

# Key Clinical Performance Objectives

**Cheat Sheet for EHR Documentation and Data Entry for CRS Version 17.0**  
**Last Updated September 2016**

## 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 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/includes/themes/newihstheme/display\\_objects/documents/crsv16/GPRAMeasuresV161.pdf](http://www.ihs.gov/crs/includes/themes/newihstheme/display_objects/documents/crsv16/GPRAMeasuresV161.pdf)

See Enter Information in EHR on Page 48 for detailed instructions on how to enter information into EHR.

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

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes Prevalence <b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul>	<b>Diabetes Prevalence Diagnosis POV</b> <a href="#">Visit Diagnosis Entry</a> 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"> <li>Less than (&lt;) 8 (Good Glycemic Control)</li> </ul>	<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"> <li>Date received</li> <li>Location</li> <li>Results</li> </ul>	<p><b>A1c Lab Test</b>  <a href="#">Lab Test Entry</a>            Enter Lab Test Type: [Enter site's defined A1c Lab Test]            Collect Sample/Specimen: [Blood, Plasma]            Clinical Indication:  <b>CPT</b>  <a href="#">Visit Services Entry</a> (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"> <li>Less than (&lt;) 140/90 (mean systolic less than (&lt;) 140, mean diastolic less than (&lt;) 90)</li> </ul>	<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"> <li>Date received</li> <li>Location</li> <li>Results</li> </ul>	<p><b>Blood Pressure Data Entry</b>  <a href="#">Vital Measurements Entry</a> (includes historical Vitals)            Value: [Enter as Systolic/Diastolic (e.g., 140/90)]            Select Qualifier:            Date/Time Vitals Taken:</p>

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<p>Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes</p>	<p>Active Clinical Patients DX with diabetes age 40 - 75 or age 21 and older with documented CVD or LDL greater than or equal to (<math>\geq</math>)190 who have statin therapy.</p>	<p>Standard EHR documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in EHR:</p> <ul style="list-style-type: none"> <li>• Date received</li> <li>• Location</li> <li>• Dosage</li> </ul>	<p><b>Statin Therapy Medication</b>  <a href="#">Medication Entry</a>            Select Medication: [Enter Statin Therapy Prescribed Medication]            Outside Drug Name (Optional): [Enter any additional name for the drug]            SIG            Quantity:            Day Prescribed:            Event Date&amp;Time:            Ordering Provider:</p> <p><b>Statin Therapy CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT Code: 4013F            Quantity:            Modifier:            Modifier 2:</p>

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<p>Diabetes: Nephropathy Assessment</p>	<p>Active Clinical Patients DX with diabetes with a Nephropathy assessment:</p> <ul style="list-style-type: none"> <li>• Estimated GFR with result during the Report Period</li> <li>• Urine Albumin-to-Creatinine Ratio during the Report Period</li> <li>• End Stage Renal Disease diagnosis/treatment</li> </ul>	<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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul>	<p><b>Estimated GFR Lab Test</b>  <a href="#">Lab Test Entry</a>            Enter Lab Test Type: [Enter site's defined Est GFR Lab Test]            Collect Sample/Specimen: [Blood]            Clinical Indication:  <b>Urine Albumin-to-Creatinine Ratio CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT: 82043 AND 82570            Quantity:            Modifier:            Modifier 2:  <b>ESRD CPT</b>  <a href="#">Visit Services Entry</a> (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><b>ESRD POV</b>  <a href="#">Visit Diagnosis Entry</a>            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><b>ESRD Procedure</b>  <a href="#">Procedure Entry</a>            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"> <li>Dilated retinal evaluation by an optometrist or ophthalmologist</li> <li>Seven standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist</li> <li>Any photographic method formally validated to seven standard fields (ETDRS).</li> </ul> <p><b>Note:</b> 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"> <li>Date received</li> <li>Location</li> <li>Results</li> </ul> <p>Exams:</p> <ul style="list-style-type: none"> <li>Diabetic Retinal Exam <ul style="list-style-type: none"> <li>Dilated retinal eye exam</li> <li>Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist</li> <li>Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos</li> <li>Routine ophthalmological examination including refraction (new or existing patient)</li> <li>Diabetic indicator; retinal eye exam, dilated, bilateral</li> </ul> </li> <li>Other Eye Exams <ul style="list-style-type: none"> <li>Non-DNKA (did not keep appointment) visits to ophthalmology or optometry clinics with an optometrist or ophthalmologist, or visits to formally validated tele-ophthalmology retinal evaluation clinics</li> </ul> </li> </ul>	<p><b>Diabetic Retinopathy Exam</b>  <a href="#">Exam Entry</a> (includes historical exams)  Select Exam: 03  Result: [Enter Results]  Comments:  Provider Performing Exam:</p> <p><b>Retinal Exam CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)  Enter CPT: 2022F, 2024F, 2026F, S0620, S0621, S3000  Quantity:  Modifier:  Modifier 2:</p> <p><b>Other Eye Exam CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)  Enter CPT: 67028, 67039, 67040, 92002, 92004, 92012, 92014  Quantity:  Modifier:  Modifier 2:</p> <p><b>Other Eye Exam POV</b>  <a href="#">Visit Diagnosis Entry</a>  Purpose of Visit: ICD-9: V72.0  Provider Narrative:  Modifier:  Cause of DX:</p> <p><b>Other Eye Exam Clinic</b>  <a href="#">Clinic Entry</a>  Clinic: A2, 17, 18, 64</p>

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Access to Dental Service	<p>Patients should have annual dental exams.</p> <p><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul>	<p><b>Dental Exam</b>  <a href="#">Exam Entry</a> (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><b>Dental Exam CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT: D0190, D0191            Quantity:            Modifier:            Modifier 2:</p> <p><b>Dental Exam POV</b>  <a href="#">Visit Diagnosis Entry</a>            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><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul>	<p><b>Dental Sealants (ADA)</b> <i>ADA codes cannot be entered into EHR.</i></p> <p><b>Dental Sealants CPT</b> <a href="#">Visit Services Entry</a> (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><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul>	<p><b>Topical Fluoride (ADA code)</b> <i>ADA codes cannot be entered into EHR.</i></p> <p><b>Topical Fluoride CPT</b> <a href="#">Visit Services Entry</a> (includes historical CPTs) Enter CPT: D1206, D1208, D5986, 99188 Quantity: Modifier: Modifier 2:</p> <p><b>Topical Fluoride POV</b> <a href="#">Visit Diagnosis Entry</a> Purpose of Visit: ICD-9: V07.31 Provider Narrative: Modifier: Cause of DX:</p>

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Influenza	<p>All patients ages 6 months and older should have an annual influenza (flu) shot.</p> <p>Refusals should be documented. <b>Note:</b> 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"> <li>• IZ type</li> <li>• Date received</li> <li>• Location</li> </ul> <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><b>Influenza Vaccine</b>  <a href="#">Immunization Entry</a> (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><b>Influenza Vaccine POV</b>  <a href="#">Visit Diagnosis Entry</a></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><b>Influenza Vaccine CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p>Enter CPT: 90630, 90654-90662, 90672, 90673, 90685-90688, G0008</p> <p>Quantity:  Modifier:  Modifier 2:</p> <p><b>NMI Refusal of Influenza</b>  <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p>

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Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Influenza (cont.)			<p><b>Contraindication Influenza</b>  <a href="#">Immunization Entry - Contraindications</a>                      Vaccine: [See codes above]                      Reason: Egg Allergy,                      Anaphylaxis</p>

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Adult Immunizations	<p>All adults ages 65 and older will have a pneumococcal vaccine.</p> <p>All adult (18 and older) diabetic patients are strongly recommended to have a pneumococcal vaccine.</p> <p>Refusals should be documented. <b>Note:</b> 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"> <li>• IZ type</li> <li>• Date received</li> <li>• Location</li> </ul> <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><b>Pneumococcal Vaccine</b>  <a href="#">Immunization Entry</a> (includes historical immunizations)            Select Immunization Name: 33, 100, 109, 133, 152            Lot:            VFC Eligibility:</p> <p><b>Pneumococcal Vaccine POV</b>  <a href="#">Visit Diagnosis Entry</a>            Purpose of Visit: ICD-9: V06.6, V03.82            Provider Narrative:            Modifier:            Cause of DX:</p> <p><b>Pneumococcal Vaccine CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT: 90669, 90670, 90732, G0009, G9279            Quantity:            Modifier:            Modifier 2:</p> <p><b>NMI Refusal of Pneumococcal</b>  <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p><b>Contraindication Pneumococcal</b>  <a href="#">Immunization Entry - Contraindications</a>            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"> <li>4 DTaP</li> <li>3 IPV</li> <li>1 MMR</li> <li>3 Hepatitis B</li> <li>3 or 4 Hib</li> <li>1 Varicella</li> <li>4 Pneumococcal</li> </ul> <p>Refusals should be documented.</p> <p><b>Note:</b> 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"> <li>• IZ type</li> <li>• Date received</li> <li>• Location</li> </ul> <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"> <li>• <b>IPV:</b> Immunization Package: "Neomycin Allergy."</li> <li>• <b>OPV:</b> Immunization Package: "Immune Deficiency."</li> <li>• <b>MMR:</b> Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</li> <li>• <b>Varicella:</b> Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</li> <li>• <b>Pneumococcal: Immunization Package:</b> "Anaphylaxis"</li> </ul>	<p><b>Childhood Immunizations</b></p> <p><a href="#">Immunization Entry</a> (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"> <li>• 4 DTaP/DTP/Tdap</li> <li>• 1 DTaP/DTP/Tdap and 3 DT/Td</li> <li>• 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus</li> <li>• 4 DT and 4 Acellular Pertussis</li> <li>• 4 Td and 4 Acellular Pertussis</li> <li>• 4 each of Diphtheria, Tetanus, and Acellular Pertussis</li> </ul> <p>3 doses of IPV:</p> <ul style="list-style-type: none"> <li>• 3 OPV</li> <li>• 3 IPV</li> <li>• Combination of OPV and IPV totaling three doses</li> </ul> <p>1 dose of MMR:</p> <ul style="list-style-type: none"> <li>• MMR</li> <li>• 1 M/R and 1 Mumps</li> <li>• 1 R/M and 1 Measles</li> <li>• 1 each of Measles, Mumps, and Rubella</li> </ul> <p>3 doses of Hepatitis B</p> <ul style="list-style-type: none"> <li>• 3 doses of Hep B</li> </ul> <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><b>Childhood Immunizations POV</b>  <a href="#">Visit Diagnosis Entry</a></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:            Modifier:            Cause of DX:</p>

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Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Childhood Immunizations (cont.)</p>		<p><b>Important Note:</b>            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><b>Childhood Immunizations CPT Visit Services Entry</b> (includes historical CPTs)            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            Quantity:            Modifier:            Modifier 2:</p> <p><b>NMI Refusal of Childhood Immunizations</b>  <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p><b>Contraindication Childhood Immunizations</b>  <a href="#">Immunization Entry - Contraindications</a>            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><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul>	<p><b>Pap Smear V Lab</b>  <a href="#">Lab Test Entry</a>            Enter Lab Test Type: [Enter site's defined Pap Smear Lab Test]            Clinical Indication:</p> <p><b>Pap Smear POV</b>  <a href="#">Visit Diagnosis Entry</a>            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><b>Pap Smear CPT</b>  <a href="#">Visit Services Entry</a> (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><b>HPV V Lab</b>  <a href="#">Lab Test Entry</a>            Enter Lab Test Type: [Enter site's defined HPV Lab Test]            Clinical Indication:</p>

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Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Cancer Screening: Pap Smear Rates (cont.)			<p><b>HPV POV</b>  <a href="#">Visit Diagnosis Entry</a>                      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><b>HPV CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)                      Enter CPT: 87623-87625                      Quantity:                      Modifier:                      Modifier 2:</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Cancer Screening: Mammogram Rates</p>	<p>Women ages 52–64 should have a mammogram every 2 years</p> <p><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul> <p>Telephone visit with patient Verbal or written lab report Patient's next visit</p>	<p><b>Mammogram POV</b> <a href="#">Visit Diagnosis Entry</a> 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><b>Mammogram CPT</b> <a href="#">Visit Services Entry</a> (includes historical CPTs) Enter CPT: 77053-77059, G0206; G0204, G0202 Quantity: Modifier: Modifier 2:</p> <p><b>Mammogram Procedure</b> <a href="#">Procedure Entry</a> Operation/Procedure: ICD-9: 87.36, 87.37; ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening	<p>Adults ages 50–75 should be screened for CRC (USPTF).</p> <p>For GPRA, IHS counts any of the following:</p> <ul style="list-style-type: none"> <li>• Annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT)</li> <li>• Flexible sigmoidoscopy in the past 5 years</li> <li>• Colonoscopy every 10 years.</li> </ul> <p><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul> <p>Telephone visit with patient</p> <p>Verbal or written lab report</p> <p>Patient's next visit</p>	<p><b>Colorectal Cancer POV</b></p> <p><a href="#">Visit Diagnosis Entry</a></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><b>Total Colectomy CPT</b></p> <p><a href="#">Visit Services Entry</a> (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><b>Total Colectomy Procedure</b></p> <p><a href="#">Procedure Entry</a></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>

# Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening (cont.)			<p><b>FOBT or FIT CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT: 82270, 82274, G0328            Quantity:            Modifier:            Modifier 2:</p> <p><b>Flexible Sigmoidoscopy CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT: 45330–45345, G0104            Quantity:            Modifier:            Modifier 2:</p> <p><b>Flexible Sigmoidoscopy Procedure</b>  <a href="#">Procedure Entry</a>            Operation/Procedure: ICD-9: 45.24; ICD-10: 0DJD8ZZ            Provider Narrative:            Operating Provider:            Diagnosis: [Enter appropriate DX]</p> <p><b>Colon Screening CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121, G9252, G9253            Quantity:            Modifier:            Modifier 2:</p>
Clinical Objectives Cheat Sheet		19	Modifier 2: Last Edited: 12/30/2016

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening (cont.)			<p><b>Colon Screening Procedure</b>  <a href="#">Procedure Entry</a>                      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>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Tobacco Use and Exposure Assessment</p> <p><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul> <p>Document on designated Health Factors section of form:</p> <ul style="list-style-type: none"> <li>• HF–Current Smoker, every day</li> <li>• HF–Current Smoker, some day</li> <li>• HF–Heavy Tobacco Smoker</li> <li>• HF–Light Tobacco Smoker</li> <li>• HF–Current Smoker, status unknown</li> <li>• HF–Current Smokeless</li> <li>• HF–Previous (Former) Smoker [or -Smokeless] (quit greater than (&gt;) 6 months)</li> <li>• HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (&lt;) 6 months)</li> <li>• HF–Smoker in Home</li> <li>• HF–Ceremonial Use Only</li> <li>• HF–Exp to ETS (Second Hand Smoke)</li> <li>• HF–Smoke Free Home</li> </ul> <p><b>Note:</b> 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"> <li>• Codes will contain "TO-", "-TO", "-SHS"</li> </ul>	<p><b>Tobacco Screening Health Factor</b></p> <p><a href="#">Health Factor Entry</a></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><b>Tobacco Screening PED–Topic</b></p> <p><a href="#">Patient Education Entry</a> (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
Tobacco Use and Exposure Assessment (cont.)		<p><b>Note:</b> Ensure you update the patient's health factors as they enter a cessation program and eventually become non-tobacco users. Patients who are in a tobacco cessation program should have their health factor changed from "Smoker" or "Smokeless" to "Cessation-Smoker" or "Cessation-Smokeless" until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to "Previous Smoker" or "Previous Smokeless."</p>	<p><b>Tobacco Users Health Factor</b> <a href="#">Health Factor Entry</a> 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><b>Smokers Health Factor</b> <a href="#">Health Factor Entry</a> Select V Health Factor: Current Smoker (every day, some day, or status unknown), or Cessation-Smoker Level/Severity: Provider: Quantity:</p> <p><b>Smokeless Health Factor</b> <a href="#">Health Factor Entry</a> Select V Health Factor: Current Smokeless or Cessation-Smokeless Level/Severity: Provider: Quantity:</p> <p><b>ETS Health Factor</b> <a href="#">Health Factor Entry</a> Select V Health Factor: Exp to ETS Level/Severity: Provider: Quantity:</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul> <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"> <li>• Last documented Tobacco Health Factor</li> <li>• Last documented Tobacco related POV</li> <li>• Last documented Tobacco related CPT</li> </ul> <p>Health factors considered to be a tobacco user:</p> <ul style="list-style-type: none"> <li>• HF–Current Smoker, every day</li> <li>• HF–Current Smoker, some day</li> <li>• HF–Heavy Tobacco Smoker</li> <li>• HF–Light Tobacco Smoker</li> <li>• HF–Current Smoker, status unknown</li> <li>• HF–Current Smokeless</li> <li>• HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (&lt;) 6 months)</li> </ul> <p>Tobacco Patient Education Codes:</p> <ul style="list-style-type: none"> <li>• Codes will contain "TO-", "-TO", "-SHS"</li> </ul>	<p><b>Tobacco Cessation PED - Topic</b>  <a href="#">Patient Education Entry</a> (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
Tobacco Cessation (cont.)		<p>Prescribe Tobacco Cessation Aids:</p> <ul style="list-style-type: none"> <li>• Predefined Site-Populated Smoking Cessation Meds</li> <li>• Meds containing:               <ul style="list-style-type: none"> <li>- “Nicotine Patch”</li> <li>- “Nicotine Polacrilex”</li> <li>- “Nicotine Inhaler”</li> <li>- “Nicotine Nasal Spray”</li> </ul> </li> </ul> <p><b>Note:</b> 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><b>Tobacco Cessation PED– Diagnosis</b>  <a href="#">Patient Education Entry</a> (includes historical patient education)            Select ICD Diagnosis Code Number: 649.00-649.04            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><b>Tobacco Cessation PED - CPT</b>            Mnemonic PED enter            Select CPT Code Number: D1320, 99406, 99407, 4000F            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>

## Key Clinical Performance Objectives

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

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Cessation (cont.)			<p><b>Tobacco Cessation Prescription CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT Code: 4001F            Quantity            Modifier:            Modifier 2:</p> <p><b>Quit Tobacco POV</b>  <a href="#">Visit Diagnosis Entry</a>            Purpose of Visit: ICD-9: 305.13, V15.82; ICD-10: F17.2*1, Z87.891            Provider Narrative:            Modifier:            Cause of DX:</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening	<p>Adult patients ages 12 through 75 should be screened for alcohol use at least annually.</p> <p><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul> <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"> <li>• <b>Negative</b>—Patient’s screening exam does not indicate risky alcohol use.</li> <li>• <b>Positive</b>—Patient’s screening exam indicates potential risky alcohol use.</li> <li>• <b>Refused</b>—Patient declined exam/screen</li> <li>• <b>Unable to screen</b> - Provider unable to screen</li> </ul> <p><b>Note:</b> 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"> <li>• When was the last time you had more than 4 drinks in one day?</li> </ul> <p><i>For Men:</i></p> <ul style="list-style-type: none"> <li>• When was the last time you had more than 5 drinks in one day?</li> </ul>	<p><b>Alcohol Screening Exam</b> <a href="#">Exam Entry</a> (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><b>Cage Health Factor</b> <a href="#">Health Factor Entry</a></p> <p>Select Health Factor: CAGE</p> <ol style="list-style-type: none"> <li>1. CAGE 0/4 (all No answers)</li> <li>2. CAGE 1/4</li> <li>3. CAGE 2/4</li> <li>4. CAGE 3/4</li> <li>5. CAGE 4/4</li> </ol> <p>Choose 1-5: [Number from above]</p> <p>Level/Severity: Provider: Quantity:</p>

# Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (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"> <li>Alcohol Screening Exam Code Result: Positive</li> </ul> <p>The patient may decline the screen or “Refuse to answer”:</p> <ul style="list-style-type: none"> <li>Alcohol Screening Exam Code Result: Refused</li> </ul> <p>The provider is unable to conduct the screen:</p> <ul style="list-style-type: none"> <li>Alcohol Screening Exam Code Result: Unable To Screen</li> </ul> <p><b>Note:</b> Provider should <b>Note</b> 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><b>Alcohol Screening POV</b>  <a href="#">Visit Diagnosis Entry</a>            Purpose of Visit: ICD-9: V11.3, V79.1            Provider Narrative:            Modifier:            Cause of DX:  <b>Alcohol Screening CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT Code: 99408, 99409, G0396, G0397, H0049, H0050            Quantity            Modifier:            Modifier 2:  <b>Alcohol-Related Diagnosis POV</b>  <a href="#">Visit Diagnosis Entry</a>            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:  <b>Alcohol-Related Procedure</b>  <a href="#">Procedure Entry</a>            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>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (cont.)		<p>Based on how many YES answers were received, document Health Factor in EHR:</p> <ul style="list-style-type: none"> <li>• HF-CAGE 0/4 (all No answers)</li> <li>• HF-CAGE 1/4</li> <li>• HF-CAGE 2/4</li> <li>• HF-CAGE 3/4</li> <li>• HF-CAGE 4/4</li> </ul> <p>Optional values:</p> <ul style="list-style-type: none"> <li>• Level/Severity: Minimal, Moderate, or Heavy/Severe</li> <li>• Quantity: # of drinks daily OR T (Tolerance) -- # drinks to get high (e.g. T-4)</li> <li>• Comment: used to capture other relevant clinical info e.g. "Non-drinker"</li> </ul> <p>Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-"</p> <p>AUDIT Measurements:</p> <ul style="list-style-type: none"> <li>• <b>Zone I:</b> Score 0–7 Low risk drinking or abstinence</li> <li>• <b>Zone II:</b> Score 8–15 Alcohol use in excess of low-risk guidelines</li> <li>• <b>Zone III:</b> Score 16–19 Harmful and hazardous drinking</li> <li>• <b>Zone IV:</b> Score 20–40 Referral to Specialist for Diagnostic Evaluation and Treatment</li> </ul>	<p><b>Alcohol-Related PED - Topic</b> <a href="#">Patient Education Entry</a> (includes historical patient education)</p> <p>Enter Education Topic: [Enter Alcohol-Related 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
Alcohol Screening (cont.)		<p>AUDIT-C Measurements:</p> <p>How often do you have a drink containing alcohol?</p> <ul style="list-style-type: none"> <li>• (0) Never (Skip to Questions 9-10)</li> <li>• (1) Monthly or less</li> <li>• (2) 2 to 4 times a month</li> <li>• (3) 2 to 3 times a week</li> <li>• (4) 4 or more times a week</li> </ul> <p>How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <ul style="list-style-type: none"> <li>• (0) 1 or 2</li> <li>• (1) 3 or 4</li> <li>• (2) 5 or 6</li> <li>• (3) 7, 8, or 9</li> <li>• (4) 10 or more</li> </ul> <p>How often do you have 6 or more drinks on one occasion?</p> <ul style="list-style-type: none"> <li>• (0) Never</li> <li>• (1) Less than monthly</li> <li>• (2) Monthly</li> <li>• (3) Weekly</li> <li>• (4) Daily or almost daily</li> </ul>	<p><b>Alcohol-Related PED - Diagnosis</b></p> <p><a href="#">Patient Education Entry</a> (includes historical patient education)</p> <p>Select ICD Diagnosis Code Number: V11.3, V79.1, 303.*, 305.0*, 291.* or 357.5*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><b>Alcohol-Related PED - CPT</b></p> <p><a href="#">Patient Education Entry</a> (includes historical patient education)</p> <p>Select CPT Code Number: 99408, 99409, G0396, G0397, H0049, or H0050</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 related text)]</p> <p>Goal Comment:</p>
Clinical Objectives Cheat Sheet		30	<p>Provider's Narrative:</p> <p style="text-align: right;">Last Edited: 12/30/2016</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (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"> <li>• In men, a score of 4 or more is considered positive</li> <li>• In women, a score of 3 or more is considered positive.</li> </ul> <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"> <li>• C–Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?</li> <li>• R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?</li> <li>• A–Do you ever use alcohol/drugs while you are by yourself, ALONE?</li> <li>• F–Do you ever FORGET things you did while using alcohol or drugs?</li> <li>• F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?</li> <li>• T–Have you gotten into TROUBLE while you were using alcohol or drugs?</li> </ul> <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><b>Alcohol Screen AUDIT Measurement</b>  <a href="#">Vital Measurements Entry</a>            (includes historical Vitals)            Value: [Enter 0-40]            Select Qualifier:            Date/Time Vitals Taken:</p> <p><b>Alcohol Screen AUDIT-C Measurement</b>  <a href="#">Vital Measurements Entry</a>            (includes historical Vitals)            Value: [Enter 0-40]            Select Qualifier:            Date/Time Vitals Taken:</p> <p><b>Alcohol Screen CRAFFT Measurement</b>  <a href="#">Vital Measurements Entry</a>            (includes historical Vitals)            Value: [Enter 0-6]            Select Qualifier:            Date/Time Vitals Taken:</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Screening, Brief Intervention, and Referral to Treatment (SBIRT)</p>	<p>Active Clinical Plus BH patients age 9 through 75 who screened positive for risky or harmful alcohol use should receive a Brief Negotiated Interview (BNI) or Brief Intervention (BI) within 7 days of the positive screen.</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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul>	<p><b>BNI/BI CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT Code: G0396, G0397, H0050, 96150-96155            Quantity            Modifier:            Modifier 2:</p> <p><b>BNI/BI PED - Topic</b>  <a href="#">Patient Education Entry</a> (includes historical patient education)            Enter Education Topic: AOD-BNI            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>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Intimate Partner (Domestic) Violence Screening (IPV/DV)	<p>Adult females should be screened for domestic violence at new encounter and at least annually Prenatal once each trimester</p> <p>(Source: Family Violence Prevention Fund National Consensus Guidelines)</p> <p><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul> <p>Medical and Behavioral Health Providers: EXAM—IPV/DV Screening</p> <ul style="list-style-type: none"> <li>• <b>Negative</b>—Denies being a current or past victim of IPV/DV</li> <li>• <b>Past</b>—Denies being a current victim, but discloses being a past victim of IPV/DV</li> <li>• <b>Present</b>—Discloses current IPV/DV</li> <li>• <b>Present and Past</b>—Discloses past victimization and current IPV/DV victimization</li> <li>• <b>Refused</b>—Patient declined exam/screen</li> <li>• <b>Unable to screen</b>—Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.)</li> </ul> <p>IPV/DV Patient Education Codes:</p> <ul style="list-style-type: none"> <li>• Codes will contain "DV-" or "-DV"</li> </ul>	<p><b>IPV/DV Screening Exam</b> <a href="#">Exam Entry</a> (includes historical exams)</p> <p>Select Exam: 34, INT</p> <p>Result:</p> <p>A—Abnormal N—Normal/Negative PR—Resent PAP—Present and Past PA—Past PO—Positive</p> <p>Comments:</p> <p>Provider Performing Exam:</p> <p><b>IPV/DV Diagnosis POV</b> <a href="#">Visit Diagnosis Entry</a></p> <p>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</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont.)			<p><b>IPV/DV–Topic</b>  <a href="#">Patient Education Entry</a> (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><b>IPV/DV PED–Diagnosis</b>  <a href="#">Patient Education Entry</a> (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:                      Provider’s Narrative:</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening	<p>All patients 12 years of age and older should be screened for depression at least annually. (Source: United States Preventive Services Task Force)</p> <p><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul> <p>Medical Providers: EXAM—Depression Screening</p> <ul style="list-style-type: none"> <li>• <b>Normal/Negative</b>—Denies symptoms of depression</li> <li>• <b>Abnormal/Positive</b>—Further evaluation indicated</li> <li>• <b>Refused</b>—Patient declined exam/screen</li> <li>• <b>Unable to screen</b>—Provider unable to screen</li> </ul> <p><b>Note:</b> 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"> <li>• Major Depressive Disorder</li> <li>• Dysthymic Disorder</li> <li>• Depressive Disorder NOS</li> <li>• Bipolar I or II Disorder</li> <li>• Cyclothymic Disorder</li> <li>• Bipolar Disorder NOS</li> <li>• Mood Disorder Due to a General Medical Condition</li> <li>• Substance-induced Mood Disorder</li> <li>• Mood Disorder NOS</li> </ul> <p><b>Note:</b> Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</p>	<p><b>Depression Screening Exam</b> <a href="#">Exam Entry</a> (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, PHQT Provider Performing Exam:</p> <p><b>Depression Screen Diagnosis POV</b> <a href="#">Visit Diagnosis Entry</a></p> <p>Purpose of Visit: ICD-9: V79.0 Provider Narrative: Modifier: Cause of DX:</p> <p><b>Depression Screening CPT</b> <a href="#">Visit Services Entry</a> (includes historical CPTs)</p> <p>Enter CPT Code: 1220F, 3725F, G0444 Quantity Modifier: Modifier 2:</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont.)		<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"> <li>• Not at all Value: 0</li> <li>• Several days Value: 1</li> <li>• More than half the days Value: 2</li> <li>• Nearly every day Value: 3</li> </ul> <p>Feeling down, depressed, or hopeless</p> <ul style="list-style-type: none"> <li>• Not at all Value: 0</li> <li>• Several days Value: 1</li> <li>• More than half the days Value: 2</li> <li>• Nearly every day Value: 3</li> </ul> <p>PHQ-2 Scaled Version (continued)</p> <p>Total Possible PHQ-2 Score: Range: 0-6</p> <ul style="list-style-type: none"> <li>• 0-2: Negative Depression Screening Exam: <ul style="list-style-type: none"> <li>- Code Result: Normal or Negative</li> </ul> </li> <li>• 3-6: Positive; further evaluation indicated Depression Screening Exam <ul style="list-style-type: none"> <li>- Code Result: <b>Abnormal or Positive</b></li> </ul> </li> </ul> <p>The patient may decline the screen or “Refuse to answer” Depression Screening Exam</p> <ul style="list-style-type: none"> <li>• Code Result: <b>Refused</b></li> </ul> <p>The provider is unable to conduct the Screen Depression Screening Exam</p> <ul style="list-style-type: none"> <li>• Code Result: <b>Unable To Screen</b></li> </ul>	<p><b>Mood Disorder Diagnosis POV</b></p> <p><a href="#">Visit Diagnosis Entry</a></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>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont.)		<p>Provider should <b>Note</b> 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"> <li>• Not at all Value: 0</li> <li>• Several days Value: 1</li> <li>• More than half the days Value: 2</li> <li>• Nearly every day Value: 3</li> </ul> <p>Feeling down, depressed, or hopeless?</p> <ul style="list-style-type: none"> <li>• Not at all Value: 0</li> <li>• Several days Value: 1</li> <li>• More than half the days Value: 2</li> <li>• Nearly every day Value: 3</li> </ul> <p>Trouble falling or staying asleep, or sleeping too much?</p> <ul style="list-style-type: none"> <li>• Not at all Value: 0</li> <li>• Several days Value: 1</li> <li>• More than half the days Value: 2</li> <li>• Nearly every day Value: 3</li> </ul> <p>Feeling tired or having little energy?</p> <ul style="list-style-type: none"> <li>• Not at all Value: 0</li> <li>• Several days Value: 1</li> <li>• More than half the days Value: 2</li> <li>• Nearly every day Value: 3</li> </ul>	

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont.)		<p>Poor appetite or overeating?</p> <ul style="list-style-type: none"> <li>• Not at all <span style="float: right;">Value: 0</span></li> <li>• Several days <span style="float: right;">Value: 1</span></li> <li>• More than half the days <span style="float: right;">Value: 2</span></li> <li>• Nearly every day <span style="float: right;">Value: 3</span></li> </ul> <p>Feeling bad about yourself—or that you are a failure or have let yourself or your family down?</p> <ul style="list-style-type: none"> <li>• Not at all <span style="float: right;">Value: 0</span></li> <li>• Several days <span style="float: right;">Value: 1</span></li> <li>• More than half the days <span style="float: right;">Value: 2</span></li> <li>• Nearly every day <span style="float: right;">Value: 3</span></li> </ul> <p>Trouble concentrating on things, such as reading the newspaper or watching television?</p> <ul style="list-style-type: none"> <li>• Not at all <span style="float: right;">Value: 0</span></li> <li>• Several days <span style="float: right;">Value: 1</span></li> <li>• More than half the days <span style="float: right;">Value: 2</span></li> <li>• Nearly every day <span style="float: right;">Value: 3</span></li> </ul> <p>Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?</p> <ul style="list-style-type: none"> <li>• Not at all <span style="float: right;">Value: 0</span></li> <li>• Several days <span style="float: right;">Value: 1</span></li> <li>• More than half the days <span style="float: right;">Value: 2</span></li> <li>• Nearly every day <span style="float: right;">Value: 3</span></li> </ul>	

## Key Clinical Performance Objectives

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

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Antidepressant Medication Management	Patients 18 years of age and older with new episodes of depression should fill a sufficient number of separate prescriptions/refills of antidepressant medication for continuous treatment of at least 84 days (12 weeks) (APT) and 180 days (6 months) (CONPT).	<p>Standard EHR documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in EHR:</p> <ul style="list-style-type: none"> <li>• Date received</li> <li>• Location</li> <li>• Dosage</li> </ul>	<p><b>Antidepressant Medication</b>  <a href="#">Medication Entry</a>            Select Medication: [Enter Antidepressant Prescribed Medication]            Outside Drug Name (Optional): [Enter any additional name for the drug]            SIG            Quantity:            Day Prescribed:            Event Date&amp;Time:            Ordering Provider:</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Weight Control	<p>Patients ages 2–5 at the beginning of the report period whose BMI could be calculated and have a BMI equal to or greater than (<math>\geq</math>) 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"> <li>• Height</li> <li>• Weight</li> <li>• Date Recorded</li> </ul> <p>BMI is calculated using NHANES II</p> <p>Age in the age groups is calculated based on the date of the most current BMI found.</p> <p>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><b>Height Measurement</b>  <a href="#">Vital Measurements Entry</a>            (includes historical Vitals)            Value:            Select Qualifier:            Actual            Estimated            Date/Time Vitals Taken:</p> <p><b>Weight Measurement</b>  <a href="#">Vital Measurements Entry</a>            (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 &gt;= 85</th> <th>BMI &gt;= 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 &gt;</th> <th>BMI &lt;</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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul>	<p><b>Blood Pressure Data Entry</b>  <a href="#">Vital Measurements Entry</a>                      (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
<p>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</p>	<p>Active Clinical Patients age 40 -75 DX with diabetes or age 21 and older with documented CVD or LDL greater than or equal to (<math>\geq</math>) 190 who have statin therapy.</p>	<p>Standard EHR documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in EHR:</p> <ul style="list-style-type: none"> <li>• Date received</li> <li>• Location</li> <li>• Dosage</li> </ul>	<p><b>Statin Therapy Medication</b>  <a href="#">Medication Entry</a>            Select Medication: [Enter Statin Therapy Prescribed Medication]            Outside Drug Name (Optional): [Enter any additional name for the drug]            SIG            Quantity:            Day Prescribed:            Event Date&amp;Time:            Ordering Provider:</p> <p><b>Statin Therapy CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT Code: 4013F            Quantity:            Modifier:            Modifier 2:</p>

## Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
HIV Screening	<p>Patients should be tested for HIV at least once; education and follow-up provided as appropriate.</p> <p><b>Note:</b> 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"> <li>• Date received</li> <li>• Location</li> <li>• Results</li> </ul>	<p><b>HIV Screen CPT</b>  <a href="#">Visit Services Entry</a> (includes historical CPTs)            Enter CPT Code: 86689, 86701-86703, 87390, 87391, 87534-87539            Quantity            Modifier:            Modifier 2:</p> <p><b>HIV Diagnoses POV</b>  <a href="#">Visit Diagnosis Entry</a>            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><b>HIV Lab Test</b>  <a href="#">Lab Test Entry</a>            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><b>Note:</b> 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><b>Infant Breastfeeding</b></p> <p><a href="#">Infant Feeding Choice Entry</a></p> <p>Enter Feeding Choice:</p> <p>Exclusive Breastfeeding</p> <p>Mostly Breastfeeding</p> <p>1/2 &amp; 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><b>Note:</b> 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"> <li>1. Education Topic/Diagnosis</li> <li>2. Readiness to Learn</li> <li>3. Level of Understanding (see below)</li> <li>4. Initials of Who Taught</li> <li>5. Time spent (in minutes)</li> <li>6. Goal Not Set, Goal Set, Goal Met, Goal Not Met</li> <li>7. Text relating to the goal or its status</li> </ol> <p>Readiness to Learn:</p> <ul style="list-style-type: none"> <li>• Distraction</li> <li>• Eager To Learn</li> <li>• Intoxication</li> <li>• Not Ready</li> <li>• Pain</li> <li>• Receptive</li> <li>• Severity of Illness</li> <li>• Unreceptive</li> </ul> <p>Levels of Understanding:</p> <ul style="list-style-type: none"> <li>• P–Poor</li> <li>• F–Fair</li> <li>• G–Good</li> <li>• GR–Group-No Assessment</li> <li>• R–Refused</li> </ul> <p>Goal Codes:</p> <ul style="list-style-type: none"> <li>• GS–Goal Set</li> <li>• GM–Goal Met</li> <li>• GNM–Goal Not Met</li> <li>• GNS–Goal Not Set</li> </ul>	<p><b>Patient Education Topic</b>  <a href="#">Patient Education Entry</a> (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><b>Patient Education Diagnosis</b>  <a href="#">Patient Education Entry</a> (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"> <li>• Anatomy and Physiology</li> <li>• Complications</li> <li>• Disease Process</li> <li>• Equipment</li> <li>• Exercise</li> <li>• Follow-up</li> <li>• Home Management</li> <li>• Hygiene</li> <li>• Lifestyle Adaptation</li> <li>• Literature</li> <li>• Medical Nutrition Therapy</li> <li>• Medications</li> <li>• Nutrition</li> <li>• Prevention</li> <li>• Procedures</li> <li>• Safety</li> <li>• Tests</li> <li>• Treatment</li> </ul>	

## Enter Information in EHR

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

- [Clinic Codes](#): Page 49.
- [Purpose of Visit/Diagnosis](#): Page 50.
- [CPT Codes](#): Page 55.
- [Procedure Codes](#): Page 62.
- [Exams](#): Page 66.
- [Health Factors](#): Page 70.
- [Immunizations](#): Page 73, including [contraindications](#): Page 78.
- [Vital Measurements](#): Page 81.
- [Lab Tests](#): Page 85.
- [Medications](#): Page 91.
- [Infant Feeding](#): Page 96.
- [Patient Education](#): Page 98.
- [Refusals](#): Page 105.

**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.

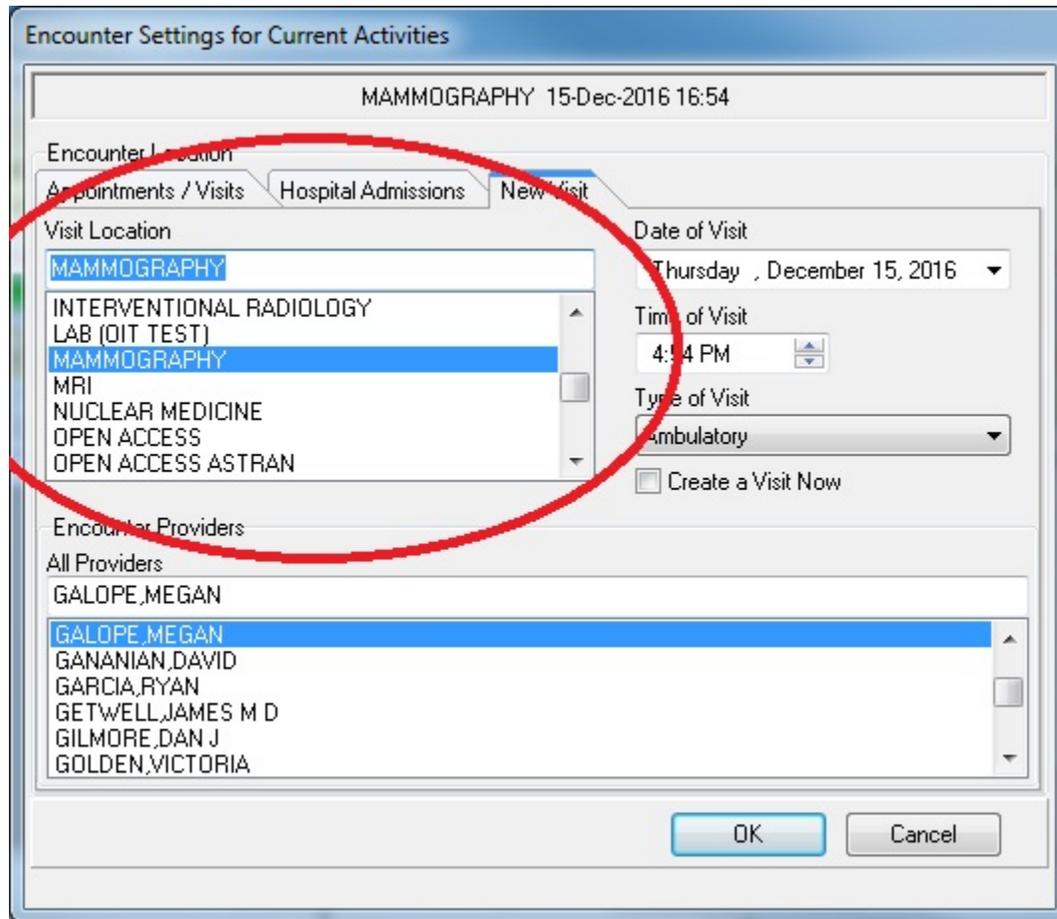


Figure 1: Choosing a clinic code

# Key Clinical Performance Objectives

## Purpose of Visit/Diagnosis

The purpose of visit (POV) is entered through the IPL on the **Problem Mngt** tab (Figure 2).

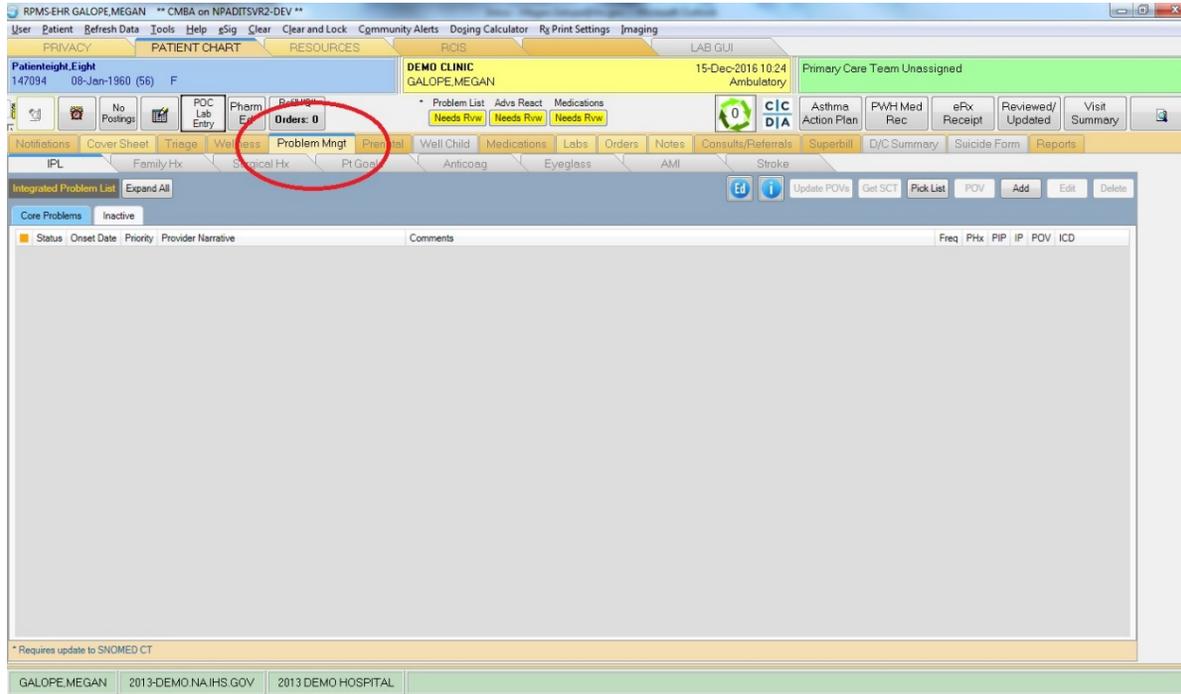


Figure 2: **Problem Mngt** tab

To enter a POV:

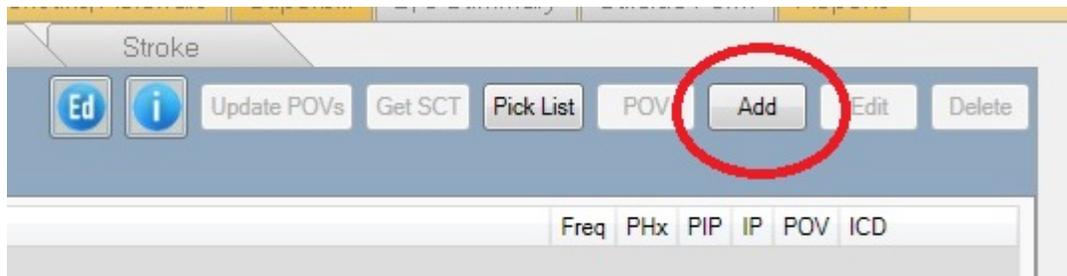


Figure 3: Entering a POV

1. Click **Add** on the **Problem Mngt** tab. The **Integrated Problem Maintenance – Add Problem** dialog (Figure 4) displays.

