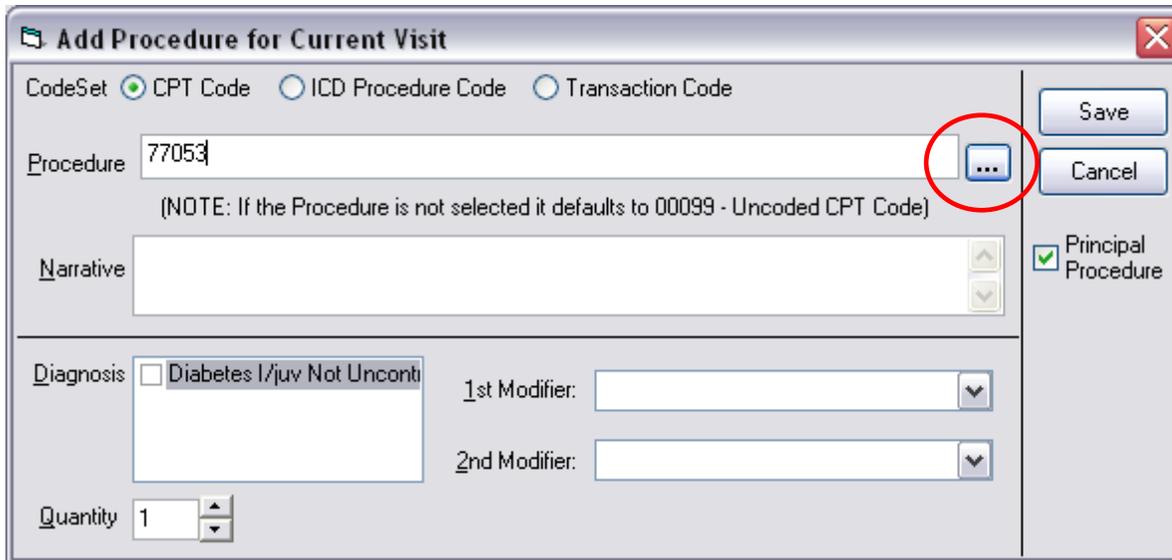
Type of Service	Level of Service	Complexity	Approx. Time	CPT Code
Office Visit	History and Exam			
Consultation	<input type="checkbox"/> Brief	Nurse Visit	5 min	99211
Preventive Medicine	<input type="checkbox"/> Problem Focused	Straightforward	10 min	99212
Emergency Services	<input type="checkbox"/> Expanded	Low	15 min	99213
Other ER Services	<input type="checkbox"/> Detailed	Moderate	25 min	99214
	<input type="checkbox"/> Comprehensive	High	40 min	99215

Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider
------	-----------	-----	-----------	------	------------	------------	----------

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

Included Code Sets:  Medical  Surgical  HCPCS  E & M  
 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

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

Principal Procedure

Diagnosis:  Diabetes I/juv Not Unconti  
 1st Modifier:   
 2nd Modifier:

Quantity: 1

Buttons: 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 displays the IHS-EHR Tucson Development System interface. At the top, the patient information is shown: Patient: Crsae, 900031, 01-Jul-1958 (32), F. The provider is 01 GENERAL POWERS, MEGAN. The date is 19-Aug-2011. The primary care team is unassigned. The 'Historical Services' component is highlighted with a red circle. It shows a table with one entry: Visit Date: 07/05/2010, CPT Code: 74280, Description: Barium Enema, Facility: Cherokee Indian Hospital, Qty: 1. Below this, there are sections for 'Super-Bills' and 'Evaluation and Management'. The 'Visit Services' component is also visible, showing a table with columns for Code, Narrative, Qty, Diagnosis, Prim, Modifier 1, Modifier 2, and Provider. The 'Add' button in the 'Visit Services' component is circled in red.

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

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

This is a close-up view of the 'Historical Services' component. It shows 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 medical 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.

The screenshot shows a software interface for 'Historical Services'. At the top left is a pencil icon. To its right is the title 'Historical Services' and a dropdown menu currently set to 'Radiology'. Further right is a button labeled 'Add to Current Visit'. On the far right are two buttons: 'Add' and 'Delete'. Below this header 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				
06/08/2009	77055	Mammography; Unilateral	Cherokee Indian Hospital	1				

