

Key Clinical Performance Objectives

Cheat Sheet for EHR Documentation and Data Entry for CRS Version 15.1 Last Updated May 2015

Data Entry Best Practices to Meet Measures

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.
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/CRS/documents/crsv15/GPRAMeasuresV151.pdf>

See Enter Information in EHR on Page 54 for detailed instructions on how to enter information into EHR.

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

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| Diabetes Prevalence Note: This is not a GPRA measure; however, it is used in determining patients that have been diagnosed with diabetes. | | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR: <ul style="list-style-type: none"> • Date received • Location • Results | Diabetes Prevalence Diagnosis POV Visit Diagnosis Entry Purpose of Visit: ICD-9: 250.00-250.93 or ICD-10: E10.*-E13.* Provider Narrative: Modifier: Cause of DX: |

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| Diabetes: Glycemic Control | <p>Active Clinical Patients DX with diabetes and with an A1c:</p> <ul style="list-style-type: none"> Less than (<) 8 (Good Glycemic Control) | <p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> Date received Location Results | <p>A1c Lab Test Lab Test Entry Enter Lab Test Type: [Enter site's defined A1c Lab Test] Collect Sample/Specimen: [Blood, Plasma] Clinical Indication: CPT Visit Services Entry (includes historical CPTs) Enter CPT: 83036, 83037, 3044F-3046F Quantity: Modifier: Modifier 2:</p> |
| Diabetes: Blood Pressure Control | <p>Active Clinical Patients DX with diabetes and with controlled blood pressure:</p> <ul style="list-style-type: none"> Less than (<) 140/90 (mean systolic less than (<) 140, mean diastolic less than (<) 90) | <p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> Date received Location Results | <p>Blood Pressure Data Entry Vital Measurements Entry (includes historical Vitals) Value: [Enter as Systolic/Diastolic (e.g., 140/90)] Select Qualifier: Date/Time Vitals Taken:</p> |

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| Diabetes: LDL Assessment | Active Clinical Patients DX with diabetes and a completed LDL test. | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR: <ul style="list-style-type: none"> • Date received • Location • Results | <p>LDL (Calculated) Lab Test Lab Test Entry Enter Lab Test Type: [Enter site's defined LDL Lab Test] Collect Sample/Specimen: [Blood] Clinical Indication:</p> <p>LDL CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F, G9271, G9272 Quantity: Modifier: Modifier 2:</p> <p>LDL POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V77.91 Provider Narrative: Modifier: Cause of DX:</p> |

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| Diabetes: Nephropathy Assessment | <p>Active Clinical Patients DX with diabetes with a Nephropathy assessment:</p> <ul style="list-style-type: none"> Estimated GFR with result during the Report Period Urine Albumin-to-Creatinine Ratio during the Report Period End Stage Renal Disease diagnosis/treatment | <p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> Date received Location Results | <p>Estimated GFR Lab Test Lab Test Entry Enter Lab Test Type: [Enter site's defined Est GFR Lab Test] Collect Sample/Specimen: [Blood] Clinical Indication: Urine Albumin-to-Creatinine Ratio CPT Visit Services Entry (includes historical CPTs) Enter CPT: 82043 AND 82570 Quantity: Modifier: Modifier 2: ESRD CPT Visit Services Entry (includes historical CPTs) Enter CPT: 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, 3066F, G0257, G9231, S2065 or S9339 Quantity: Modifier: Modifier 2:</p> |

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| Diabetes: Nephropathy Assessment (cont.) | | | <p>ESRD POV Visit Diagnosis Entry Purpose of Visit: ICD-9: 585.6, V42.0, V45.11, V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2 Provider Narrative: Modifier: Cause of DX:</p> <p>ESRD Procedure Procedure Entry Operation/Procedure: ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6* Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX (ESRD)]</p> |

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| Diabetic Retinopathy | <p>Patients with diabetes and no bilateral blindness 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"> • Dilated retinal evaluation by an optometrist or ophthalmologist • Seven standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist • Any photographic method formally validated to seven standard fields (ETDRS). <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p> | <p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Exams:</p> <ul style="list-style-type: none"> • Diabetic Retinal Exam <ul style="list-style-type: none"> - Dilated retinal eye exam - Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist - Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos - Routine ophthalmological examination including refraction (new or existing patient) - Diabetic indicator; retinal eye exam, dilated, bilateral • Other Eye Exams <ul style="list-style-type: none"> - Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or validated teleophthalmology retinal evaluation clinics - Non-DNKA visits to an optometrist or ophthalmologist | <p>Diabetic Retinopathy Exam Exam Entry (includes historical exams) Select Exam: 03 Result: [Enter Results] Comments: Provider Performing Exam:</p> <p>Retinal Exam CPT Visit Services Entry (includes historical CPTs) Enter CPT: 2022F, 2024F, 2026F, S0620, S0621, S3000 Quantity: Modifier: Modifier 2:</p> <p>Other Eye Exam CPT Visit Services Entry (includes historical CPTs) Enter CPT: 67028, 67039, 67040, 92002, 92004, 92012, 92014 Quantity: Modifier: Modifier 2:</p> <p>Other Eye Exam POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V72.0 Provider Narrative: Modifier: Cause of DX:</p> <p>Other Eye Exam Clinic Clinic Entry Clinic: A2, 17, 18, 64</p> |

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| 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>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results | <p>Dental Exam Exam Entry (includes historical exams) Select Exam: 30 Result: [Enter Results] Comments: Provider Performing Exam: Dental Exam (ADA code) ADA codes cannot be entered into EHR.</p> <p>Dental Exam CPT Visit Services Entry (includes historical CPTs) Enter CPT: D0190, D0191 Quantity: Modifier: Modifier 2:</p> <p>Dental Exam POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V72.2; ICD-10: Z01.20, Z01.21 Provider Narrative: Modifier: Cause of DX:</p> |

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| Dental Sealants | <p>Patients should have one or more intact dental sealants.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p> | <p>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results | <p>Dental Sealants (ADA) <i>ADA codes cannot be entered into EHR.</i></p> <p>Dental Sealants CPT Visit Services Entry (includes historical CPTs) Enter CPT: D1351, D1352, D1353 Quantity: Modifier: Modifier 2:</p> |
| Topical Fluoride | <p>Patients should have one or more topical fluoride applications.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p> | <p>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results | <p>Topical Fluoride (ADA code) <i>ADA codes cannot be entered into EHR.</i></p> <p>Topical Fluoride CPT Visit Services Entry (includes historical CPTs) Enter CPT: D1206, D1208, D5986 Quantity: Modifier: Modifier 2:</p> <p>Topical Fluoride POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V07.31 Provider Narrative: Modifier: Cause of DX:</p> |

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| Influenza | <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>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • IZ type • Date received • Location <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include:</p> <p>Immunization Package of "Egg Allergy" or "Anaphylaxis"</p> <p>NMI Refusal</p> | <p>Influenza Vaccine Immunization Entry (includes historical immunizations)</p> <p>Select Immunization Name: 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166 (other options are 111, 15, 16, 88)</p> <p>Lot: VFC Eligibility:</p> <p>Influenza Vaccine POV Visit Diagnosis Entry</p> <p>Purpose of Visit: ICD-9: *V04.81, *V06.6</p> <p>Provider Narrative: Modifier: Cause of DX: * NOT documented with 90663, 90664, 90666-90668, 90470, G9141, G9142</p> <p>Influenza Vaccine CPT Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT: 90630, 90654-90662, 90672, 90673, 90685-90688, G0008</p> <p>Quantity: Modifier: Modifier 2:</p> <p>NMI Refusal of Influenza <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> |

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| Influenza (cont.) | | | <p>Contraindication Influenza Immunization Entry - Contraindications Vaccine: [See codes above] Reason: Egg Allergy, Anaphylaxis</p> |

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| <p>Adult Immunizations</p> | <p>All adults ages 65 and older will have a pneumococcal vaccine. All adult (18 and older) diabetic patients are strongly recommended to have a pneumococcal vaccine. Refusals should be documented. Note: Only NMI refusals are counted toward the GPRA Measure.</p> | <p>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • IZ type • Date received • Location <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include: Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal</p> | <p>Pneumococcal Vaccine Immunization Entry (includes historical immunizations) Select Immunization Name: 33, 100, 109, 133, 152 Lot: VFC Eligibility:</p> <p>Pneumococcal Vaccine POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V06.6, V03.82 Provider Narrative: Modifier: Cause of DX:</p> <p>Pneumococcal Vaccine CPT Visit Services Entry (includes historical CPTs) Enter CPT: 90669, 90670, 90732, G0009, G9279 Quantity: Modifier: Modifier 2:</p> <p>NMI Refusal of Pneumococcal <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p>Contraindication Pneumococcal Immunization Entry - Contraindications Vaccine: [See codes above] Reason: Egg Allergy, Anaphylaxis</p> |

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| Childhood Immunizations | <p>Children age 19–35 months will be up-to-date for all ACIP recommended immunizations.</p> <p>This is the 4313*314 combo:</p> <ul style="list-style-type: none"> 4 DTaP 3 IPV 1 MMR 3 Hepatitis B 3 or 4 Hib 1 Varicella 4 Pneumococcal <p>Refusals should be documented.</p> <p>Note: Only NMI refusals are counted toward the GPRA Measure.</p> | <p>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • IZ type • Date received • Location <p>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</p> <p>Contraindications should be documented and are counted toward the GPRA Measure.</p> <p>Contraindications include Immunization Package of "Anaphylaxis" for all childhood immunizations. The following additional contraindications are also counted:</p> <ul style="list-style-type: none"> • IPV: Immunization Package: "Neomycin Allergy." • OPV: Immunization Package: "Immune Deficiency." • MMR: Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy." • Varicella: Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy." • Pneumococcal: Immunization Package: "Anaphylaxis" | <p>Childhood Immunizations</p> <p>Immunization Entry (includes historical immunizations)</p> <p>Select Immunization Name: DTaP: 20, 50, 102, 106, 107, 110, 120, 130, 146; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113, 138, 139; 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; Pneumococcal: 33, 100, 109, 133, 152</p> <p>Lot: VFC Eligibility:</p> |

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| <p>Childhood Immunizations (cont.)</p> | | <p>Dosage and types of immunization definitions:</p> <p>4 doses of DTaP:</p> <ul style="list-style-type: none"> • 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>3 doses of IPV:</p> <ul style="list-style-type: none"> • 3 OPV • 3 IPV • Combination of OPV and IPV totaling three doses <p>1 dose of MMR:</p> <ul style="list-style-type: none"> • MMR • 1 M/R and 1 Mumps • 1 R/M and 1 Measles • 1 each of Measles, Mumps, and Rubella <p>3 doses of Hepatitis B</p> <ul style="list-style-type: none"> • 3 doses of Hep B <p>3 or 4 doses of HIB, depending on the vaccine administered</p> <p>1 dose of Varicella</p> <p>4 doses of Pneumococcal</p> | <p>Childhood Immunizations POV</p> <p>Visit Diagnosis Entry</p> <p>Purpose of Visit: DTaP: ICD-9: V06.1; DTP: ICD-9: V06.1, V06.2, V06.3; DT: ICD-9: V06.5; Td: ICD-9: V06.5; Diphtheria: ICD-9: V03.5; Tetanus: ICD-9: V03.7; Acellular Pertussis: ICD-9: V03.6; IPV: ICD-9: V04.0, V06.3; IPV (evidence of disease): ICD-9: 730.70-730.79, ICD-10: M89.6*; MMR: ICD-9: V06.4; Measles: ICD-9: V04.2; Measles (evidence of disease): ICD-9: 055*, ICD-10: B05.*; Mumps: ICD-9: V04.6; Mumps (evidence of disease): ICD-9: 072*, ICD-10: B26.*; Rubella: ICD-9: V04.3; Rubella (evidence of disease): ICD-9: 056*, 771.0, ICD-10: B06.*; Hepatitis B (evidence of disease): ICD-9: V02.61, 070.2, 070.3, ICD-10: B16.*, B19.1*, Z22.51; HIB: ICD-9: V03.81; Varicella: ICD-9: V05.4; Varicella (evidence of disease): ICD-9: 052*, 053*, ICD-10: B01.*-B02.*; Pneumococcal: ICD-9: V06.6, V03.82</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> |

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| <p>Childhood Immunizations (cont.)</p> | | <p>Important Note: 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 Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT: DTaP: 90696, 90698, 90700, 90721, 90723; DTP: 90701, 90720; Tdap: 90715; DT: 90702; Td: 90714, 90718; Diphtheria: 90719; Tetanus: 90703; OPV: 90712; IPV: 90696, 90698, 90713, 90723; MMR: 90707, 90710; M/R: 90708; Measles: 90705; Mumps: 90704; Rubella: 90706; Hepatitis B: 90636, 90723, 90740, 90743-90748, G0010; HIB: 90645-90648, 90698, 90720-90721, 90748; Varicella: 90710, 90716; Pneumococcal: 90669, 90670, 90732, G0009, G9279</p> <p>Quantity: Modifier: Modifier 2:</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>Immunization Entry - Contraindications</p> <p>Vaccine: [See codes above] Reason: [See Contraindications section under the Provider Documentation column]</p> |

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| <p>Cancer Screening: Pap Smear Rates</p> | <p>Women ages 24-64 should have a Pap Smear every 3 years, or if patient is 30 to 64 years of age, either a Pap Smear documented in the past 3 years or a Pap Smear and an HPV DNA documented in the past 5 years.</p> <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 tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results | <p>Pap Smear V Lab Lab Test Entry Enter Lab Test Type: [Enter site's defined Pap Smear Lab Test] Clinical Indication:</p> <p>Pap Smear POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V72.32, V76.2, 795.0*; ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4 Provider Narrative: Modifier: Cause of DX:</p> <p>Pap Smear CPT Visit Services Entry (includes historical CPTs) Enter CPT: 88141-88154, 88160-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 Quantity: Modifier: Modifier 2:</p> <p>HPV V Lab Lab Test Entry Enter Lab Test Type: [Enter site's defined HPV Lab Test] Clinical Indication:</p> |

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| Cancer Screening: Pap Smear Rates (cont.) | | | <p>HPV POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V73.81, 079.4, 796.75, 795.05, 795.15, 796.79, 795.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51 Provider Narrative: Modifier: Cause of DX:</p> <p>HPV CPT Visit Services Entry (includes historical CPTs) Enter CPT: 87623-87625 Quantity: Modifier: Modifier 2:</p> |

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| 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>Standard EHR documentation for Radiology performed at the facility. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Telephone visit with patient Verbal or written lab report Patient's next visit</p> | <p>Mammogram POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V76.11, V76.12, 793.80, 793.81, 793.89; ICD-10: R92.0, R92.1, R92.8, Z12.31 Provider Narrative: Modifier: Cause of DX:</p> <p>Mammogram CPT Visit Services Entry (includes historical CPTs) Enter CPT: 77053-77059, G0206; G0204, G0202 Quantity: Modifier: Modifier 2:</p> <p>Mammogram Procedure Procedure Entry Operation/Procedure: ICD-9: 87.36, 87.37; ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> |

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| 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"> Annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT) Flexible sigmoidoscopy in the past 5 years Colonoscopy every 10 years. <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 record historical information in EHR:</p> <ul style="list-style-type: none"> Date received Location Results <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>Visit Diagnosis Entry</p> <p>Purpose of Visit: ICD-9: 153.*, 154.0, 154.1, 197.5, V10.05; ICD-10: C18.*, C19, C20, C78.5, Z85.030, Z85.038</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Total Colectomy CPT</p> <p>Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT: 44150-44151, 44155-44158, 44210-44212</p> <p>Quantity:</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>Total Colectomy Procedure</p> <p>Procedure Entry</p> <p>Operation/Procedure: ICD-9: 45.8*; ICD-10: 0DTE*ZZ</p> <p>Provider Narrative:</p> <p>Operating Provider:</p> <p>Diagnosis: [Enter appropriate DX]</p> |

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| Colorectal Cancer Screening (cont.) | | | <p>FOBT or FIT CPT Visit Services Entry (includes historical CPTs) Enter CPT: 82270, 82274, G0328 Quantity: Modifier: Modifier 2:</p> <p>Flexible Sigmoidoscopy CPT Visit Services Entry (includes historical CPTs) Enter CPT: 45330–45345, G0104 Quantity: Modifier: Modifier 2:</p> <p>Flexible Sigmoidoscopy Procedure Procedure Entry Operation/Procedure: ICD-9: 45.24; ICD-10: 0DJD8ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>Colon Screening CPT Visit Services Entry (includes historical CPTs) Enter CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121, G9252, G9253 Quantity: Modifier: Modifier 2:</p> |
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| Colorectal Cancer Screening (cont.) | | | <p>Colon Screening Procedure Procedure Entry Operation/Procedure: ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; ICD-10: (see logic manual for codes) Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> |

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| <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>Ask all patients age five and over about tobacco use at least annually.</p> | <p>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Document on designated Health Factors section of form:</p> <ul style="list-style-type: none"> • HF–Current Smoker, every day • HF–Current Smoker, some day • HF–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Previous (Former) Smoker [or -Smokeless] (quit greater than (>) 6 months) • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 6 months) • HF–Smoker in Home • HF–Ceremonial Use Only • HF–Exp to ETS (Second Hand Smoke) • HF–Smoke Free Home <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:</p> <ul style="list-style-type: none"> • Codes will contain "TO-", "-TO", "-SHS" | <p>Tobacco Screening Health Factor</p> <p>Health Factor Entry</p> <p>Select V Health Factor: [Enter HF (See the Provider Documentation column)]</p> <p>Level/Severity:</p> <p>Provider:</p> <p>Quantity:</p> <p>Tobacco Screening PED–Topic</p> <p>Patient Education Entry (includes historical patient education)</p> <p>Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> |

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| <p>Tobacco Use and Exposure Assessment (cont.)</p> | | <p>Note: 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 Health Factor Entry Select V Health Factor: Current Smoker (every day, some day, or status unknown), Current Smokeless, Cessation-Smoker, Cessation-Smokeless Level/Severity: Provider: Quantity:</p> <p>Smokers Health Factor Health Factor Entry Select V Health Factor: Current Smoker (every day, some day, or status unknown), or Cessation-Smoker Level/Severity: Provider: Quantity:</p> <p>Smokeless Health Factor Health Factor Entry Select V Health Factor: Current Smokeless or Cessation-Smokeless Level/Severity: Provider: Quantity:</p> <p>ETS Health Factor Health Factor Entry Select V Health Factor: Exp to ETS Level/Severity: Provider: Quantity:</p> |

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| Tobacco Cessation | <p>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 or quit tobacco use.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p> | <p>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Current tobacco users are defined by having any of the following documented prior to the report period:</p> <ul style="list-style-type: none"> • Last documented Tobacco Health Factor • Last documented Tobacco related POV • Last documented Tobacco related CPT <p>Health factors considered to be a tobacco user:</p> <ul style="list-style-type: none"> • HF–Current Smoker, every day • HF–Current Smoker, some day • HF–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 6 months) <p>Tobacco Patient Education Codes:</p> <ul style="list-style-type: none"> • Codes will contain "TO-", "-TO", "-SHS" | <p>Tobacco Cessation PED - Topic Patient Education Entry (includes historical patient education)</p> <p>Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> |

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| Tobacco Cessation (cont.) | | <p>Prescribe Tobacco Cessation Aids:</p> <ul style="list-style-type: none"> • Predefined Site-Populated Smoking Cessation Meds • Meds containing: <ul style="list-style-type: none"> - “Nicotine Patch” - “Nicotine Polacrilex” - “Nicotine Inhaler” - “Nicotine Nasal Spray” <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</p> <p>Patient Education Entry (includes historical patient education)</p> <p>Select ICD Diagnosis Code Number: 649.00-649.04</p> <p>Category:</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Provider’s Narrative:</p> <p>Tobacco Cessation PED - CPT</p> <p>Mnemonic PED enter</p> <p>Select CPT Code Number: D1320, 99406, 99407, 4000F</p> <p>Category:</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Provider’s Narrative:</p> |

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| Tobacco Cessation (cont.) | | | <p>Tobacco Cessation Clinic Clinic Entry Clinic: 94 Tobacco Cessation Dental (ADA) <i>ADA codes cannot be entered into EHR.</i></p> <p>Tobacco Cessation CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: D1320, 99406, 99407, 4000F Quantity Modifier: Modifier 2:</p> <p>Tobacco Cessation Medication Medication Entry Select Medication: [Enter Tobacco Cessation Prescribed Medication] Outside Drug Name (Optional): [Enter any additional name for the drug] SIG Quantity: Day Prescribed: Event Date&Time: Ordering Provider:</p> |

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| Tobacco Cessation (cont.) | | | <p>Tobacco Cessation Prescription CPT</p> <p>Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT Code: 4001F</p> <p>Quantity</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>Quit Tobacco POV</p> <p>Visit Diagnosis Entry</p> <p>Purpose of Visit: ICD-9: 305.13, V15.82; ICD-10: F17.2*1, Z87.891</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> |

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| 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>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <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> <ul style="list-style-type: none"> • Negative—Patient’s screening exam does not indicate risky alcohol use. • Positive—Patient’s screening exam indicates potential risky alcohol use. • Refused—Patient declined exam/screen • Unable to screen - Provider unable to screen <p>Note: Recommended Brief Screening Tool: SASQ (below). <i>Single Alcohol Screening Question (SASQ)</i></p> <p><i>For Women:</i></p> <ul style="list-style-type: none"> • When was the last time you had more than 4 drinks in one day? <p><i>For Men:</i></p> <ul style="list-style-type: none"> • When was the last time you had more than 5 drinks in one day? | <p>Alcohol Screening Exam Exam Entry (includes historical exams)</p> <p>Select Exam: 35, ALC</p> <p>Result:</p> <p>A—Abnormal N—Normal/Negative PR—Resent PAP—Present and Past PA—Past PO—Positive</p> <p>Comments: SASQ</p> <p>Provider Performing Exam:</p> <p>Cage Health Factor Health Factor Entry</p> <p>Select Health Factor: CAGE</p> <ol style="list-style-type: none"> 1. CAGE 0/4 (all No answers) 2. CAGE 1/4 3. CAGE 2/4 4. CAGE 3/4 5. CAGE 4/4 <p>Choose 1-5: [Number from above]</p> <p>Level/Severity: Provider: Quantity:</p> |