# Key Clinical Performance Objectives

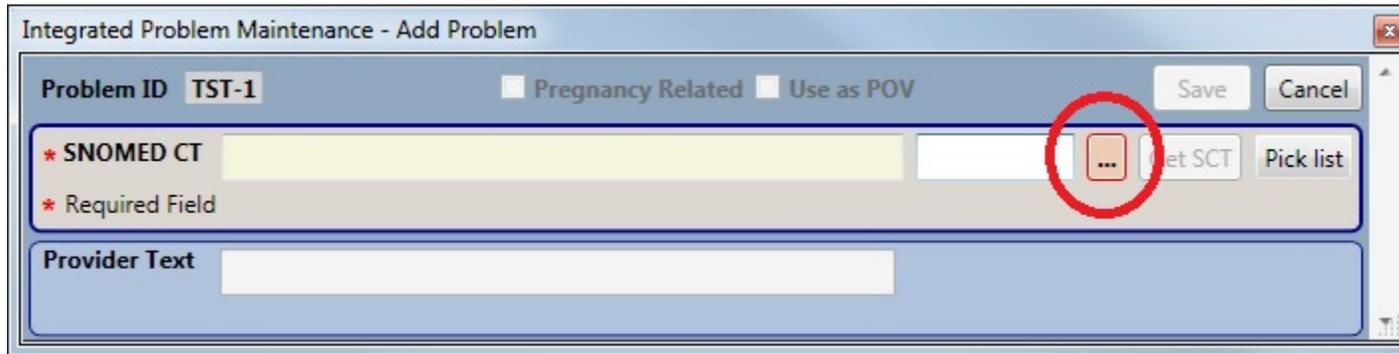


Figure 4: Integrated Problem Maintenance – Add Problem dialog

2. Type the **diagnosis** and click the ellipses (...) button. The **SNOMED CT Lookup** dialog (Figure 5) displays.

# Key Clinical Performance Objectives

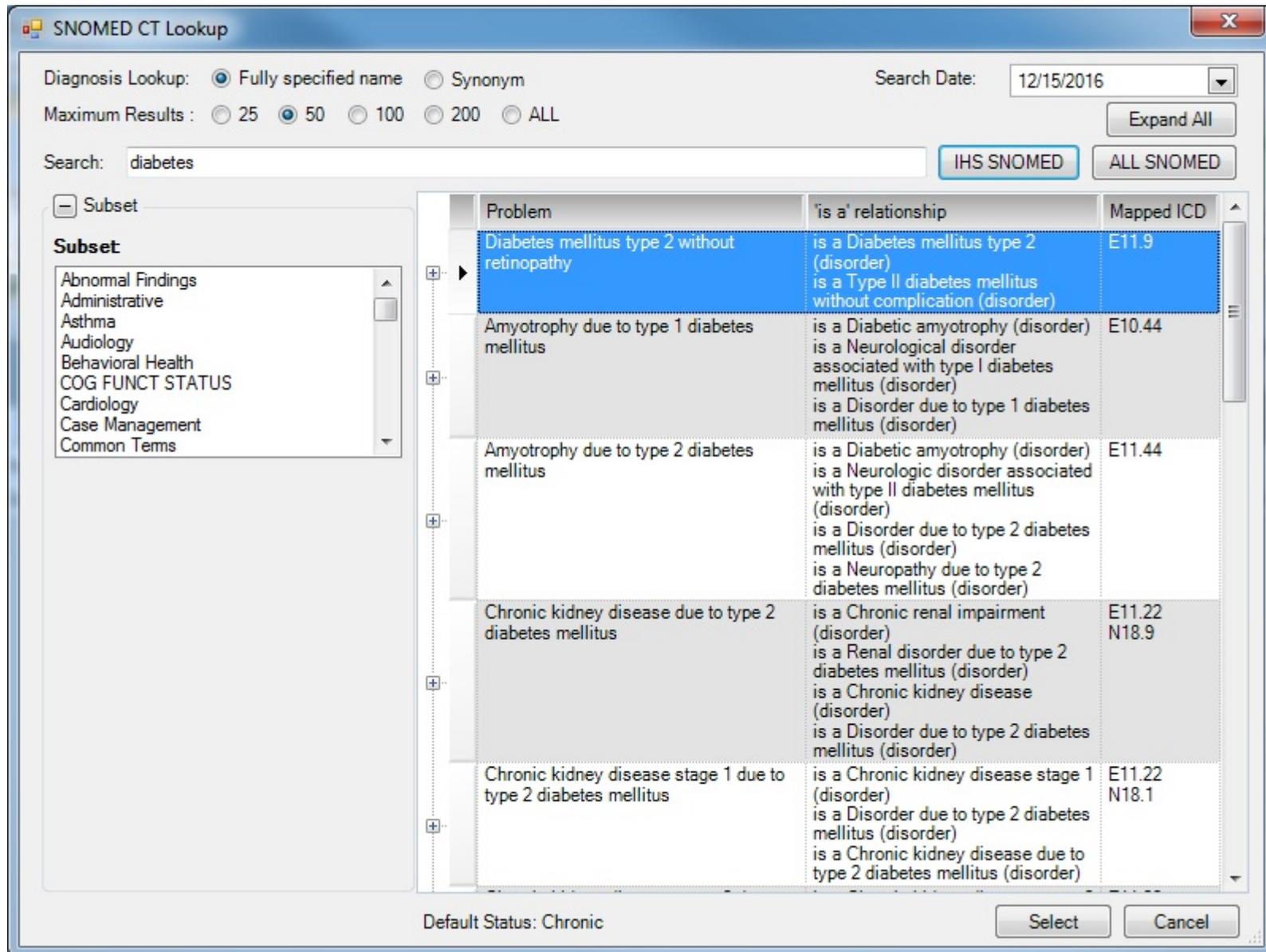


Figure 5: Entering the diagnosis

# Key Clinical Performance Objectives

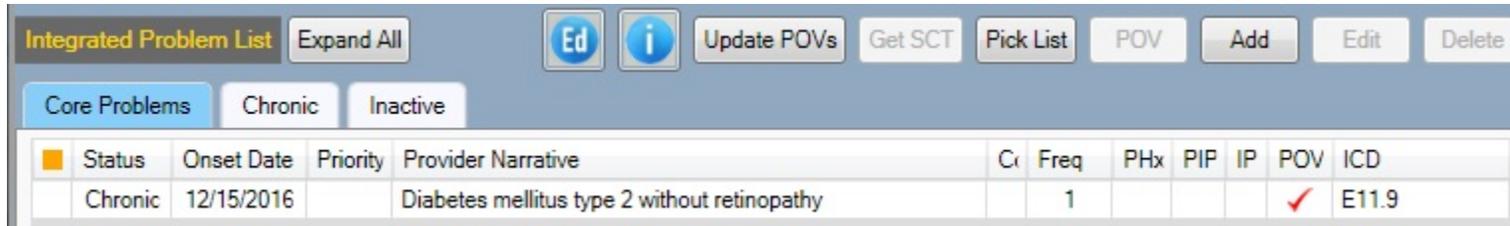
3. Click to highlight the diagnosis and click **Select**. The **Integrated Problem Maintenance – Add Problem** dialog (Figure 6) displays.

The screenshot shows the 'Integrated Problem Maintenance - Add Problem' dialog box. At the top, there are fields for 'Problem ID' (TST-1), 'Priority', 'Pregnancy Related' (unchecked), 'Use as POV' (checked), and 'Primary' (checked). The 'Use as POV' checkbox is circled in red. Below these are 'Save' and 'Cancel' buttons. The main section contains a 'SNOMED CT' field with the text 'Diabetes mellitus type 2 without retinopathy' and a search box containing 'diabetes'. There are 'Get SCT' and 'Pick list' buttons. Below this is a 'Status' section with radio buttons for 'Chronic' (selected), 'Sub-acute', 'Episodic', 'Social/Environmental', 'Inactive', 'Personal Hx', and 'Routine/Admin'. A '\* Required Field' label is present. The 'Provider Text' field contains 'Diabetes mellitus type 2 without retinopathy E11.9'. The 'Date of Onset' field is set to '12/15/2016'. The 'Qualifiers' section has tabs for 'Severity' and 'Clinical Course', with dropdown menus for 'Severity' and 'Episodicities'. There is an 'Is Injury' checkbox. A 'Comments' text area is below. The 'Care Plan Info' section has a button 'Add Visit Instruction / Care Plans / Goal Activities' and four columns: 'Goal Notes', 'Care Plans', 'Visit Instructions', and 'Care Planning Activities', each with a scrollable area.

Figure 6: Entering additional POV information

## Key Clinical Performance Objectives

4. To use this diagnosis as a POV, check the **Use as POV** and/or **Primary** checkboxes. Enter any other pertinent information and click **Save**. The newly added POV should display in the **Integrated Problem List** (Figure 7).



The screenshot shows the 'Integrated Problem List' interface. At the top, there are several buttons: 'Expand All', 'Ed', 'i', 'Update POVs', 'Get SCT', 'Pick List', 'POV', 'Add', 'Edit', and 'Delete'. Below these are three tabs: 'Core Problems', 'Chronic', and 'Inactive'. The 'Chronic' tab is selected. The main area contains a table with the following data:

Status	Onset Date	Priority	Provider Narrative	Cr	Freq	PHx	PIP	IP	POV	ICD
Chronic	12/15/2016		Diabetes mellitus type 2 without retinopathy		1				✓	E11.9

Figure 7: Example of a newly added POV to **Integrated Problem List**

# Key Clinical Performance Objectives

## CPT Codes

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

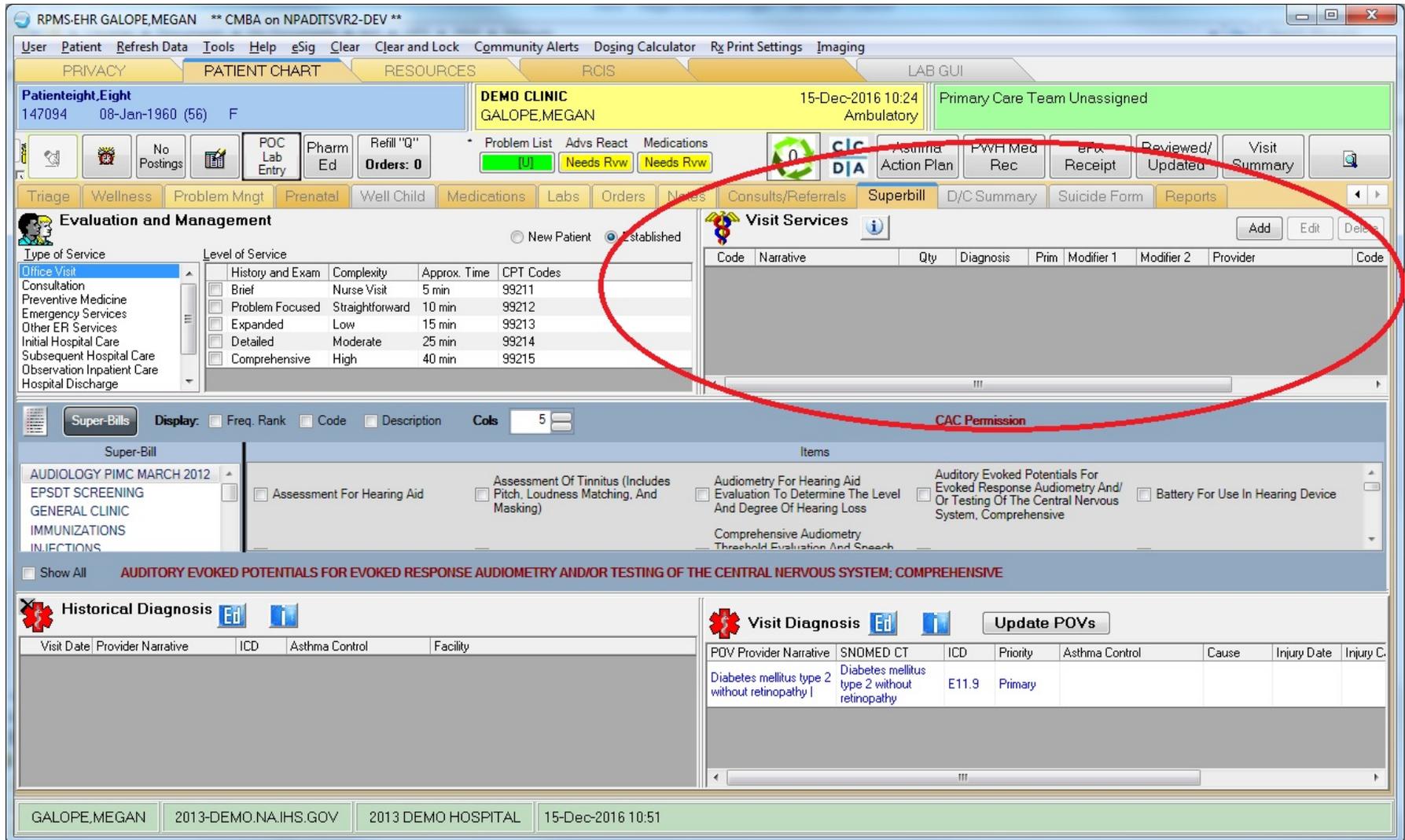


Figure 8: Visit Services component

# Key Clinical Performance Objectives

To enter a CPT code:

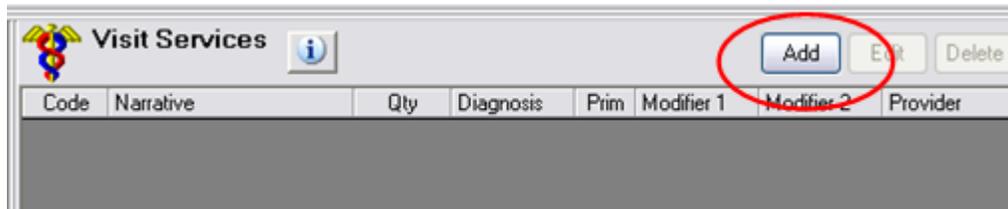


Figure 9: Entering a CPT code

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

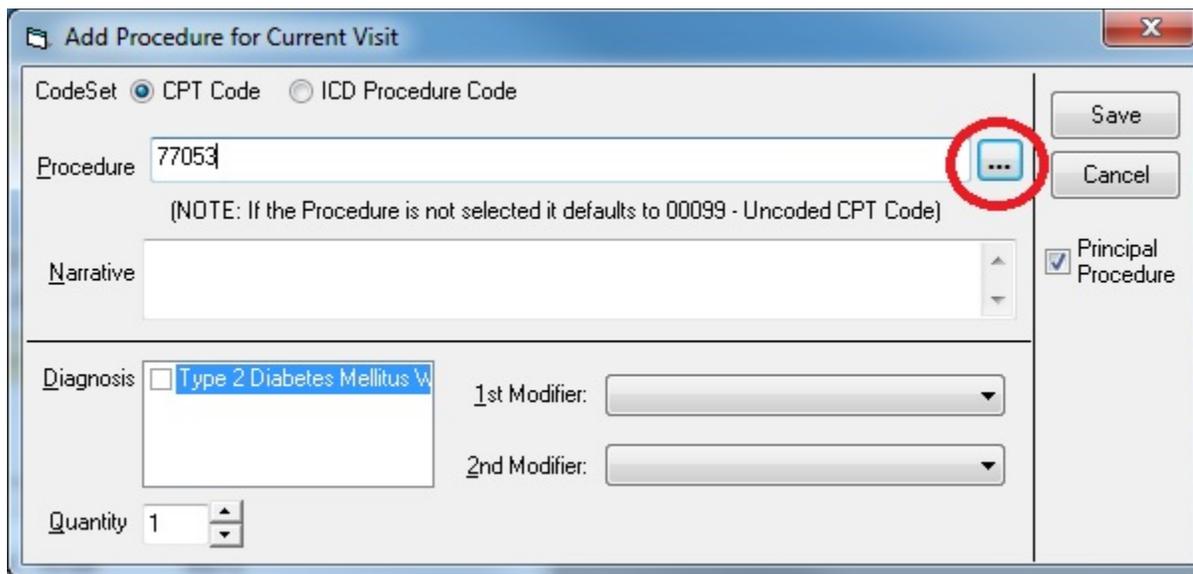


Figure 10: Entering the CPT code

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

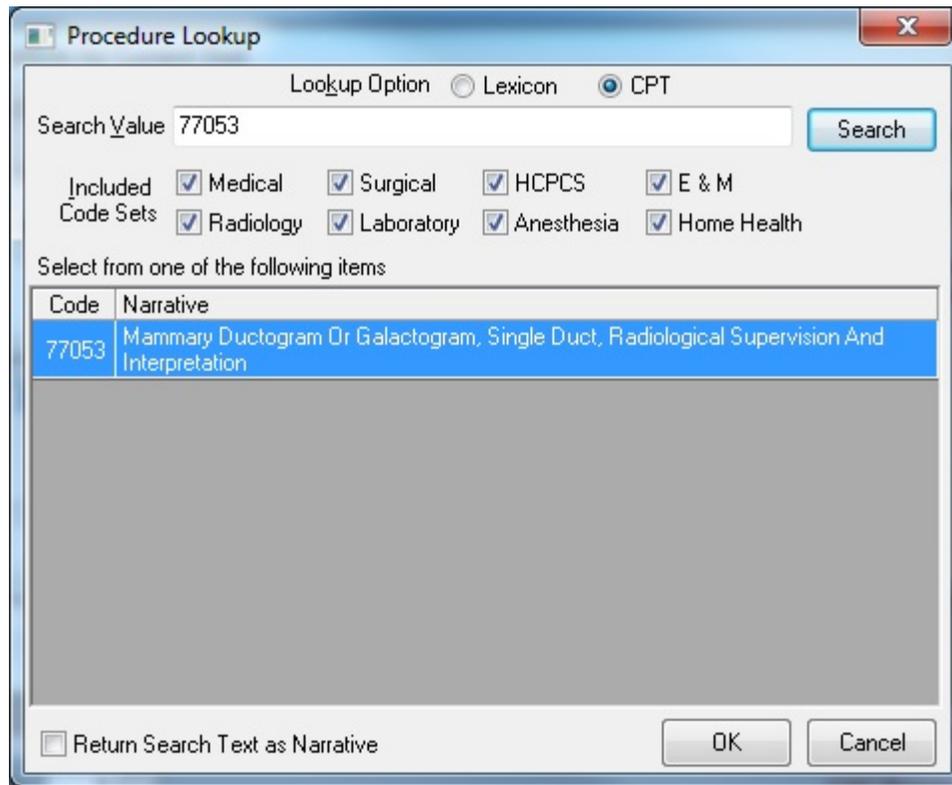


Figure 11: **Procedure Lookup** dialog

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

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:  Type 2 Diabetes Mellitus W  
 1st Modifier:   
 2nd Modifier:

Quantity: 1

Save  
 Cancel  
 Principal Procedure

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 **Surgical Hx** tab under the **Problem Mngt** tab (Figure 14).

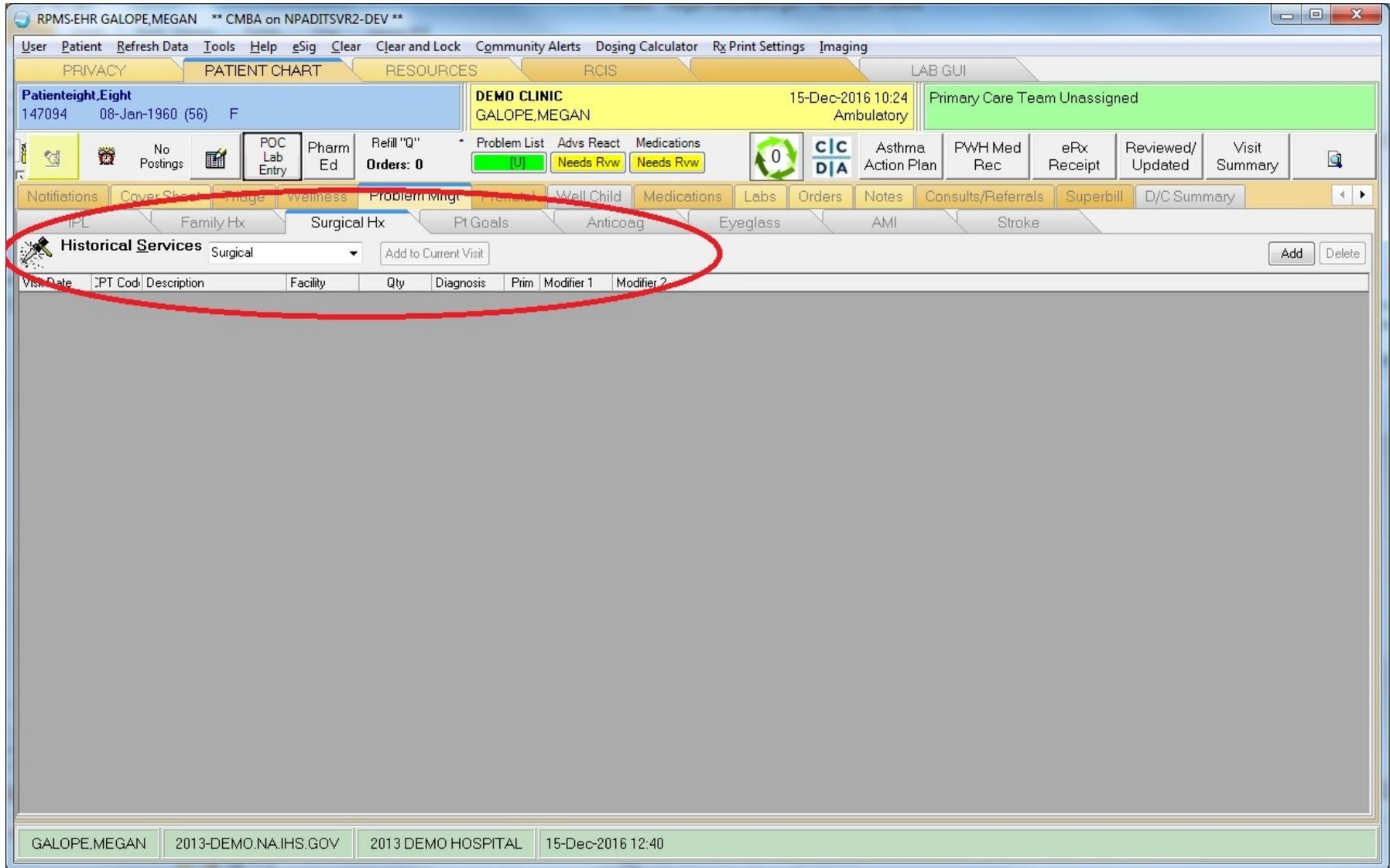


Figure 14: **Historical Services** component

# Key Clinical Performance Objectives

To enter a CPT code:

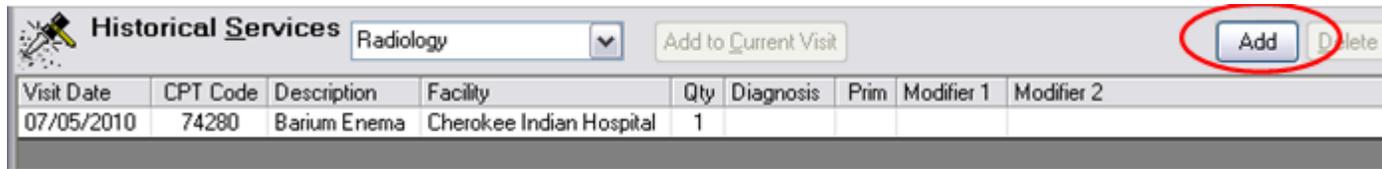


Figure 15: Example of entering a CPT code

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

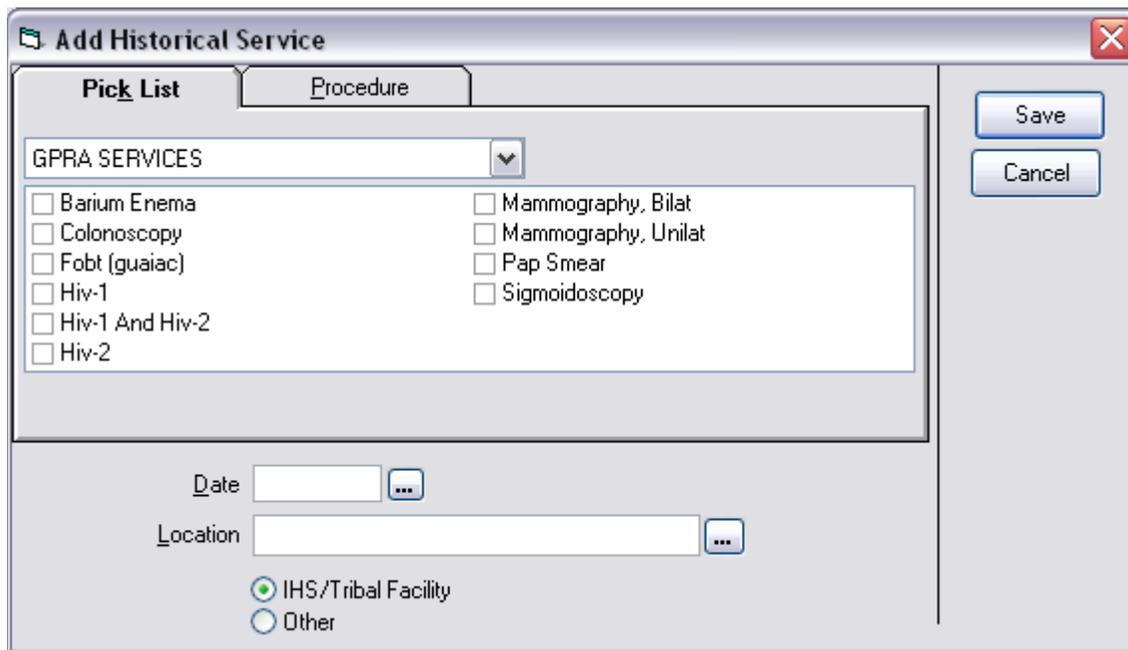


Figure 16: Adding a historical service using the **Pick List**

- 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", with "Procedure" selected. The "Procedure" field is a text box with a dropdown arrow and a note below it: "(NOTE: If the Procedure is not selected it defaults to 00099 - Uncoded CPT Code)". Below this is a "Narrative" text box with scroll arrows. There are two dropdown menus for "1st Modifier" and "2nd Modifier". A "Quantity" spinner box is set to "1". At the bottom, there are "Date" and "Location" text boxes with dropdown arrows, and two radio buttons: "IHS/Tribal Facility" (selected) and "Other". On the right side of the dialog, there 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 56.
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).

The screenshot displays the RPMS-EHR GALOPE, MEGAN interface. The top navigation bar includes tabs for PRIVACY, PATIENT CHART, RESOURCES, RCIS, and LAB GUI. The patient information section shows 'Patienteight.Eight' (147094, 08-Jan-1960, 56, F) at 'DEMO CLINIC GALOPE, MEGAN' on '15-Dec-2016 10:24' in 'Ambulatory' status. The 'Primary Care Team Unassigned' is noted. The 'Visit Services' component is highlighted with a red circle and contains the following table:

Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider	Code

Below the Visit Services table, the 'Super-Bills' section is visible, showing 'AUDIOLOGY PIMC MARCH 2012' and 'EPSDT SCREENING'. The 'Historical Diagnosis' and 'Visit Diagnosis' sections are also present, with the Visit Diagnosis table showing:

POV	Provider Narrative	SNOMED CT	ICD	Priority	Asthma Control	Cause	Injury Date	Injury C
	Diabetes mellitus type 2 without retinopathy	Diabetes mellitus type 2 without retinopathy	E11.9	Primary				

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.