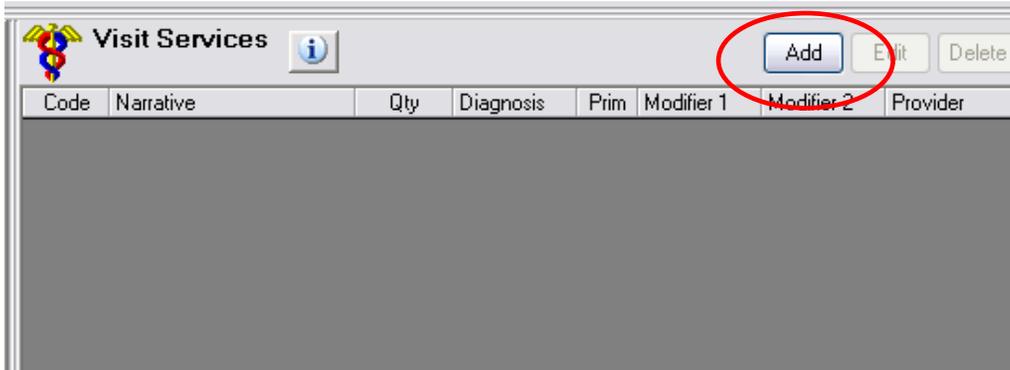
## Procedure Codes

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

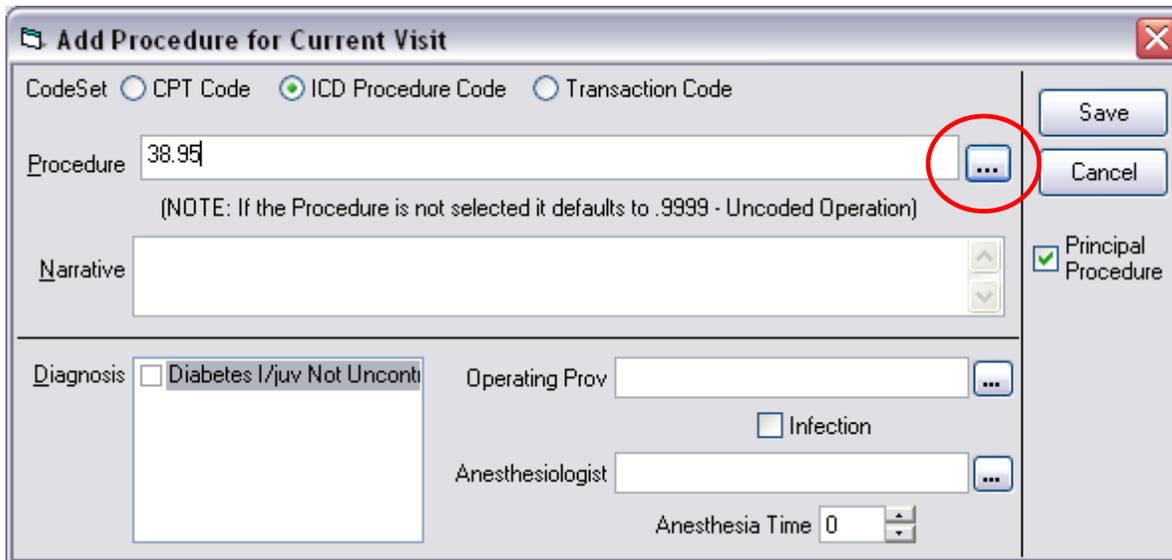
The screenshot displays the IHS-EHR Tucson Development System interface. The top navigation bar includes 'User', 'Patient', 'Tools', and 'Help'. Below this, there are tabs for 'Patient Chart', 'Communication', 'RPMS', 'CIHA Intranet', 'Micromedex', and 'E-Mail'. The patient information section shows 'Patient.Crsae' with ID 900031, born 01-Jul-1958, female. The visit is for '01 GENERAL POWERS,MEGAN' on 19-Aug-2010, with the primary care team unassigned. The 'Historical Services' section shows a radiology service on 07/05/2010. The 'Super-Bills' section is currently empty. The 'Evaluation and Management' section shows options for 'New Patient' and 'Established' patient, with a table of service levels. The 'Visit Services' section is highlighted with a red circle and contains a table for adding services.

Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider

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    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: \_\_\_\_\_

Infection

Anesthesiologist: \_\_\_\_\_

Anesthesia Time: 0

Principal Procedure

Save    Cancel

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

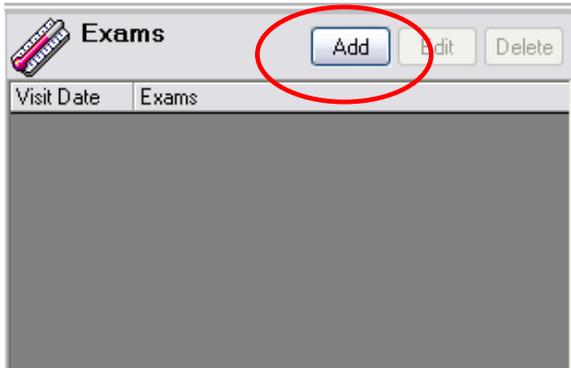
Visit Services 									
Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider	CPT Name	Visit Date
38.95	Venous Catheterization For Renal Dialysis						POWERS,MEGAN	Venous Catheterization For Dialysis	08/19/2010

## Exams

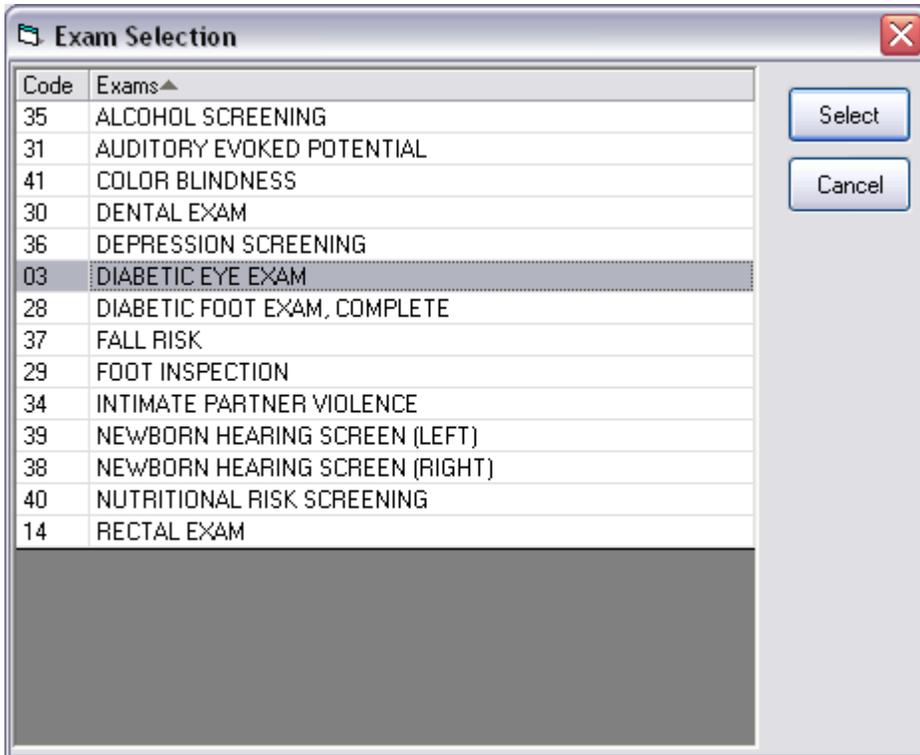
Exam codes are entered in the Exams component, which is located on the Wellness tab.

The screenshot displays the IHS-EHR Tucson Development System interface. At the top, the patient information is shown: Patient Crsae, ID 900031, DOB 01-Jul-1958 (52), F. The patient is identified as 01 GENERAL POWERS, MEGAN, born 19-Aug-2010. 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 Exams section is highlighted with a red circle. At the bottom, there is an Immunization Record section with a forecast for Tdap (past due) and contraindications for PNEUMO-PS (Egg Allergy) on 19-Aug-2010. 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 bottom status bar 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 a dialog box titled "Document an Exam" with a close button (X) in the top right corner. The dialog is divided into two main sections. The left section contains the following fields: "Exam" with the text "DIABETIC EYE EXAM" and a search icon (...); "Result" with a dropdown menu showing "NORMAL/NEGATIVE"; "Comment" with a text area and scroll arrows; and "Provider" with the text "POWERS,MEGAN" and a search icon (...). The right section contains two buttons, "Add" and "Cancel", and three radio buttons: "Current" (which is selected), "Historical", and "Refusal".