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| 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> <ul style="list-style-type: none"> Alcohol Screening Exam Code Result: Positive <p>The patient may decline the screen or “Refuse to answer”:</p> <ul style="list-style-type: none"> Alcohol Screening Exam Code Result: Refused <p>The provider is unable to conduct the screen:</p> <ul style="list-style-type: none"> Alcohol Screening Exam Code Result: Unable To Screen <p>Note: Provider should Note the screening tool used was the SASQ at the Comment Mnemonic for the Exam code.</p> <p>All Providers: Use the CAGE questionnaire: Have you ever felt the need to Cut down on your drinking? Have people Annoyed you by criticizing your drinking? Have you ever felt bad or Guilty about your drinking? Have you ever needed an Eye-opener the first thing in the morning to steady your nerves or get rid of a hangover? Tolerance: How many drinks does it take you to get high?</p> | <p>Alcohol Screening POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V11.3, V79.1 Provider Narrative: Modifier: Cause of DX: Alcohol Screening CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 99408, 99409, G0396, G0397, H0049, H0050 Quantity Modifier: Modifier 2: Alcohol-Related Diagnosis POV Visit Diagnosis Entry Purpose of Visit: ICD-9: 303.*, 305.0*, 291.*, 357.5*; ICD-10: F10.1*, F10.20, F10.220-F10.29, F10.920-F10.982, F10.99, G62.1 Provider Narrative: Modifier: Cause of DX: Alcohol-Related Procedure Procedure Entry Operation/Procedure: ICD-9: 94.46, 94.53, 94.61-94.63, 94.67-94.69 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> |

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| Alcohol Screening (FAS Prevention) (cont.) | | <p>Based on how many YES answers were received, document Health Factor in EHR:</p> <ul style="list-style-type: none"> • HF-CAGE 0/4 (all No answers) • HF-CAGE 1/4 • HF-CAGE 2/4 • HF-CAGE 3/4 • HF-CAGE 4/4 <p>Optional values:</p> <ul style="list-style-type: none"> • Level/Severity: Minimal, Moderate, or Heavy/Severe • Quantity: # of drinks daily OR T (Tolerance) -- # drinks to get high (e.g. T-4) • Comment: used to capture other relevant clinical info e.g. "Non-drinker" <p>Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-"</p> <p>AUDIT Measurements:</p> <ul style="list-style-type: none"> • Zone I: Score 0–7 Low risk drinking or abstinence • Zone II: Score 8–15 Alcohol use in excess of low-risk guidelines • Zone III: Score 16–19 Harmful and hazardous drinking • Zone IV: Score 20–40 Referral to Specialist for Diagnostic Evaluation and Treatment | <p>Alcohol-Related PED - Topic Patient Education Entry (includes historical patient education)</p> <p>Enter Education Topic: [Enter Alcohol-Related Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> |

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| <p>Alcohol Screening (FAS Prevention) (cont.)</p> | | <p>AUDIT-C Measurements: How often do you have a drink containing alcohol?</p> <ul style="list-style-type: none"> • (0) Never (Skip to Questions 9-10) • (1) Monthly or less • (2) 2 to 4 times a month • (3) 2 to 3 times a week • (4) 4 or more times a week <p>How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <ul style="list-style-type: none"> • (0) 1 or 2 • (1) 3 or 4 • (2) 5 or 6 • (3) 7, 8, or 9 • (4) 10 or more <p>How often do you have 6 or more drinks on one occasion?</p> <ul style="list-style-type: none"> • (0) Never • (1) Less than monthly • (2) Monthly • (3) Weekly • (4) Daily or almost daily | <p>Alcohol-Related PED - Diagnosis Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: V11.3, V79.1, 303.*, 305.0*, 291.* or 357.5*Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:</p> <p>Alcohol-Related PED - CPT Patient Education Entry (includes historical patient education) Select CPT Code Number: 99408, 99409, G0396, G0397, H0049, or H0050 Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the related text)] Goal Comment:</p> |
| Clinical Objectives Cheat Sheet | | 30 | <p>Provider's Narrative: Last Edited: 5/25/2015</p> |

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| 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> <ul style="list-style-type: none"> • In men, a score of 4 or more is considered positive • In women, a score of 3 or more is considered positive. <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> <ul style="list-style-type: none"> • C–Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? • R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? • A–Do you ever use alcohol/drugs while you are by yourself, ALONE? • F–Do you ever FORGET things you did while using alcohol or drugs? • F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? • T–Have you gotten into TROUBLE while you were using alcohol or drugs? <p>Total CRAFFT score (Range: 0–6).</p> <p>A positive answer to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated.</p> | <p>Alcohol Screen AUDIT Measurement Vital Measurements Entry (includes historical Vitals) Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken:</p> <p>Alcohol Screen AUDIT-C Measurement Vital Measurements Entry (includes historical Vitals) Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken:</p> <p>Alcohol Screen CRAFFT Measurement Vital Measurements Entry (includes historical Vitals) Value: [Enter 0-6] Select Qualifier: Date/Time Vitals Taken:</p> |

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| <p>Intimate Partner (Domestic) Violence Screening (IPV/DV)</p> | <p>Adult females should be screened for domestic violence at new encounter and at least annually Prenatal once each trimester (Source: Family Violence Prevention Fund National Consensus Guidelines) Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</p> | <p>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Medical and Behavioral Health Providers: EXAM—IPV/DV Screening</p> <ul style="list-style-type: none"> • Negative—Denies being a current or past victim of IPV/DV • Past—Denies being a current victim, but discloses being a past victim of IPV/DV • Present—Discloses current IPV/DV • Present and Past—Discloses past victimization and current IPV/DV victimization • Refused—Patient declined exam/screen • Unable to screen—Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.) <p>IPV/DV Patient Education Codes:</p> <ul style="list-style-type: none"> • Codes will contain "DV-" or "-DV" | <p>IPV/DV Screening Exam Exam Entry (includes historical exams) Select Exam: 34, INT Result: A—Abnormal N—Normal/Negative PR—Resent PAP—Present and Past PA—Past PO—Positive Comments: Provider Performing Exam: IPV/DV Diagnosis POV Visit Diagnosis Entry Purpose of Visit: ICD-9: 995.80-83, 995.85, V15.41, V15.42, V15.49; ICD-10: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, Z91.410; IPV/DV Counseling: ICD-9: V61.11; ICD-10: Z69.11 Provider Narrative: Modifier: Cause of DX:</p> |

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| Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont.) | | | <p>IPV/DV–Topic Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter IPV/DV Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Education (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:</p> <p>IPV/DV PED–Diagnosis Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: 995.80-83, 995.85, V15.41, V15.42, V15.49 Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (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:</p> |

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| Depression Screening | <p>Adult patients 18 years of age and older should be screened for depression at least annually. (Source: United States Preventive Services Task Force)</p> <p>Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</p> | <p>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Medical Providers: EXAM—Depression Screening</p> <ul style="list-style-type: none"> • Normal/Negative—Denies symptoms of depression • Abnormal/Positive—Further evaluation indicated • Refused—Patient declined exam/screen • Unable to screen—Provider unable to screen <p>Note: Refusals are not counted toward the GPRA measure, but should be documented.</p> <p>Mood Disorders: Two or more visits with POV related to:</p> <ul style="list-style-type: none"> • Major Depressive Disorder • Dysthymic Disorder • Depressive Disorder NOS • Bipolar I or II Disorder • Cyclothymic Disorder • Bipolar Disorder NOS • Mood Disorder Due to a General Medical Condition • Substance-induced Mood Disorder • Mood Disorder NOS <p>Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</p> | <p>Depression Screening Exam Exam Entry (includes historical exams)</p> <p>Select Exam: 36, DEP Result: A—Abnormal N—Normal/Negative PR—Resent PAP—Present and Past PA—Past PO—Positive Comments: PHQ-2 Scaled, PHQ9 Provider Performing Exam:</p> <p>Depression Screen Diagnosis POV Visit Diagnosis Entry</p> <p>Purpose of Visit: ICD-9: V79.0 Provider Narrative: Modifier: Cause of DX:</p> <p>Depression Screening CPT Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT Code: 1220F, 3725F, G0444 Quantity Modifier: Modifier 2:</p> |

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| <p>Depression Screening (cont.)</p> | | <p>Patient Health Questionnaire (PHQ-2 Scaled Version)</p> <p>Over the past two 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"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>Feeling down, depressed, or hopeless</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>PHQ-2 Scaled Version (continued)</p> <p>Total Possible PHQ-2 Score: Range: 0-6</p> <ul style="list-style-type: none"> • 0-2: Negative Depression Screening Exam: <ul style="list-style-type: none"> - Code Result: Normal or Negative • 3-6: Positive; further evaluation indicated Depression Screening Exam <ul style="list-style-type: none"> - Code Result: Abnormal or Positive <p>The patient may decline the screen or “Refuse to answer” Depression Screening Exam</p> <ul style="list-style-type: none"> • Code Result: Refused <p>The provider is unable to conduct the Screen Depression Screening Exam</p> <ul style="list-style-type: none"> • Code Result: Unable To Screen | <p>Mood Disorder Diagnosis POV</p> <p>Visit Diagnosis Entry</p> <p>Purpose of Visit: ICD-9: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311; ICD-10: F06.31-F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0-F31.71, F31.73, F31.75, F31.77, F31.81-F31.9, F32.*-F39</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> |

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| Depression Screening (cont.) | | <p>Provider should Note the screening tool used was the PHQ-2 Scaled at the Comment Mnemonic for the Exam Code.</p> <p>PHQ9 Questionnaire Screening Tool</p> <p>Little interest or pleasure in doing things?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>Feeling down, depressed, or hopeless?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>Trouble falling or staying asleep, or sleeping too much?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>Feeling tired or having little energy?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 | |

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| Depression Screening (cont.) | | <p>Poor appetite or overeating?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <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"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>Trouble concentrating on things, such as reading the newspaper or watching television?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <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"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 | |

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| Depression Screening (cont.) | | <p>Thoughts that you would be better off dead, or of hurting yourself in some way?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>PHQ9 Questionnaire (Continued) Total Possible PHQ-2 Score: Range: 0–27 0-4 Negative/None Depression Screening Exam: Code Result: None 5-9 Mild Depression Screening Exam: Code Result: Mild depression 10-14 Moderate Depression Screening Exam: Code Result: Moderate depression 15-19 Moderately Severe Depression Screening Exam: Code Result: Moderately Severe depression 20-27 Severe Depression Screening Exam: Code Result: Severe depression</p> <p>Provider should Note the screening tool used was the PHQ9 Scaled at the Comment Mnemonic for the Exam Code.</p> | |

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| Childhood Weight Control | <p>Patients ages 2–5 at the beginning of the report period whose BMI could be calculated and have a BMI equal to or greater than (\geq) 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>Standard EHR documentation. obtain height and weight during visit and record information in EHR:</p> <ul style="list-style-type: none"> • Height • Weight • Date Recorded <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>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.</p> <p>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).</p> | <p>Height Measurement Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken:</p> <p>Weight Measurement Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Bed Chair Dry Estimated Standing Date/Time Vitals Taken:</p> |

Key Clinical Performance Objectives

| Performance Measure | Standard | Provider Documentation | How to Enter Data in EHR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|-------------------|-----------|-----------|-------------------|--|------|-----|-------------|-------|-------|-------|-----|---|------|------|------|-----|---|------|------|------|-----|-----|---|------|------|------|-----|---|------|------|------|-----|-----|---|------|------|------|-----|---|------|------|------|-----|-----|---|------|------|------|-----|---|------|------|------|-----|--|
| Childhood Weight Control (cont.) | | <p>Patients with BMI either greater or less than the Data Check Limit range shown below will not be included in the report counts for Overweight or Obese.</p> <table border="1"> <thead> <tr> <th>Low-High</th> <th></th> <th>BMI >= 85</th> <th>BMI >= 95</th> <th colspan="2">Data Check Limits</th> </tr> <tr> <th>Ages</th> <th>Sex</th> <th>Over Weight</th> <th>Obese</th> <th>BMI ></th> <th>BMI <</th> </tr> </thead> <tbody> <tr> <td rowspan="2">2-2</td> <td>M</td> <td>17.7</td> <td>18.7</td> <td>36.8</td> <td>7.2</td> </tr> <tr> <td>F</td> <td>17.5</td> <td>18.6</td> <td>37.0</td> <td>7.1</td> </tr> <tr> <td rowspan="2">3-3</td> <td>M</td> <td>17.1</td> <td>18.0</td> <td>35.6</td> <td>7.1</td> </tr> <tr> <td>F</td> <td>17.0</td> <td>18.1</td> <td>35.4</td> <td>6.8</td> </tr> <tr> <td rowspan="2">4-4</td> <td>M</td> <td>16.8</td> <td>17.8</td> <td>36.2</td> <td>7.0</td> </tr> <tr> <td>F</td> <td>16.7</td> <td>18.1</td> <td>36.0</td> <td>6.9</td> </tr> <tr> <td rowspan="2">5-5</td> <td>M</td> <td>16.9</td> <td>18.1</td> <td>36.0</td> <td>6.9</td> </tr> <tr> <td>F</td> <td>16.9</td> <td>18.5</td> <td>39.2</td> <td>6.8</td> </tr> </tbody> </table> | Low-High | | BMI >= 85 | BMI >= 95 | Data Check Limits | | Ages | Sex | Over Weight | Obese | BMI > | BMI < | 2-2 | M | 17.7 | 18.7 | 36.8 | 7.2 | F | 17.5 | 18.6 | 37.0 | 7.1 | 3-3 | M | 17.1 | 18.0 | 35.6 | 7.1 | F | 17.0 | 18.1 | 35.4 | 6.8 | 4-4 | M | 16.8 | 17.8 | 36.2 | 7.0 | F | 16.7 | 18.1 | 36.0 | 6.9 | 5-5 | M | 16.9 | 18.1 | 36.0 | 6.9 | F | 16.9 | 18.5 | 39.2 | 6.8 | |
| Low-High | | BMI >= 85 | BMI >= 95 | Data Check Limits | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ages | Sex | Over Weight | Obese | BMI > | BMI < | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2-2 | M | 17.7 | 18.7 | 36.8 | 7.2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | F | 17.5 | 18.6 | 37.0 | 7.1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3-3 | M | 17.1 | 18.0 | 35.6 | 7.1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | F | 17.0 | 18.1 | 35.4 | 6.8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4-4 | M | 16.8 | 17.8 | 36.2 | 7.0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | F | 16.7 | 18.1 | 36.0 | 6.9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5-5 | M | 16.9 | 18.1 | 36.0 | 6.9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | F | 16.9 | 18.5 | 39.2 | 6.8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Controlling High Blood Pressure - Million Hearts | User Population patients ages 18 through 85 diagnosed with hypertension and no documented history of ESRD or current diagnosis of pregnancy who have BP less than (<) 140/90 (mean systolic less than (<) 140, mean diastolic less than (<) 90). | <p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results | <p>Blood Pressure Data Entry Vital Measurements Entry (includes historical Vitals) Value: [Enter as Systolic/Diastolic (e.g., 140/90)] Select Qualifier: Date/Time Vitals Taken:</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Key Clinical Performance Objectives

| 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 Coronary Heart Disease (CHD) prior to the Report Period, AND at least 2 visits during the Report Period, AND 2 CHD-related visits ever who had the following tests documented:</p> <ul style="list-style-type: none"> • Blood Pressure • LDL Assessment • Tobacco Use Assessment • BMI Calculated • Lifestyle Counseling <p>Note: This does not include depression screening and does not 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>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Note: See related individual measures above for recording historical information.</p> <ul style="list-style-type: none"> • Blood Pressure Control • LDL Assessment • Tobacco Use and Assessment • BMI (Obesity) <p>Tobacco Use Health Factors:</p> <ul style="list-style-type: none"> • HF–Current Smoker, every day • HF–Current Smoker, some day • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Previous (Former) Smoker [or -Smokeless] (quit greater than (>) 6 months) • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 6 months) • HF–Smoker in Home • HF–Ceremonial Use Only • HF–Exp to ETS (Second Hand Smoke) • HF–Smoke Free Home <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:</p> <ul style="list-style-type: none"> • Codes will contain "TO-", "-TO", "-SHS" | <p>CHD Diagnosis POV (Prior to the report period)</p> <p>Visit Diagnosis Entry</p> <p>Purpose of Visit: ICD-9: 410.0-413.*, 414.0-414.9, 429.2, V45.81, V45.82; ICD-10: I20.0-I22.8, I24.0-I25.83, I25.89, I25.9</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>CHD Diagnosis CPT (Prior to the report period)</p> <p>Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT Code: 33510-33514, 33516-33519, 33521-33523, 33533-33536, S2205-S2209, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, G0290</p> <p>Quantity:</p> <p>Modifier:</p> <p>Modifier 2:</p> |

Key Clinical Performance Objectives

| Performance Measure | Standard | Provider Documentation | How to Enter Data in EHR |
|--|----------|--|---|
| Comprehensive CVD-Related Assessment (cont.) | | <p>BMI is calculated using NHANES II.</p> <ul style="list-style-type: none"> Adults 19–50, height and weight at least every 5 years, not required to be on same day. Adults over 50, height and weight taken every 2 years, not required to be on same day. <p>Nutrition, dietary surveillance and counseling Patient Education Codes:</p> <ul style="list-style-type: none"> Codes will contain "-N" (Nutrition) or "-MNT" <p>Exercise Patient Education Codes:</p> <ul style="list-style-type: none"> Codes will contain "-EX" <p>Lifestyle Patient Education Codes:</p> <ul style="list-style-type: none"> Codes will contain "-LA" <p>Other Related Nutrition and Exercise Patient Educations Codes:</p> <ul style="list-style-type: none"> Codes will contain "-OBS" (Obesity) <p>Lifestyle Counseling includes:</p> <ul style="list-style-type: none"> Lifestyle adaptation counseling Medical nutrition therapy Nutrition counseling Exercise counseling <p>Other lifestyle education</p> | <p>CHD Diagnosis Procedure (Prior to the report period) Procedure Entry Operation/Procedure: ICD-9: 36.1*, 36.2*, 00.66, 36.06-36.07; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*, 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**</p> <p>Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX (ESRD)]</p> <p>Blood Pressure Data Entry Vital Measurements Entry (includes historical Vitals) Value: [Enter as Systolic/Diastolic (e.g., 140/90)] Select Qualifier: Date/Time Vitals Taken:</p> <p>LDL (Calculated) Lab Test Lab Test Entry Enter Lab Test Type: LDL Collect Sample/Specimen: [Blood] Clinical Indication: LDL CPT</p> |

Key Clinical Performance Objectives

| Performance Measure | Standard | Provider Documentation | How to Enter Data in EHR |
|--|----------|------------------------|---|
| Comprehensive CVD-Related Assessment (cont.) | | | <p>Visit Services Entry (includes historical CPTs) Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F, G9271, G9272 Quantity: Modifier: Modifier 2:</p> <p>Tobacco Use Assessment Health Factor Entry Select V Health Factor: [Enter HF (See the Provider Documentation column)] Level/Severity: Provider: Quantity: Tobacco Use Dental (ADA) ADA codes cannot be entered into EHR.</p> <p>Tobacco Screening CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: D1320, 99406, 99407, 1034F, 1035F, 1036F, 1000F, G9275, G9276 Quantity Modifier: Modifier 2:</p> |

Key Clinical Performance Objectives

| Performance Measure | Standard | Provider Documentation | How to Enter Data in EHR |
|--|----------|------------------------|--|
| Comprehensive CVD-Related Assessment (cont.) | | | <p>Tobacco Related Diagnoses POV</p> <p>Visit Diagnosis Entry</p> <p>Purpose of Visit: ICD-9: 305.1, 649.00-649.04, V15.82; ICD-10: F17.2*, O99.33*, Z87.891</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Tobacco Screening PED - Topic</p> <p>Patient Education Entry (includes historical patient education)</p> <p>Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> |

Key Clinical Performance Objectives

| Performance Measure | Standard | Provider Documentation | How to Enter Data in EHR |
|--|----------|------------------------|---|
| Comprehensive CVD-Related Assessment (cont.) | | | <p>Tobacco Screening PED–Diagnosis</p> <p>Patient Education Entry (includes historical patient education)</p> <p>Select ICD Diagnosis Code Number: 305.1, 649.00-649.04, V15.82</p> <p>Category:</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Provider’s Narrative:</p> |

Key Clinical Performance Objectives

| Performance Measure | Standard | Provider Documentation | How to Enter Data in EHR |
|--|----------|------------------------|--|
| Comprehensive CVD-Related Assessment (cont.) | | | <p>Tobacco Screening PED–CPT Patient Education Entry (includes historical patient education) Select CPT Code Number: D1320, 99406, 99407, 1034F, 1035F, 1036F, 1000F, G8453, G9275, G9276 Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider’s Narrative: BMI Data Entry</p> <p>Height Measurement Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken:</p> |

Key Clinical Performance Objectives

| Performance Measure | Standard | Provider Documentation | How to Enter Data in EHR |
|--|----------|------------------------|--|
| Comprehensive CVD-Related Assessment (cont.) | | | <p>Weight Measurement Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Bed Chair Dry Estimated Standing Date/Time Vitals Taken: Lifestyle Counseling Data Entry</p> <p>Medical Nutrition Therapy CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 97802-97804, G0270, G0271 Quantity Modifier: Modifier 2:</p> <p>Medical Nutrition Therapy Clinic Clinic Entry Clinic: 67, 36</p> <p>Nutrition Education POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V65.3; ICD-10: Z71.3 Provider Narrative: Modifier: Cause of DX:</p> |