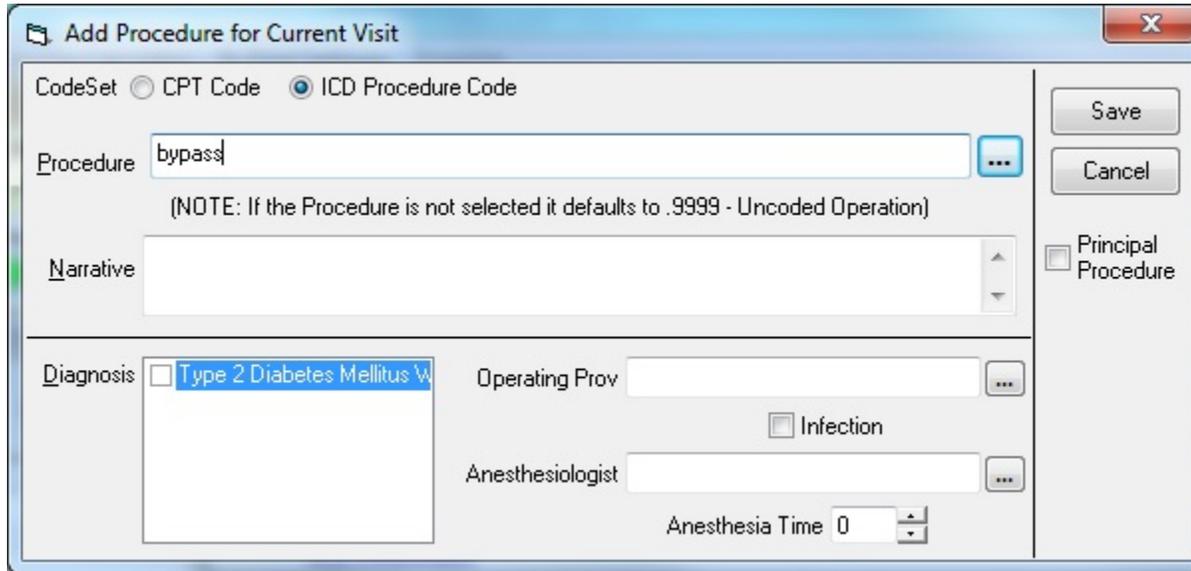


Figure 21: **Add Procedure for Current Visit** dialog

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

## Key Clinical Performance Objectives

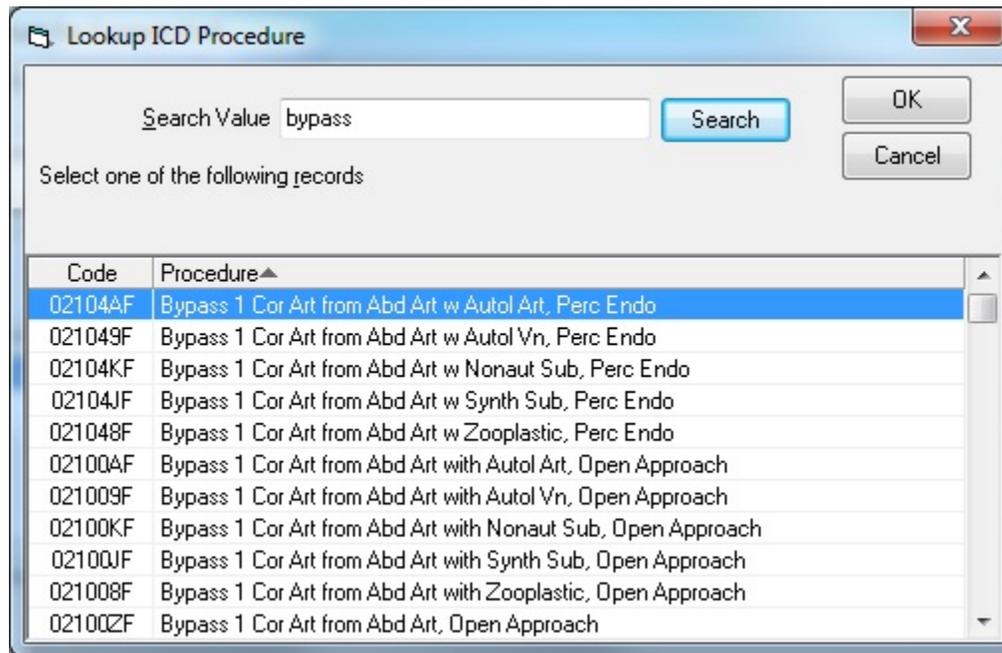


Figure 22: Choosing a Procedure

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

Procedure: 02104AF - Bypass 1 Cor Art from Abd Art w Autol Art, Perc Endo  
(NOTE: If the Procedure is not selected it defaults to .9999 - Uncoded Operation)

Narrative: Bypass 1 Cor Art from Abd Art w Autol Art, Perc Endo

Diagnosis:  Type 2 Diabetes Mellitus W

Operating Prov:

Infection

Anesthesiologist:

Anesthesia Time: 0

Buttons: Save, Cancel, Principal Procedure

Figure 23: Entering additional Procedure information

6. 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	Code
02104AF	Bypass 1 Cor Art From Abd Art W Autol Art, Perc Endo						GALOPE,MEGAN	Bypass Art W

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).

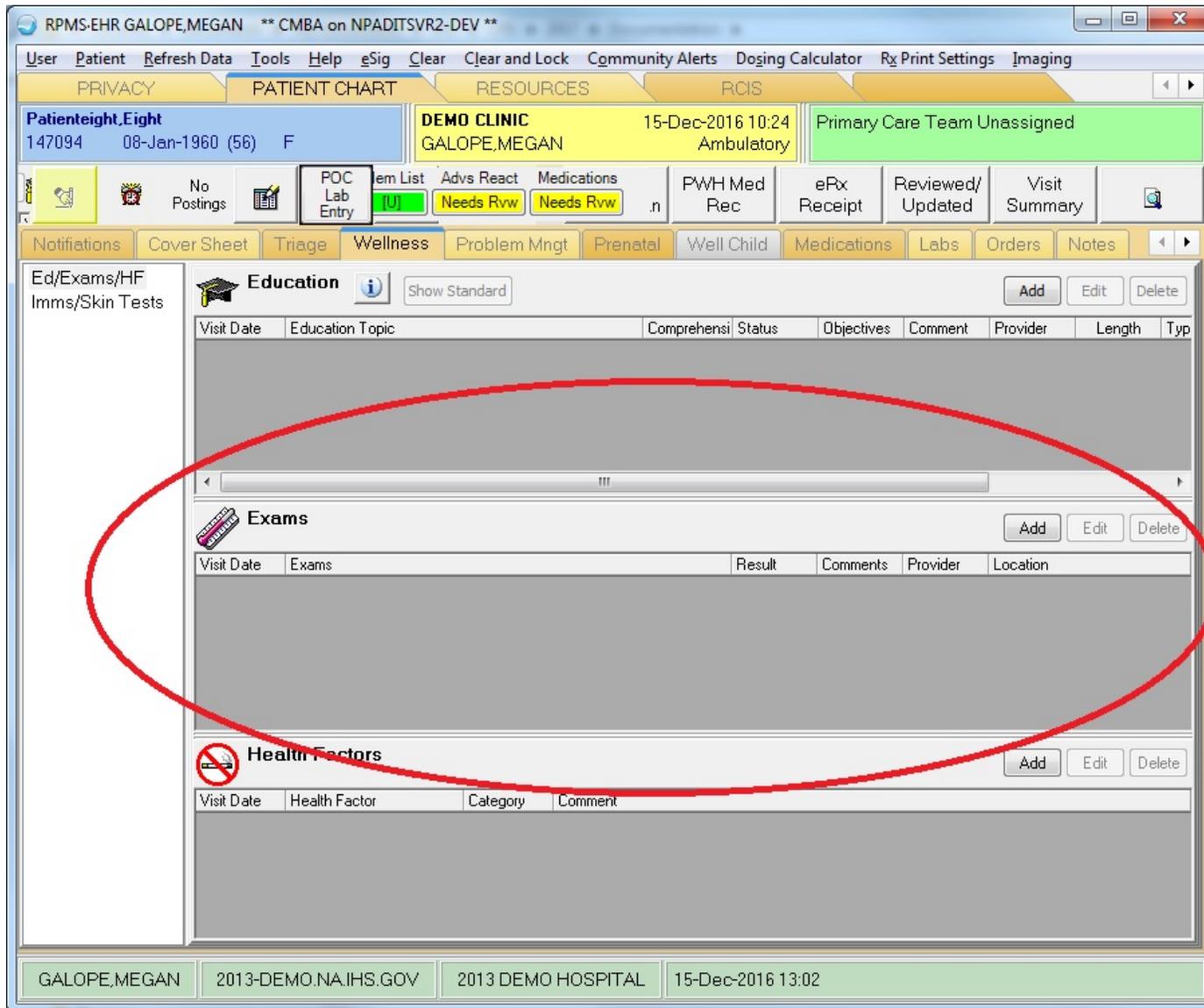


Figure 25: **Exams** component

# Key Clinical Performance Objectives

To enter an Exam code:

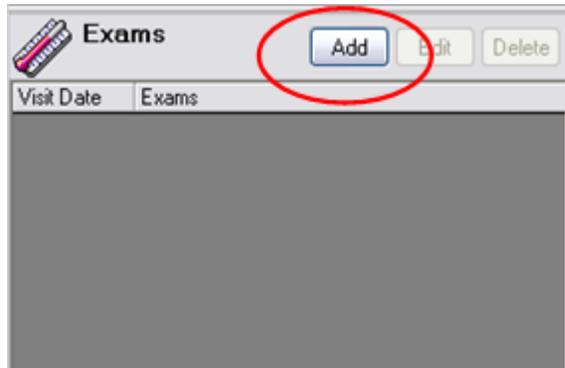


Figure 26: Entering an Exam code

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

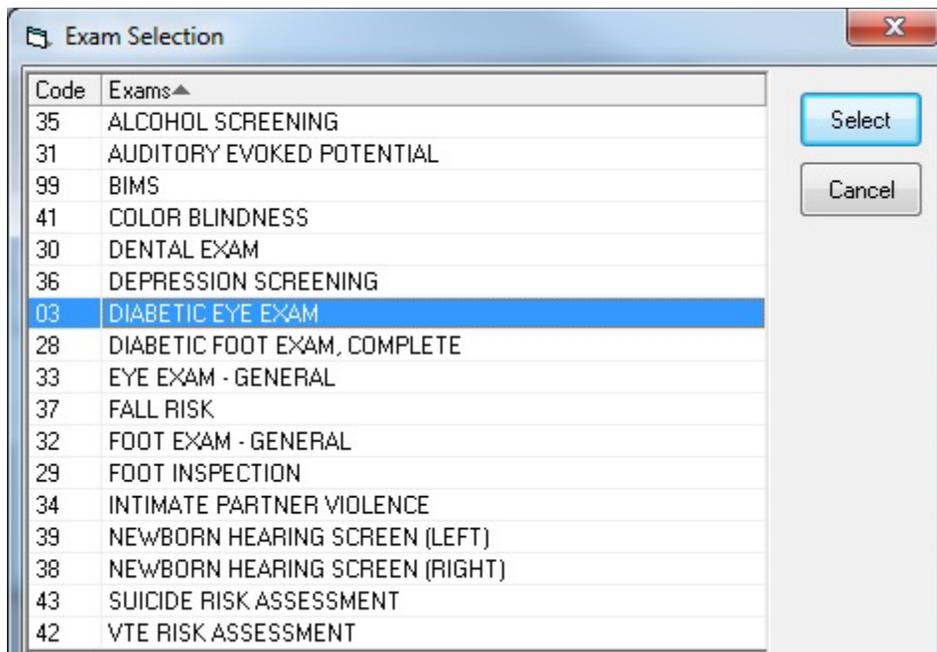
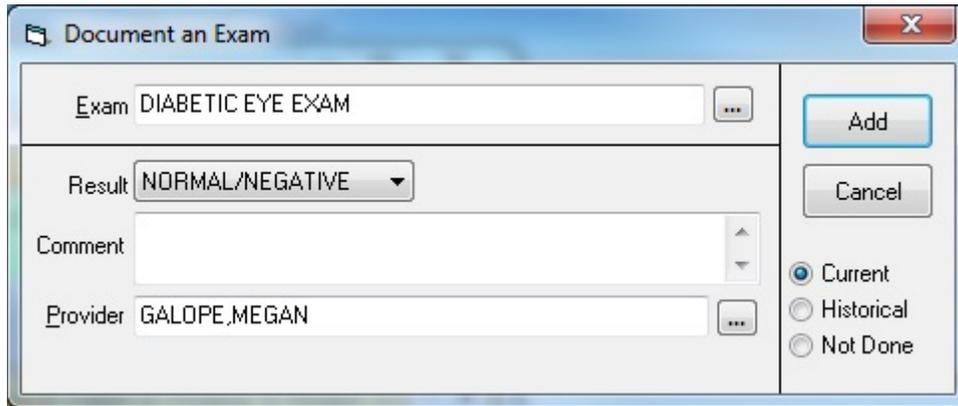


Figure 27: Selecting an exam

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

## Key Clinical Performance Objectives

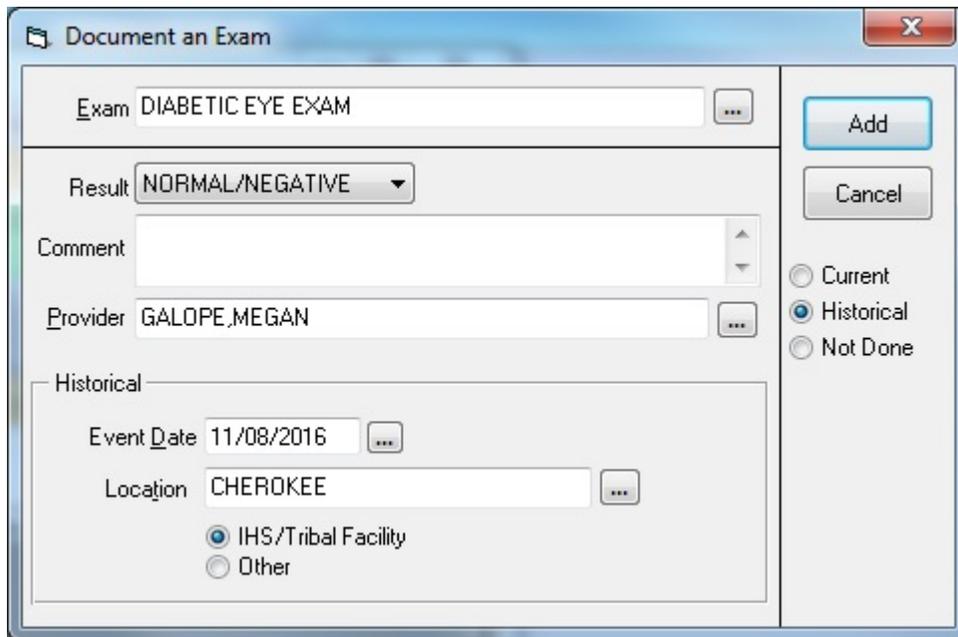


The screenshot shows a dialog box titled "Document an Exam". It contains the following fields and controls:

- Exam:** Text box containing "DIABETIC EYE EXAM" with a dropdown arrow.
- Result:** Dropdown menu showing "NORMAL/NEGATIVE".
- Comment:** Text area with up and down arrows.
- Provider:** Text box containing "GALOPE,MEGAN" with a dropdown arrow.
- Buttons:** "Add" (highlighted in blue) and "Cancel".
- Radio Buttons:** "Current" (selected), "Historical", and "Not Done".

Figure 28: Entering a result and additional comments

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



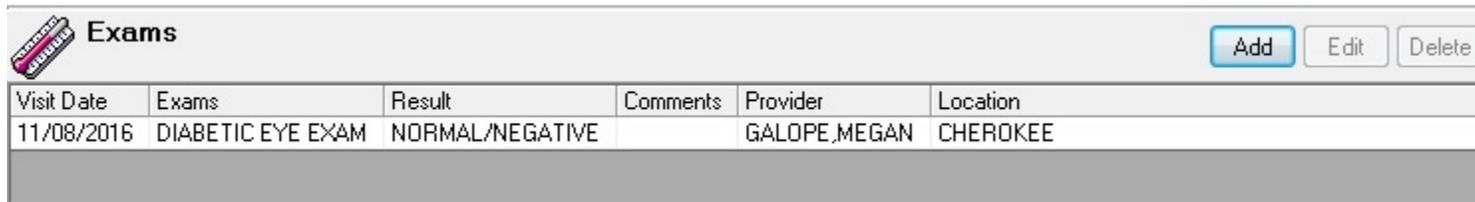
The screenshot shows the same "Document an Exam" dialog box, but with the "Historical" radio button selected. It includes additional fields for historical exams:

- Historical Section:**
  - Event Date:** Text box containing "11/08/2016" with a dropdown arrow.
  - Location:** Text box containing "CHEROKEE" with a dropdown arrow.
  - Radio Buttons:** "IHS/Tribal Facility" (selected) and "Other".
- Buttons:** "Add" and "Cancel".
- Radio Buttons:** "Current", "Historical" (selected), and "Not Done".

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



The image shows a software interface for managing exams. At the top left is a pencil icon and the word "Exams". To the right are three buttons: "Add" (highlighted in blue), "Edit", and "Delete". Below this is a table with six columns: "Visit Date", "Exams", "Result", "Comments", "Provider", and "Location". One row of data is visible, showing a visit on 11/08/2016 for a "DIABETIC EYE EXAM" with a "NORMAL/NEGATIVE" result, performed by "GALOPE, MEGAN" at "CHEROKEE".

Visit Date	Exams	Result	Comments	Provider	Location
11/08/2016	DIABETIC EYE EXAM	NORMAL/NEGATIVE		GALOPE, MEGAN	CHEROKEE

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 under **Ed/Exams/HF** (Figure 31).

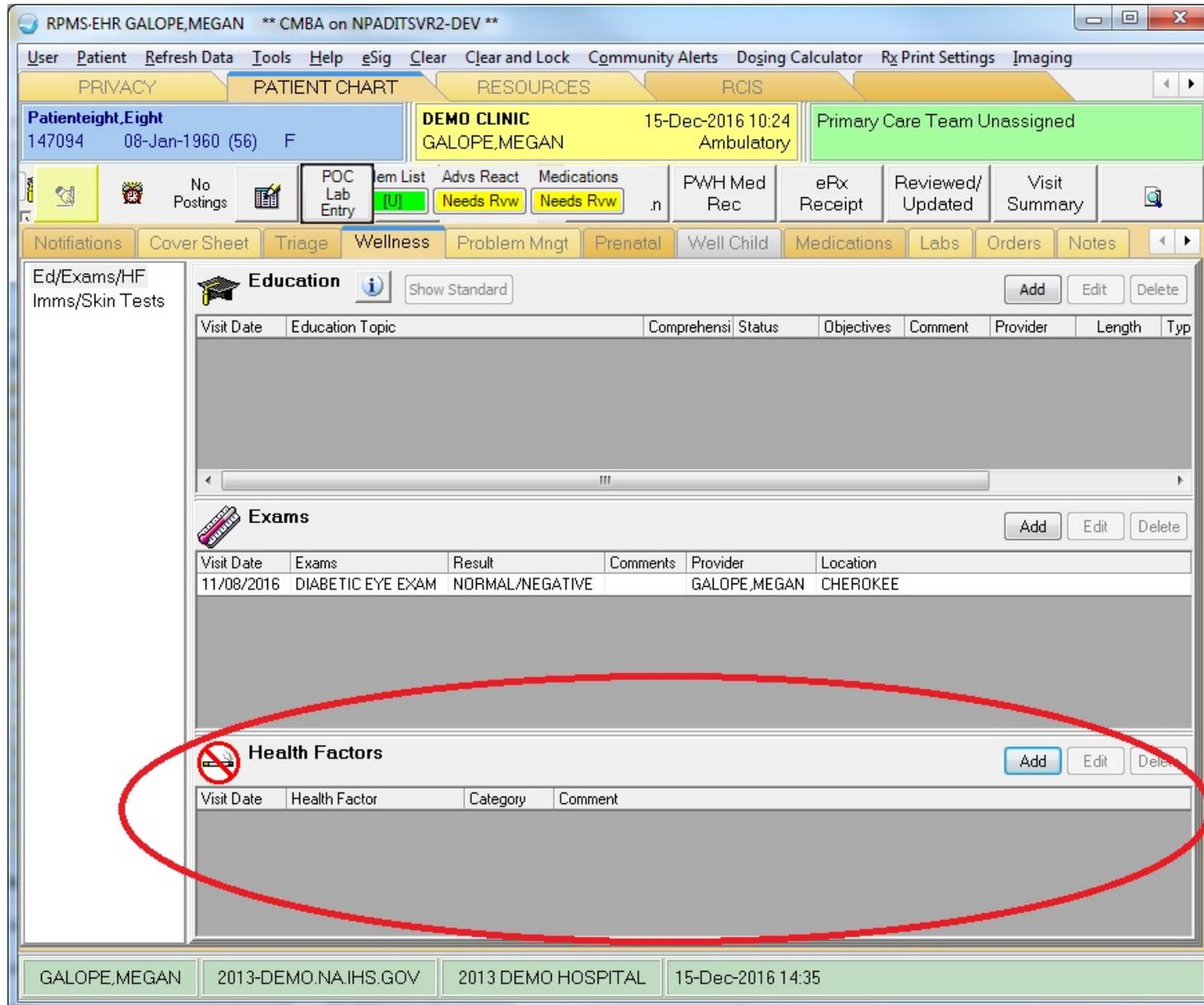


Figure 31: **Health Factors** component

# 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.

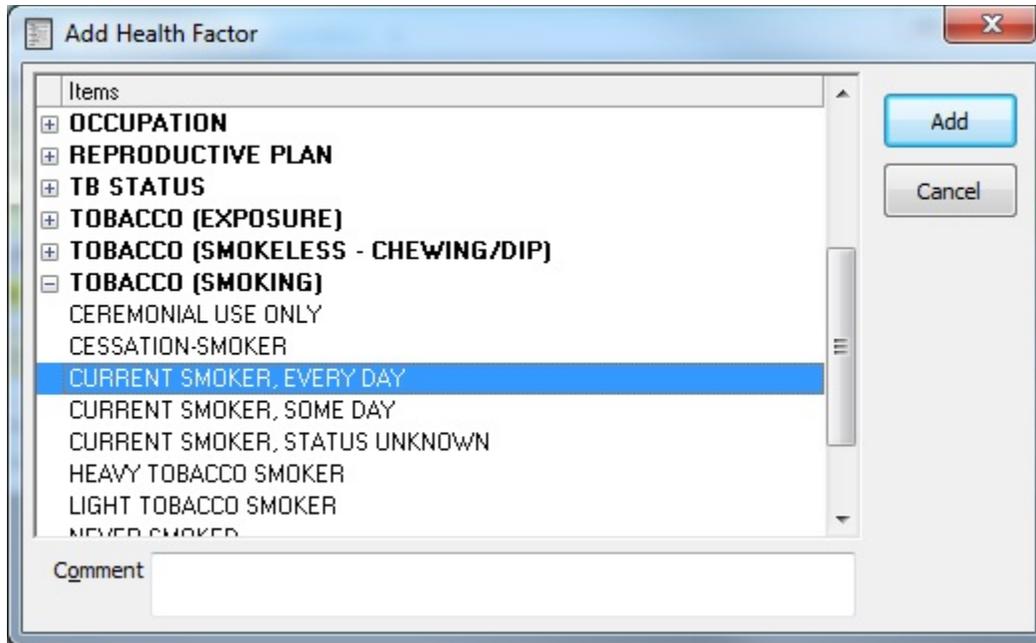
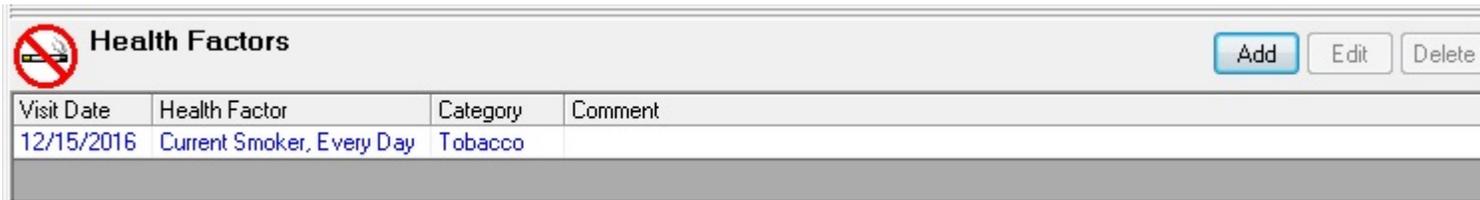


Figure 33: Choosing a **Health Factor**

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
12/15/2016	Current Smoker, Every Day	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 under **Imms/Skin Tests** (Figure 35).