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

The screenshot shows the same "Document an Exam" dialog box, but with the "Historical" radio button selected. The "Exam" field still contains "DIABETIC EYE EXAM". The "Result" dropdown is "NORMAL/NEGATIVE". The "Comment" field is empty. The "Provider" field contains "POWERS,MEGAN". Below the provider field, there is a section titled "Historical" which contains two text fields: "Event Date" with the value "06/02/2010" and a search icon (...), and "Location" with the value "CHEROKEE INDIAN HOSPITAL" and a search icon (...). Below these fields are two radio buttons: "IHS/Tribal Facility" (which is selected) and "Other". The "Add" and "Cancel" buttons are still present on the right side.

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

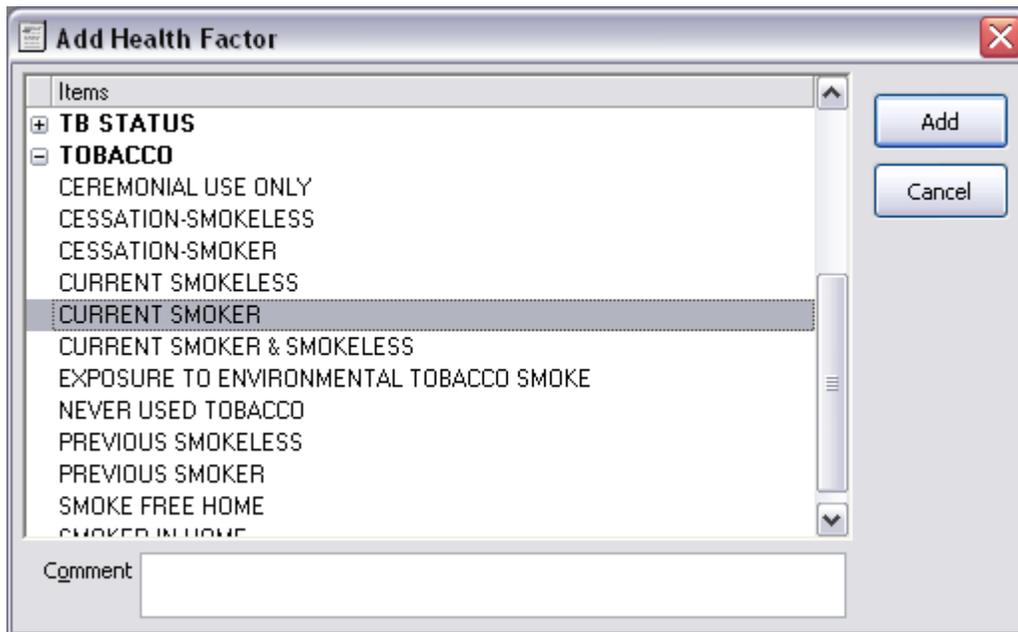
Health Factors are entered in the Health Factors component, which is located on the Wellness tab.

The screenshot displays the IHS-EHR Tucson Development System interface. At the top, the patient information bar shows 'Patient, Crsae' with ID 900031, birth date 01-Jul-1958, and gender F. The patient's name is also listed as '01 GENERAL POWERS, MEGAN' with a birth date of 19-Aug-2010. The primary care team is listed as 'Primary Care Team Unassigned'. Below this, the 'Education' section is visible with a 'Show Standard' button. The main content area is divided into three panels: 'Health Factors', 'Exams', and 'Skin Test History'. The 'Health Factors' panel is circled in red and contains a red 'X' icon, indicating it is currently disabled or unavailable. Below the panels, the 'Infant Feeding' section shows 'Not Applicable'. The 'Immunization Record' section includes a 'Forecast' table with 'Tdap' listed as 'past due', and a 'Contraindications' table with 'PNEUMO-PS' and 'Egg Allergy' listed. The bottom 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 patient name 'POWERS, MEGAN', the system name 'DEMO.OKLAHOMA.IHS.GOV', the location 'DEMO INDIAN HOSPITAL', and the timestamp '20-Aug-2010 16:06'.

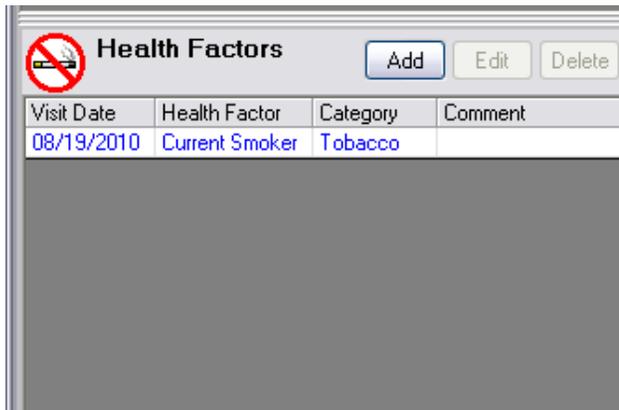
To enter a Health Factor, click Add in the Health Factors component.



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 web interface titled "Health Factors". It features a "No" icon (a red circle with a slash) in the top left corner. To the right of the title are three buttons: "Add", "Edit", and "Delete". Below the title is a table with four columns: "Visit Date", "Health Factor", "Category", and "Comment". The table contains one data row with the following values: "08/19/2010", "Current Smoker", "Tobacco", and an empty "Comment" field. 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.Crsae, ID 900031, DOB 01-Jul-1958 (52), and gender F. The primary care team is assigned to POWERS, MEGAN. 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.

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

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 bottom status bar shows the user POWERS, MEGAN and the system DEMO. OKLAHOMA. IHS. GOV.

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 '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 two radio buttons: 'Show All Active Vaccines' (selected) and 'Show Only active Vaccines with a Lot Number'. Below this is a list of immunizations with two columns: 'Immunization' and 'Description'. The 'INFLUENZA, SPLIT (INCL. PURIFIED)' record is selected.

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: U12934A

Injection Site: Intranasal

Volume: .5 ml Vac. Info. Sheet: 08/11/2009 ...

Given: 08/20/2010 4:30 PM ...  Patient/Family Counselling 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.