Key Clinical Performance Objectives

| Performance Measure | Standard | Provider Documentation | How to Enter Data in EHR |
|--|----------|------------------------|--|
| Comprehensive CVD-Related Assessment (cont.) | | | <p>Nutrition/Exercise/Lifestyle Adaption PED–Topic</p> <p>Patient Education Entry (includes historical patient education)</p> <p>Enter Education Topic: [Enter Nutrition/Exercise/Lifestyle Adaption Patient Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> |

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

| 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>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <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 Visit Services Entry (includes historical CPTs) Enter CPT Code: 86689, 86701-86703, 87390, 87391, 87534-87539 Quantity Modifier: Modifier 2:</p> <p>HIV Diagnoses POV Visit Diagnosis Entry Purpose of Visit: ICD-9: 042, 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711-O98.73 Provider Narrative: Modifier: Cause of DX:</p> <p>HIV Lab Test Lab Test Entry Enter Lab Test Type: [Enter site's defined HIV Screen Lab Test] Collect Sample/Specimen: [Blood, Serum] Clinical Indication:</p> |

Key Clinical Performance Objectives

| 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>All providers 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>Exclusive Breastfeeding–Breastfed or expressed breast milk only, no formula</p> <p>Mostly Breastfeeding–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>½ Breastfeeding, ½ Formula Feeding–Half the time breastfeeding/expressed breast milk, half formula feeding</p> <p>Mostly Formula–The baby is mostly formula fed, but breastfeeds at least once a week</p> <p>Formula Only–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>Infant Feeding Choice Entry</p> <p>Enter Feeding Choice:</p> <p>Exclusive Breastfeeding</p> <p>Mostly Breastfeeding</p> <p>1/2 & 1/2 Breast and Formula</p> <p>Mostly Formula</p> <p>Formula Only</p> |

Key Clinical Performance Objectives

| 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 all components of patient education.</p> | N/A | <p><i>All providers should document all 5 patient education elements and elements #6–7 if a goal was set for the patient:</i></p> <ol style="list-style-type: none"> 1. Education Topic/Diagnosis 2. Readiness to Learn 3. Level of Understanding (see below) 4. Initials of Who Taught 5. Time spent (in minutes) 6. Goal Not Set, Goal Set, Goal Met, Goal Not Met 7. Text relating to the goal or its status <p>Readiness to Learn:</p> <ul style="list-style-type: none"> • Distraction • Eager To Learn • Intoxication • Not Ready • Pain • Receptive • Severity of Illness • Unreceptive <p>Levels of Understanding:</p> <ul style="list-style-type: none"> • P–Poor • F–Fair • G–Good • GR–Group-No Assessment • R–Refused <p>Goal Codes:</p> <ul style="list-style-type: none"> • GS–Goal Set • GM–Goal Met • GNM–Goal Not Met • GNS–Goal Not Set | <p>Patient Education Topic Patient Education Entry (includes historical patient education) Topic: [Enter Topic] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider: Length of Education (minutes): Comment: Goal Code: GS, GM, GNM, GNS Goal Comment:</p> <p>Patient Education Diagnosis Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: Category: [Enter Category] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider: Length of Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider’s Narrative:</p> |

Key Clinical Performance Objectives

| Performance Measure | Standard | Provider Documentation | How to Enter Data in EHR |
|---|----------|---|--------------------------|
| Patient Education Measures (Patient Education Report) (cont.) | | Diagnosis Categories: <ul style="list-style-type: none"> • 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 | |

Enter Information in EHR

This section contains general instructions on how to enter the following information in EHR:

- [Clinic Codes](#): Page 55.
- [Purpose of Visit/Diagnosis](#): Page 56.
- [CPT Codes](#): Page 60.
- [Procedure Codes](#): Page 67.
- [Exams](#): Page 71.
- [Health Factors](#): Page 75.
- [Immunizations](#): Page 78, including [contraindications](#): Page 81.
- [Vital Measurements](#): Page 85.
- [Lab Tests](#): Page 91.
- [Medications](#): Page 96.
- [Infant Feeding](#): Page 100.
- [Patient Education](#): Page 102.
- [Refusals](#): Page 109.

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.

Note: EHR is highly configurable, so components may be found on tabs other than those listed here. Tabs may also be named differently.

Key Clinical Performance Objectives

Clinic Codes

Clinic codes are chosen when a visit is created.

The screenshot shows a software window 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. The code "17 OPHTHALMOLOGY" is selected and highlighted, and a red circle is drawn around this selection. Other codes in the list include 11 HOME CARE, 12 IMMUNIZATION, 13 INTERNAL MEDICINE, 14 MENTAL HEALTH, 16 OBSTETRICS, and 18 OPTOMETRY. To the right of the dropdown, 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" which is unchecked. Below the "Visit Location" section, there is a section for "Encounter Providers" with a list of provider names: POWERS,MEGAN (selected), REGA,ANN, RICHARDS,SUSAN P, ROBARDS,DARLENE G, ROZSNYAI,DUANE, and SALMON,PHILLIP. At the bottom of the window are "OK" and "Cancel" buttons.

Figure 1: Choosing a clinic code

Key Clinical Performance Objectives

Purpose of Visit/Diagnosis

The purpose of visit (POV) is entered in the **Visit Diagnosis** component, located on the **Prob/POV** tab (Figure 2).

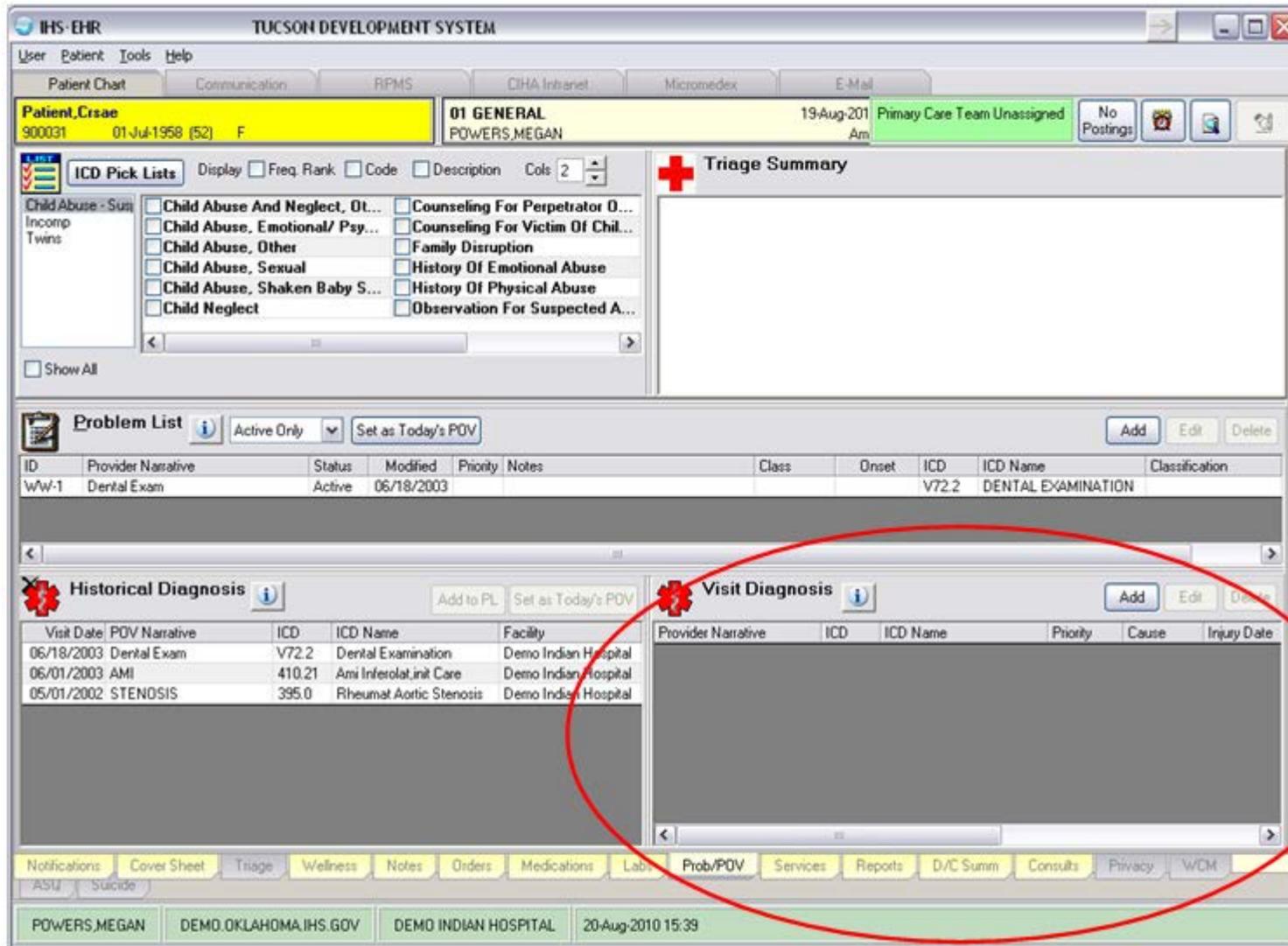


Figure 2: Visit Diagnosis component

Key Clinical Performance Objectives

To enter a POV:



Figure 3: Entering a POV

1. Click **Add** in the **Visit Diagnosis** component. The **Add POV for Current Visit** dialog (Figure 4) displays.



Figure 4: Add POV for Current Visit dialog

Key Clinical Performance Objectives

2. Type the **ICD** code and click the ellipses (...) button. The **Diagnosis Lookup** dialog (Figure 5) displays.

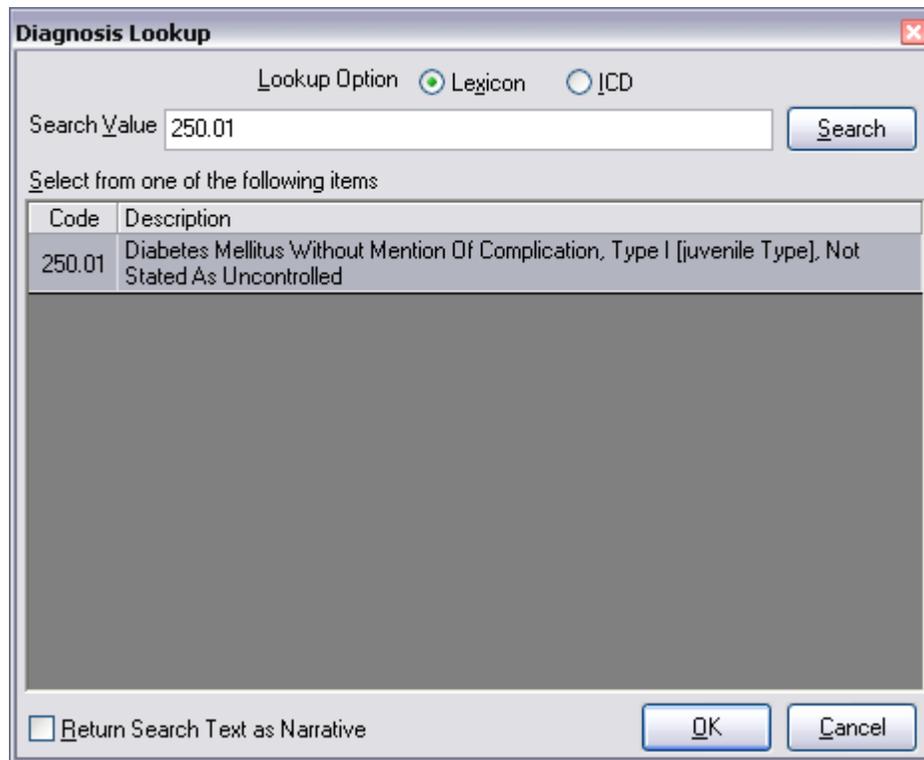


Figure 5: Entering the ICD code

Key Clinical Performance Objectives

- Click to highlight the ICD to find and click **OK**. The **Add POV for Current Visit** dialog (Figure 6) displays.

Figure 6: Entering additional POV information

- Enter any other pertinent information and click **Save**. The newly added POV should display in the **Visit Diagnosis** component (Figure 7).

| 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 UNCTRL | Primary | | | | | |

Figure 7: Example of a newly added POV

Key Clinical Performance Objectives

CPT Codes

CPT codes are entered in the **Visit Services** component, located on the **Services** tab (Figure 8).

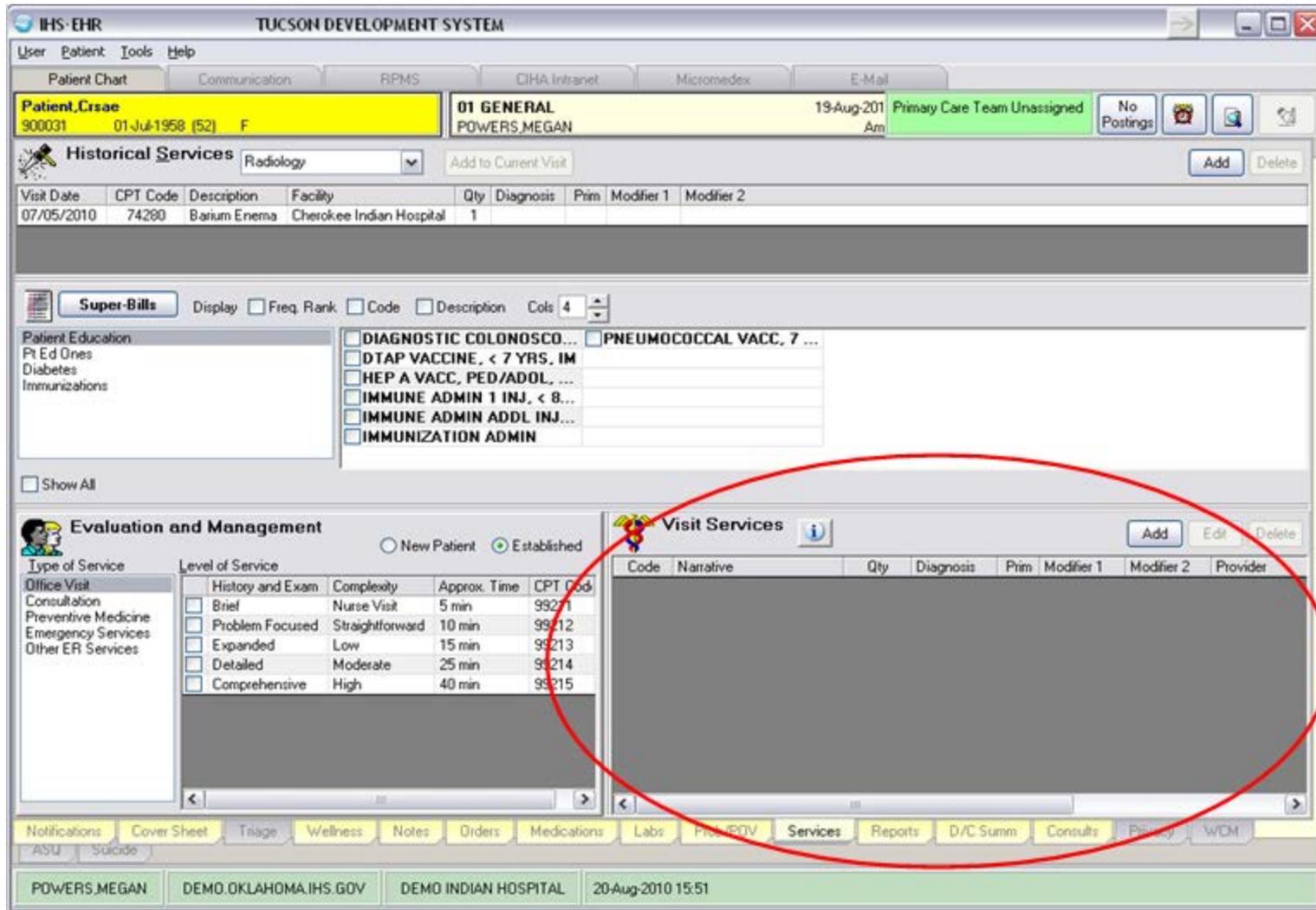


Figure 8: Visit Services component

Key Clinical Performance Objectives

To enter a CPT code:

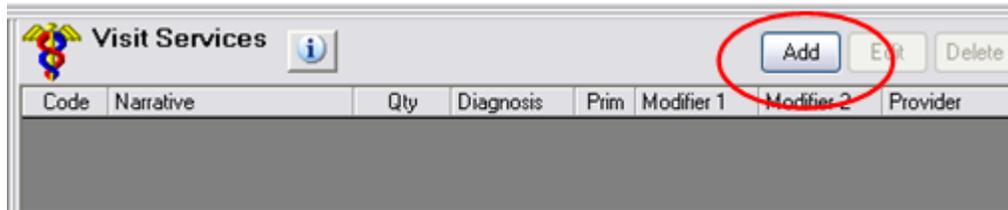


Figure 9: Entering a CPT code

1. Click the **Add** button in the **Visit Services** component. The **Add Procedure for Current Visit** dialog (Figure 10) displays.

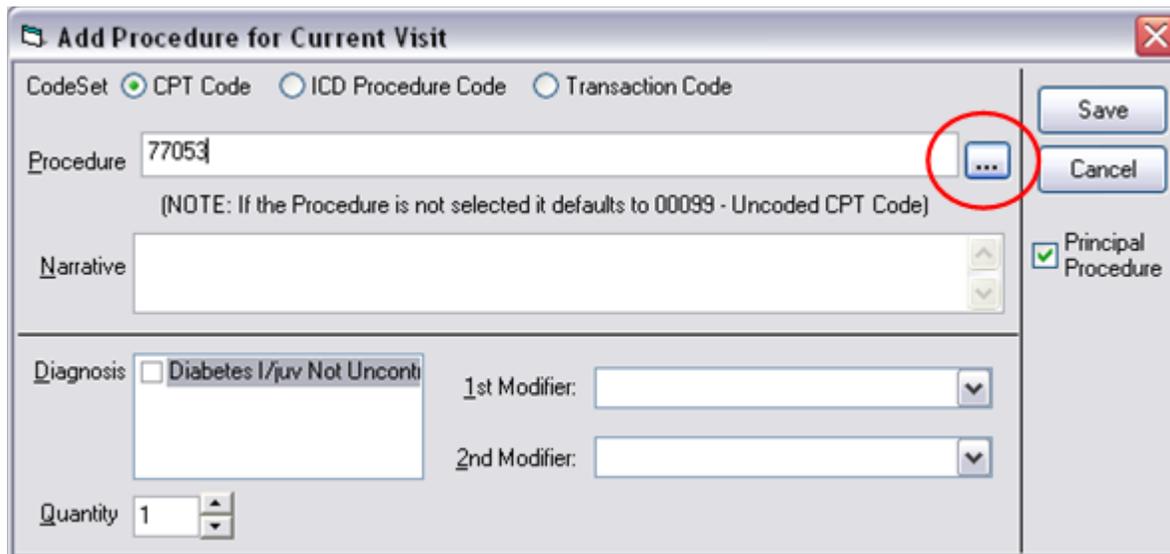


Figure 10: Entering the CPT code

2. In the **Procedure** field, type the CPT code and click the ellipses (...) button. The **Procedure Lookup** dialog (Figure 11) displays.

Key Clinical Performance Objectives

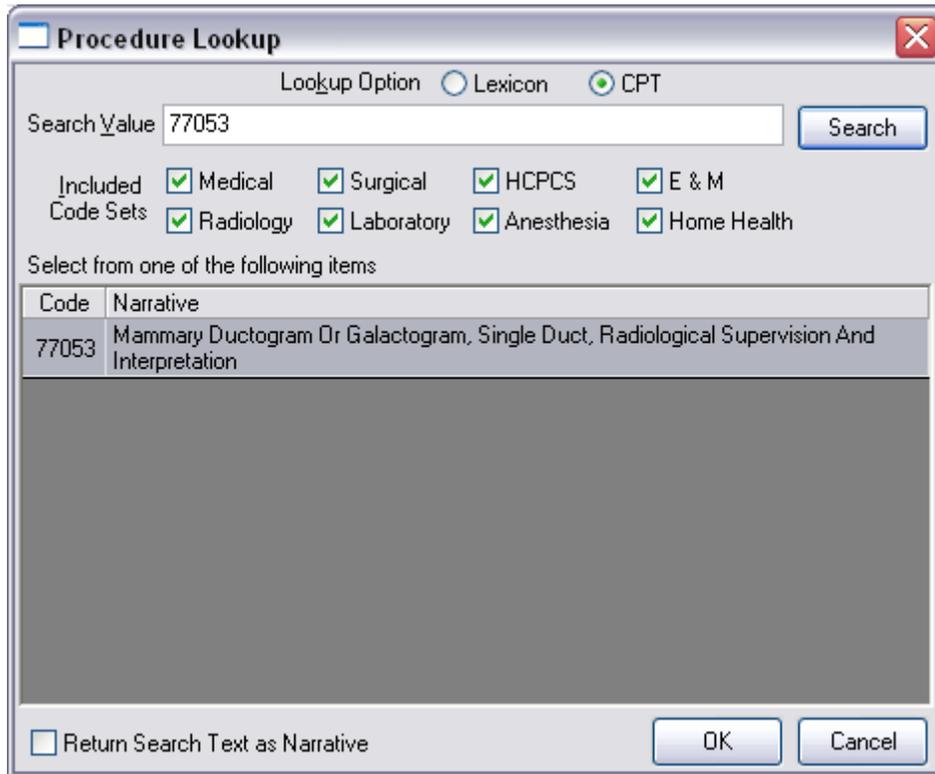


Figure 11: **Procedure Lookup** dialog

3. Click to select the CPT to enter and click **OK**. The Add Procedure for Current Visit dialog (Figure 12) displays. If you cannot find the CPT code, try the following:
 - a. Ensure that **CPT** is chosen in the **Lookup Option**.
 - b. Select additional **Included Code Sets**.