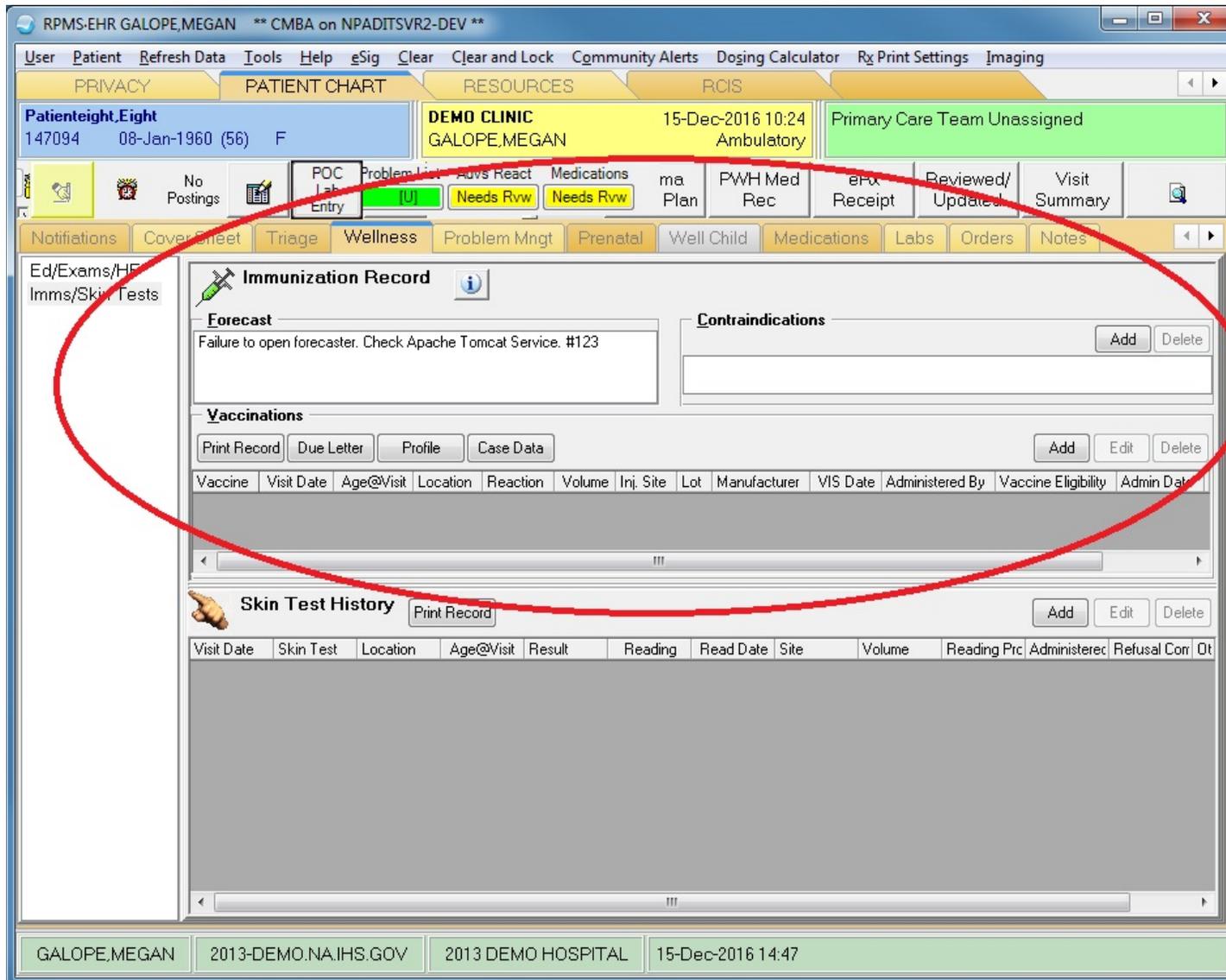
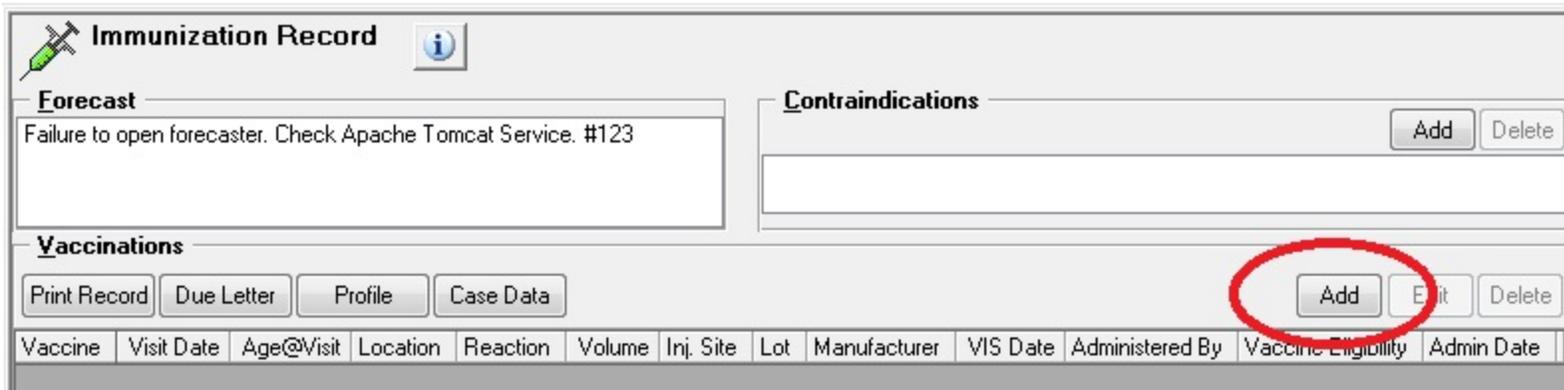


Figure 35: Immunization Record component

# Key Clinical Performance Objectives

To enter an Immunization:



The screenshot shows the 'Immunization Record' interface. It includes a 'Forecast' section with an error message, a 'Contraindications' section, and a 'Vaccinations' section. The 'Vaccinations' section contains buttons for 'Print Record', 'Due Letter', 'Profile', 'Case Data', 'Add', 'Edit', and 'Delete'. The 'Add' button is circled in red. Below the buttons is a table with columns for Vaccine, Visit Date, Age@Visit, Location, Reaction, Volume, Inj. Site, Lot, Manufacturer, VIS Date, Administered By, Vaccine Eligibility, and Admin Date.

Figure 36: Entering an Immunization

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

# Key Clinical Performance Objectives

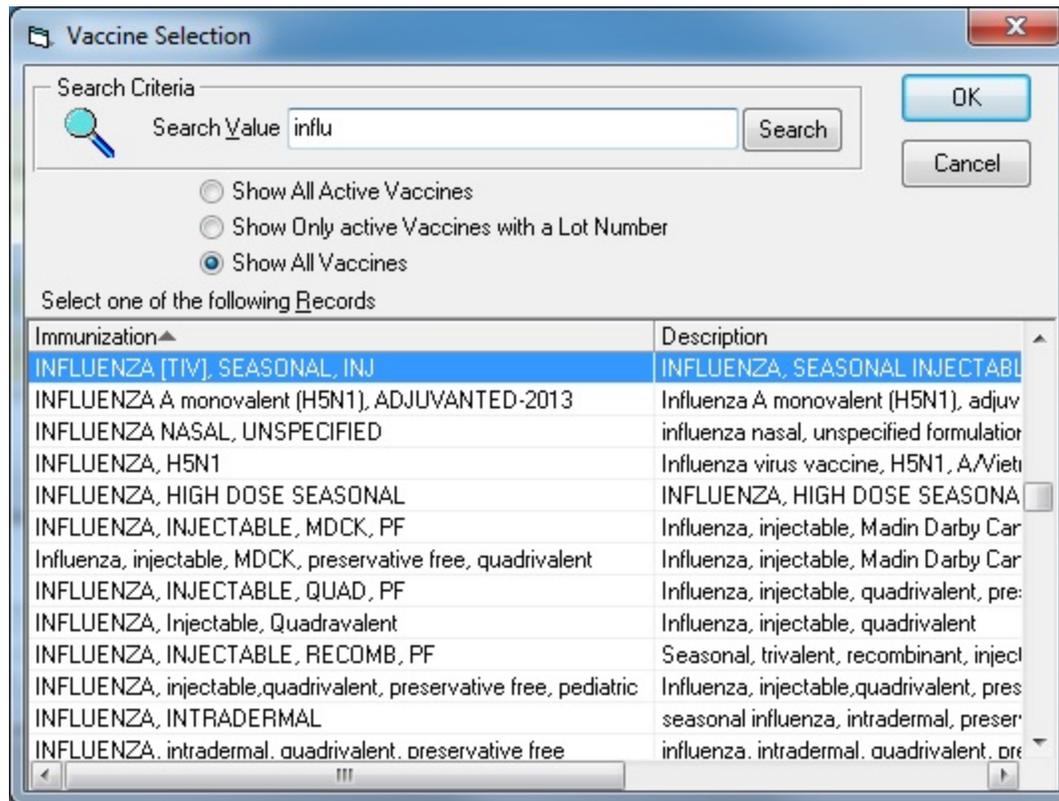


Figure 37: Choosing the Immunization

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

## Key Clinical Performance Objectives

The screenshot shows a window titled "Add Immunization" with the following fields and options:

- Vaccine:** INFLUENZA (TIV), SEASONAL, INJ
- Administered By:** GALOPE, MEGAN
- Lot:** (Lot Not Specified)
- Injection Site:** Left Arm SQ
- Volume:** 0.5 ml
- Vac. Info. Sheet:** 08/07/2015
- Given:** 12/15/2016 2:50 PM
- Vac. Eligibility:** (Empty dropdown)
- Admin Notes:** (Empty text area)
- Options:**
  - Current
  - Historical
  - Not Done
- Buttons:** OK, Cancel

Figure 38: Entering additional immunization information

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

# Key Clinical Performance Objectives

Figure 39: Entering a historical immunization

- 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).

Vaccine	Visit Date	Age@Visit	Location	Reaction	Volume	Inj. Site	Lot	Manufacturer	VIS I
FLU-IV3	12/15/2016	56 yrs	2013 DEMO HOSPITAL (CMBA)		0.5	Left Arm SQ	1205901	NOVARTIS PHARMACEUTICAL	08/07

Figure 40: Example of a newly added Immunization

# Key Clinical Performance Objectives

To enter a contraindication for an immunization:

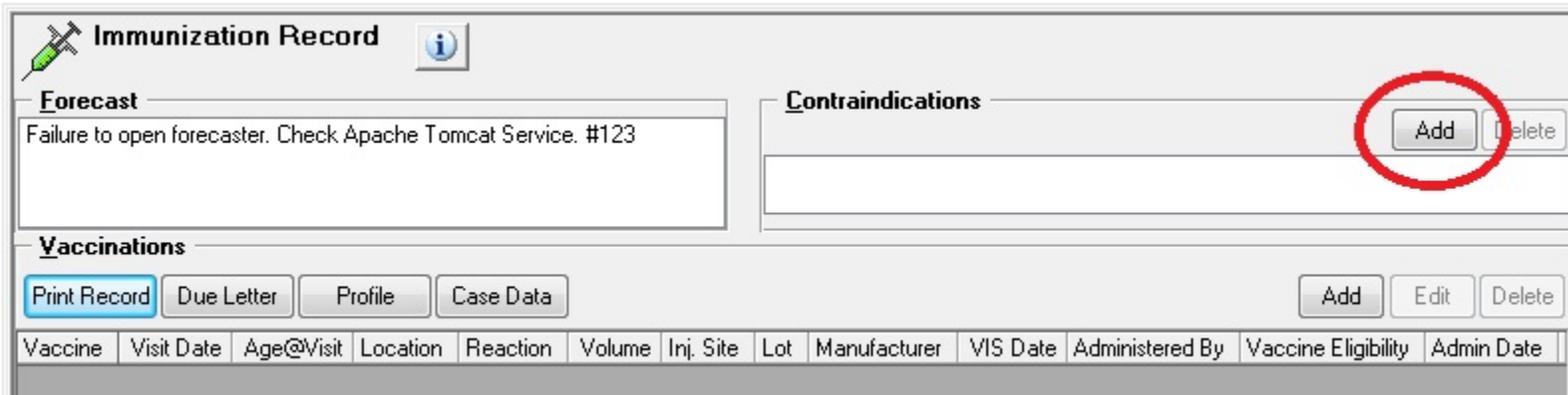


Figure 41: Entering a contraindication

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

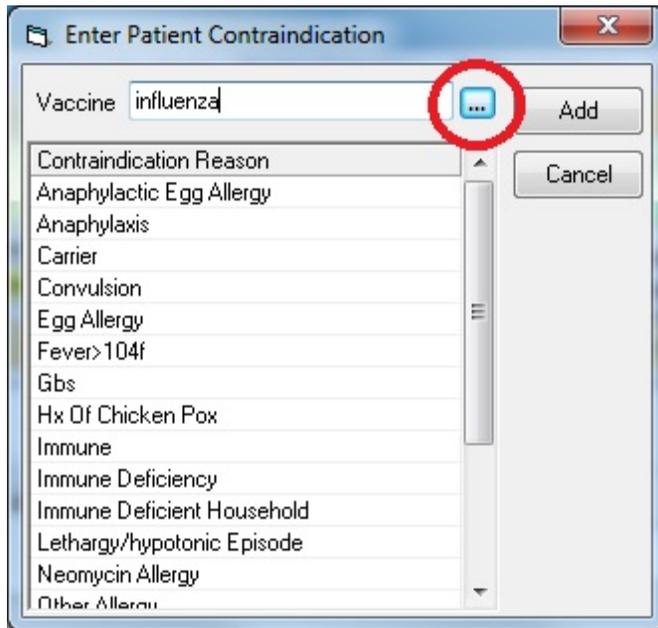


Figure 42: Choosing a contraindication

2. Choose the **Contraindication Reason** and type the **Vaccine** name.

## Key Clinical Performance Objectives

3. Click the ellipses (...) button. The **Vaccine Selection** dialog (Figure 43) displays.

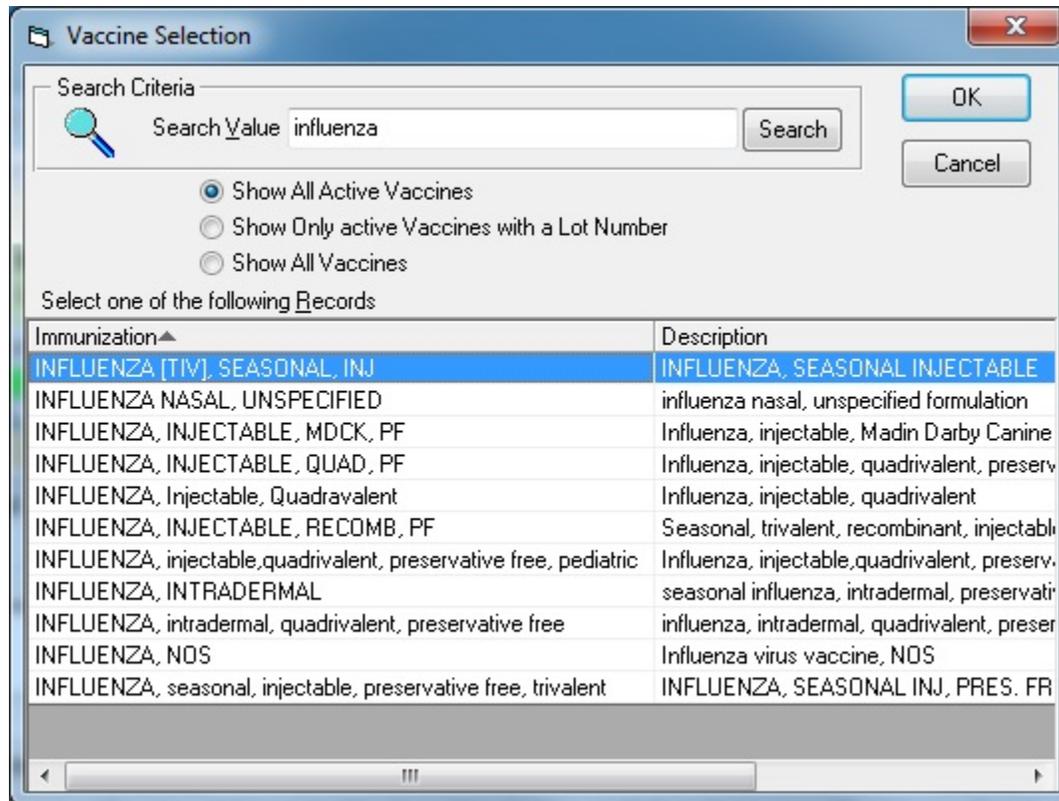


Figure 43: Selecting the immunization

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

# Key Clinical Performance Objectives

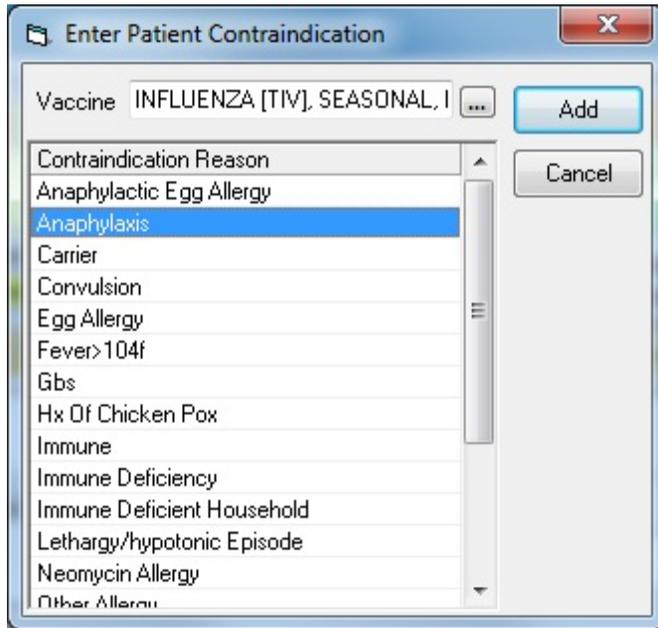


Figure 44: Enter Patient Contraindication dialog

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

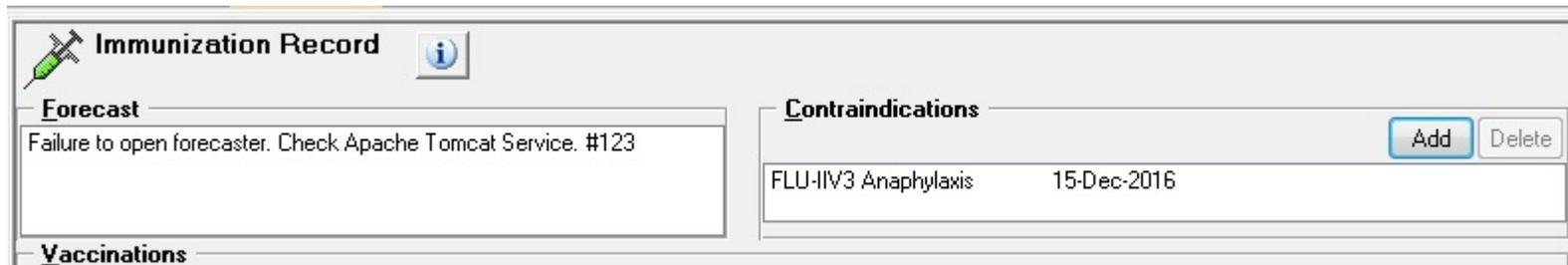


Figure 45: Example of a newly added contraindication

# Key Clinical Performance Objectives

## Vital Measurements

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

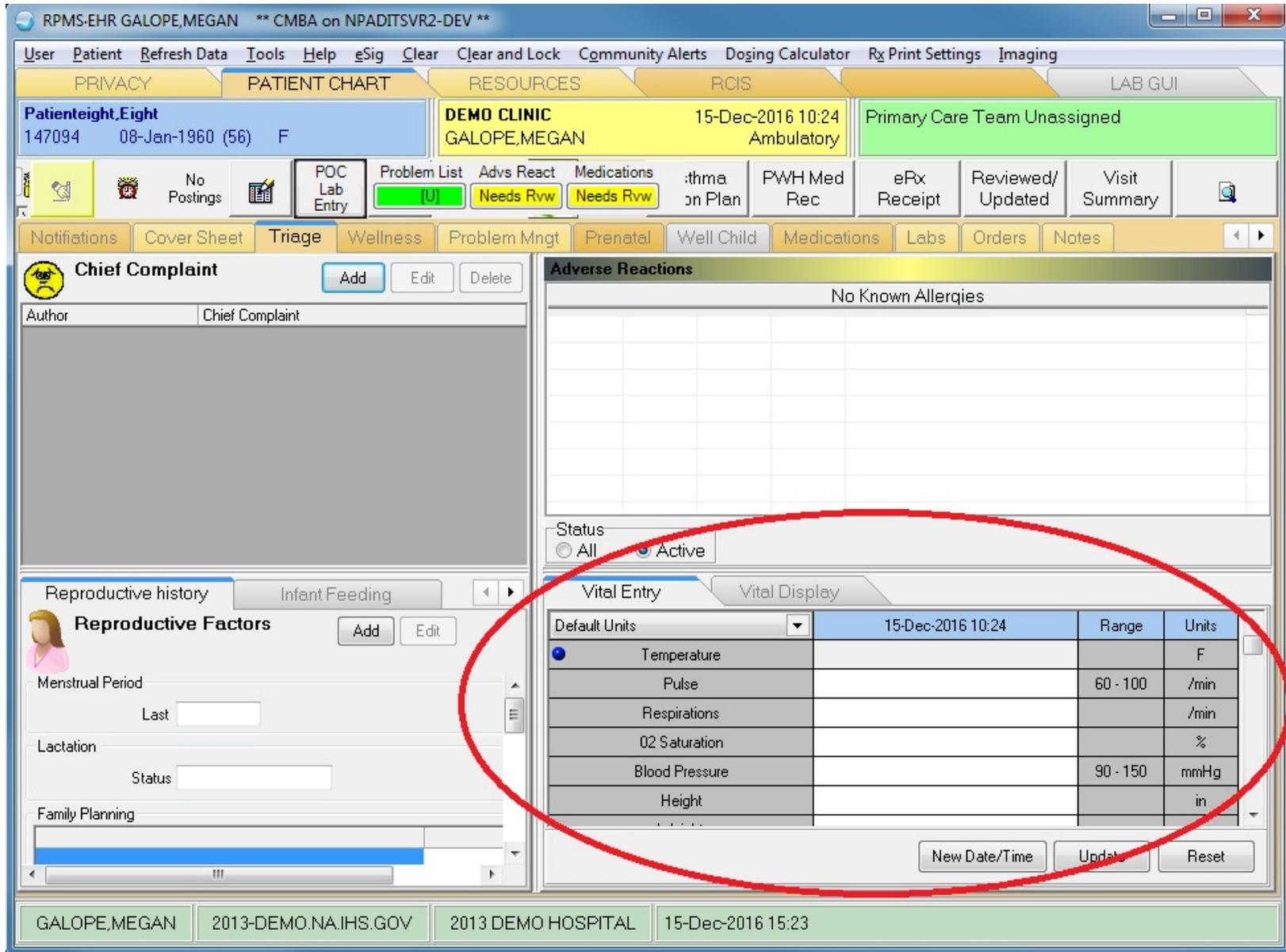
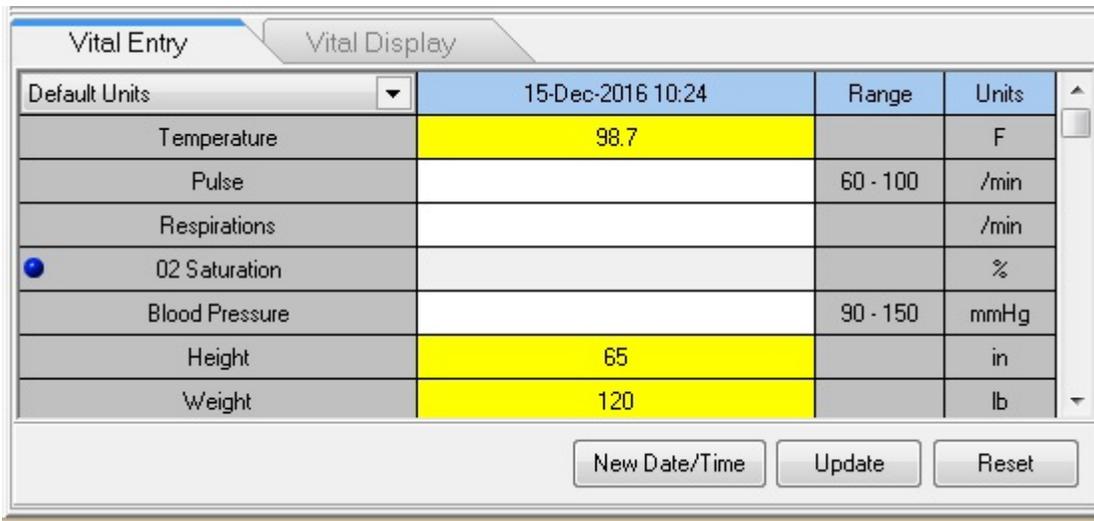


Figure 46: Vitals component

# Key Clinical Performance Objectives

To enter Vital Measurements:



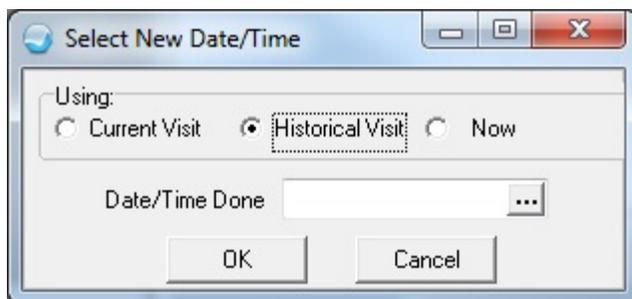
The screenshot shows a software window titled "Vital Entry" with a "Vital Display" tab. It contains a table with the following data:

Default Units	15-Dec-2016 10:24	Range	Units
Temperature	98.7		F
Pulse		60 - 100	/min
Respirations			/min
<input checked="" type="radio"/> O2 Saturation			%
Blood Pressure		90 - 150	mmHg
Height	65		in
Weight	120		lb

Below the table are three buttons: "New Date/Time", "Update", and "Reset".