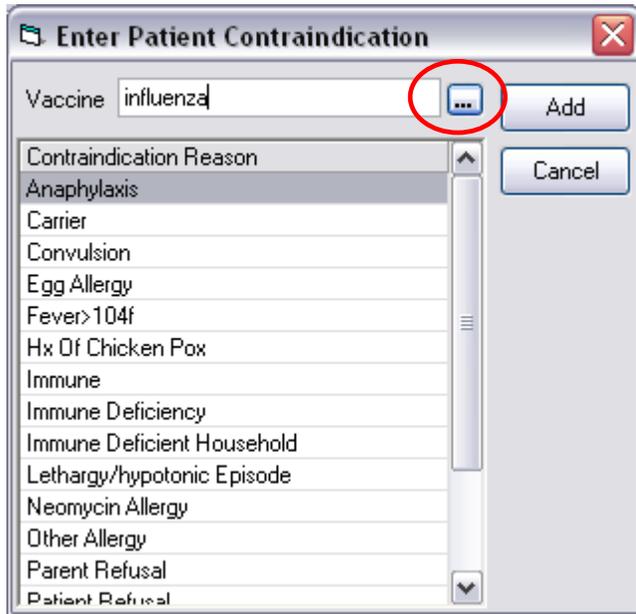
The screenshot shows the 'Immunization Record' interface. It features a 'Forecast' section with a text box containing 'Tdap past due'. The 'Contraindications' section contains a table with one entry: 'PNEUMO-PS', 'Egg Allergy', and '19-Aug-2010'. Below this is a 'Vaccinations' section with buttons for 'Print Record', 'Due Letter', 'Profile', 'Case Data', 'Add', 'Edit', and 'Delete'. A table below the buttons lists vaccination records.

Vaccine	Visit Date	Age@Visit	Location	Reaction	Volume	Inj. Site	Lot	VIS Date	Administered By
FLU-TIV	08/19/2010	52 yrs	DEMO INDIAN HOSPITAL		.5	Intranasal	U1293AA	08/11/2009	POWERS,MEGAN

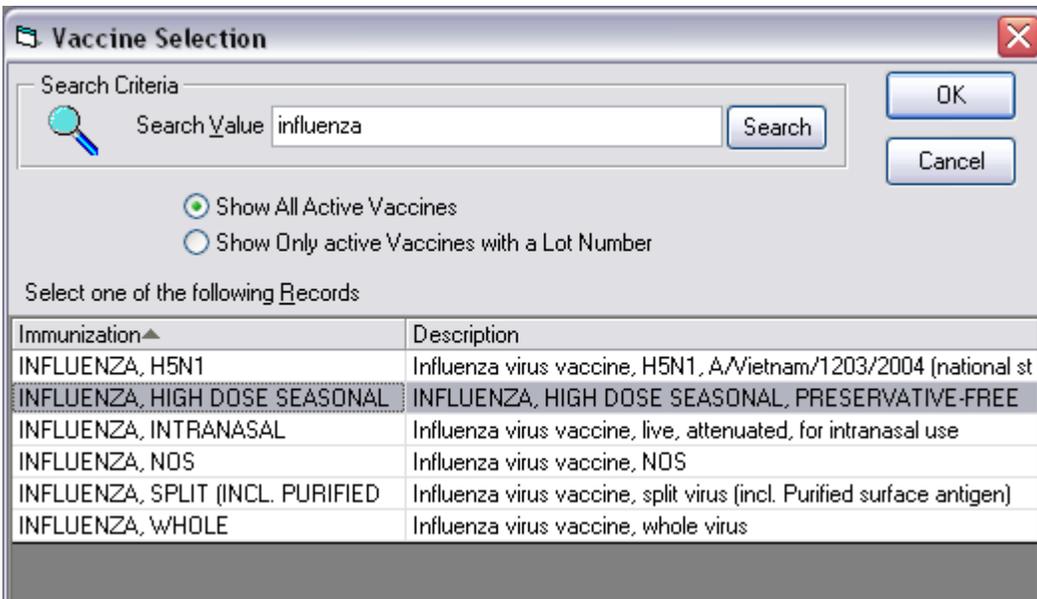
**Contraindications:** To enter a contraindication for an immunization, click Add in the Contraindications section of the Immunization Record component.

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.

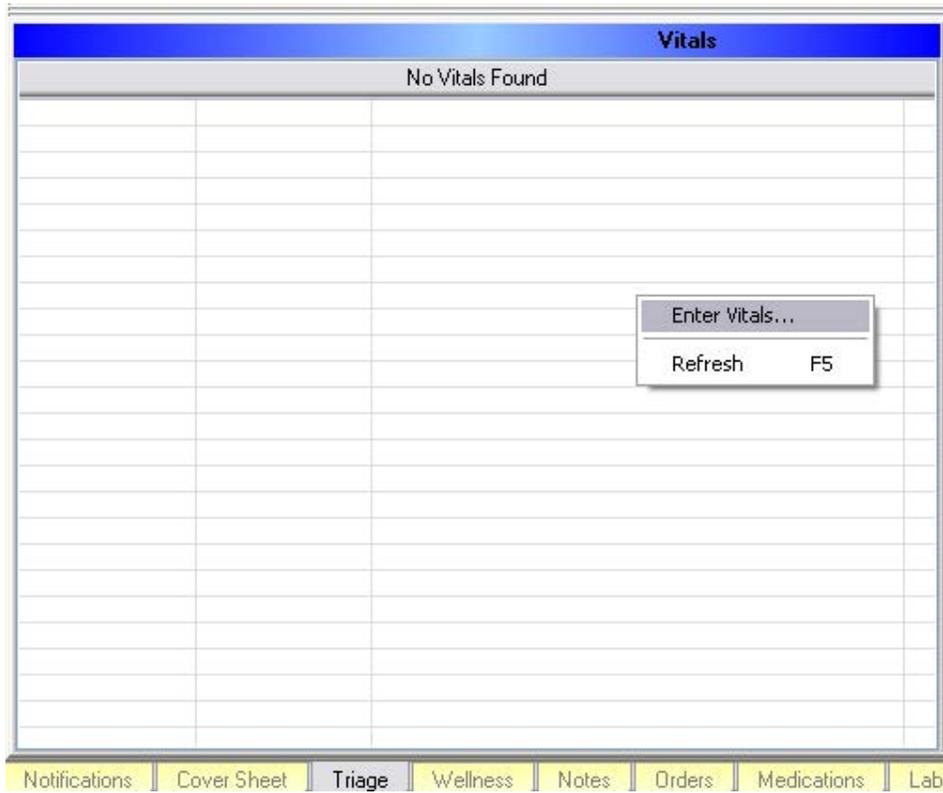
The screenshot displays the IHS-EHR Tucson Development System interface. At the top, the window title is "IHS-EHR TUCSON DEVELOPMENT SYSTEM". Below the title bar, there are menu options: "User", "Patient", "Tools", and "Help". A navigation bar contains tabs for "Patient Chart", "Communication", "RPMS",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

The main content area is divided into several sections:

- Patient Information:** A yellow header bar displays "Patient: Crsae" with ID "900031", birth date "01-Jul-1958 (52)", and gender "F". To the right, it shows "01 GENERAL POWERS,MEGAN" and "19-Aug-201 Am". A green status bar indicates "Primary Care Team Unassigned".
- Chief Complaint:** A section with a sad face icon and the text "Chief Complaint". It includes an "Author" field and a "Chief Complaint" field. Buttons for "Add", "Edit", and "Delete" are present.
- Vitals:** A blue header bar labeled "Vitals" contains the text "No Vitals Found". This section is circled in red. Below the header is a large, empty table with multiple columns and rows.
- Activity Time:** A section titled "Activity Time" for "POWERS,MEGAN". It includes input fields for "Encounter Time" (0 minutes), "Travel Time" (0 minutes), and "Total" (0 minutes).