Key Clinical Performance Objectives

Add Procedure for Current Visit

CodeSet CPT Code ICD Procedure Code Transaction Code

Procedure: Mammary Ductogram Or Galactogram, Single Duct, Radiological Supervision And Inter

(NOTE: If the Procedure is not selected it defaults to 00099 - Uncoded CPT Code)

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

Diagnosis: Diabetes I/juv Not Unconti

1st Modifier: []

2nd Modifier: []

Quantity: 1

Principal Procedure

Save Cancel

Figure 12: Entering additional Procedure information

4. Enter any other pertinent information and click **Save**. The newly added CPT code should display in the **Visit Services** component (Figure 13).

| 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 |

Figure 13: Example of a newly added CPT code

Key Clinical Performance Objectives

Historical CPT codes are entered in the **Historical Services** component, located on the **Services** tab (Figure 14).

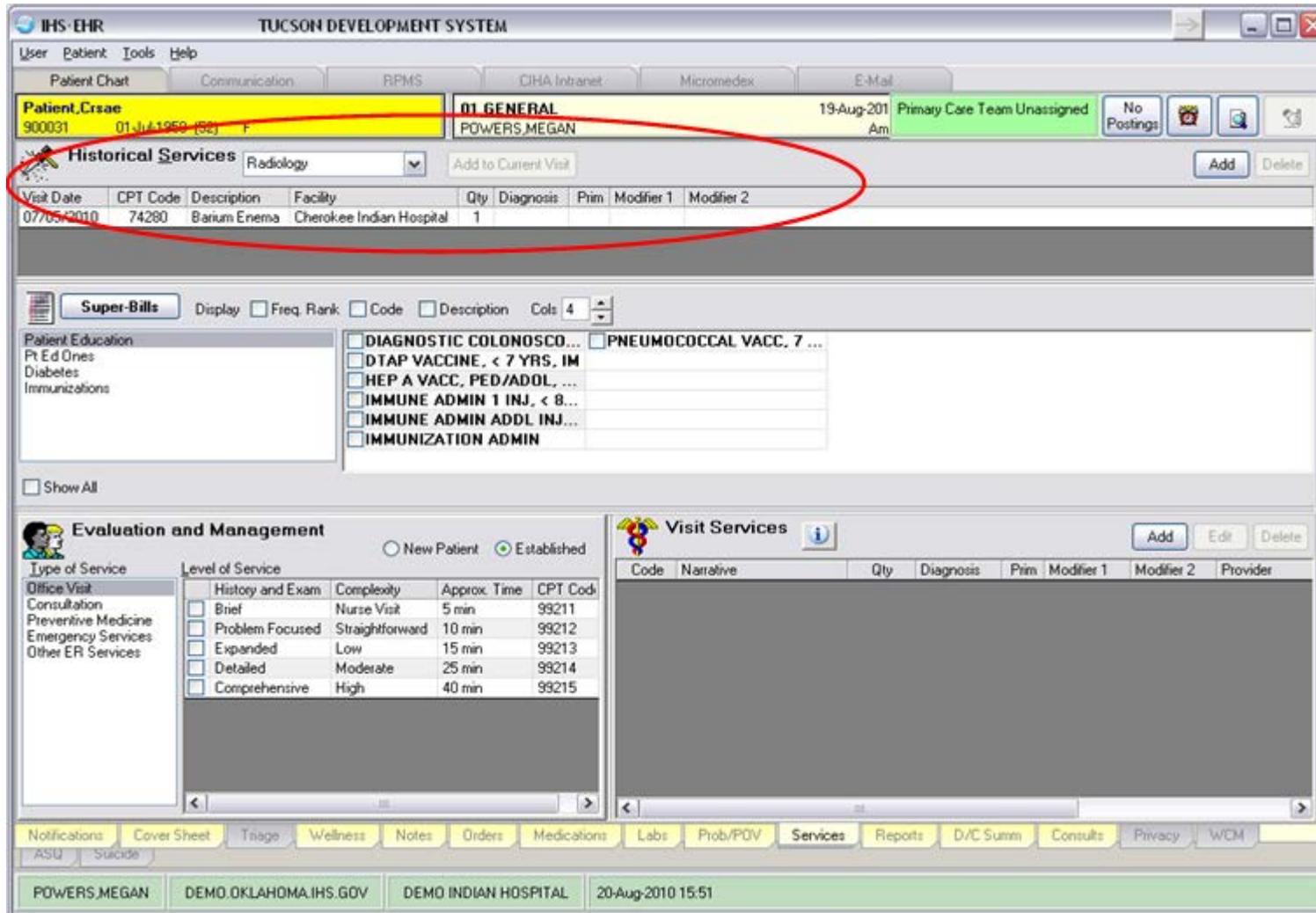


Figure 14: **Historical Services** component

Key Clinical Performance Objectives

To enter a CPT code:

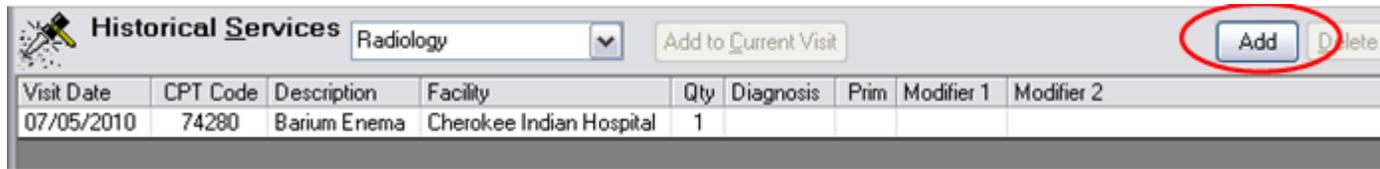


Figure 15: Example of entering a CPT code

1. Click **Add** in the **Visit Services** component. The **Add Historical Service** dialog (Figure 16) displays.
2. Do one of the following:

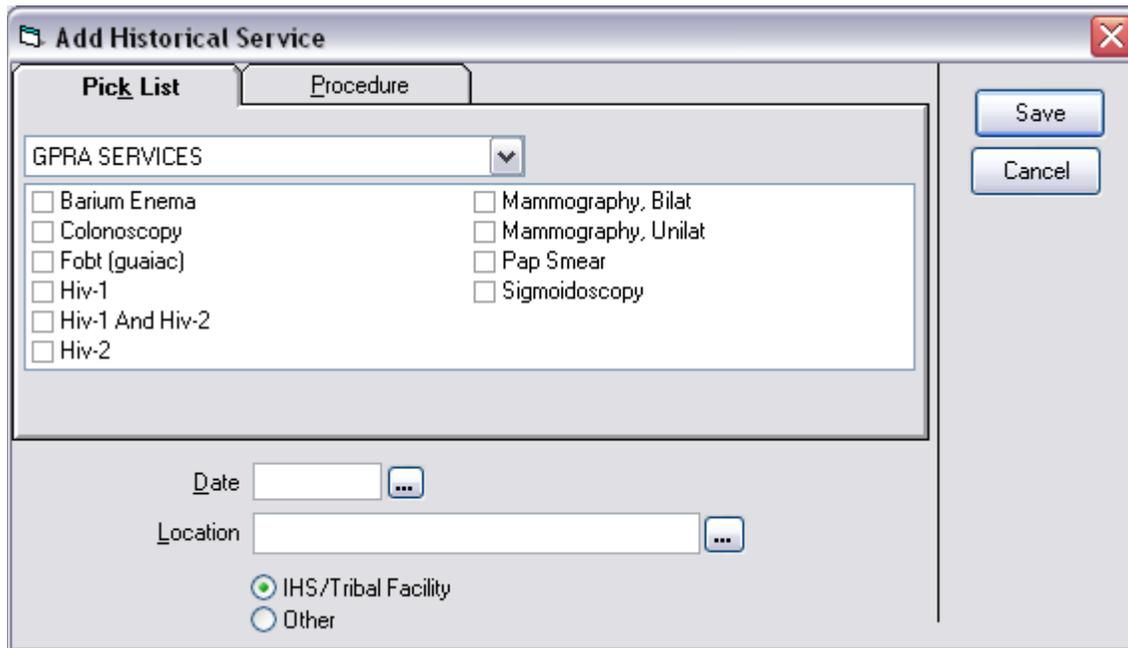


Figure 16: Adding a historical service using the **Pick List**

- At the **Pick List** tab (Figure 16), choose a service and select a procedure:

Key Clinical Performance Objectives

The screenshot shows a dialog box titled "Add Historical Service" with a close button (X) in the top right corner. It has two tabs: "Pick List" and "Procedure". The "Procedure" tab is active. Inside the "Procedure" tab, there is a "Procedure" text field with a dropdown arrow and a note: "(NOTE: If the Procedure is not selected it defaults to 00099 - Uncoded CPT Code)". Below this is a "Narrative" text area with scrollbars. There are two dropdown menus for "1st Modifier" and "2nd Modifier". A "Quantity" spinner is set to "1". At the bottom, there are "Date" and "Location" text fields with dropdown arrows. Below these are two radio buttons: "IHS/Tribal Facility" (selected) and "Other". To the right of the dialog are "Save" and "Cancel" buttons.

Figure 17: Adding a historical service by **Procedure**

- At the **Procedure** tab in the **Procedure** field (Figure 17), type the CPT code and proceed as in Steps 2-3 starting on Page 61.
3. Type the **Date** and **Location** of the service.
 4. Click **Save**. The newly added CPT code should display in the **Historical Services** component (Figure 18).

The screenshot shows the "Historical Services" component. At the top, there is a dropdown menu set to "Radiology", an "Add to Current Visit" button, and "Add" and "Delete" buttons. Below 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 | | | | |

Figure 18: Example of a newly added Historical Service

Key Clinical Performance Objectives

Procedure Codes

Procedure codes are entered in the **Visit Services** component, located on the **Services** tab (Figure 19).

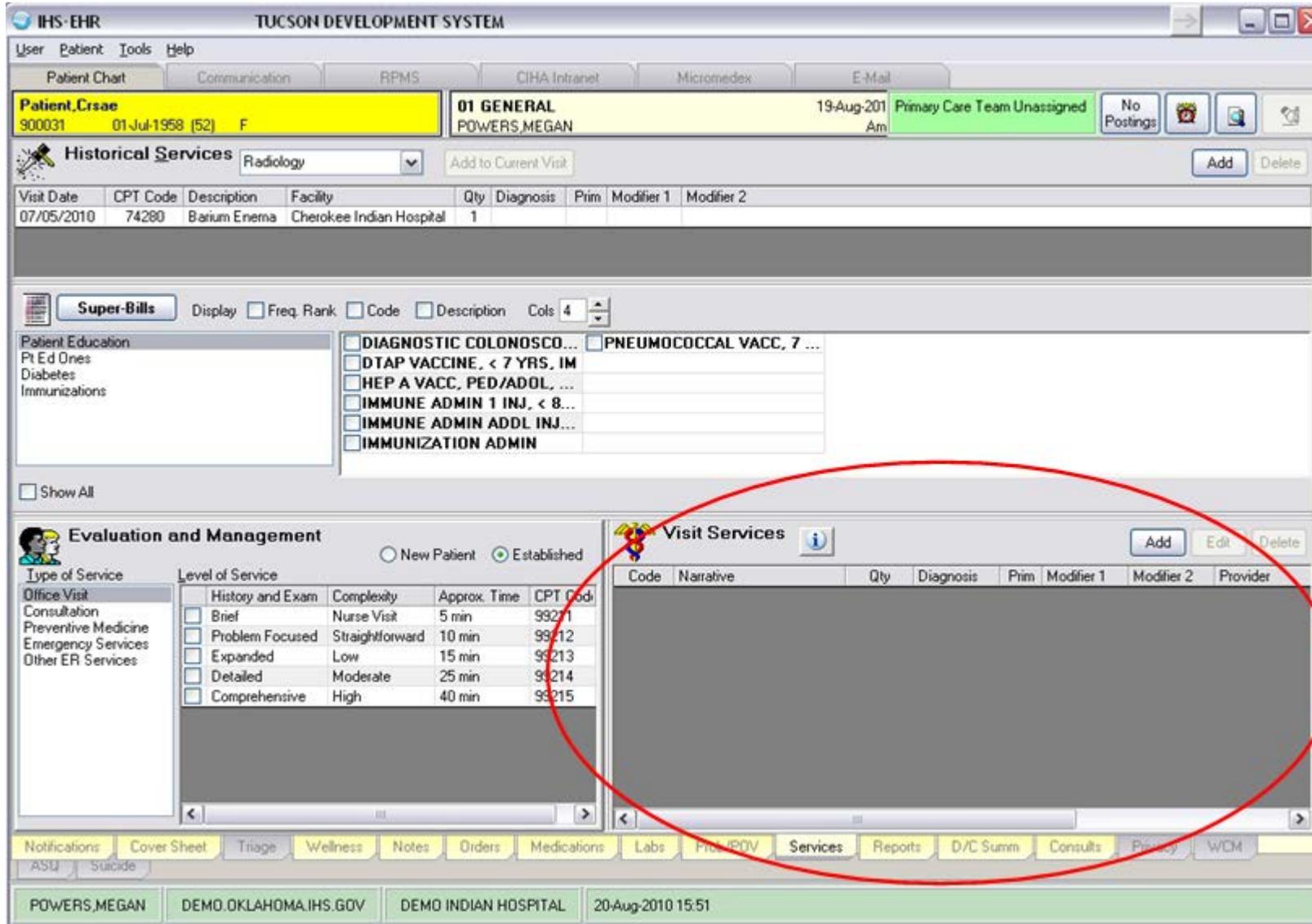


Figure 19: Visit Services component

Key Clinical Performance Objectives

To enter a Procedure code:



Figure 20: Entering a Procedure code

1. Click **Add** in the **Visit Services** component. The **Add Procedure for Current Visit** dialog (Figure 21) displays.

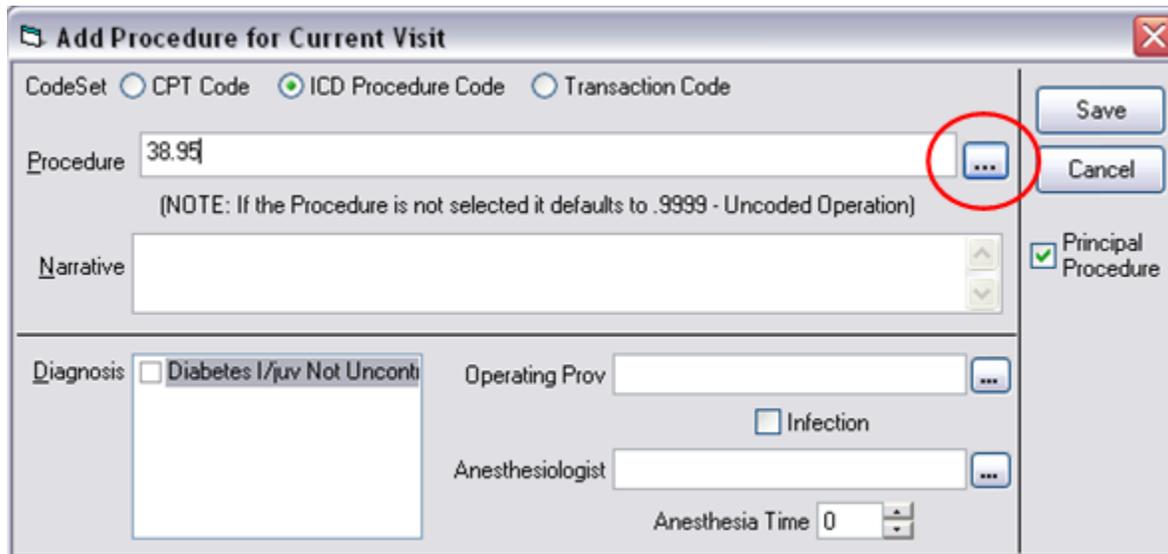


Figure 21: **Add Procedure for Current Visit** dialog

2. Ensure that the **CodeSet** value is set to **ICD Procedure Code**.
3. Type the **Procedure** code and click the ellipsis (...) button. The **Lookup ICD Procedure** dialog (Figure 22) displays.

Key Clinical Performance Objectives

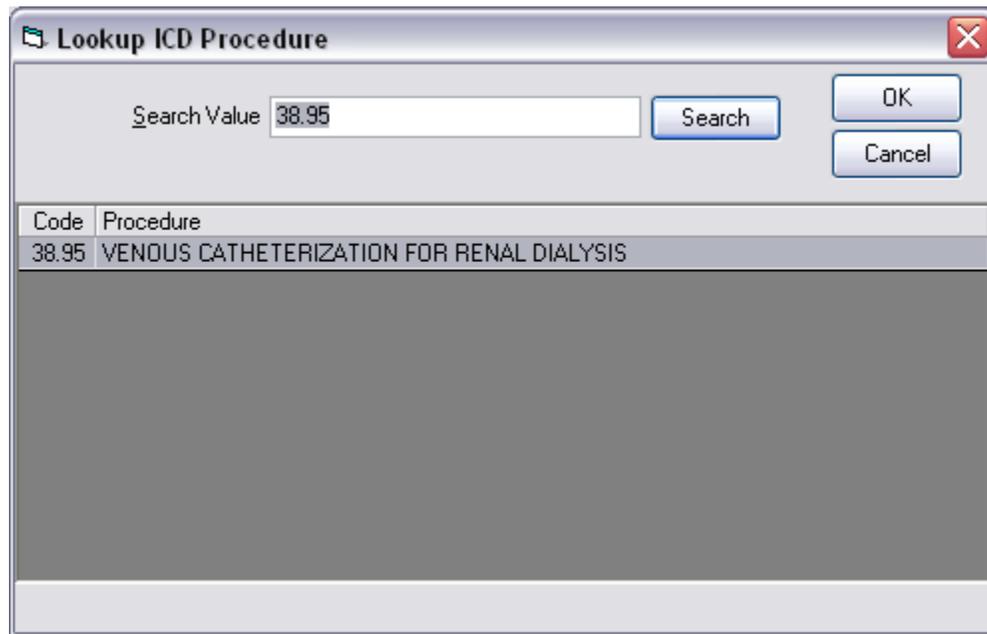


Figure 22: Choosing a Procedure

4. Click to select the **Procedure**.
5. Click **OK** to return to the **Add Procedure for Current Visit** dialog (Figure 23).

Key Clinical Performance Objectives

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

Principal Procedure

Diagnosis: Diabetes I/juv Not Unconti

Operating Prov: _____

Infection

Anesthesiologist: _____

Anesthesia Time: 0

Figure 23: Entering additional Procedure information

- Type any other pertinent information and click **Save**. The newly added CPT code should appear in the **Visit Services** component (Figure 24).

| 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 |

Figure 24: Example of a newly added Procedure code

Key Clinical Performance Objectives

Exams

Exam codes are entered in the **Exams** component, located on the **Wellness** tab (Figure 25).