Figure 47: Entering a Vital Measurement

1. Enter vitals directly in the **Vitals** component.
2. To enter historical vitals:
  - a. Click the **New Date/Time** button.
  - b. Choose **Historical Visit** (Figure 48)



The screenshot shows a dialog box titled "Select New Date/Time". It has three radio buttons under the label "Using": "Current Visit", "Historical Visit" (which is selected), and "Now". Below the radio buttons is a text field labeled "Date/Time Done" with a calendar icon to its right. At the bottom are "OK" and "Cancel" buttons.

Figure 48: Selecting a new date/time for an historical vital

- c. The **Select Location for Historical Entry** dialog (Figure 50) displays.

## Key Clinical Performance Objectives

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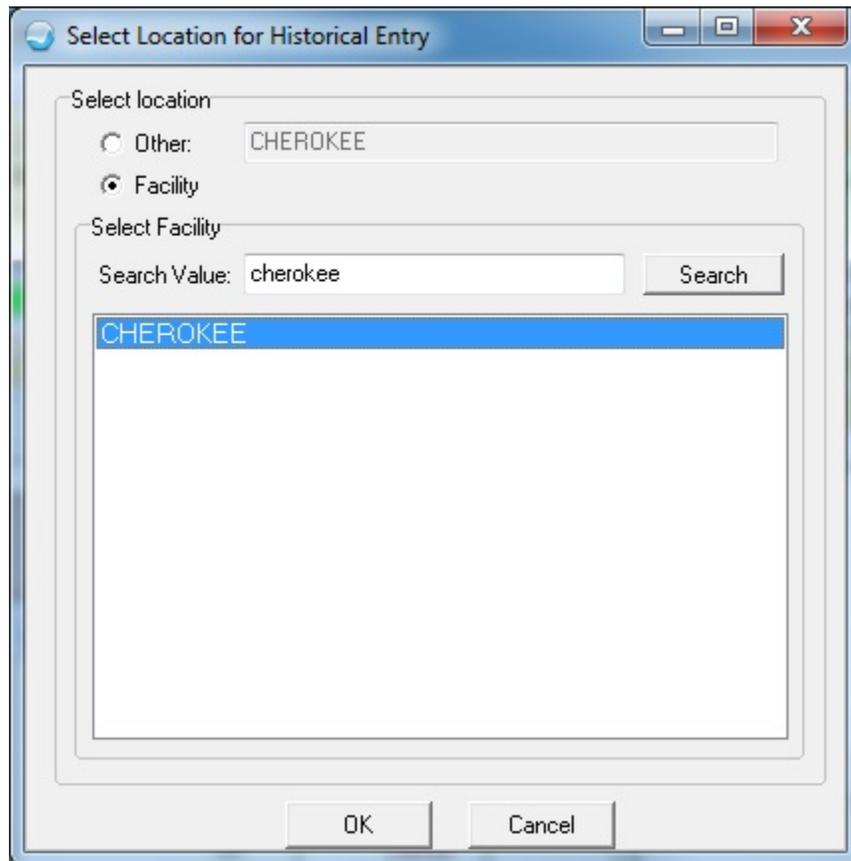


Figure 49: Choosing the historical location

- d. Choose the location and click **OK**. Click the ellipses (...) button. The **Select Date/Time** dialog (Figure 50) displays.

# Key Clinical Performance Objectives

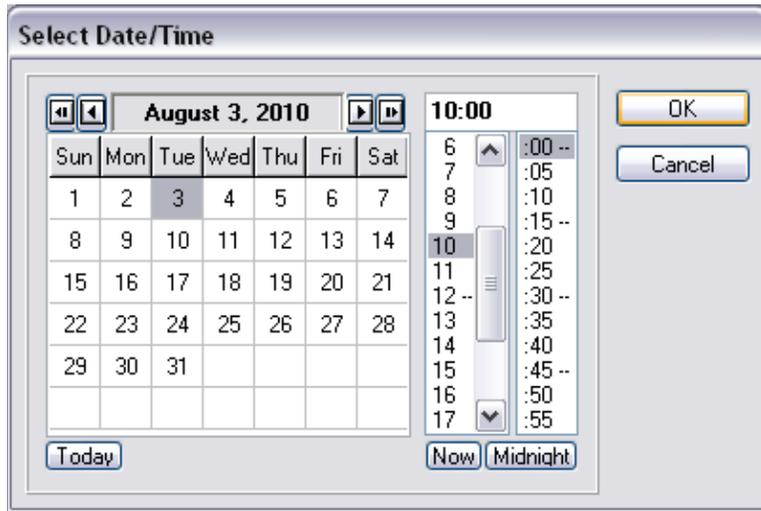


Figure 50: Choosing the historical date

e. Choose the historical date and click **OK**. The **Vital Measurement Entry** (Figure 51) redisplay.

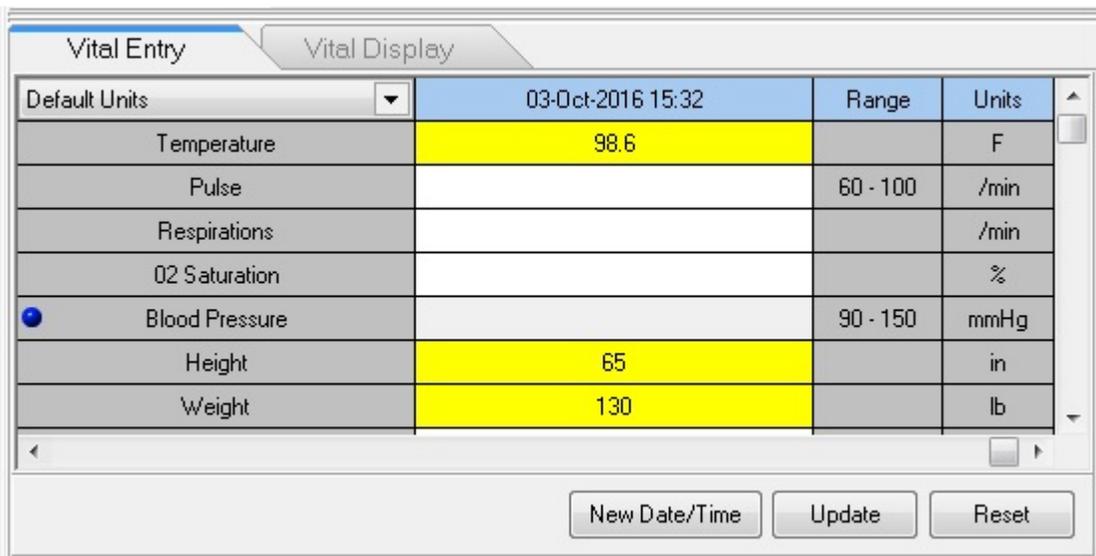


Figure 51: Entering Vital Measurements

# Key Clinical Performance Objectives

## Lab Tests

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

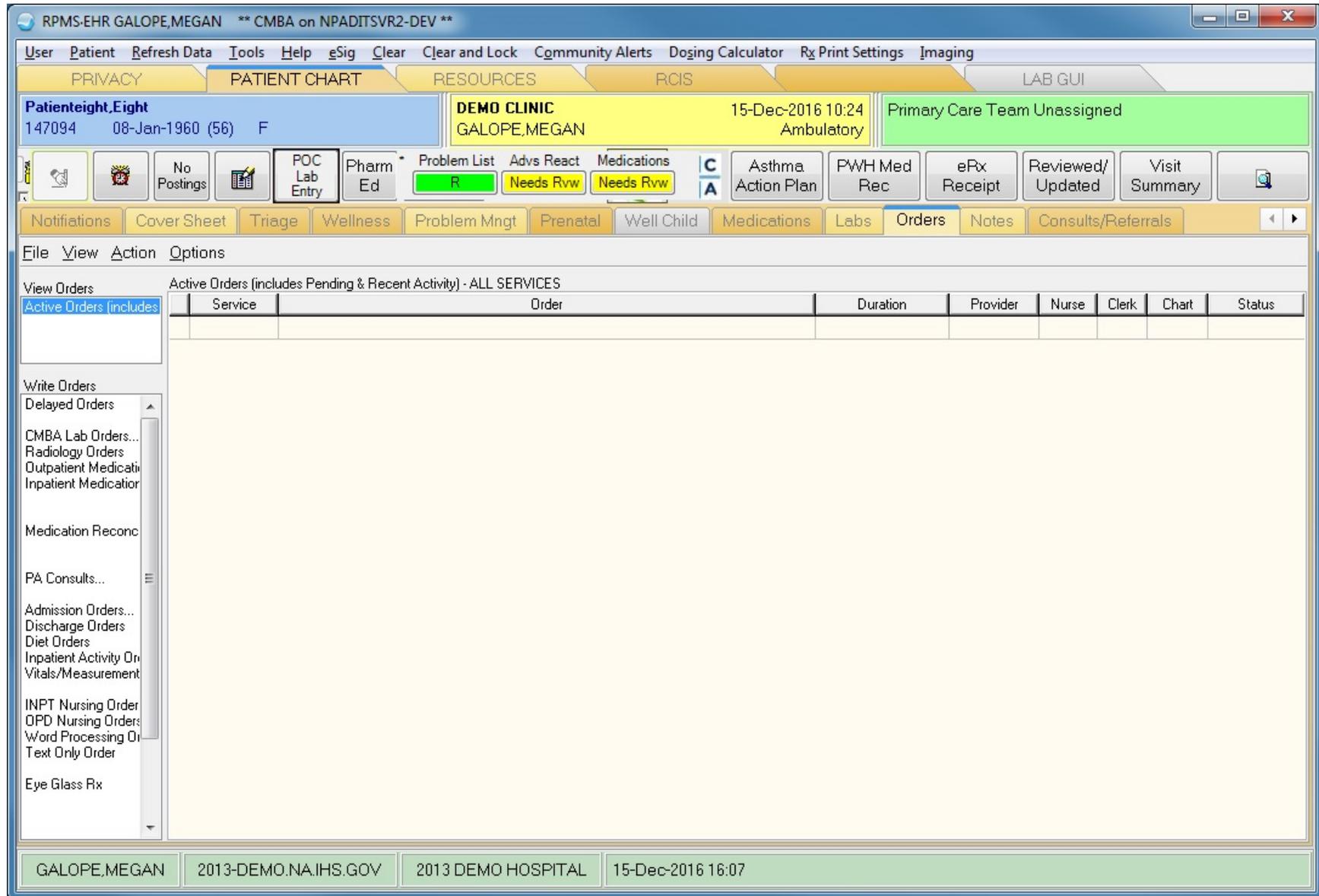


Figure 52: **Orders** component

# Key Clinical Performance Objectives

To enter a Lab test:

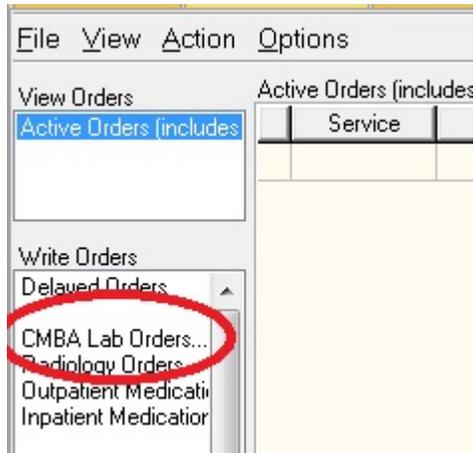


Figure 53: Entering a Lab test

1. Select the **[Database name] Lab Orders...** option in the **Write Orders** section of the **Orders** component. The **Lab Orders...** dialog (Figure 54) displays.

**Note:** This may be named differently at your site.

# Key Clinical Performance Objectives

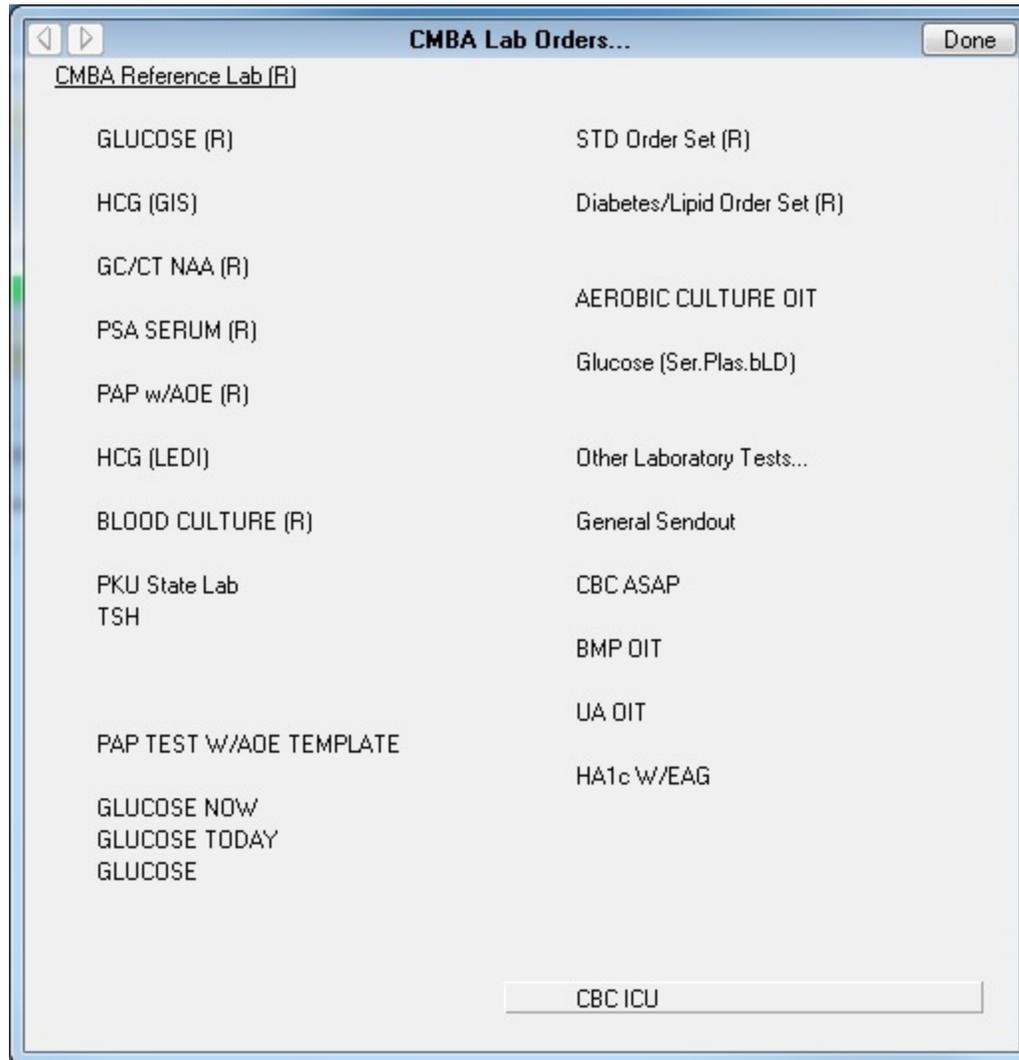


Figure 54: **Lab Orders...** dialog

2. Select the appropriate lab test and the **Order a Lab Test** dialog (Figure 54) displays.

# Key Clinical Performance Objectives

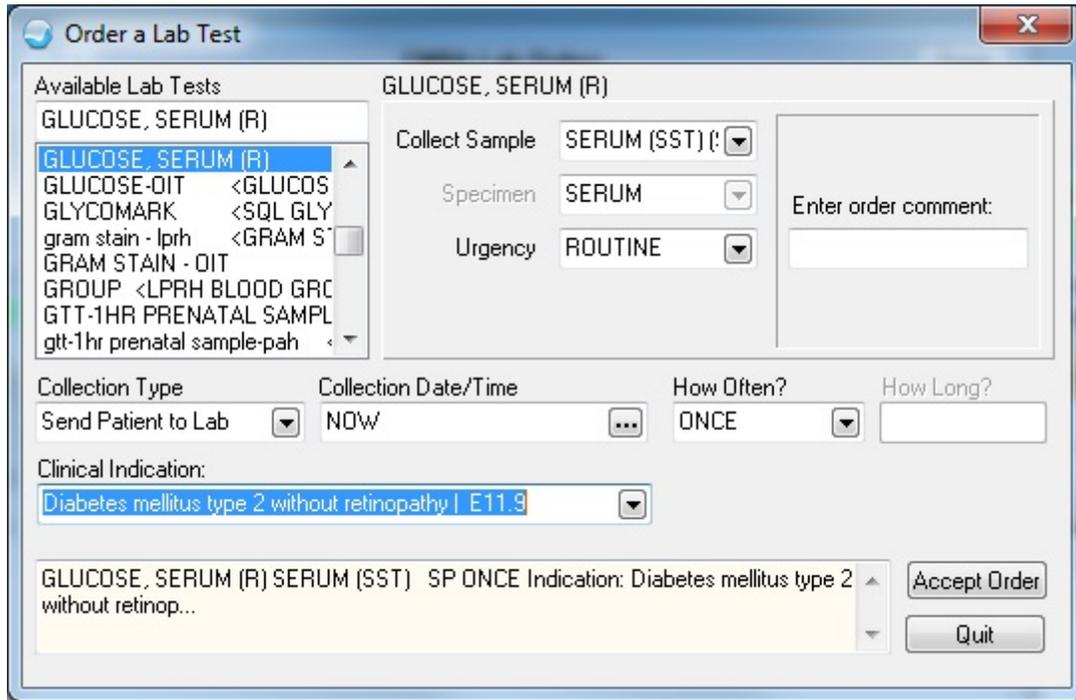


Figure 55: Order a Lab Test dialog

3. Select the appropriate lab test and enter any other pertinent information.
4. Click **Accept Order**. The newly added Lab test should display in the **Active Orders** section of the **Orders** component (Figure 56).

Options							
Active Orders (includes Pending & Recent Activity) - ALL SERVICES							
Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
Lab	GLUCOSE, SERUM (R) SERUM (SST) SP ONCE Indication: Diabetes mellitus type 2 without retinop... *UNSIGNED*	Start: NOW	Galope,M				unreleased

Figure 56: Example of a newly added Lab test

5. 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 57).

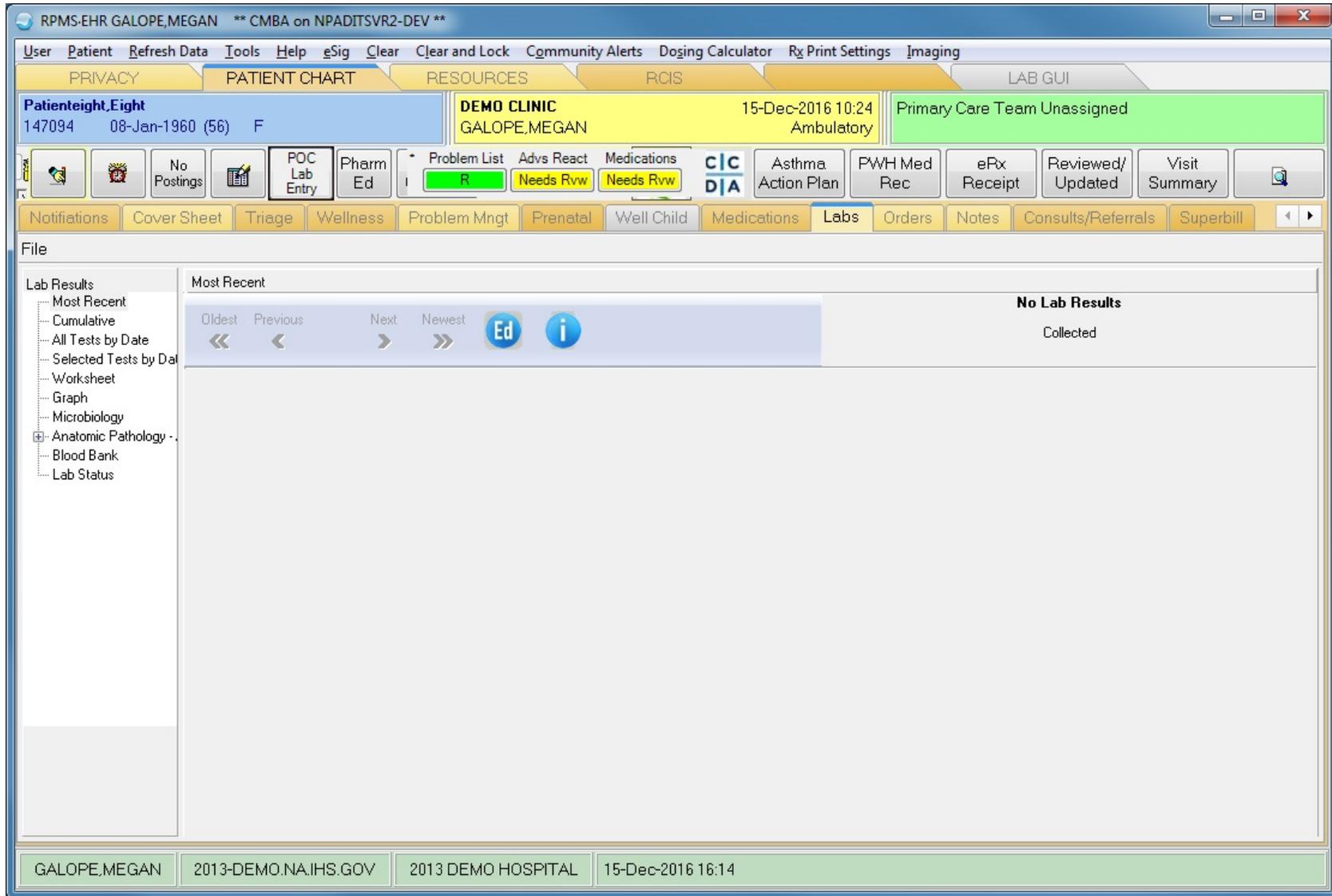


Figure 57: Viewing the lab results

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.