At the bottom, 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, a status bar shows "POWERS,MEGAN", "DEMO.OKLAHOMA.IHS.GOV", "DEMO INDIAN HOSPITAL", and "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.

	Range	Units
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		

Choose the historical date and click OK.

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

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

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			
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

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

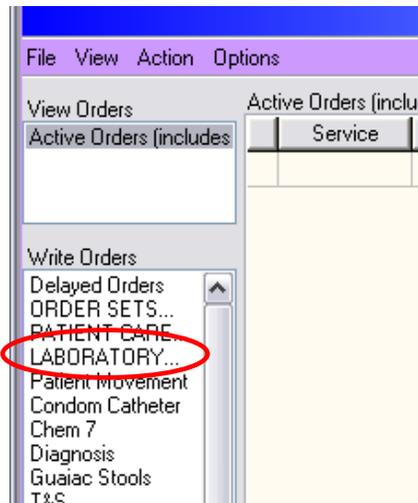
Vitals		
Vital	Value	Date ▼
TMP	98.8 F (37.11 C)	20-Aug-2010 16:44
PU	75 /min	20-Aug-2010 16:44
BP	128/80 mmHg	20-Aug-2010 16:44
HT	72 in (182.88 cm)	20-Aug-2010 16:44
WT	203 lb (92.08 kg)	20-Aug-2010 16:44
BMI	27.53	20-Aug-2010 16:44

## Lab Tests

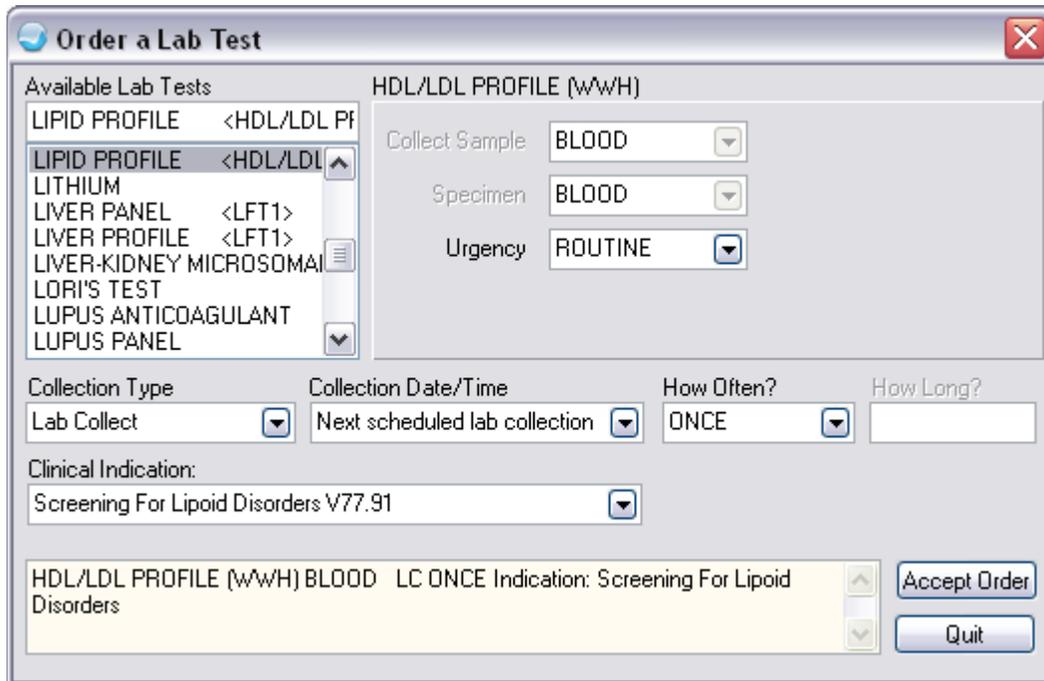
Lab tests are entered in the Orders component, which is located on the Orders tab.

The screenshot displays the IHS EHR Tucson Development System interface. The window title is "IHS EHR TUCSON DEVELOPMENT SYSTEM". The menu bar includes "User", "Patient", "Tools", and "Help". Below the menu bar, there are tabs for "Patient Chart", "Communication", "RPMS", "CIHA Intranet", "Micromedex", and "E-Mail". The main content area is titled "Orders" and shows a patient record for "Patient, Crae" with ID "900031", birth date "01 Jul-1958", gender "F", and room "01 GENERAL". The patient's name is "POWERS, MEGAN". The date is "23-Aug-2011" and the time is "Am". The primary care team is "Primary Care Team Unassigned". There is a "No Postings" button and a "Print" icon. The "Orders" section has a menu with "View Orders" and "Active Orders (includes Pending & Recent Activity) - ALL SERVICES". Below this is a table with columns: "Service", "Order", "Duration", "Provider", "Nurse", "Clerk", "Chart", and "Status". The table is currently empty. On the left side, there is a "Write Orders" section with a list of order types: "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 & D", "NPO at Midnight", "LDH", "Call HO on", and "Urinalysis". At the bottom, there is a navigation bar with tabs: "Notifications", "Cover Sheet", "Triage", "Wellness", "Notes", "Orders", "Medications", "Labs", "Prob/POV", "Services", "Reports", "D/C Summ", "Consults", "Privacy", and "WCM". Below the navigation bar, there are three buttons: "ASU", "Suicide", and "POWERS, MEGAN". At the bottom of the window, 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 Lipid Disorders *UNSIGNED*	Start: NEXT	Powers,M				unreleased	

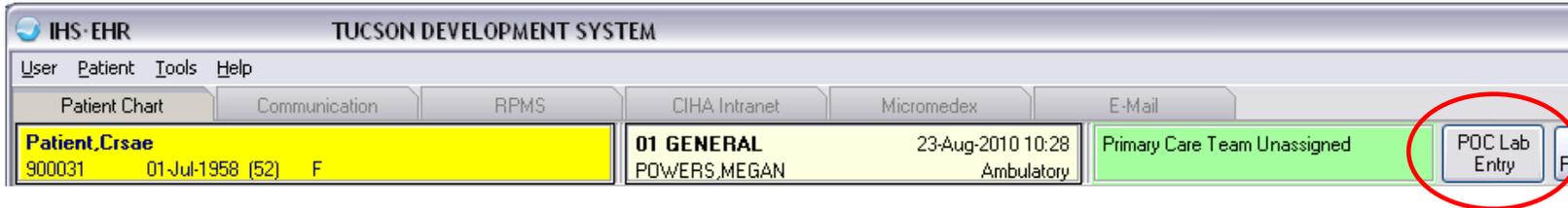
You will need to sign the order before it is released.