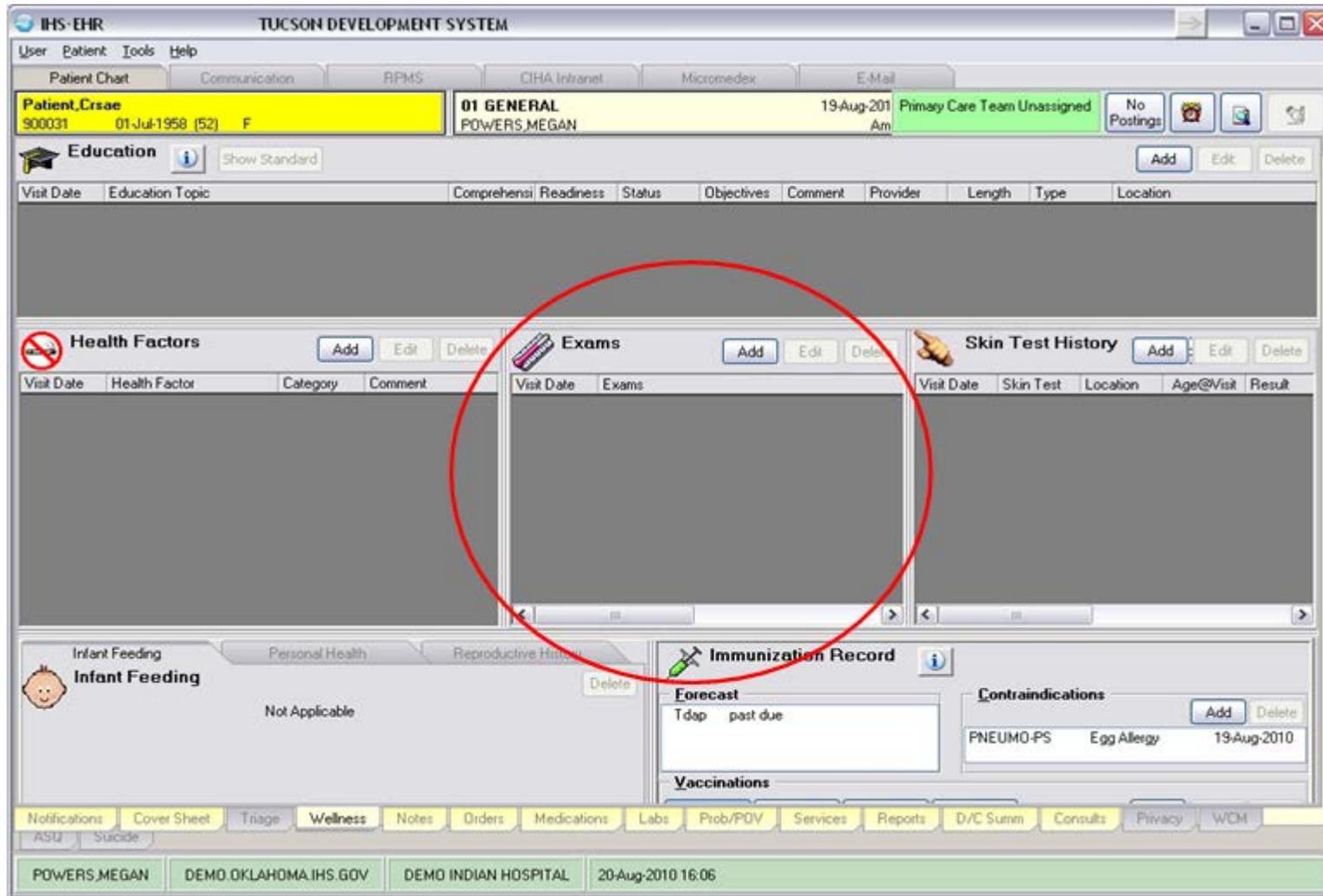


Figure 25: Exams component

Key Clinical Performance Objectives

To enter an Exam code:

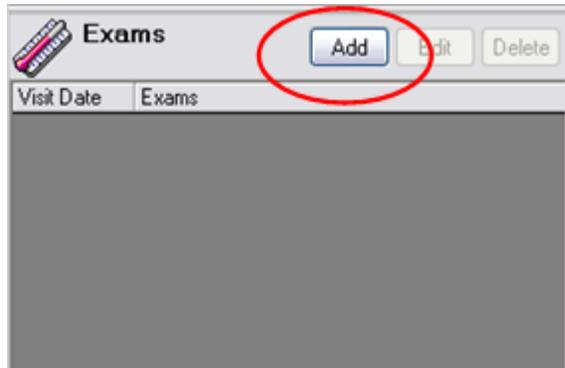


Figure 26: Entering an Exam code

1. Click **Add** in the **Exams** component. The **Exam Selection** dialog (Figure 27) displays.

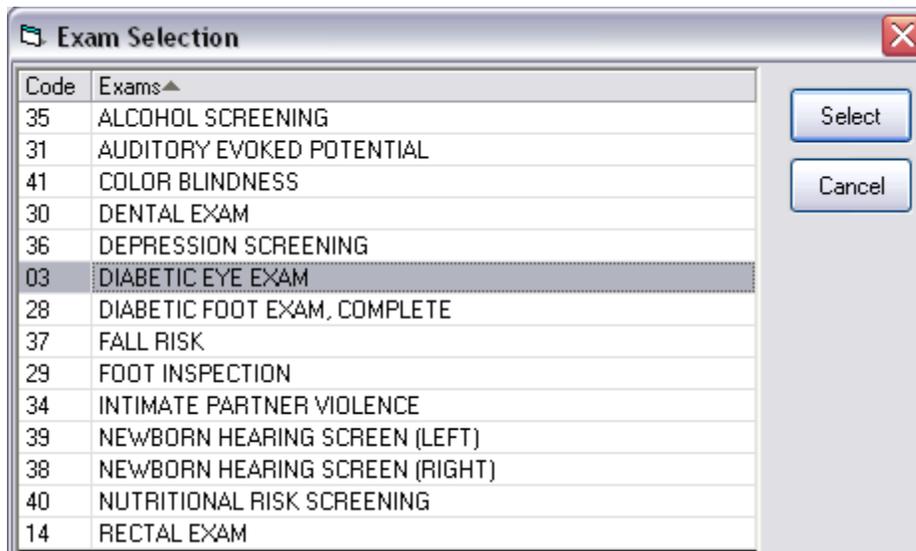
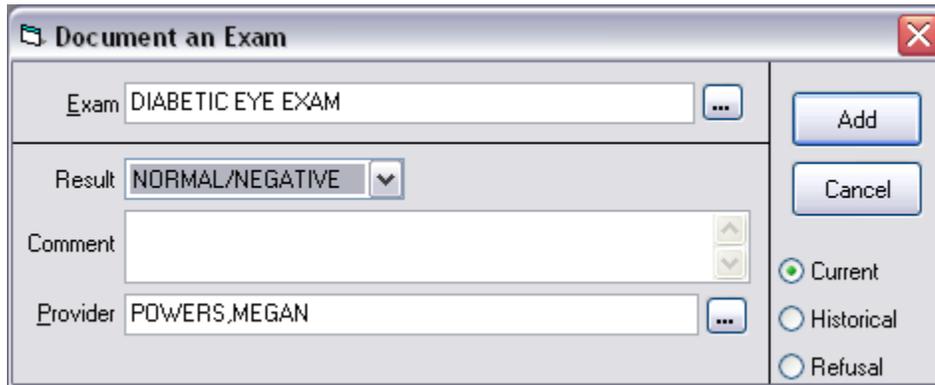


Figure 27: Selecting an exam

2. Click to highlight the **Exam** and click **Select**. The **Document an Exam** dialog (Figure 28) displays.

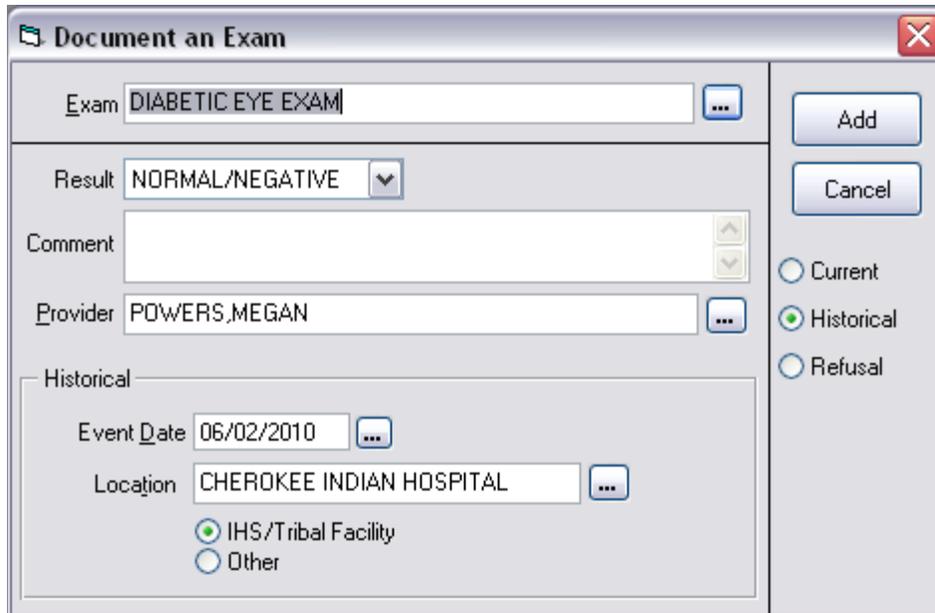
Key Clinical Performance Objectives



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 an empty 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".

Figure 28: Entering a result and additional comments

3. Type the **Result** and any **Comments**.

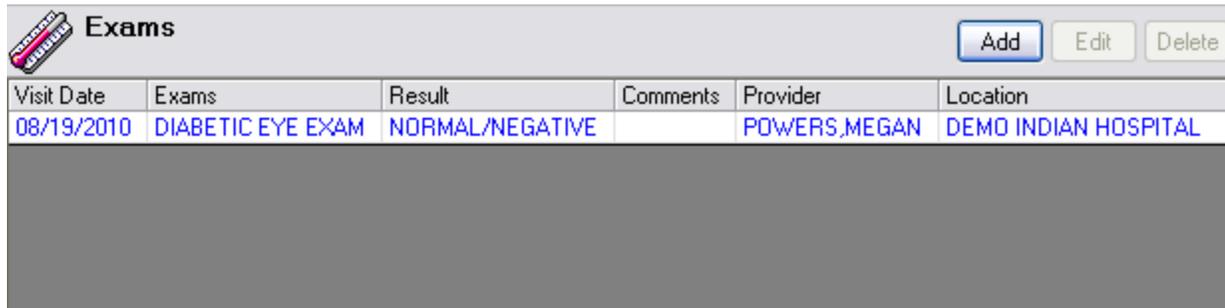


The screenshot shows the same "Document an Exam" dialog box. The "Exam" field is "DIABETIC EYE EXAM", "Result" is "NORMAL/NEGATIVE", and "Provider" is "POWERS,MEGAN". The "Historical" section is expanded, showing "Event Date" as "06/02/2010" and "Location" as "CHEROKEE INDIAN HOSPITAL". Below the location field are two radio buttons: "IHS/Tribal Facility" (which is selected) and "Other". The "Current" radio button is now unselected, and the "Historical" radio button is selected. The "Add" and "Cancel" buttons are still present.

Figure 29: Entering a historical exam

4. If this is a historical exam, select **Historical** and type the **Date** and **Location** of the exam (Figure 29).
5. Click **Save**. The newly added Exam code should appear in the **Exams** component (Figure 30).

Key Clinical Performance Objectives



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

Figure 30: Example of a newly added Exam

Key Clinical Performance Objectives

Health Factors

Health Factors are entered in the **Health Factors** component, located on the **Wellness** tab (Figure 31).

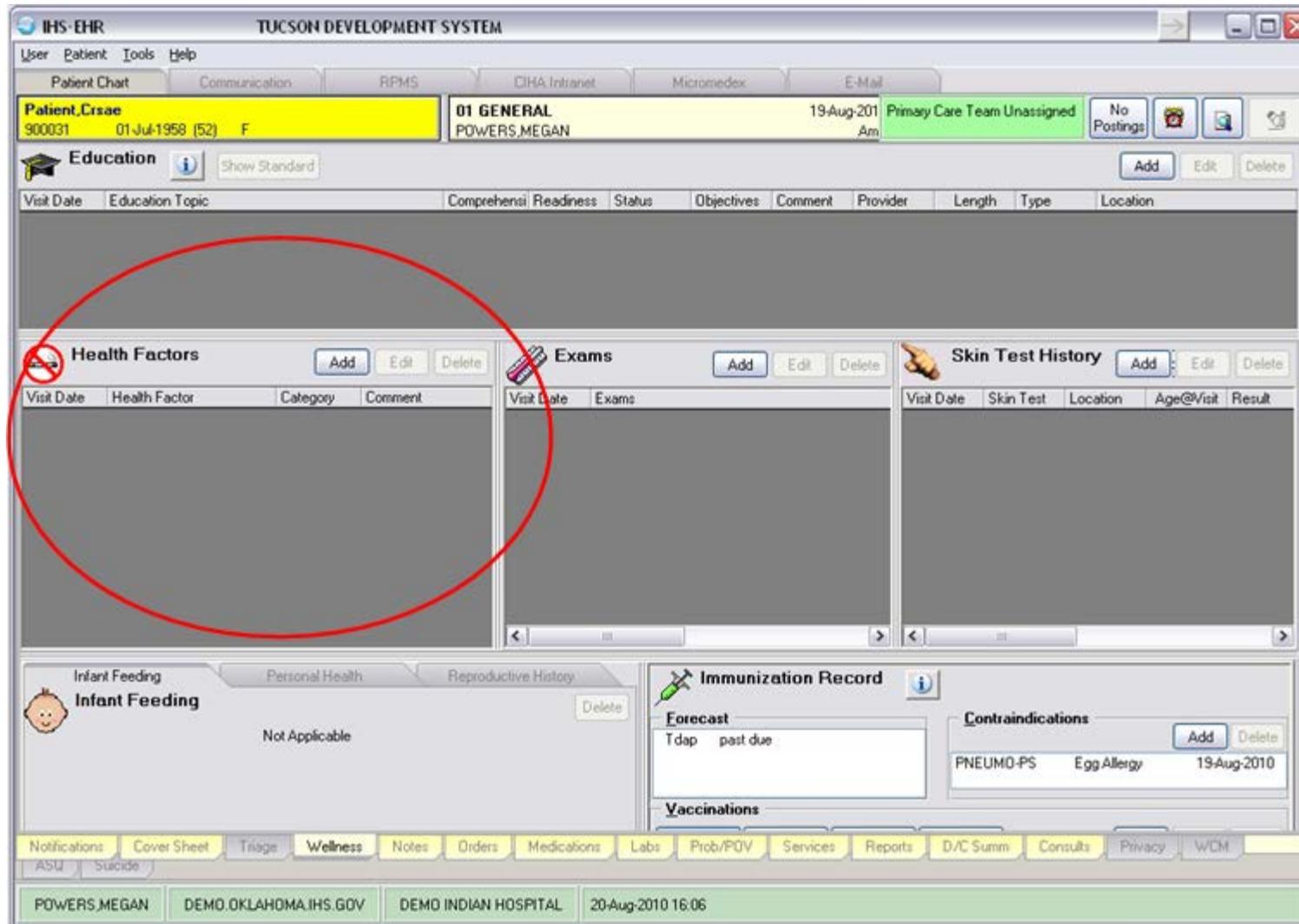


Figure 31: Health Factors component

Key Clinical Performance Objectives

To enter a Health Factor:



Figure 32: Entering a Health Factor

1. Click **Add** in the **Health Factors** component. The **Add Health Factor** dialog (Figure 33) displays.

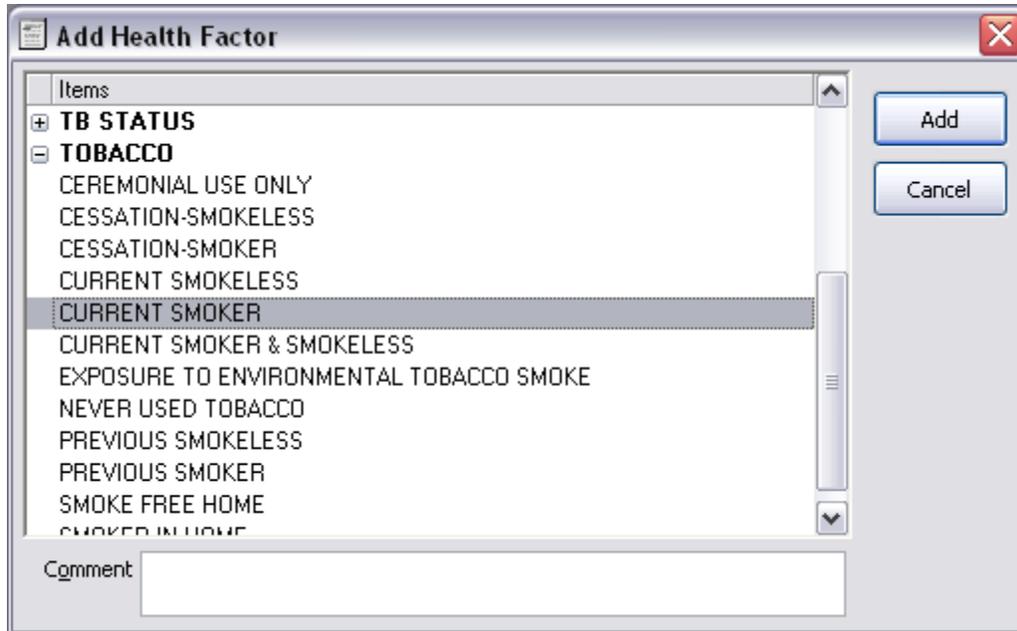
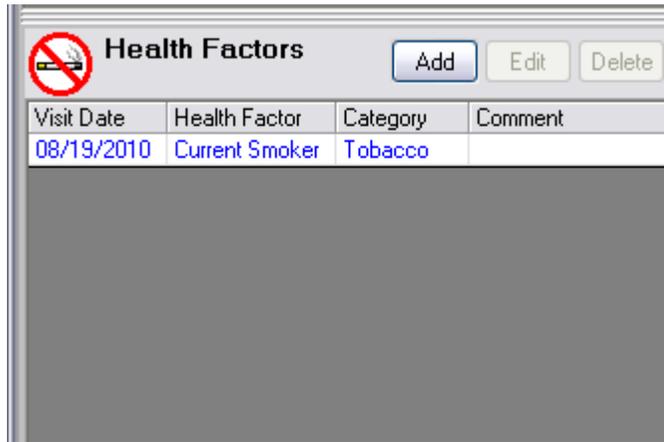


Figure 33: Choosing a Health Factor

2. Choose the **Health Factor** to enter and click **Add**. The newly added **Health Factor** should appear in the **Health Factors** component (Figure 34).

Key Clinical Performance Objectives



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

Figure 34: Example of a newly added **Health Factor**

Key Clinical Performance Objectives

Immunizations

Immunizations are entered in the **Immunization Record** component, located on the **Wellness** tab (Figure 35).

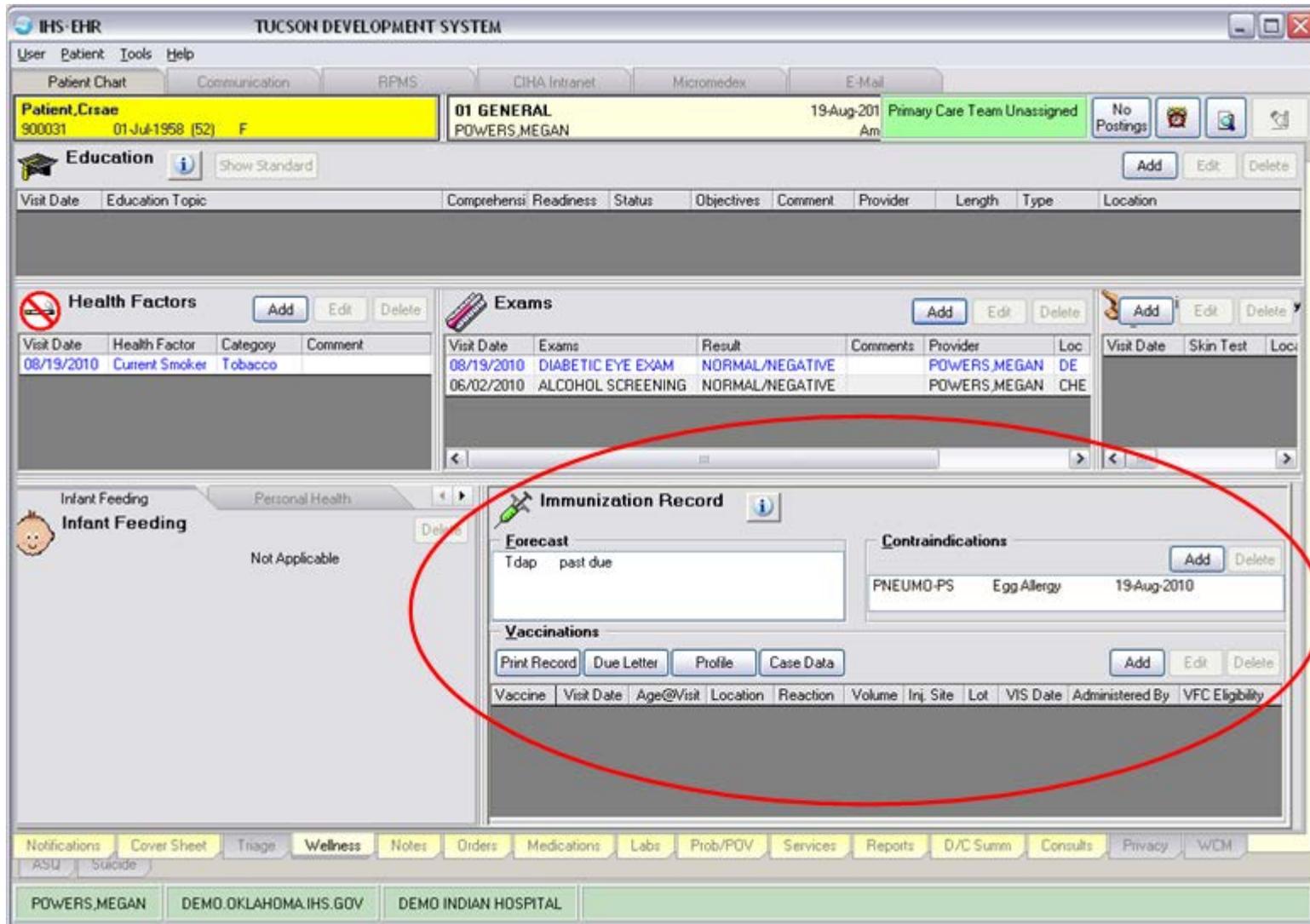


Figure 35: Immunization Record component

Key Clinical Performance Objectives

To enter an Immunization:

The screenshot shows the 'Immunization Record' window. It has several sections: 'Forecast' with a text box containing 'Tdap past due'; 'Contraindications' with a table containing one row: 'PNEUMO-PS', 'Egg Allergy', and '19-Aug-2010'. Below these are 'Print Record', 'Due Letter', 'Profile', and 'Case Data' buttons. The 'Vaccinations' section contains 'Add', 'Edit', and 'Delete' buttons, with the 'Add' button 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.

Figure 36: Entering an Immunization

1. Click **Add** in the **Vaccinations** section of the **Immunization Record** component. The **Vaccine Selection** dialog (Figure 37) displays.