# Key Clinical Performance Objectives

To enter Point of Care Lab tests and results:

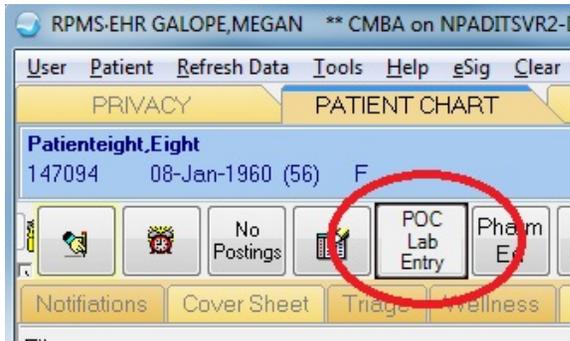


Figure 58: Entering a Point of Care Lab test

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 59) displays.

A screenshot of the 'Lab Point of Care Data Entry Form' dialog box. The window title is 'Lab Point of Care Data Entry Form'. The form has a yellow header bar with 'Patient: PATIENT,CRSAE' and 'Hospital Location: 01 GENERAL'. Below the header are several fields: 'Ordering Provider' (POWERS,MEGAN), 'Nature of Order/Change' (WRITTEN), 'Test' (GLUCOSE), 'Sample Type' (BLOOD), 'Collection Date and Time' (08/23/2010 09:55 AM), and 'Sign or Symptom' (714.0 Rheumatoid Arthritis). There is a text area for 'Comment/Lab Description:' with an 'Add Canned Comment' button. Below this is a blue header bar for 'TEST RESULTS' and a table with the following data:

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

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

Figure 59: **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 60).

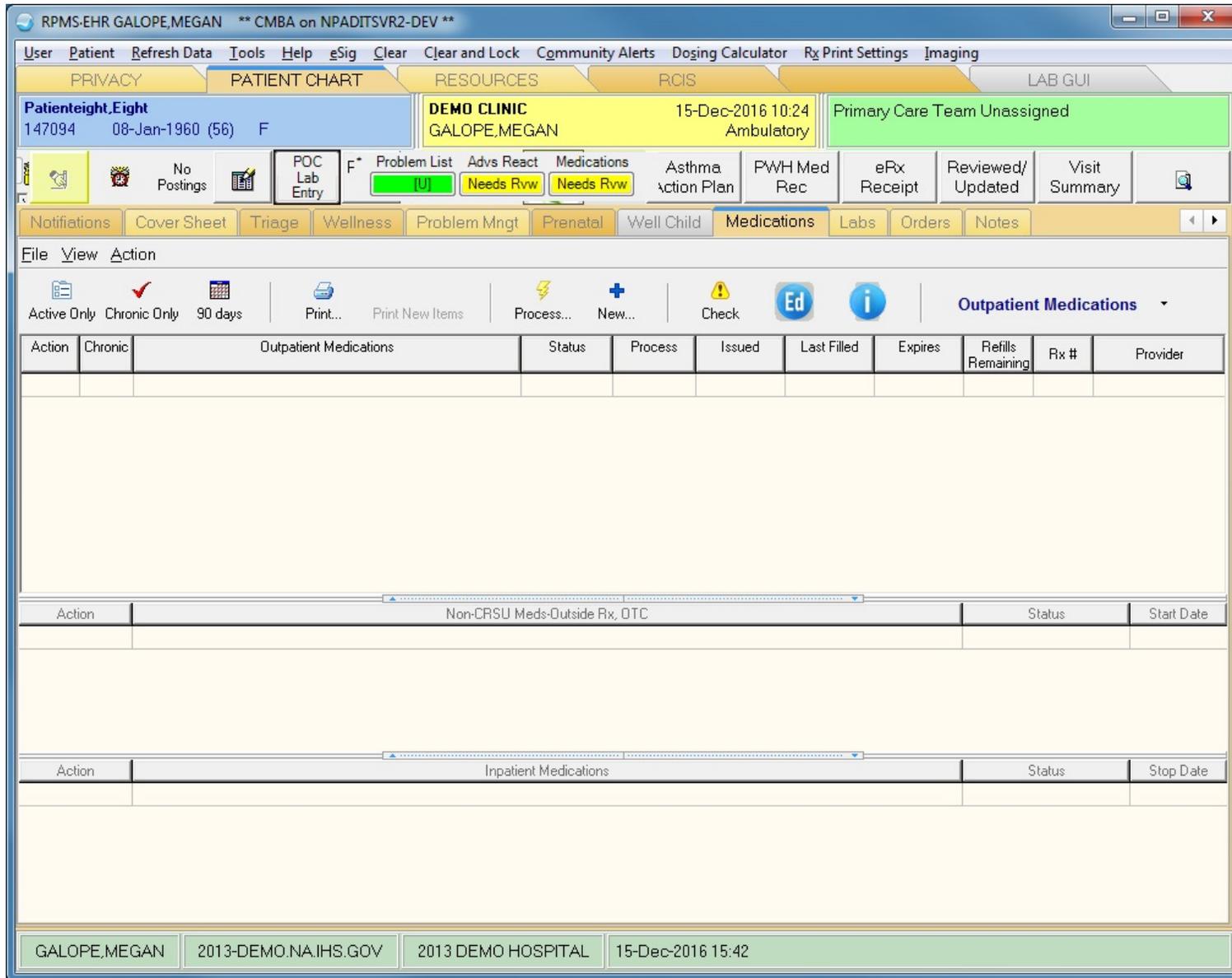


Figure 60: **Medications** component

# Key Clinical Performance Objectives

To enter a prescription for a medication:

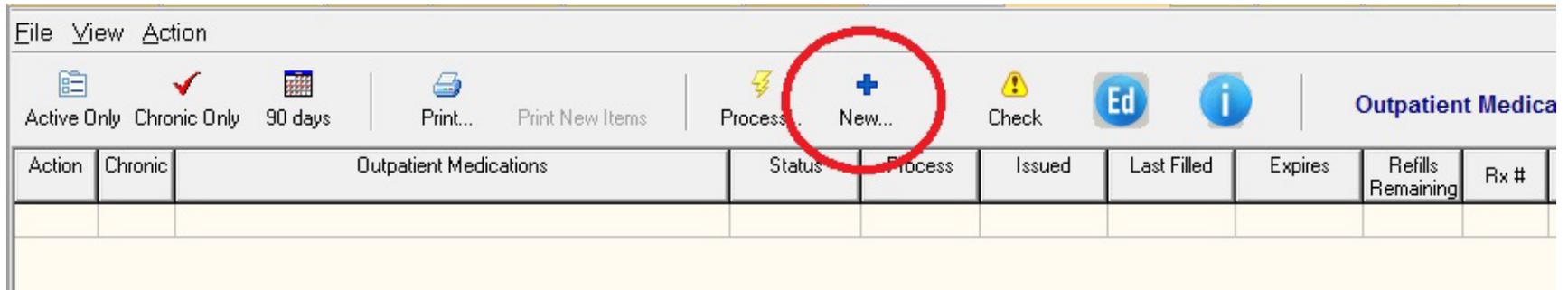


Figure 61: Entering a patient medication

1. Click **New**. The Medication Order dialog (Figure 61) displays.

# Key Clinical Performance Objectives

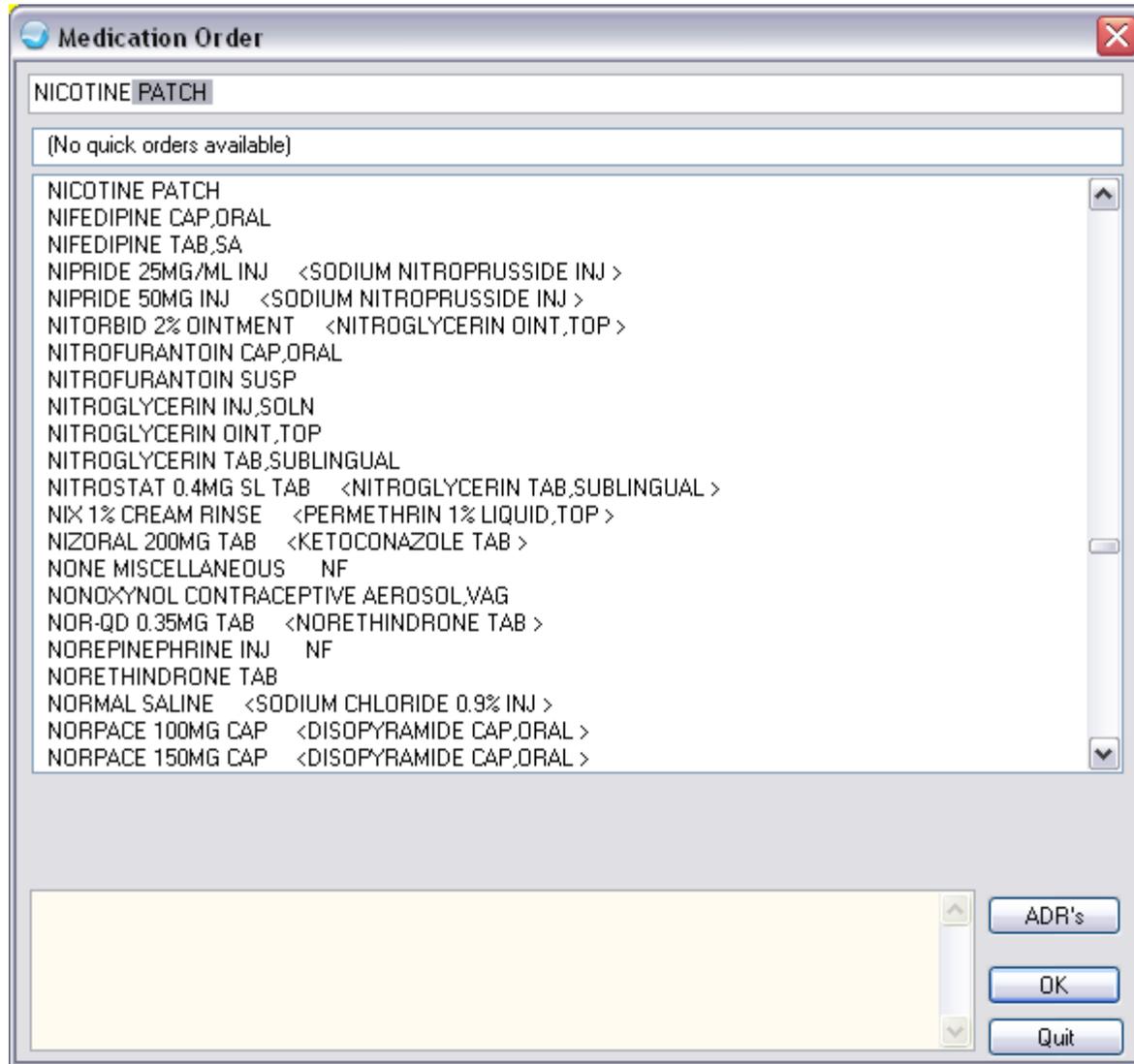


Figure 62: Medication Order dialog

2. Click to highlight the appropriate medication and click **OK**. The dialog redisplay with new fields (Figure 63).

## Key Clinical Performance Objectives

The screenshot shows a 'Medication Order' window with the following fields and options:

- Medication Name: NICOTINE PATCH (highlighted in yellow)
- Change button
- Complex tab selected under Dosage
- Dosage: 1 patch
- Route: TRANSDERMAL
- Schedule: DAILY (with PRN checkbox)
- Comments: (empty text area)
- Days Supply: 90
- Quantity: 1
- Refills: 1
- Clinical Indication: Personal History of Tobacco Use
- Chronic Med checkbox: unchecked
- Dispense as Written checkbox: unchecked
- Priority: ROUTINE
- Pick Up options: Clinic, Mail, Window (Window is selected)
- Summary text: NICOTINE PATCH APPLY ONE (1) PATCH TO SKIN DAILY Quantity: 1 Refills: 1 Chronic Med: NO Dispense as Written: NO Indication: Personal History of Tobacco Use
- Buttons: ADR's, Accept Order, Quit

Figure 63: Entering additional medication information

3. Type other pertinent information about the prescription.
4. Click **Accept Order**. The updated **Medications** component (Figure 64) displays.

# Key Clinical Performance Objectives

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

Figure 64: 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, located on the **Triage** tab (Figure 65).

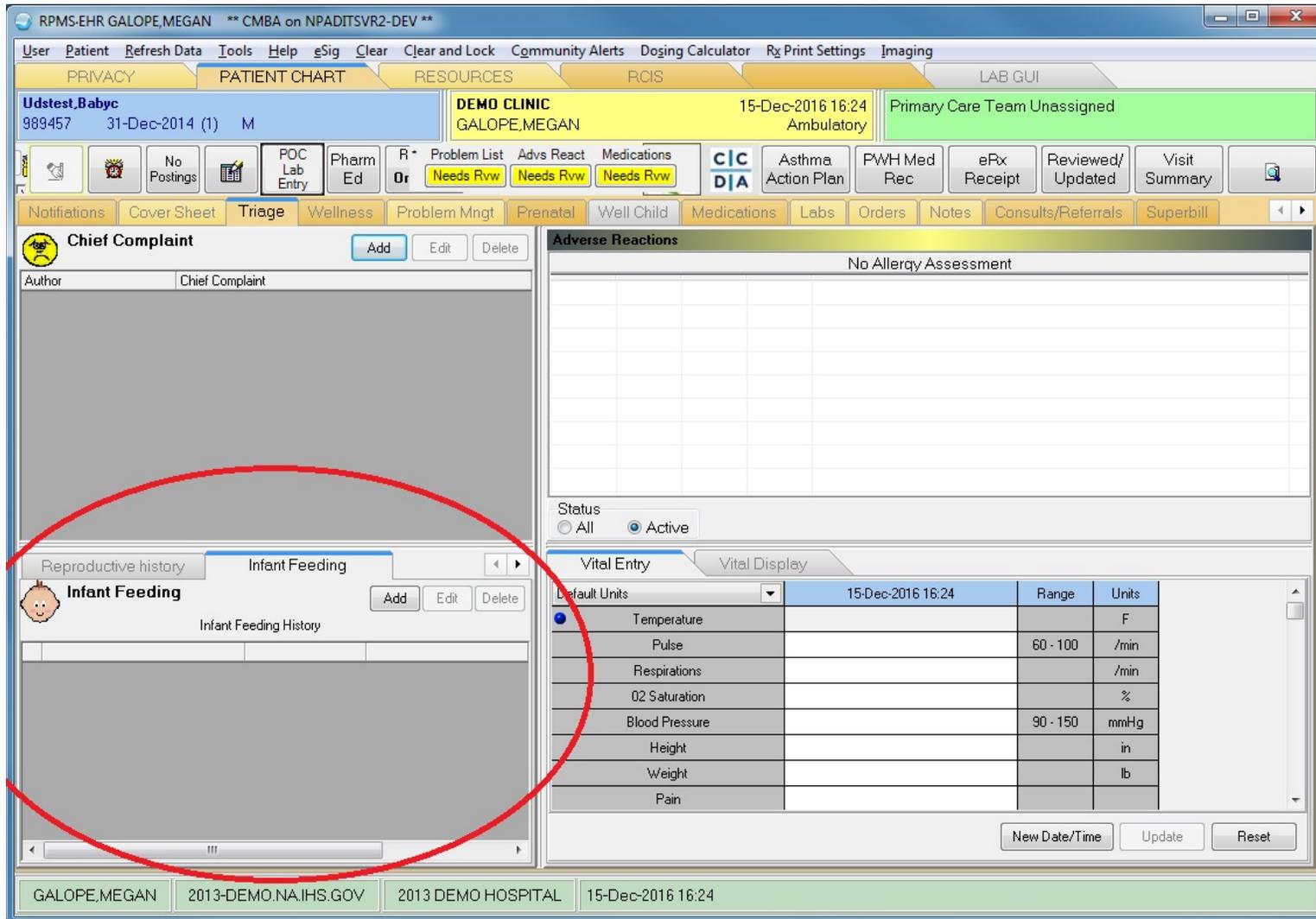


Figure 65: **Infant Feeding** component

# Key Clinical Performance Objectives

To enter Infant Feeding:



Figure 66: Entering Infant Feeding information

1. Click **Add** in the **Infant Feeding** component. The **Infant Feeding Choice** dialog (Figure 67) displays.

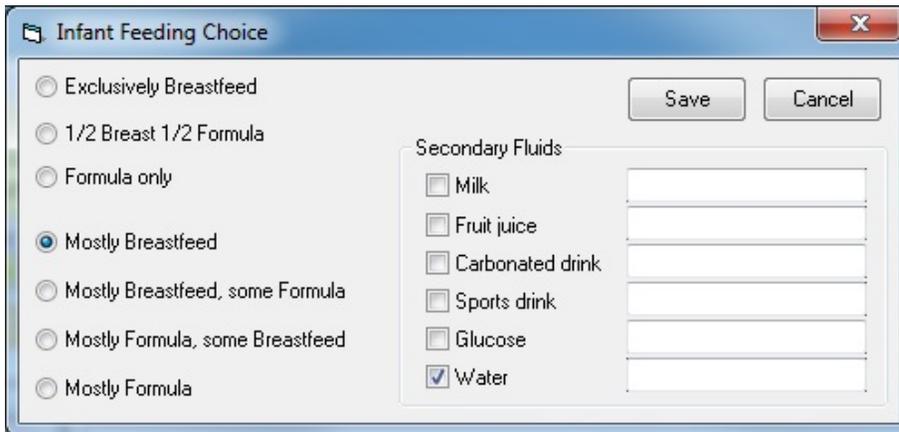


Figure 67: Selecting an Infant Feeding choice

2. Select the infant feeding choice and any secondary fluids and click **OK**. The newly added choice should display in the **Infant Feeding** component (Figure 68).



Figure 68: 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 69).

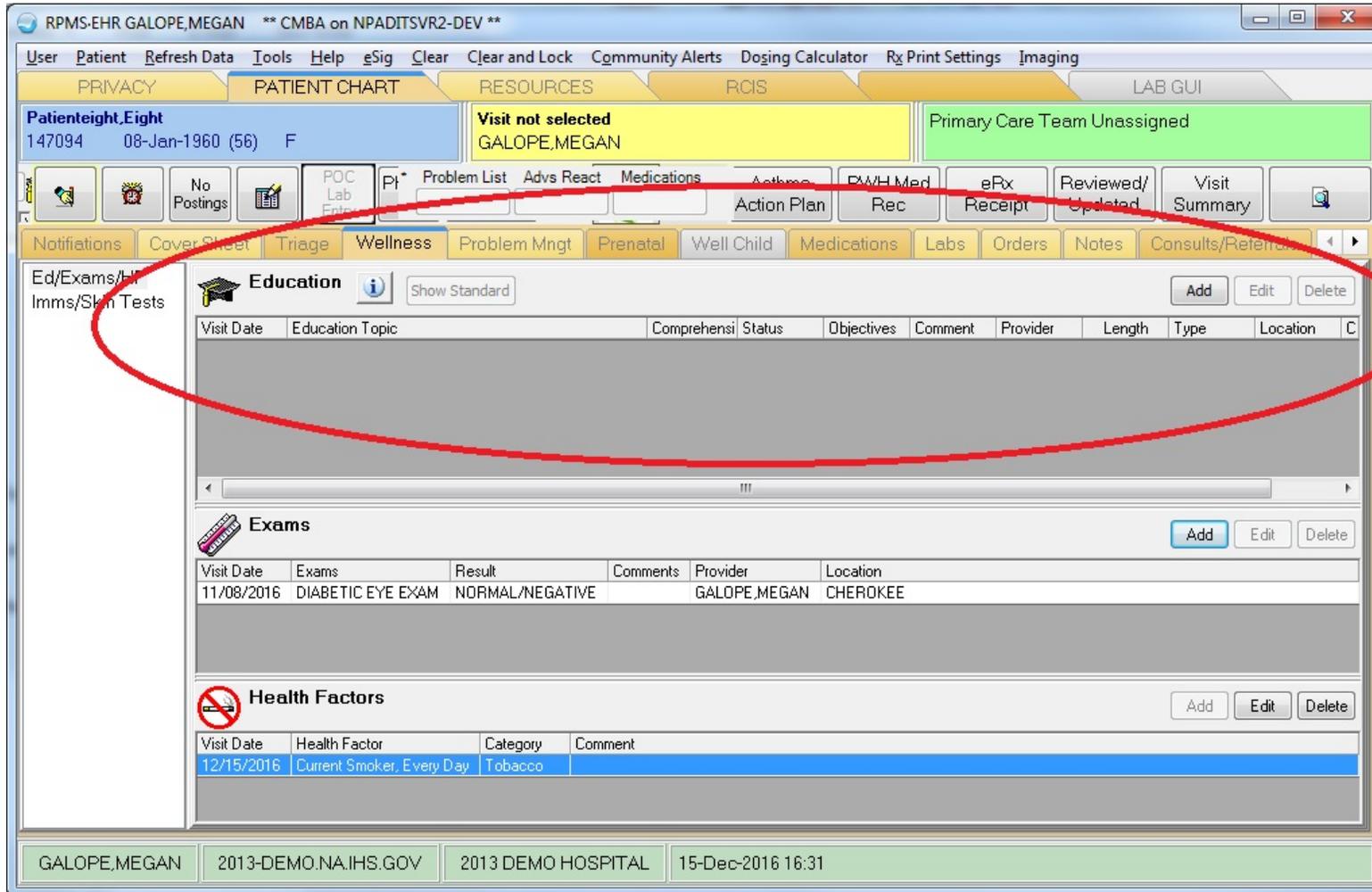


Figure 69: Education component

# Key Clinical Performance Objectives

To enter Patient Education:

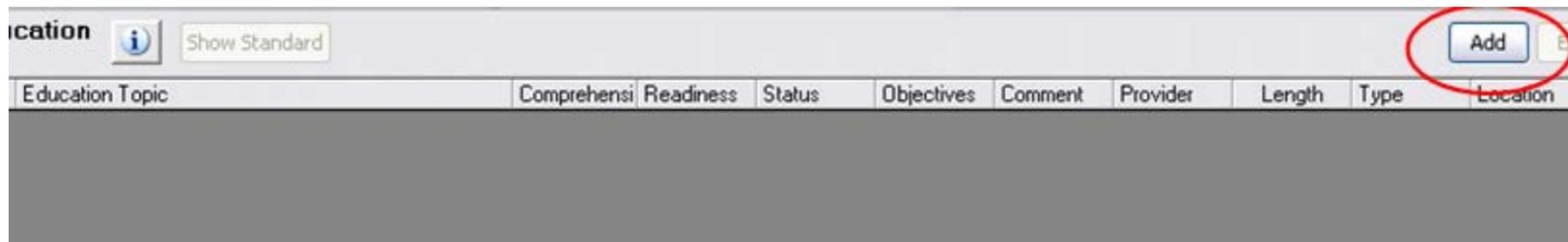


Figure 70: Entering Patient Education

1. Click **Add** in the **Education** component. The **Education Topic Selection** dialog (Figure 71) displays.

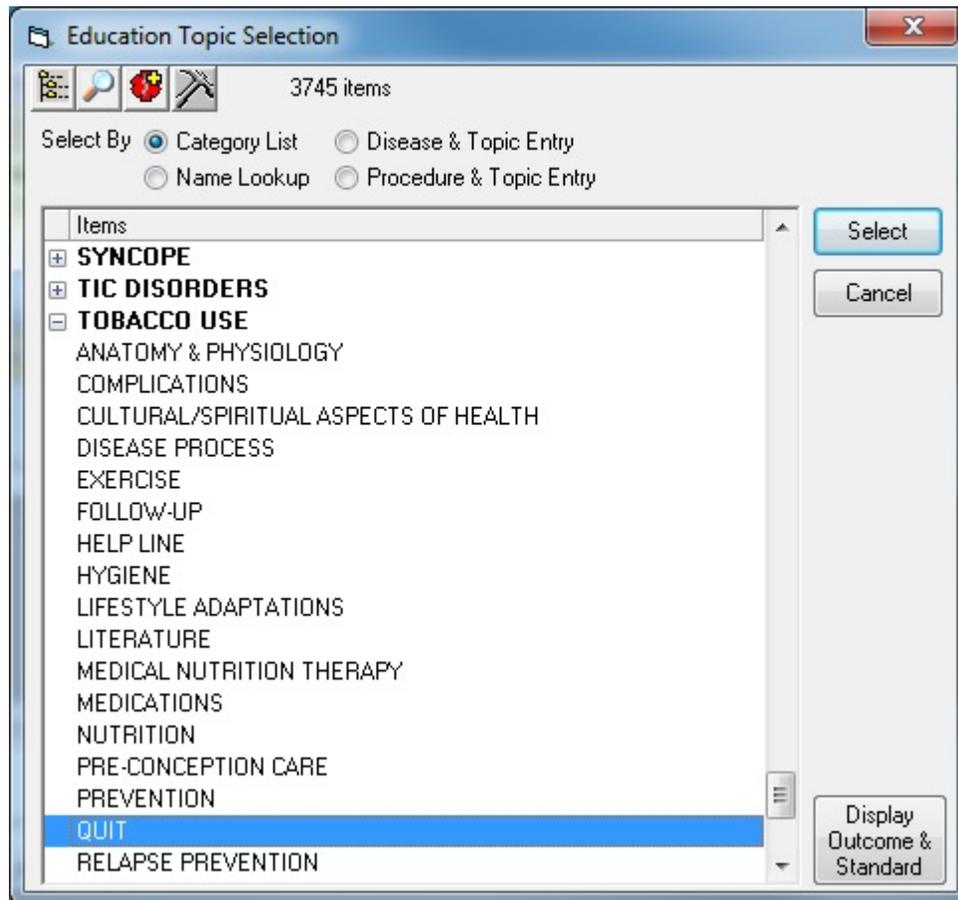


Figure 71: Selecting the education

## Key Clinical Performance Objectives

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

To enter Patient Education by disease:

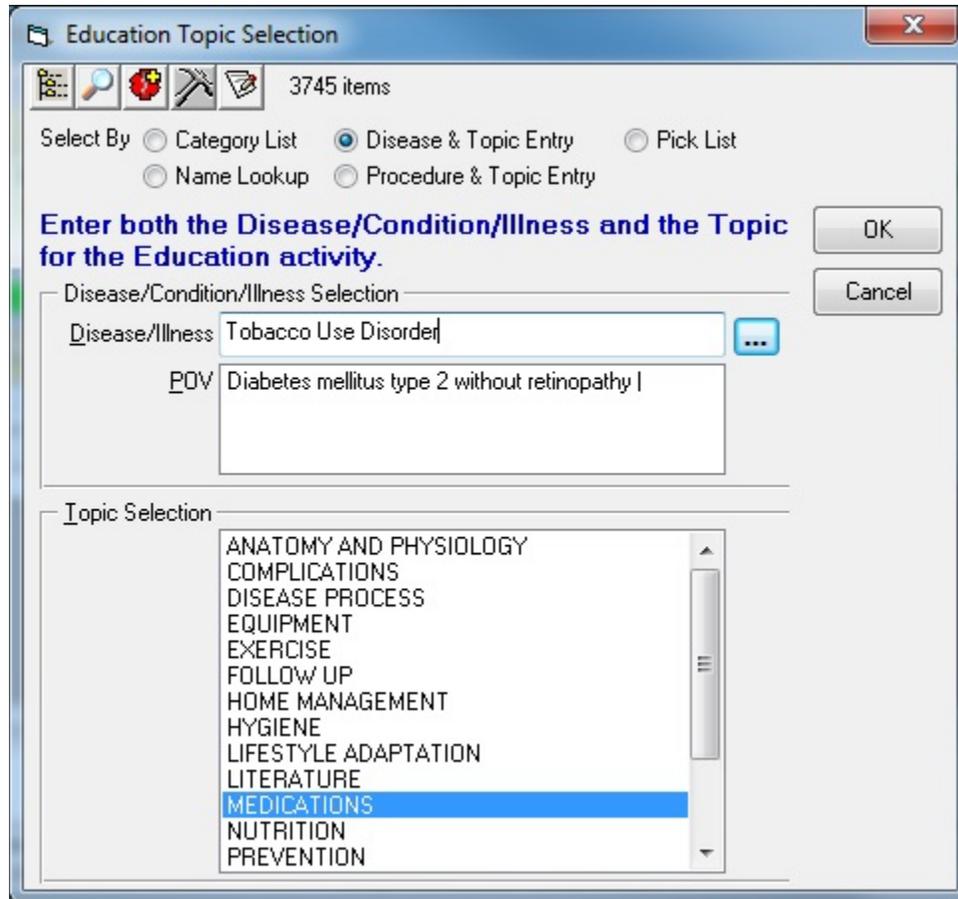


Figure 72: Entering Patient Education by disease

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 73) displays.

# Key Clinical Performance Objectives

The screenshot shows a software dialog box titled "Add Patient Education Event". It has a standard Windows-style title bar with a close button (X) in the top right corner. The dialog is divided into two main sections. The left section contains several input fields and controls: "Education Topic" is a text box with "Tobacco Use-Quit" and "(Tobacco Use)" below it; "Type of Training" has two radio buttons, "Individual" (selected) and "Group"; "Comprehension Level" is a dropdown menu set to "GOOD"; "Length" is a text box with "10" and "(min)" next to it; "Comment" is a large empty text area; "Provided By" is a text box with "GALOPE, MEGAN"; "Readiness to Learn" is a dropdown menu set to "RECEPTIVE"; and "Status/Outcome" has three radio buttons: "Goal Set", "Goal Met", and "Goal Not Met". The right section contains a vertical stack of buttons: "Add" (highlighted in blue), "Cancel", "Historical" (with a checkbox), "Display Outcome & Standard", and "Patient's Learning Health Factors" (with a text box below it).

Figure 73: Add Patient Education Event dialog

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

## 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: GALOPE,MEGAN

Readiness to Learn:

Status/Outcome:  Goal Set  Goal Met  Goal Not Met

Historical:

Event Date: 11/29/2016

Location: CHEROKEE

IHS/Tribal Facility  Other

Buttons: Add, Cancel, Display Outcome & Standard

Historical checkbox:  Historical

Patient's Learning Health Factors:

Figure 74: Entering historical education

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

# Key Clinical Performance Objectives

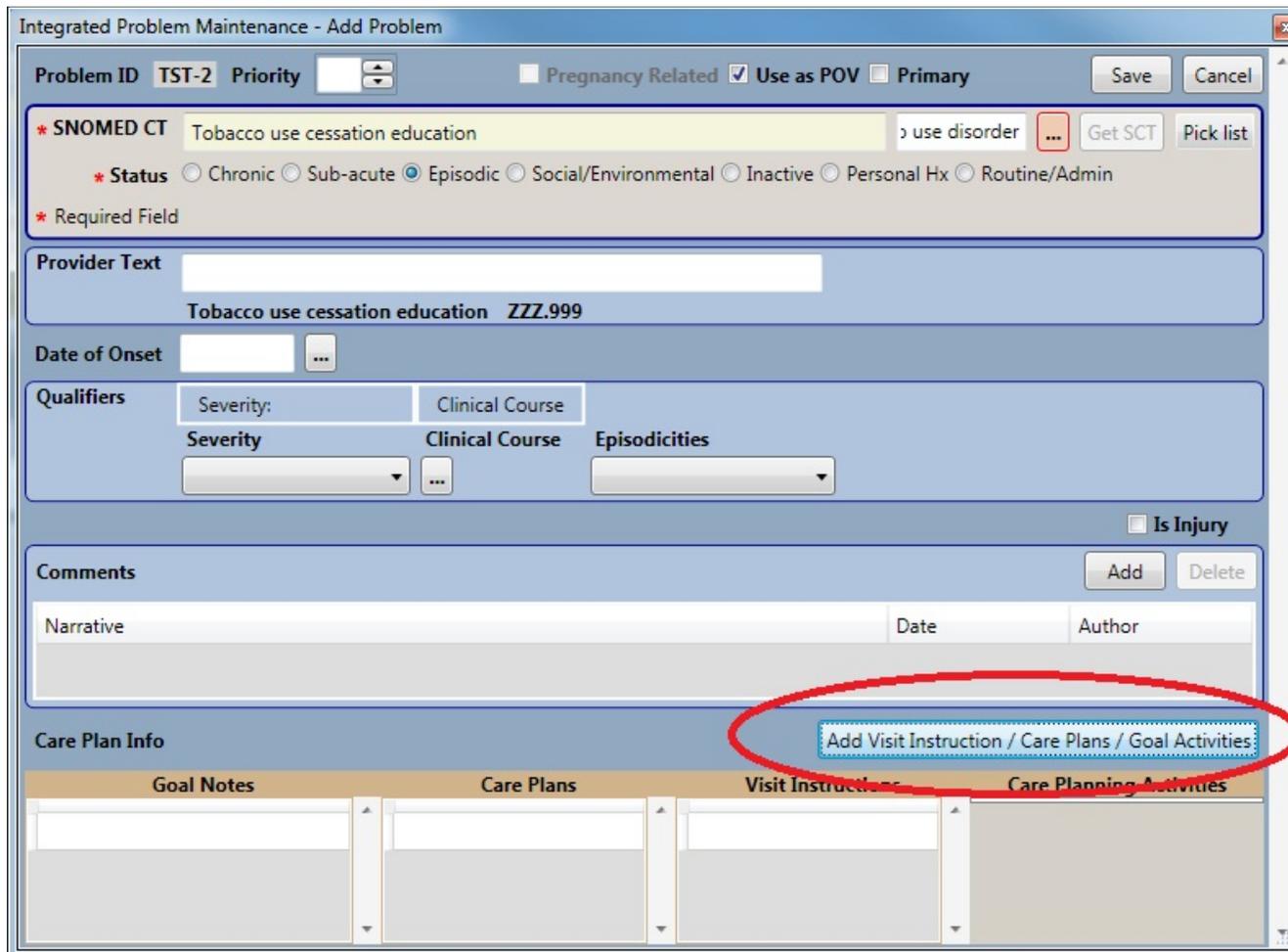
The newly added Patient Education should display in the **Education** component.



Visit Date	Education Topic	Comprehension	Status	Objectives	Comment	Provider	Length	Type	Location	Code
12/15/2016	Tobacco Use-Quit	GOOD				GALOPE,MEGAN	10	Individual	2013 DEMO HOSPITAL (CMBA)	No Code

Figure 75: Example of a newly added Patient Education

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



Integrated Problem Maintenance - Add Problem

Problem ID: TST-2 Priority: [dropdown]  Pregnancy Related  Use as POV  Primary Save Cancel

\* SNOMED CT: Tobacco use cessation education use disorder ... Get SCT Pick list

\* Status:  Chronic  Sub-acute  Episodic  Social/Environmental  Inactive  Personal Hx  Routine/Admin

\* Required Field

Provider Text: Tobacco use cessation education ZZZ.999

Date of Onset: [calendar icon]

Qualifiers: Severity: [dropdown] Clinical Course: [dropdown] Episodicities: [dropdown]

Is Injury

Comments: Add Delete

Care Plan Info: Add Visit Instruction / Care Plans / Goal Activities

Goal Notes	Care Plans	Visit Instructions	Care Planning Activities
[empty]	[empty]	[empty]	[empty]

Figure 76: Entering the Patient Education

# Key Clinical Performance Objectives

1. After entering the POV and choosing **Use as POV**, click **Add Visit Instruction/Care Plans/Goal Activities**. The **Add Visit Instruction/Care Plans/Goal Activities** dialog (Figure 77) displays.

**Add Visit Instructions / Care Plans / Goal Notes / Care Planning Activities**

**Visit Instructions**

Date: 12/15/2016

**Goal Notes**

Date: 12/15/2016

**Care Plans**

Date: 12/15/2016

**Patient Education provided**

Disease Process     Nutrition  
 Exercise     Lifestyle Adaptation  
 Medications     Prevention

**Comprehension Level**: FAIR

**Length**: 10 (min)

**Readiness to Learn**: RECEPTIVE

Treatment/Regimen/Follow-up

**Current Visit - Care Planning Activities**

**Treatment/Regimen/Follow-up**

**Education Provided**

Had Disease Process Education.  
Comprehension Level: FAIR  
Length: 10 mins  
Readiness to Learn: RECEPTIVE

OK    Cancel

Figure 77: Add Visit Instruction/Care Plans/Goal Activities 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 78).

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

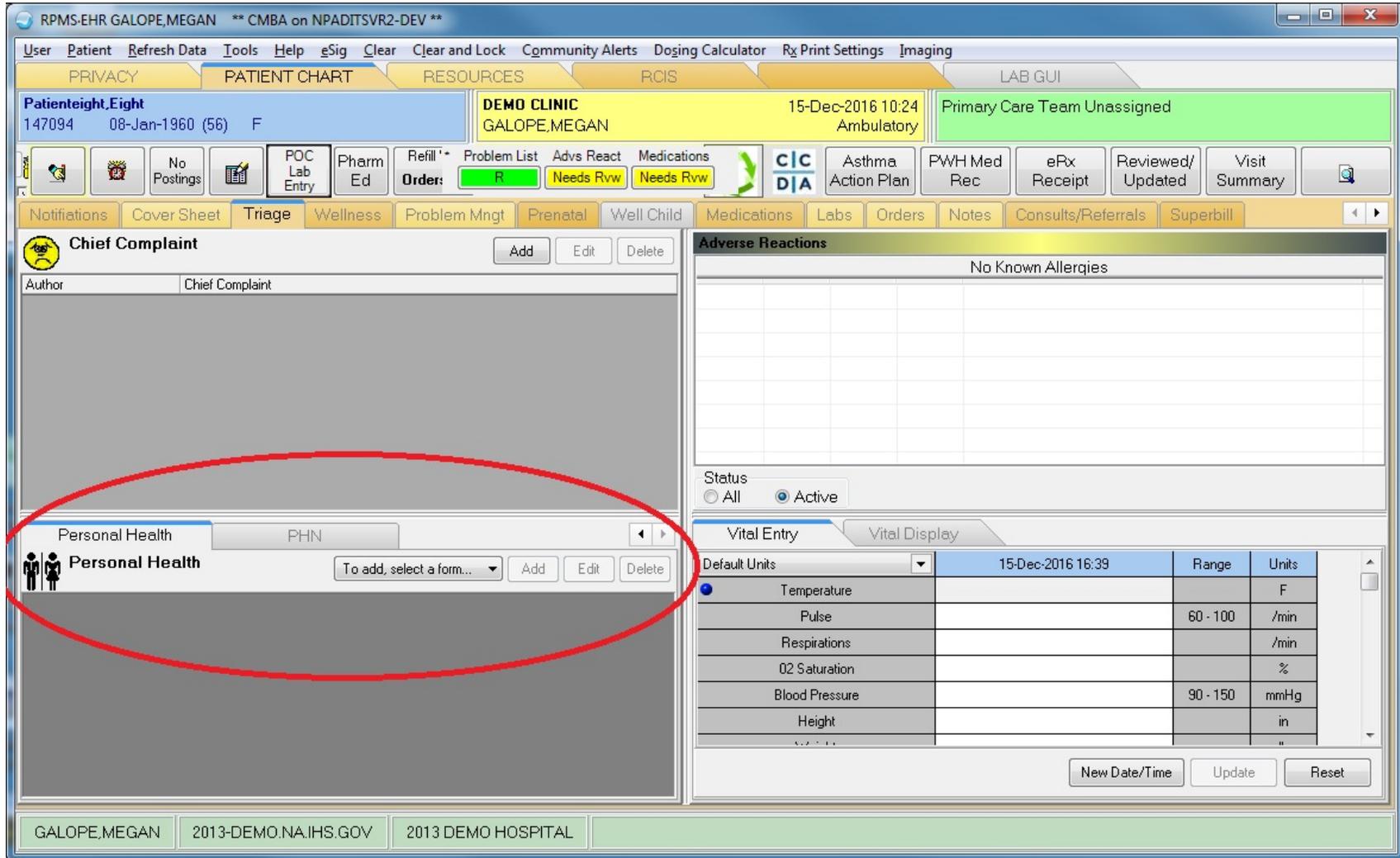


Figure 78: **Personal Health** component

# Key Clinical Performance Objectives

To enter a Refusal:

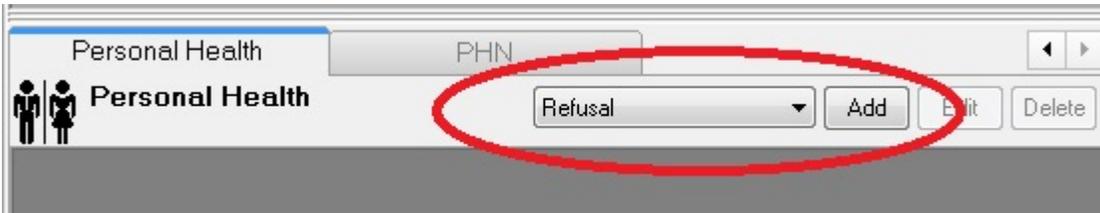


Figure 79: Entering a Refusal

1. Select **Refusal** from the drop-down list.
2. Click **Add**. The **Enter Refusal** dialog (Figure 80) displays.

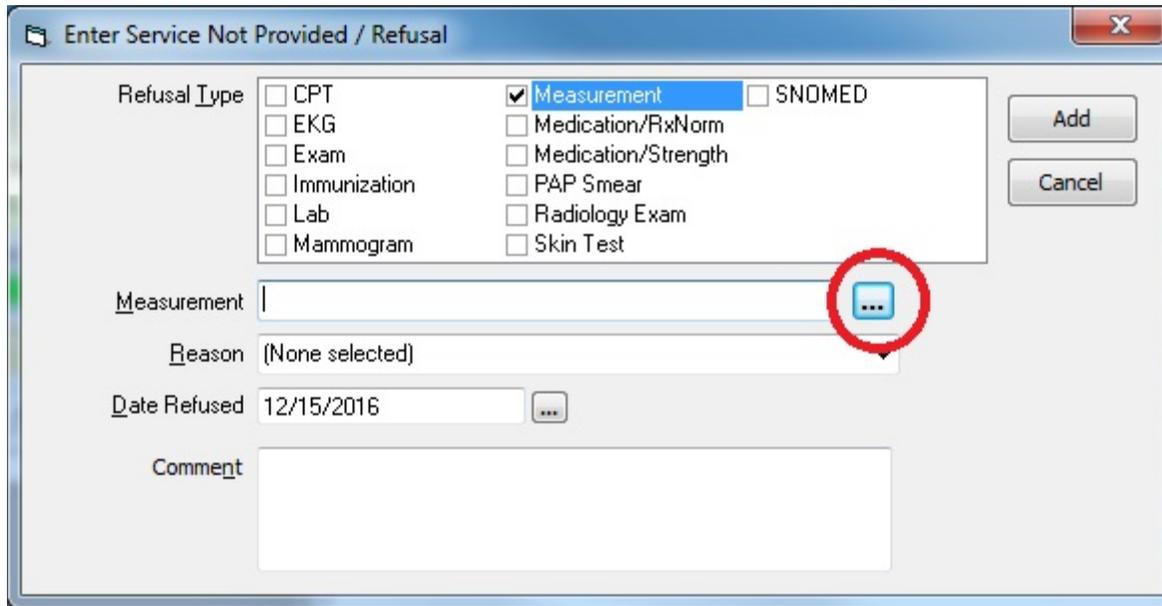


Figure 80: Selecting the Refusal Type

3. Select the **Refusal Type** and click the ellipses (...) button. The Lookup Measurement dialog (Figure 81) displays.

# Key Clinical Performance Objectives

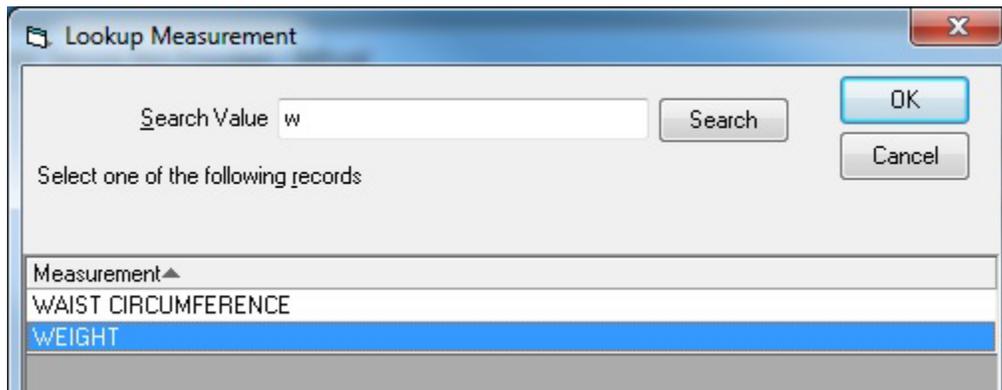


Figure 81: **Lookup Measurement** dialog

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 82) displays.

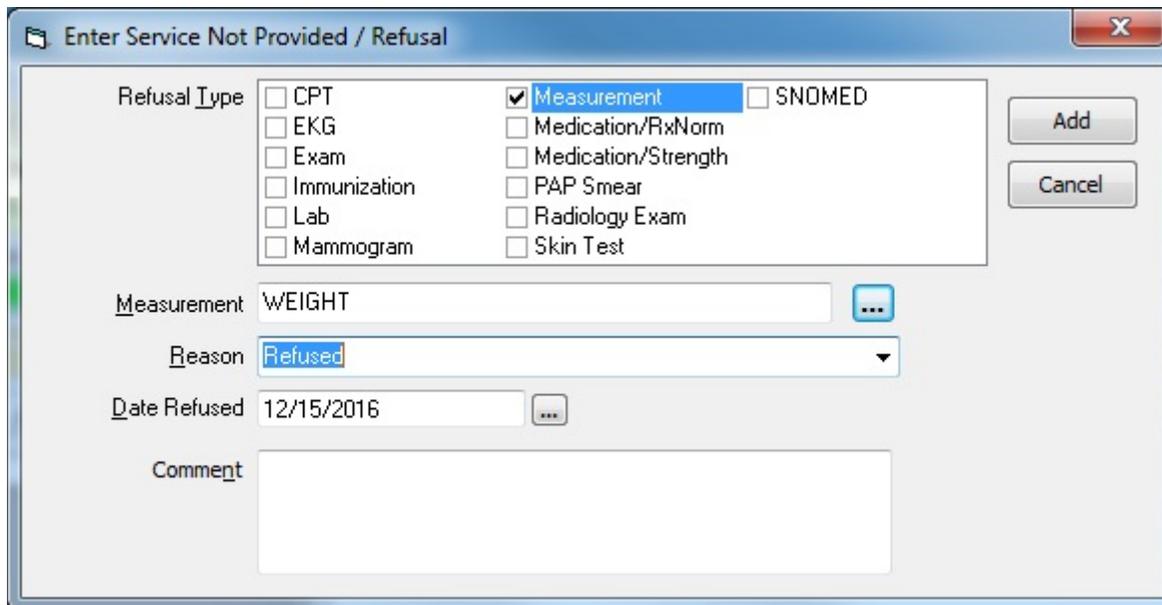


Figure 82: Entering a comment

6. Type a **Comment** (if applicable) and click **Add**. The newly added Refusal should display in the **Personal Health** component (Figure 83).

# Key Clinical Performance Objectives

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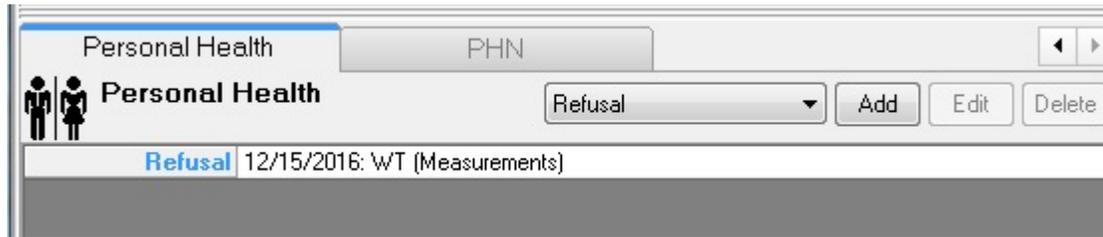


Figure 83: Example of a newly added Refusal