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 Laboratory Results interface. At the top, the patient information is displayed: Patient: Csae, ID: 900031, DOB: 01-Jul-1958, Gender: F. The provider is listed as 01 GENERAL POWERS.MEGAN, with a date of 23-Aug-2011 and a note 'Primary Care Team Unassigned'. The interface includes a 'File' menu on the left with options like 'Lab Results', 'Cumulative', and 'All Tests By Date'. The main area shows 'Laboratory Results - Most Recent' with navigation buttons for 'Oldest', 'Previous', 'Next', and 'Newest'. A message on the right states 'No Lab Results Collected'. The bottom navigation bar includes tabs for 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', and 'WCM'.

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' window. The patient information is 'PATIENT, CRSAE' and the hospital location is '01 GENERAL'. The ordering provider is 'POWERS, MEGAN' and the nature of the order is 'WRITTEN'. The test is 'GLUCOSE' with a sample type of 'BLOOD'. The collection date and time is '08/23/2010 09:55 AM' and the sign or symptom is '714.0 Rheumatoid Arthritis'. There is a text area for 'Comment/Lab Description' and an 'Add Canned Comment' button. The 'TEST RESULTS' section is highlighted in blue and contains the following table:

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

At the bottom of the form are 'Save' and 'Cancel' buttons.

## Medications

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

**IHS-EHR TUCSON DEVELOPMENT SYSTEM**

User Patient Tools Help

Patient Chart Communication RPMS CIHA Intranet Micromedex E-Mail

**Patient, Crsae**  
900031 01-Jul-1958 (52) F

**01 GENERAL** 23-Aug-2010 10:28  
POWERS, MEGAN Ambulatory

Primary Care Team Unassigned POC La Entry No Postings

**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

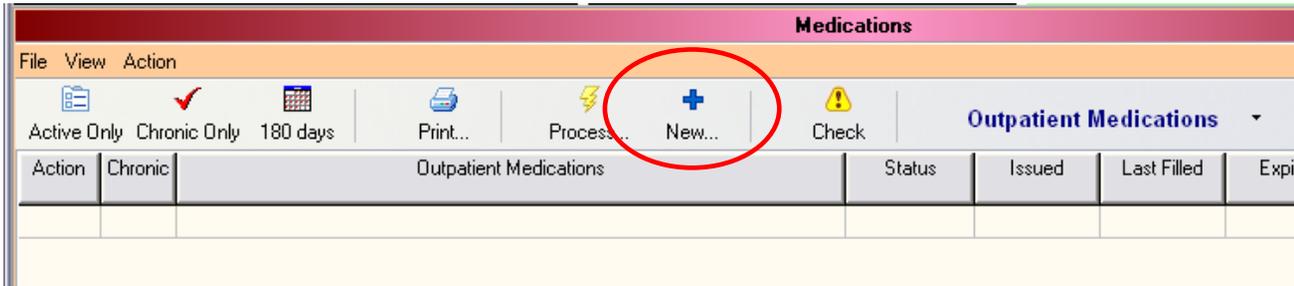
Action	MY OUTSIDE MEDS	Status	Start Date

Notifications Cover Sheet Triage Wellness Notes Orders **Medications** Labs Prob/POV Services Reports D/C Summ Consults Privacy WCM

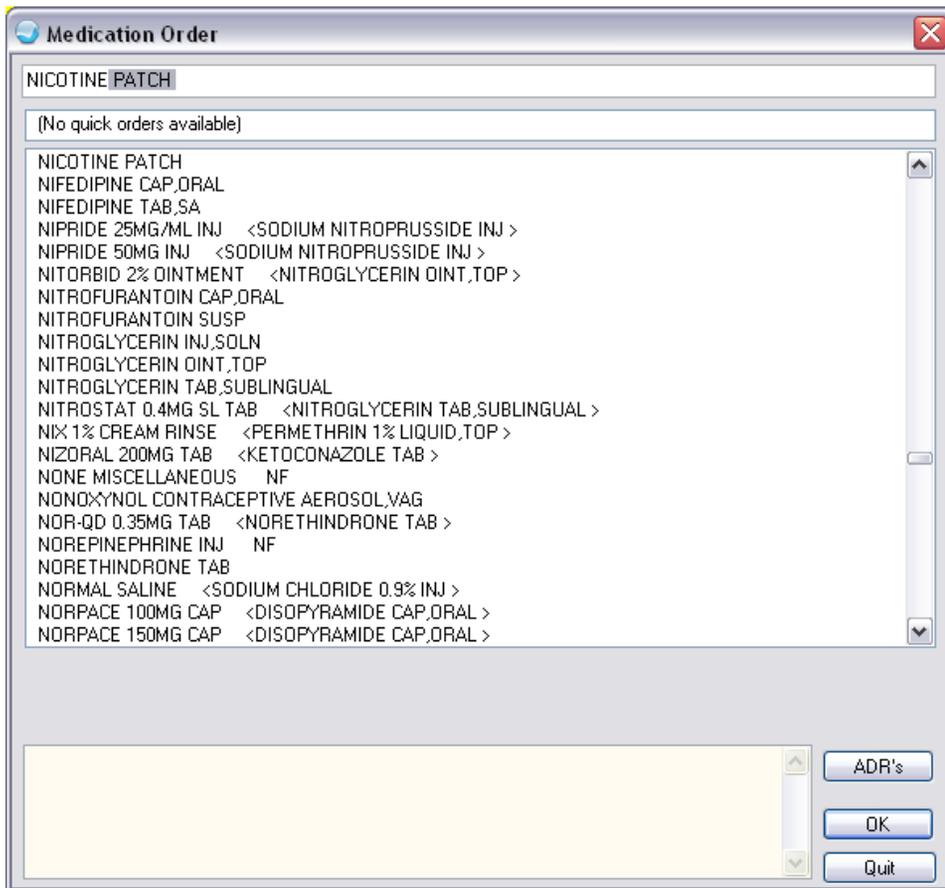
ASU Suicide

POWERS, MEGAN DEMO.OKLAHOMA.IHS.GOV DEMO INDIAN HOSPITAL 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** [Close]

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 |  Dispense as Written | Priority: ROUTINE

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		NICOTINE PATCH 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, and Primary Care Team Unassigned. The interface 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. The Immunization Record section shows a list of vaccines with their due dates and a table for recording vaccinations.