The 'Vaccine Selection' dialog box has a search criteria section with a magnifying glass icon, a text box containing 'influ', and a 'Search' button. There are 'OK' and 'Cancel' buttons. Below the search section are two radio buttons: 'Show All Active Vaccines' (selected) and 'Show Only active Vaccines with a Lot Number'. A section titled 'Select one of the following Records' contains a table with two columns: 'Immunization' and 'Description'. The table lists various influenza and Japanese Encephalitis vaccines. The row 'INFLUENZA, SPLIT (INCL. PURIFIED)' is highlighted.

| Immunization | Description |
|-----------------------------------|--|
| INFLUENZA, H5N1 | Influenza virus vaccine, H5N1, A/Vietnam/120 |
| INFLUENZA, HIGH DOSE SEASONAL | INFLUENZA, HIGH DOSE SEASONAL, PRESI |
| INFLUENZA, INTRANASAL | Influenza virus vaccine, live, attenuated, for intr |
| INFLUENZA, NOS | Influenza virus vaccine, NOS |
| INFLUENZA, SPLIT (INCL. PURIFIED) | Influenza virus vaccine, split virus (incl. Purified |
| INFLUENZA, WHOLE | Influenza virus vaccine, whole virus |
| IPV | Poliovirus vaccine, inactivated |
| JAPANESE ENCEPHALITIS | Japanese Encephalitis virus vaccine |
| Japanese Encephalitis-IM | Japanese Encephalitis vaccine for intramuscula |

Figure 37: Choosing the Immunization

2. Highlight the chosen **Immunization** and click **OK**. The **Add Immunization** dialog (Figure 38) displays.

Key Clinical Performance Objectives

Add Immunization

Vaccine: INFLUENZA, SPLIT (INCL. PURIFIED)

Administered By: POWERS, MEGAN

Lot: U1293AA

Injection Site: Intranasal

Volume: .5 ml

Vac. Info. Sheet: 08/11/2009

Given: 08/20/2010 4:30 PM

Patient/Family Counseled by Provider

Current
 Historical
 Refusal

OK
Cancel

Figure 38: Entering additional immunization information

3. Type any other pertinent information and click **OK**.

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

Figure 39: Entering a historical immunization

4. If this is a historical immunization, select **Historical** and enter the **Date** and **Location** of the immunization. The newly added Immunization should appear in the **Immunization Record** component (Figure 40).

Key Clinical Performance Objectives

The screenshot shows the 'Immunization Record' interface. It includes a 'Forecast' section with 'Tdap past due', a 'Contraindications' section with one entry: 'PNEUMO-PS Egg Allergy 19-Aug-2010', and a 'Vaccinations' section with a table of immunizations. The table has columns for Vaccine, Visit Date, Age@Visit, Location, Reaction, Volume, Inj. Site, Lot, VIS Date, and Administered By. The first row shows 'FLU-TIV' administered on '08/19/2010' to a '52 yrs' old patient at 'DEMO INDIAN HOSPITAL' with a volume of '.5' and lot 'U1293AA' by 'POWERS,MEGAN'.

| 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 |

Figure 40: Example of a newly added Immunization

To enter a contraindication for an immunization:

This screenshot is similar to Figure 40 but highlights the 'Add' button in the 'Contraindications' section with a red circle, indicating the step to add a new contraindication.

Figure 41: Entering a contraindication

1. Click **Add** in the **Contraindications** section of the **Immunization Record** component. The Enter Patient Contraindication dialog (Figure 42) displays.

Key Clinical Performance Objectives

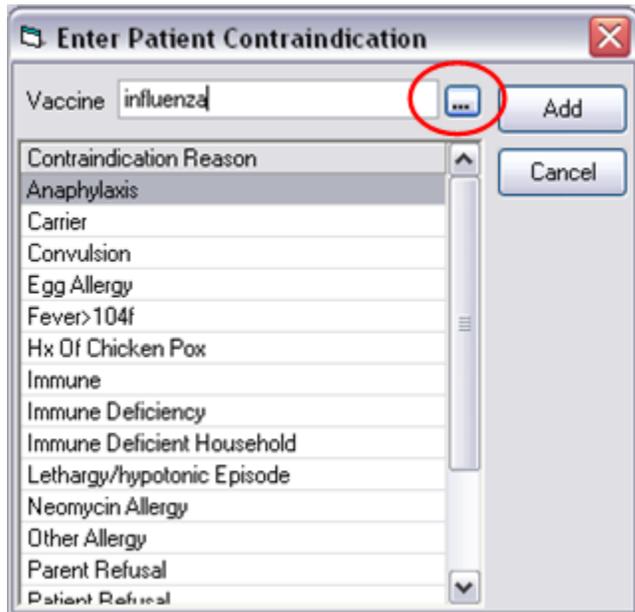


Figure 42: Choosing a contraindication

2. Choose the **Contraindication Reason** and type the **Vaccine** name.
3. Click the ellipsis (...) button. The **Vaccine Selection** dialog (Figure 43) displays.

Key Clinical Performance Objectives

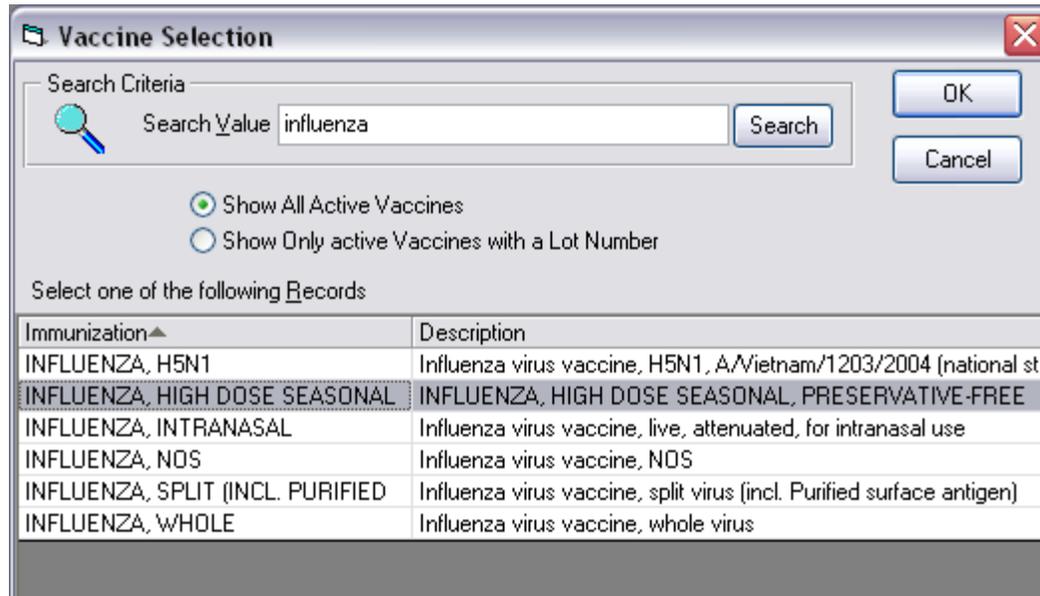


Figure 43: Selecting the immunization

- Click to highlight the **Immunization** and click **OK**. The **Enter Patient Contraindication** dialog (Figure 44) displays.

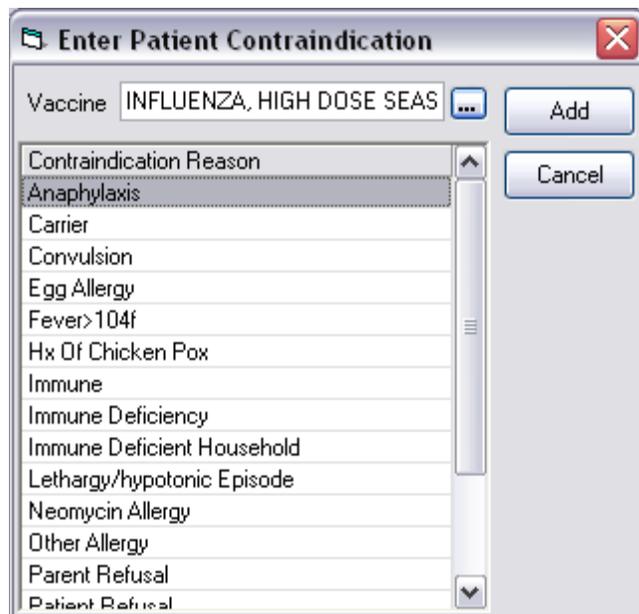
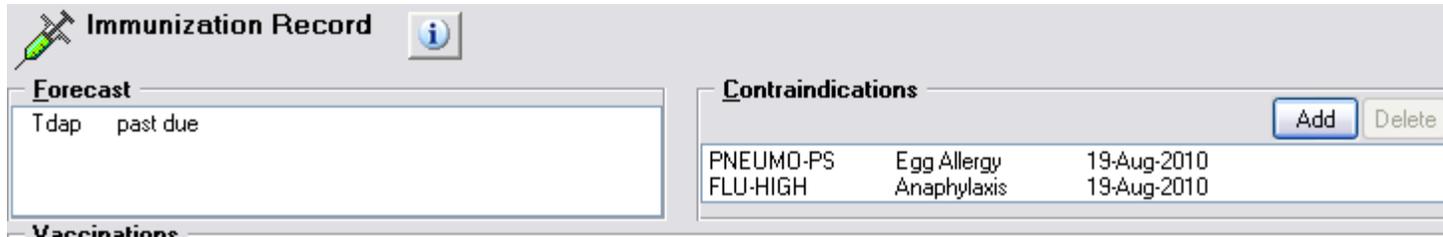


Figure 44: **Enter Patient Contraindication** dialog

Key Clinical Performance Objectives

5. Click **Add**. The newly added contraindication should appear in the **Immunization Record** component (Figure 45).



The screenshot shows the 'Immunization Record' interface. It features a syringe icon and an information icon. The 'Forecast' section contains the text 'Tdap past due'. The 'Contraindications' section includes an 'Add' button and a 'Delete' button. Below these buttons is a table with two rows of data.

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

Figure 45: Example of a newly added contraindication

Key Clinical Performance Objectives

Vital Measurements

Vital Measurements are entered in the **Vitals** component, located on the **Triage** tab (Figure 46).

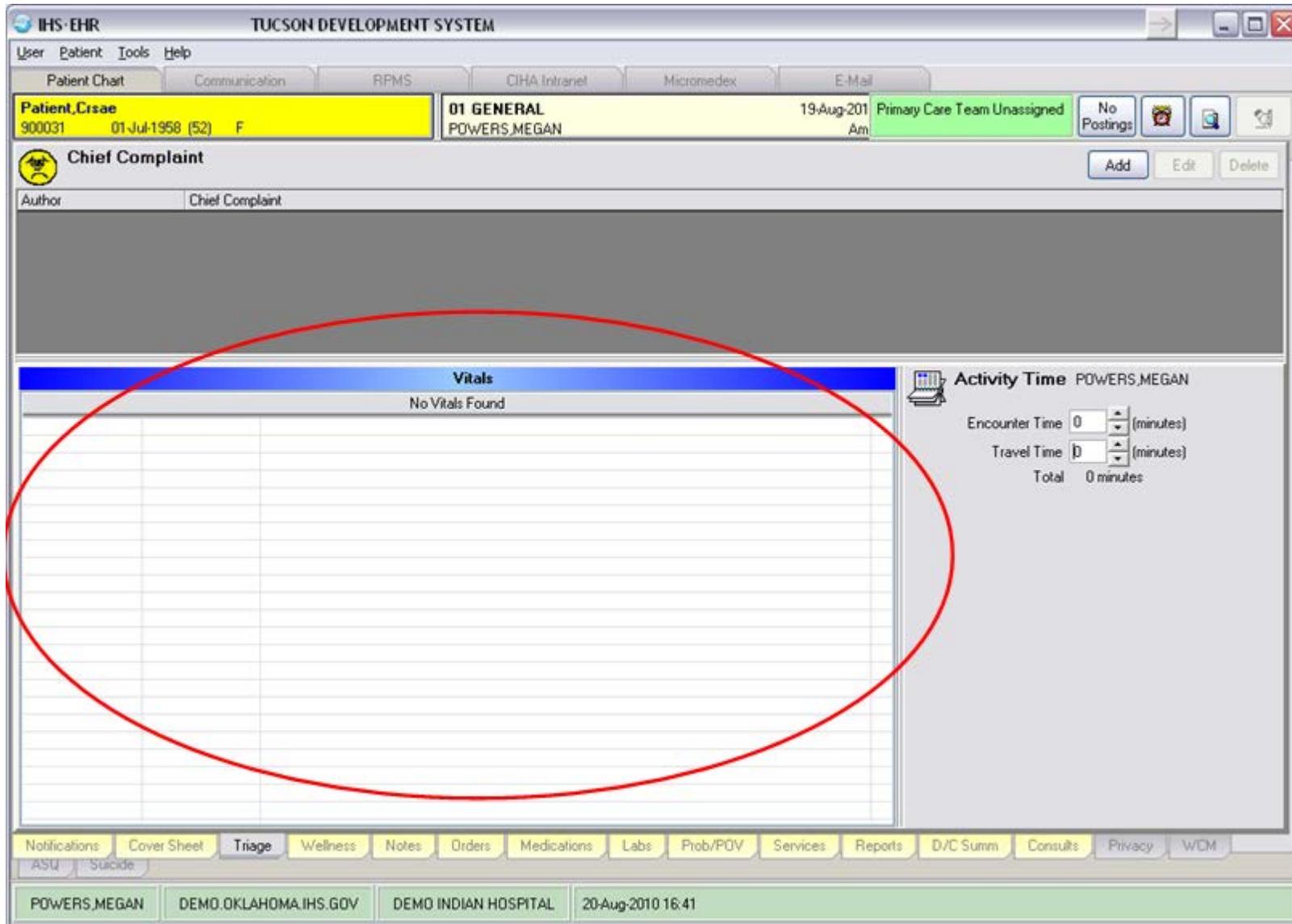


Figure 46: **Vitals** component

Key Clinical Performance Objectives

To enter Vital Measurements:

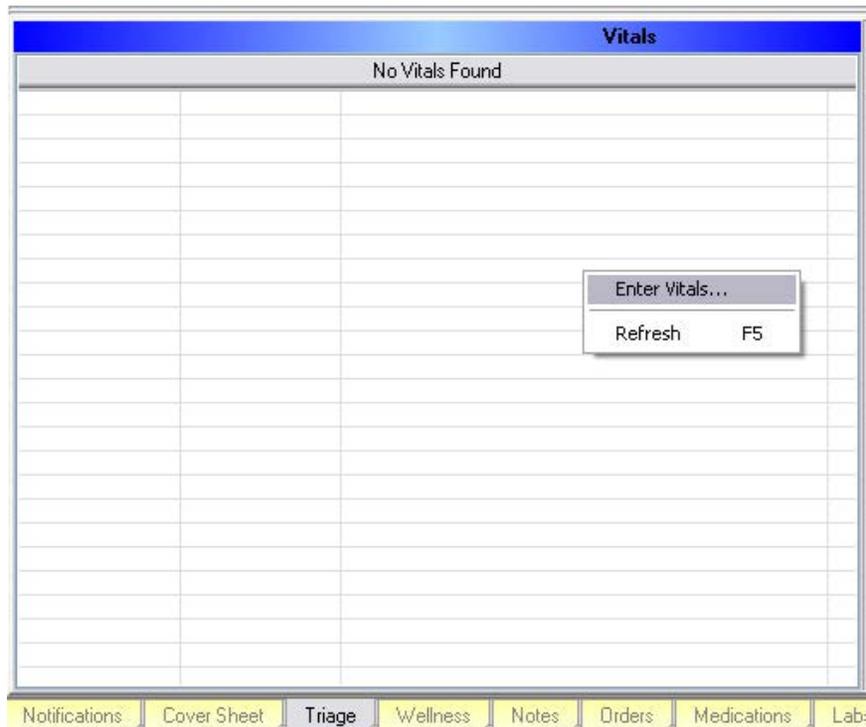


Figure 47: Entering a Vital Measurement

1. Right-click in the **Vitals** component and select **Enter Vitals** from the menu. The **Vital Measurement Entry** dialog (Figure 48) displays.

Key Clinical Performance Objectives

| | 20-Aug-2010 16:45 | 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 | | | |

Figure 48: Entering an historical vital

2. To enter historical vitals:
 - a. Click the date and time in the column header.
 - b. Click the ellipses (...) button. The **Select Date/Time** dialog (Figure 49) displays.

Key Clinical Performance Objectives

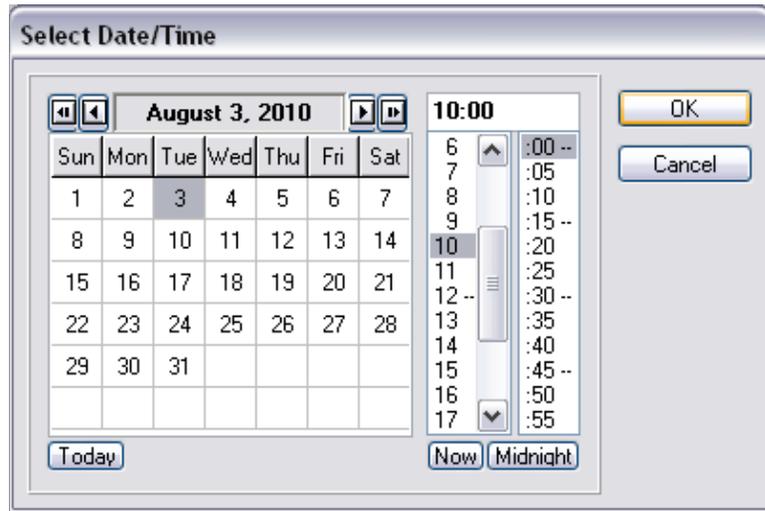


Figure 49: Choosing the historical date

- c. Choose the historical date and click **OK**. The **Vital Measurement Entry** dialog (Figure 50) redisplay.

Key Clinical Performance Objectives

| 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 | | | |

Figure 50: Entering Vital Measurements

3. Type the vital measurements to add and click **OK**. The newly added vital measurements should display in the **Vitals** component (Figure 51).

Key Clinical Performance Objectives

| 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 |

Figure 51: Example of a newly entered Vital Measurement

Key Clinical Performance Objectives

Lab Tests

Lab tests are entered in the **Orders** component, located on the **Orders** tab (Figure 52).

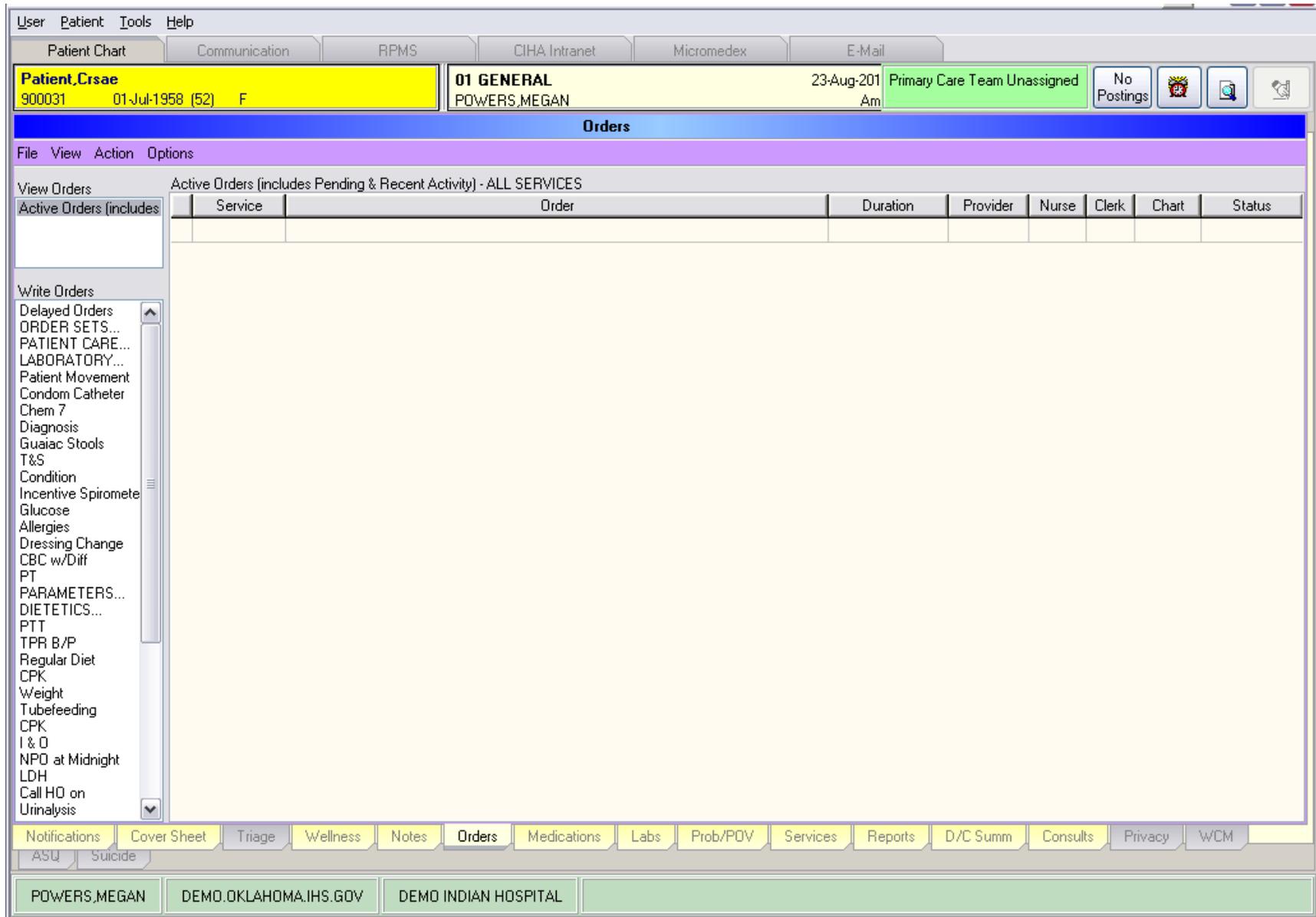


Figure 52: **Orders** component

Key Clinical Performance Objectives

To enter a Lab test:

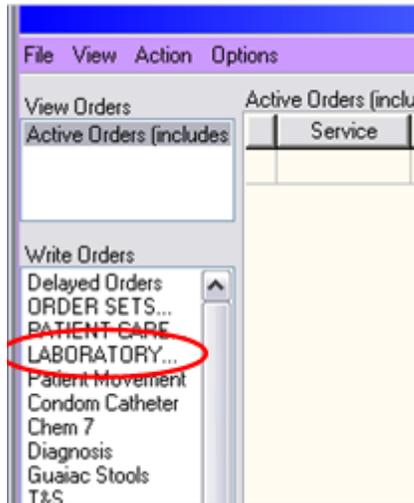


Figure 53: Entering a Lab test

1. Select the **Laboratory** option in the **Write Orders** section of the **Orders** component. The **Order a Lab Test** dialog (Figure 54) displays.

Note: This may be named differently at your site.

Key Clinical Performance Objectives

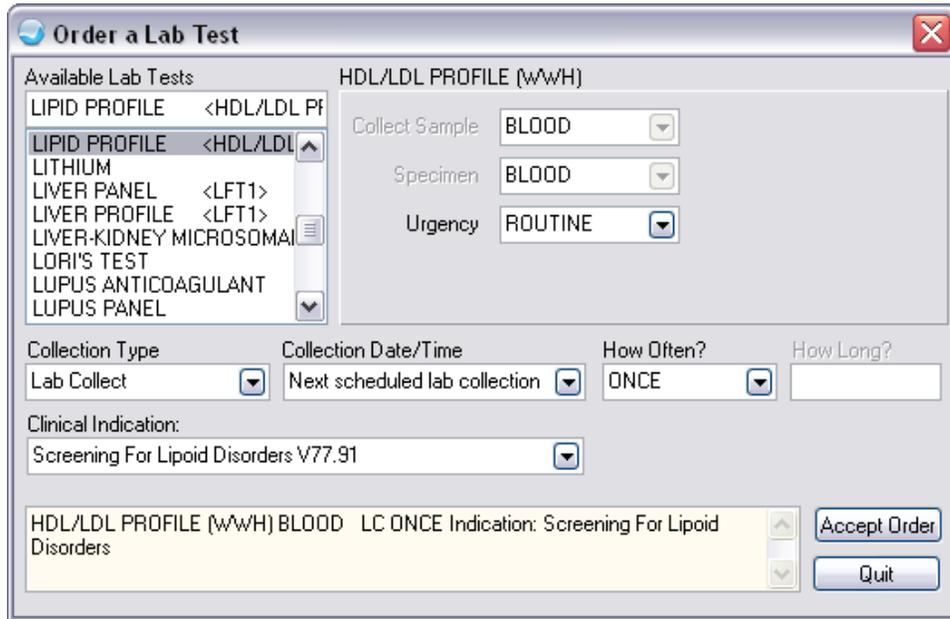


Figure 54: Order a Lab Test dialog

2. Select the appropriate lab test and enter any other pertinent information.
3. Click **Accept Order**. The newly added Lab test should display in the **Active Orders** section of the **Orders** component (Figure 55).

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

Figure 55: Example of a newly added Lab test

4. You must sign the order before it can be released.

Key Clinical Performance Objectives

Lab results can be viewed in the **Laboratory Results** component, located on the **Labs** tab (Figure 56).

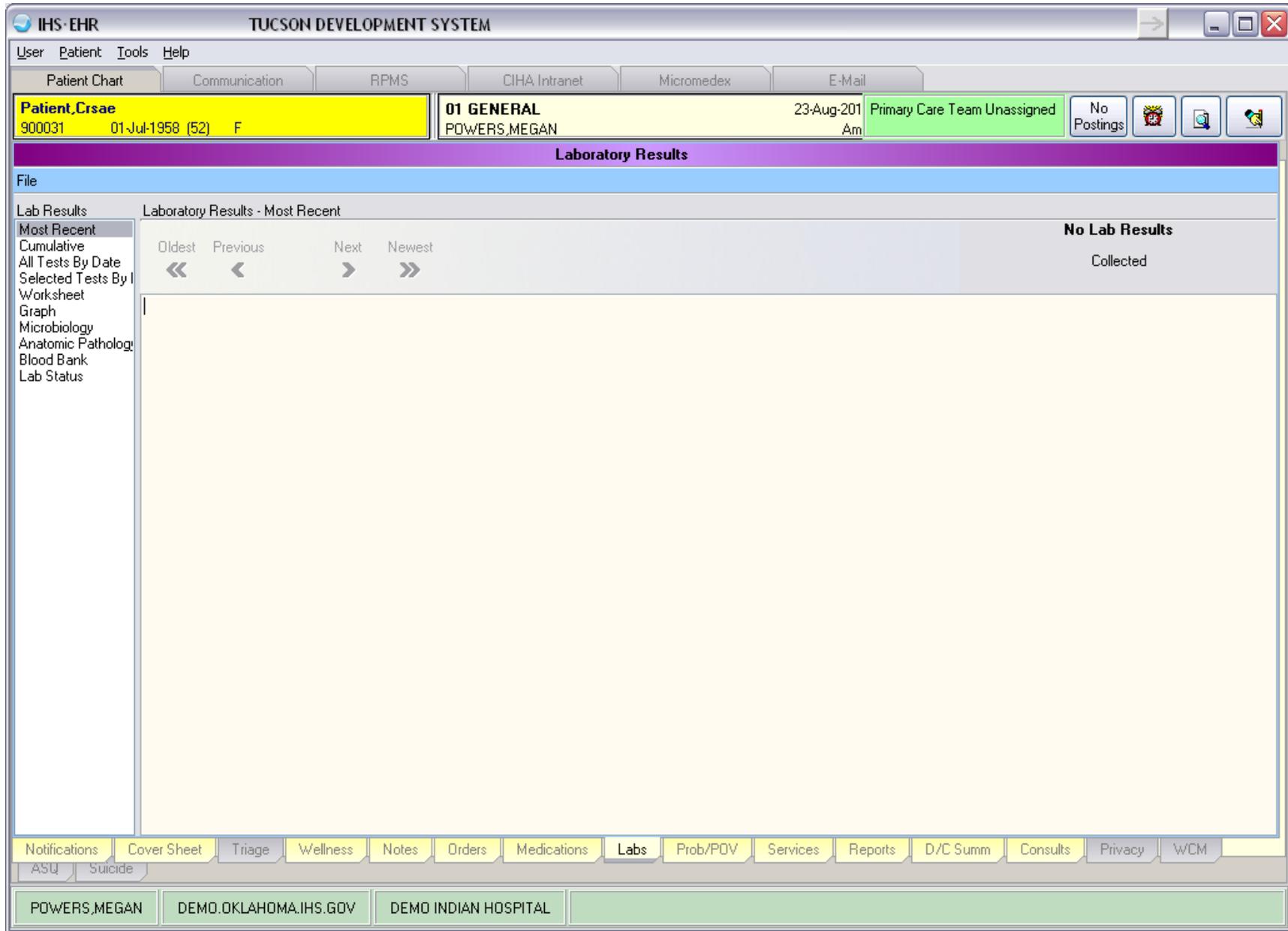


Figure 56: Viewing the lab results

Key Clinical Performance Objectives

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:



Figure 57: Entering a Point of Care Lab test

1. 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** dialog (Figure 58) displays.

The screenshot shows the 'Lab Point of Care Data Entry Form' dialog box. It contains the following fields:

- Patient: PATIENT,CRSAE
- Hospital Location: 01 GENERAL
- Ordering Provider: POWERS,MEGAN
- Nature of Order/Change: WRITTEN
- Test: GLUCOSE
- Sample Type: BLOOD
- Collection Date and Time: 08/23/2010 09:55 AM
- Sign or Symptom: 714.0 Rheumatoid Arthritis

There is a text area for 'Comment/Lab Description' and an 'Add Canned Comment' button. Below this is a 'TEST RESULTS' section with a table:

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

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

Figure 58: Lab Point of Care Data Entry Form dialog

2. Choose the appropriate laboratory **Test** and enter the test results and any other pertinent information.
3. Click **Save**.

Key Clinical Performance Objectives

Medications

Medications are entered in the **Medications** component, located on the **Medications** tab (Figure 59).



Figure 59: **Medications** component

To enter a prescription for a medication:

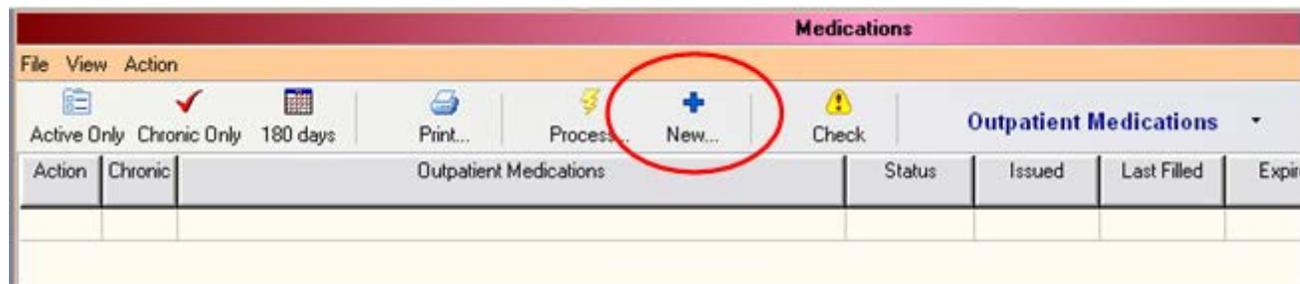


Figure 60: Entering a patient medication

Key Clinical Performance Objectives

1. Click **New**. The Medication Order dialog (Figure 60) displays.

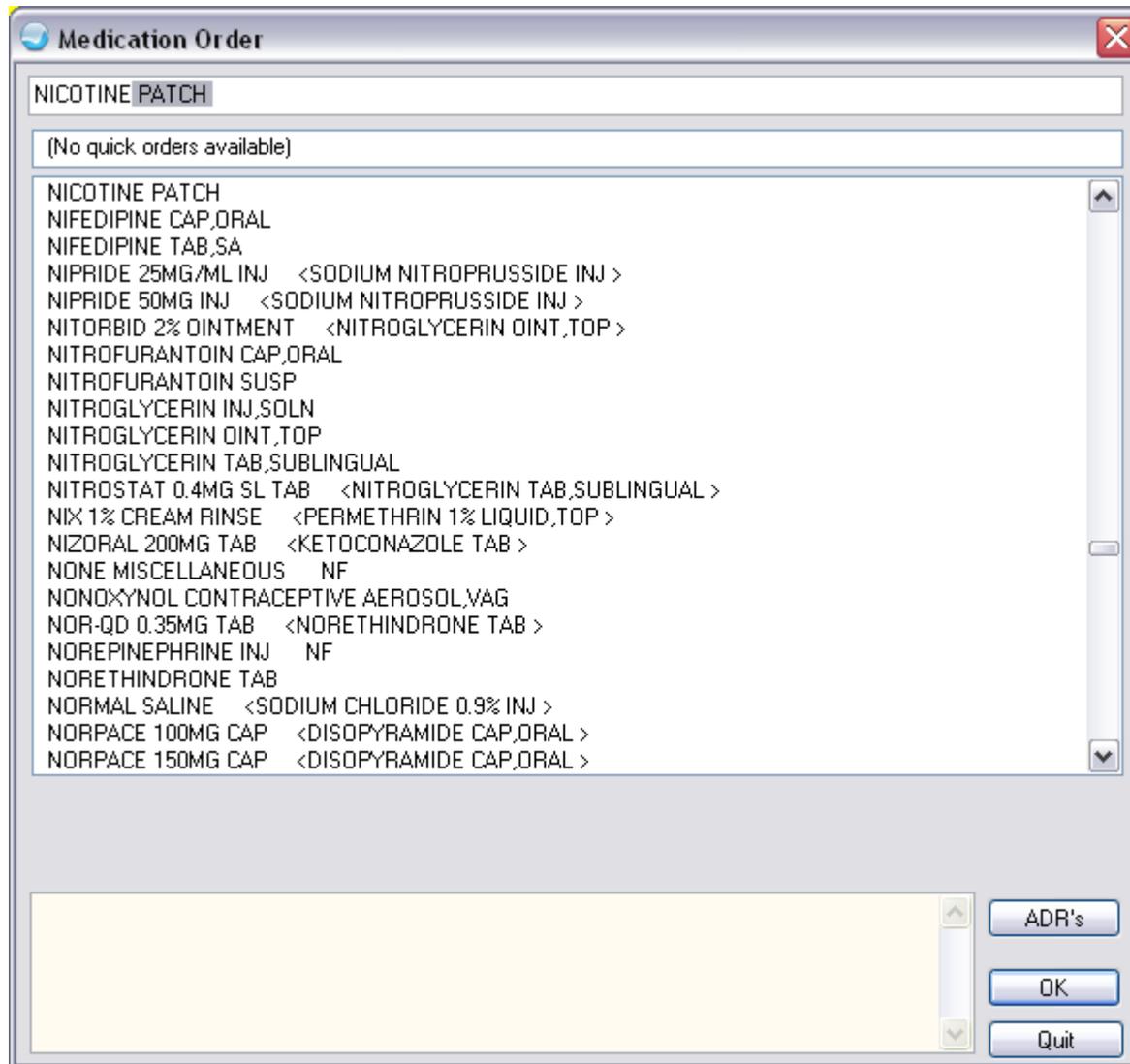


Figure 61: Medication Order dialog

2. Click to highlight the appropriate medication and click **OK**. The dialog redisplay with new fields (Figure 62).

Key Clinical Performance Objectives

The screenshot shows a software window titled "Medication Order" with a red close button in the top right corner. At the top, a yellow highlighted box contains the text "NICOTINE PATCH" and a "Change" button to its right. Below this, there are three tabs: "Dosage", "Complex", and "Complex" (the second "Complex" tab is selected). The main area is divided into three columns: "Dosage", "Route", and "Schedule".

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

Below the columns is a "Comments:" text area with up and down arrow buttons on the right. Further down are several input fields: "Days Supply" (90), "Quantity" (1), "Refills" (1), "Clinical Indication" (Personal History of Tobacco Use), "Chronic Med" (checkbox), "Dispense as Written" (checkbox), and "Priority" (ROUTINE). A "Pick Up" section has three radio buttons: "Clinic", "Mail", and "Window" (which is selected).

At the bottom, a yellow highlighted box contains a summary of the order: "NICOTINE PATCH", "APPLY ONE (1) PATCH TO SKIN DAILY", and "Quantity: 1 Refills: 1 Chronic Med: NO Dispense as Written: NO Indication: Personal History of Tobacco Use". To the right of this box are three buttons: "ADR's", "Accept Order", and "Quit".

Figure 62: Entering additional medication information

3. Type other pertinent information about the prescription.
4. Click **Accept Order**. The updated **Medications** component (Figure 63) displays.

Key Clinical Performance Objectives

| 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* | | | | | | | |

Figure 63: Example of a newly added medication

5. You must sign the order before it can be released.

Key Clinical Performance Objectives

Infant Feeding

Infant Feeding choices are entered in the **Infant Feeding** component (new in EHR v1.1 patch 6), located on the **Wellness** tab (Figure 64).

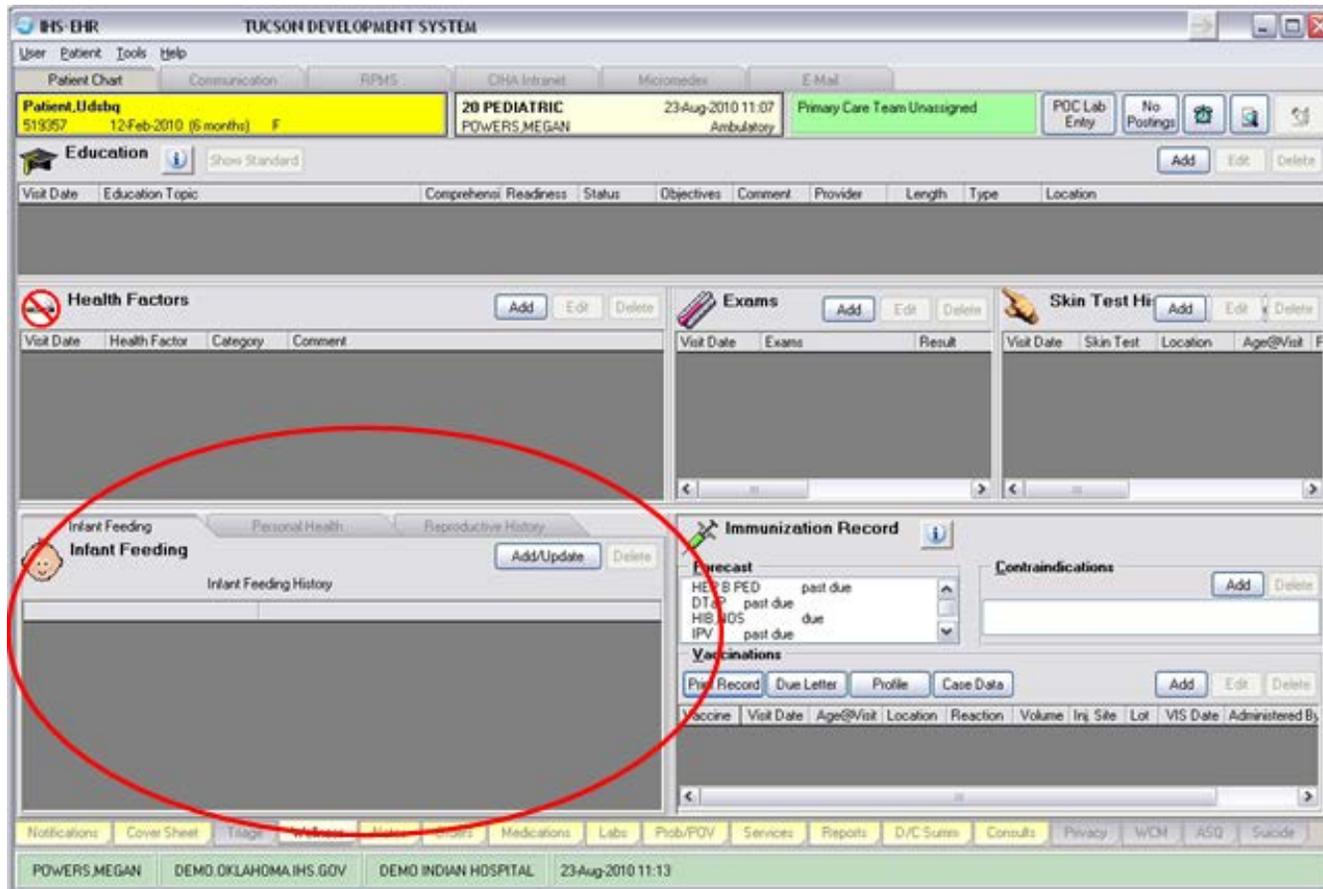


Figure 64: **Infant Feeding** component

Key Clinical Performance Objectives

To enter Infant Feeding:



Figure 65: Entering Infant Feeding information

1. Click **Add/Update** in the **Infant Feeding** component. The **Infant Feeding Choice** dialog (Figure 66) displays.

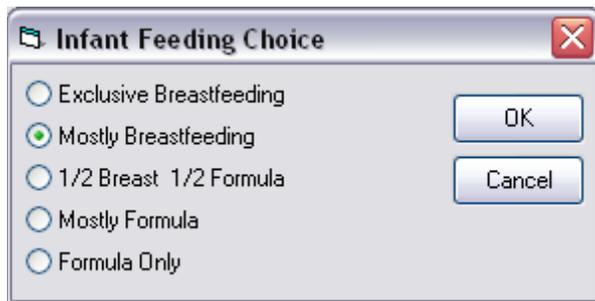


Figure 66: Selecting an Infant Feeding choice

2. Select the infant feeding choice to enter and click **OK**. The newly added choice should display in the **Infant Feeding** component (Figure 67).

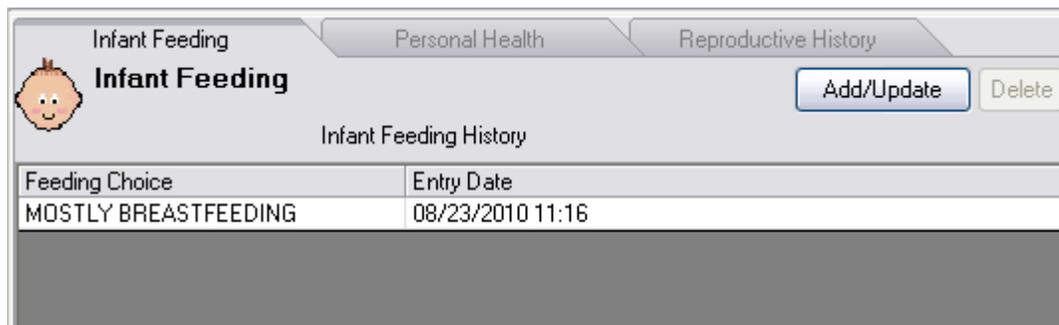


Figure 67: Example of a newly added Infant Feeding choice

Key Clinical Performance Objectives

Patient Education

Patient Education can be entered several ways. The most common method is through the **Education** component, located on the **Wellness** tab (Figure 68).