Visit Date	Education Topic	Comprehensi	Readiness	Status	Objectives	Comment	Provider	Length	Type	Location
------------	-----------------	-------------	-----------	--------	------------	---------	----------	--------	------	----------

Visit Date	Health Factor	Category	Comment
------------	---------------	----------	---------

Visit Date	Exams	Result
------------	-------	--------

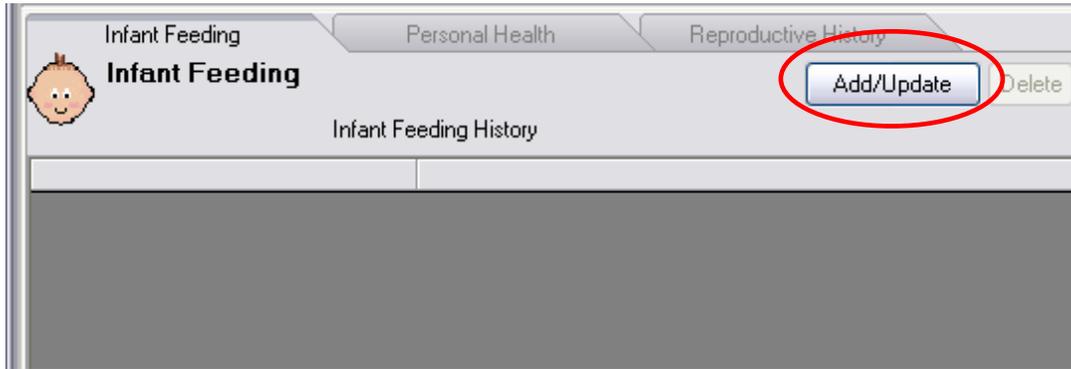
Visit Date	Skin Test	Location	Age@Visit	F
------------	-----------	----------	-----------	---

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

Notifications Cover Sheet Triage Wellness **Notes** Orders Medications Labs Prob/POV Services Reports D/C Summ Consults Privacy WCM ASQ Suicide

POWERS, MEGAN DEMO.DKLAHOMA.IHS.GOV DEMO INDIAN HOSPITAL 23-Aug-2010 11:13

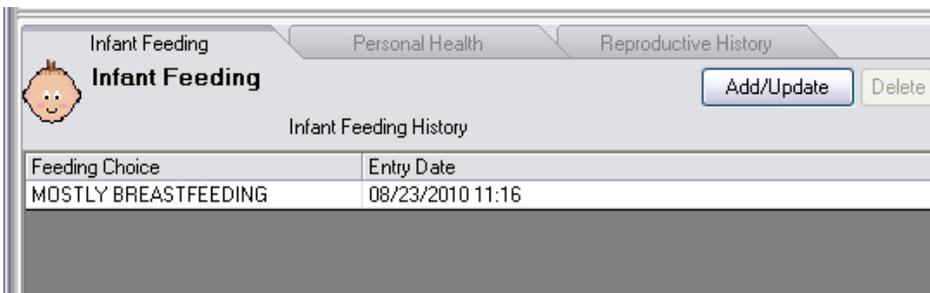
To enter Infant Feeding, click Add/Update in the Infant Feeding component.



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 bar shows 'Patient\_Crsae' with ID 900031, DOB 01-Jul-1958 (52), and gender F. The primary care team is listed as '01 GENERAL POWERS,MEGAN' with a last update of 19-Aug-2011. The primary care team is currently unassigned.

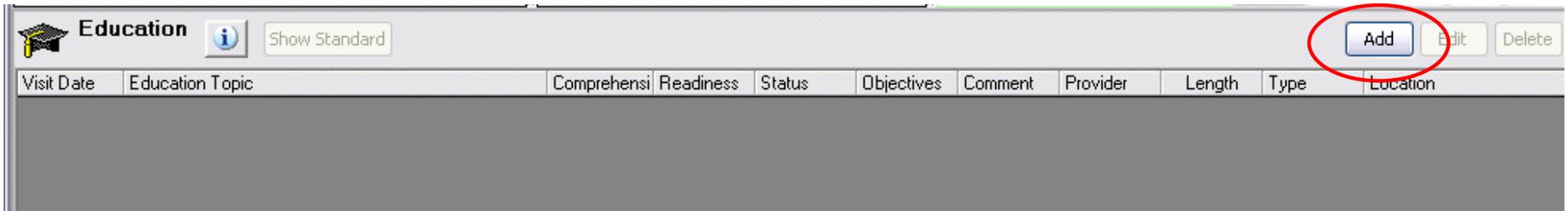
The 'Education' component is highlighted with a red circle. It features a table with the following columns: Visit Date, Education Topic, Comprehensi, Readiness, Status, Objectives, Comment, Provider, Length, Type, and Location. The table is currently empty.

Other visible components include:

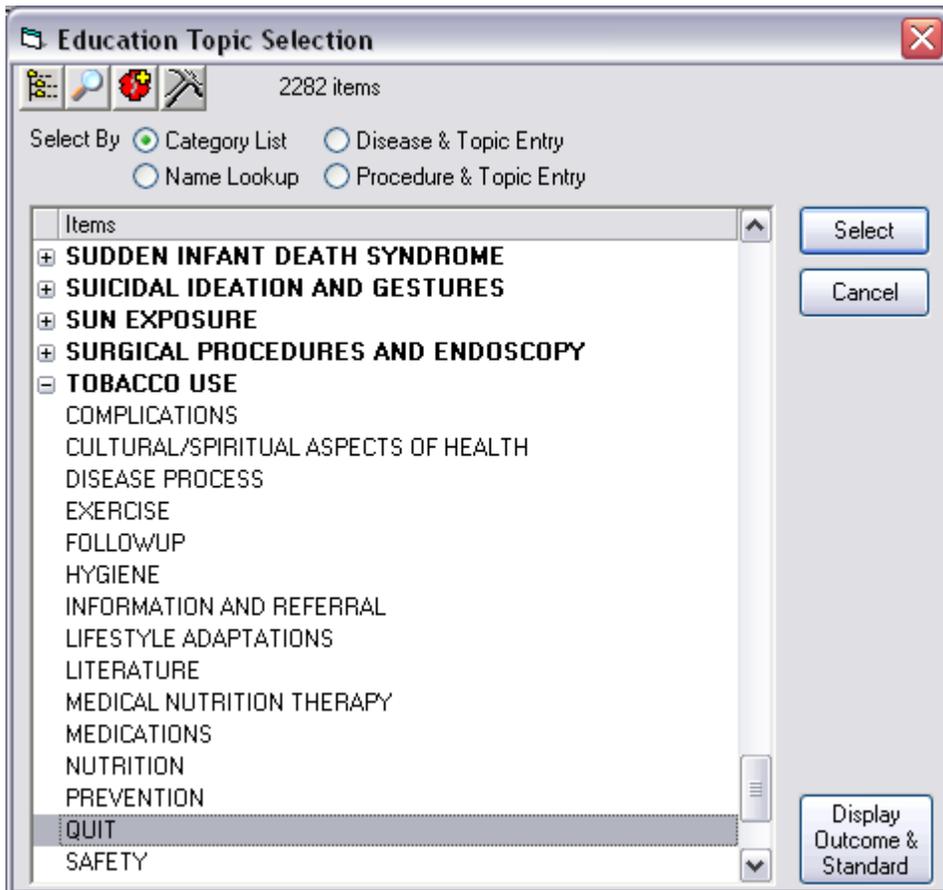
- Health Factors:** A table with columns for Visit Date, Health Factor, Category, and Comment.
- Exams:** A table with columns for Visit Date and Exams.
- Skin Test History:** A table with columns for Visit Date, Skin Test, Location, Age@Visit, and Result.
- Infant Feeding:** A section with a 'Delete' button and the text 'Not Applicable'.
- Immunization Record:** A section with a 'Forecast' table (containing 'Tdap past due'), a 'Contraindications' table (containing 'PNEUMO-PS Egg Allergy 19-Aug-2010'), and a 'Vaccinations' section.

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 bottom status bar 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 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.

**Add Patient Education Event**

Education Topic:  (Tobacco Use)

Type of Training:  Individual  Group

Comprehension Level:

Length:  (min)

Comment:

Provided By:

Readiness to Learn:

Status/Outcome:  Goal Set  Goal Met  Goal Not Met

Historical:  Historical

Event Date:

Location:    
 IHS/Tribal Facility   
 Other

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

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

**Education**

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, Historical checkbox

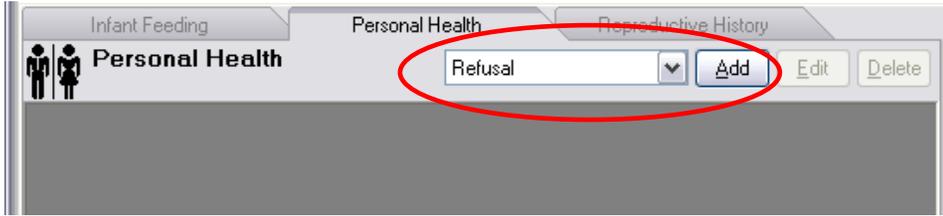
Patient's Learning Health Factors:

## Refusals

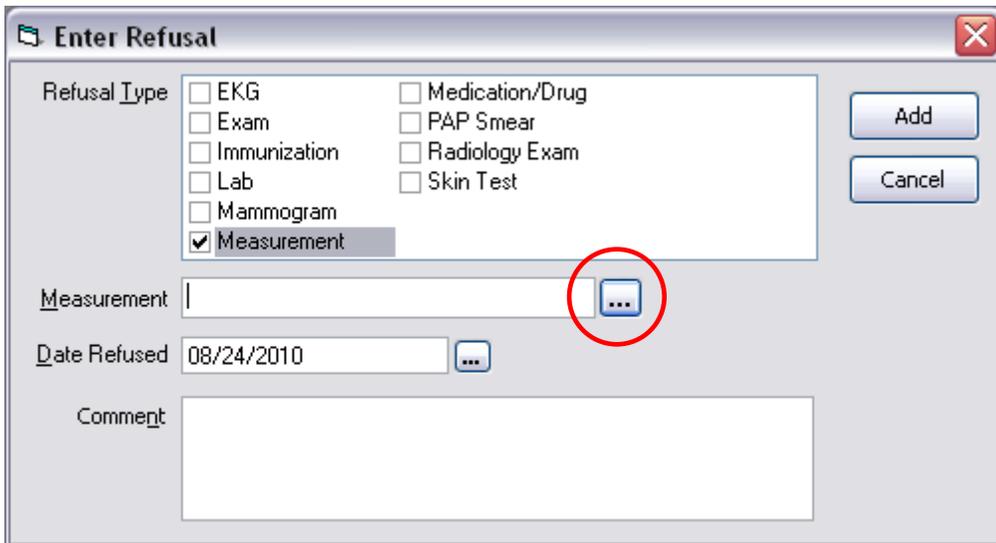
Refusals are entered in the Personal Health component, which is located on the Wellness tab. *Note: refusals are not counted toward the GPRA measure, but should still be documented.*

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' with ID '900031', birth date '01-Jul-1958 (52)', and gender 'F'. The primary care team is listed as '01 GENERAL POWERS,MEGAN' with a last update of '23-Aug-2010 10:28'. A green status bar indicates 'Primary Care Team Unassigned'. The 'Education' section shows a record for 'Tobacco Use-Quit' on '08/23/2010' with a status of 'GOOD' and 'RECEPTIVE'. The 'Health Factors' section shows 'Current Smoker' on '08/19/2010'. The 'Exams' section shows 'DIABETIC EYE EXAM' and 'ALCOHOL SCREENING'. 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 shows a forecast for 'Tdap' as 'past due' and contraindications for 'PNEUMO-PS' and 'FLU-HIGH'. The bottom navigation bar includes 'Notifications', 'Cover Sheet', 'Triage', 'Wellness', 'Notes', 'Orders', 'Medications', 'Labs', 'Prob/POV', 'Services', 'Reports', 'D/C Summ', 'Consults', 'Privacy', 'WCM', 'ASQ', and 'Suicide'. The status bar at the bottom shows 'POWERS,MEGAN', 'DEMO.OKLAHOMA.IHS.GOV', 'DEMO INDIAN HOSPITAL', and '24-Aug-2010 15:41'.

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.