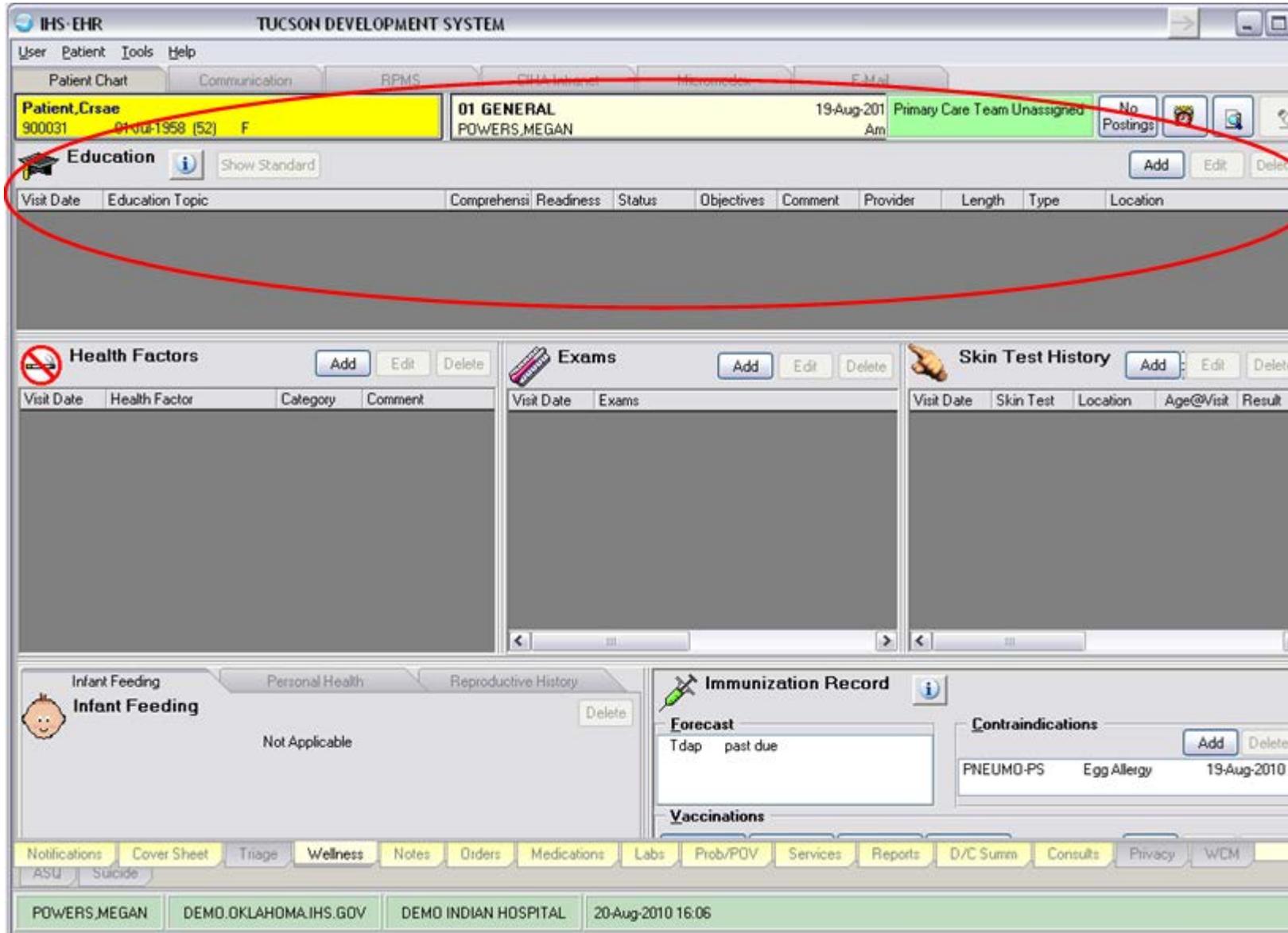


Figure 68: Education component

Key Clinical Performance Objectives

To enter Patient Education:

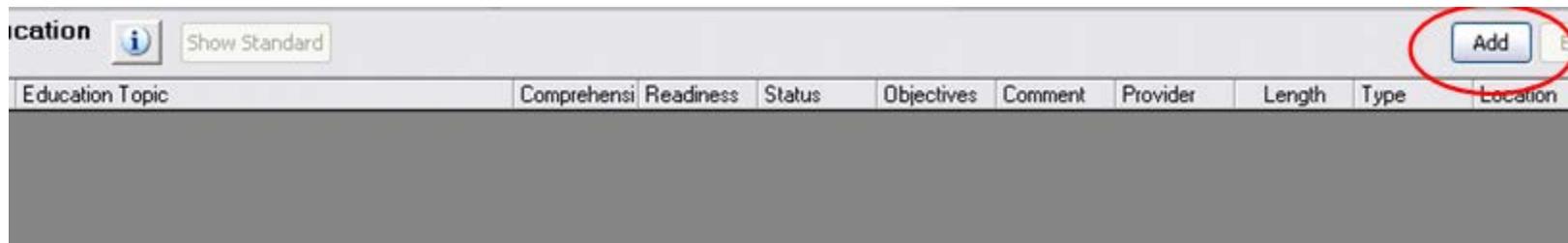


Figure 69: Entering Patient Education

1. Click **Add** in the **Education** component. The **Education Topic Selection** dialog (Figure 70) displays.

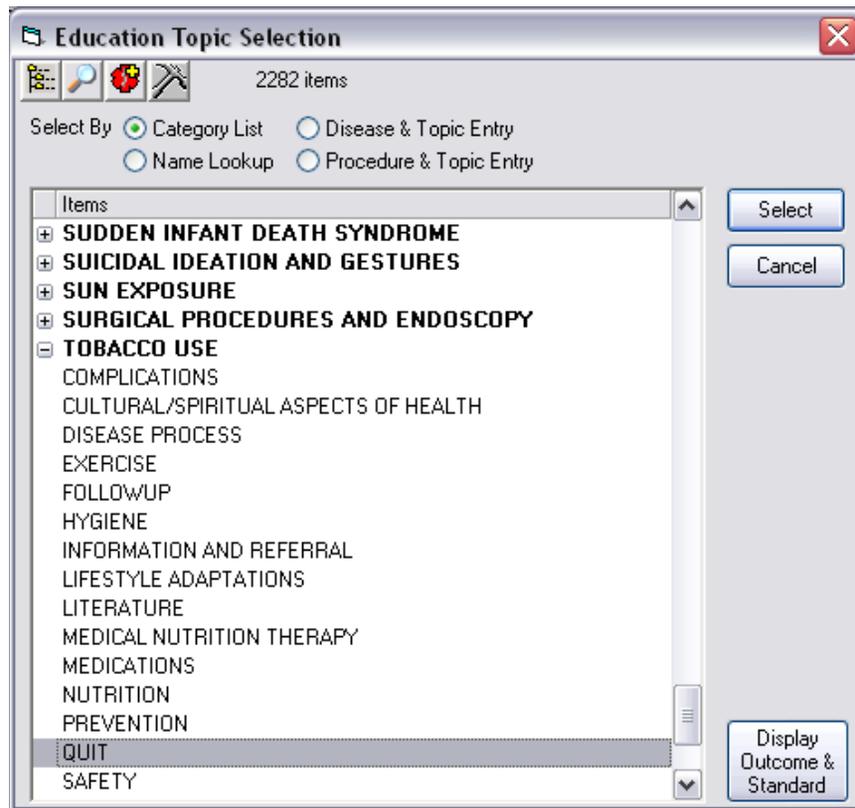


Figure 70: Selecting the education

2. Choose the education item to enter and click **Select**. To expand a topic, click the plus sign (+) next to the topic.

Key Clinical Performance Objectives

To enter Patient Education by disease:

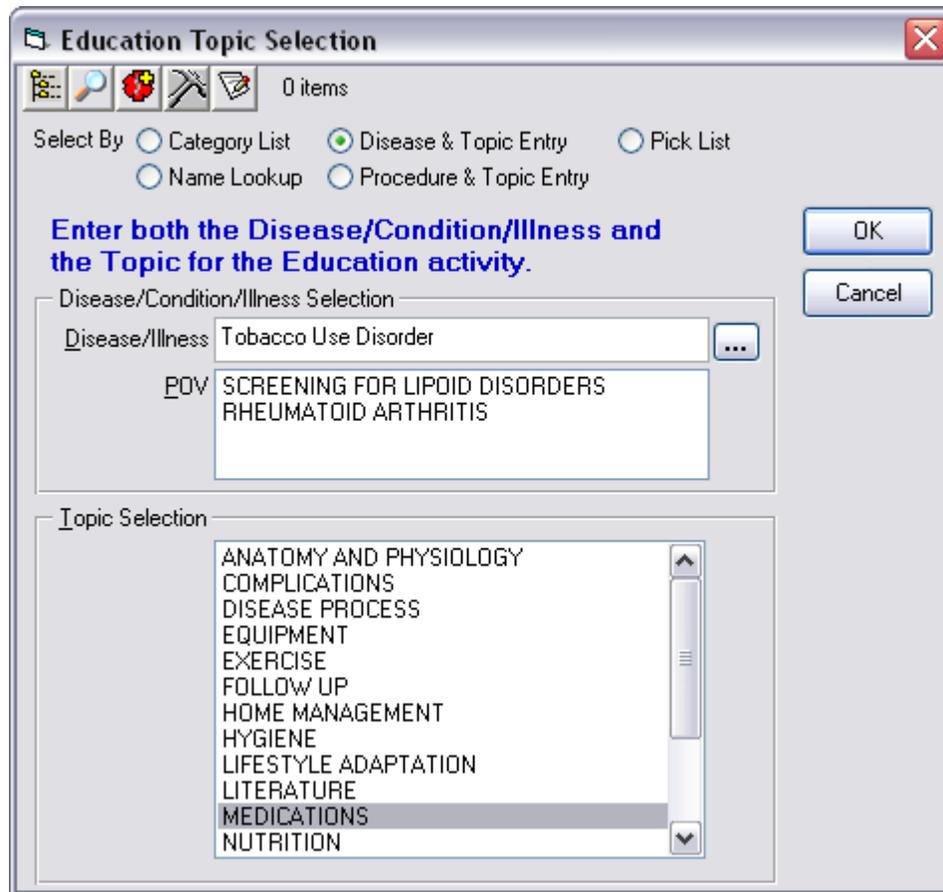


Figure 71: Entering Patient Education by disease

1. Select **Disease & Topic Entry**.

Note: Patient Education can be entered using any of the radio buttons.

2. Select values for **Disease/Illness** and **Topic Selection**.
3. Click **OK**. The **Add Patient Education Event** dialog (Figure 72) displays.

Key Clinical Performance Objectives

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

Figure 72: Add Patient Education Event dialog

4. Type any pertinent information and click **Add**.

Key Clinical Performance Objectives

Figure 73: Entering historical education

5. If this is historical education:
 - a. Select **Historical**.
 - b. Type the **Event Date** and **Location** of the education.

The newly added Patient Education should display in the **Education** component.

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

Figure 74: Example of a newly added Patient Education

Key Clinical Performance Objectives

Patient Education can also be entered when the Visit Diagnosis is entered:

The screenshot shows a dialog box titled "Add POV for Current Visit". The ICD field is set to "Tobacco Use Disorder" and is circled in red. Below it, a note states "(NOTE: If the ICD is not selected it defaults to .9999 - Uncoded Diagnosis)". The Narrative field contains "Tobacco Use Disorder". The Date of Onset and Modifier fields are empty. The "POV is Injury Related" checkbox is unchecked. The "Primary Diagnosis" checkbox is checked. The "Add to Problem List" checkbox is unchecked. The "Education..." button is visible at the bottom right.

Figure 75: Entering the Patient Education

1. After entering the POV, click **Education**. The **Document Patient Education** dialog (Figure 76) displays.

Key Clinical Performance Objectives

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

Patient's Learning Health Factors

Figure 76: Document Patient Education dialog

2. Type any pertinent information and click **Save**.

Key Clinical Performance Objectives

Refusals

Refusals are entered in the **Personal Health** component, located on the **Wellness** tab (Figure 77).

Note: Refusals are not counted toward the GPRA measure, but should still be documented.

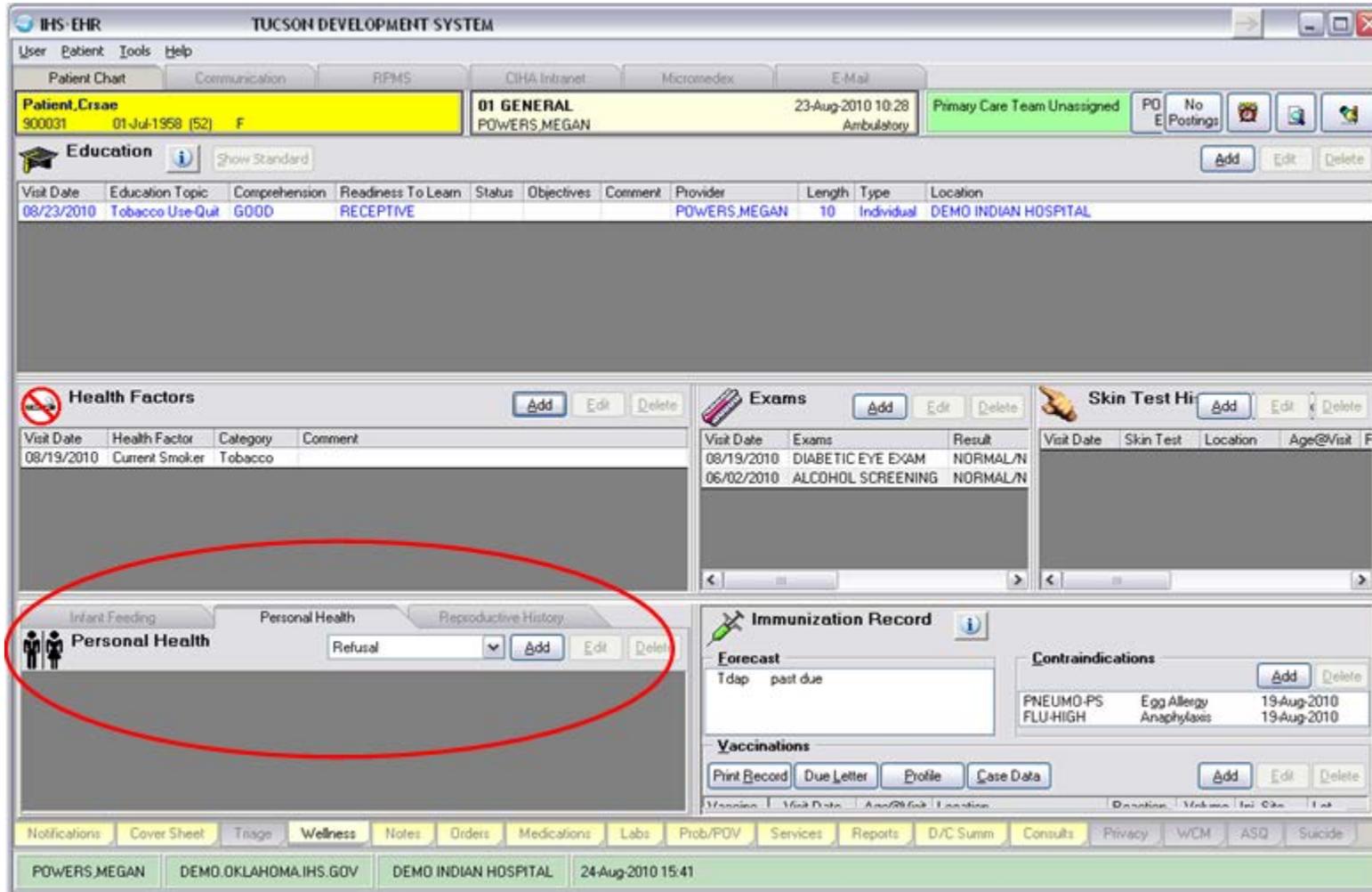


Figure 77: **Personal Health** component

Key Clinical Performance Objectives

To enter a Refusal:



Figure 78: Entering a Refusal

1. Select **Refusal** from the drop-down list.
2. Click **Add**. The **Enter Refusal** dialog (Figure 79) displays.

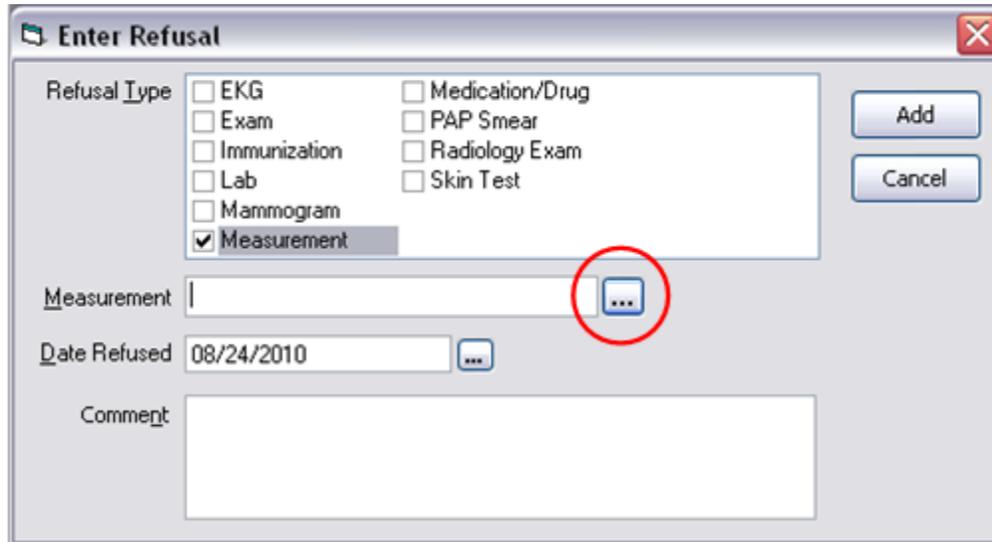


Figure 79: Selecting the Refusal Type

3. Select the **Refusal Type** and click the ellipses (...) button. The Lookup Measurement dialog (Figure 80) displays.

Key Clinical Performance Objectives

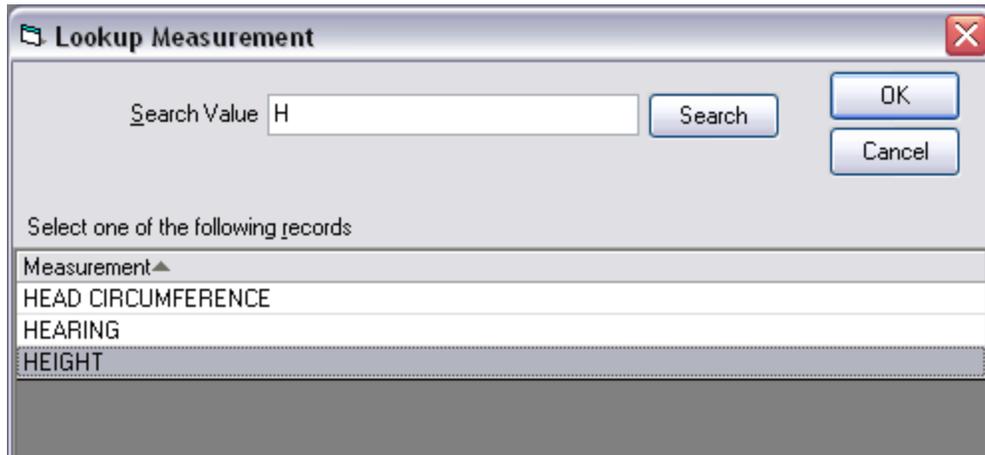


Figure 80: Lookup Measurement dialog

4. Find the refusal item:
 - a. Type the first few letters of the item's name in the **Search Value** field.
 - b. Click **Search**. A list of matching items displays in the lower portion of the dialog.
5. Click to highlight the item and click **OK**. The **Enter Refusal** dialog (Figure 81) displays.

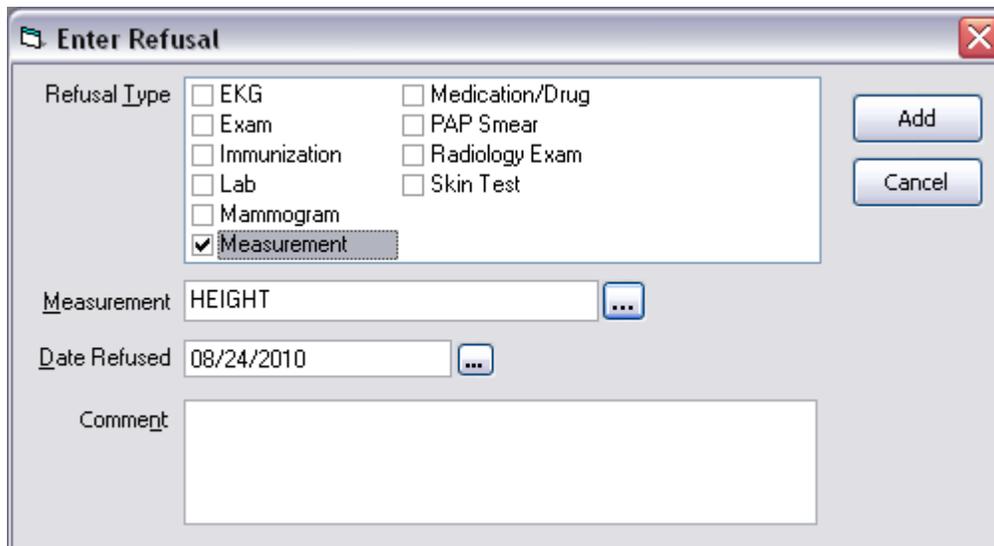


Figure 81: Entering a comment

6. Type a **Comment** (if applicable) and click **Add**. The newly added Refusal should display in the **Personal Health** component (Figure 82).

Key Clinical Performance Objectives

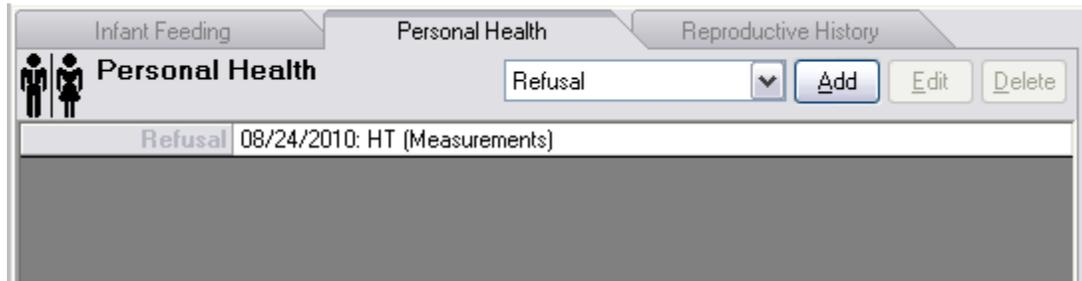


Figure 82: Example of a newly added Refusal