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:


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.

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</table>
| **Diabetes Prevalence** | **Note:** This is not a GPRA measure; however, it is used in determining patients that have been diagnosed with diabetes. | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:  
- Date received  
- Location  
- Results | **Diabetes Prevalence Diagnosis**  
**POV**  
**Visit Diagnosis Entry**  
Purpose of Visit: ICD-9: 250.00-250.93 or ICD-10: E10.*-E13.*  
Provider Narrative:  
Modifier:  
Cause of DX: |
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| **Diabetes: Glycemic Control** | Active Clinical Patients DX with diabetes and with an A1c:  
• Less than (<) 8 (Good Glycemic Control) | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:  
• Date received  
• Location  
• Results | **A1c Lab Test**  
**Lab Test Entry**  
Enter Lab Test Type: [Enter site’s defined A1c Lab Test]  
Collect Sample/Specimen: [Blood, Plasma]  
Clinical Indication:  
**CPT**  
Visit Services Entry (includes historical CPTs)  
Enter CPT: 83036, 83037, 3044F-3046F  
Quantity:  
Modifier:  
Modifier 2: |
| **Diabetes: Blood Pressure Control** | Active Clinical Patients DX with diabetes and with controlled blood pressure:  
• Less than (<) 140/90 (mean systolic less than (<) 140, mean diastolic less than (<) 90) | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:  
• Date received  
• Location  
• Results | **Blood Pressure Data Entry**  
**Vital Measurements Entry** (includes historical Vitals)  
Value: [Enter as Systolic/Diastolic (e.g., 140/90)]  
Select Qualifier:  
Date/Time Vitals Taken: |
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</table>
| Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes     | Active Clinical Patients DX with diabetes age 40 - 75 or age 21 and older with documented CVD or LDL greater than or equal to (>=)190 who have statin therapy. | Standard EHR documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in EHR:  
  - Date received  
  - Location  
  - Dosage | **Statin Therapy Medication**  
  **Medication Entry**  
  Select Medication: [Enter Statin Therapy Prescribed Medication]  
  Outside Drug Name (Optional): [Enter any additional name for the drug]  
  SIG  
  Quantity:  
  Day Prescribed:  
  Event Date&Time:  
  Ordering Provider:  
  **Statin Therapy CPT**  
  **Visit Services Entry** (includes historical CPTs)  
  Enter CPT Code: 4013F  
  Quantity:  
  Modifier:  
  Modifier 2: |
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</table>
| Diabetes: Nephropathy        | Active Clinical Patients DX with diabetes with a Nephropathy assessment:  | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR: | **Estimated GFR Lab Test**  
**Lab Test Entry**  
Enter Lab Test Type: [Enter site’s defined Est GFR Lab Test]  
Collect Sample/Specimen: [Blood]  
Clinical Indication:  
**Urine Albumin-to-Creatinine Ratio CPT**  
**Visit Services Entry** (includes historical CPTs)  
Enter CPT: 82043 AND 82570  
Quantity:  
Modifier:  
Modifier 2:  
**ESRD CPT**  
**Visit Services Entry** (includes historical CPTs)  
Enter CPT: 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G9231, S2065 or S9339  
Quantity:  
Modifier:  
Modifier 2: |
| Assessment                   | • Estimated GFR with result during the Report Period  
• Urine Albumin-to-Creatinine Ratio during the Report Period  
• End Stage Renal Disease diagnosis/treatment | • Date received  
• Location  
• Results | |
### Key Clinical Performance Objectives

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<tr>
<td>Diabetes: Nephropathy Assessment (cont.)</td>
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<td><strong>ESRD POV</strong></td>
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<td><strong>Visit Diagnosis Entry</strong></td>
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<td>Purpose of Visit: ICD-9: 585.6, V42.0, V45.11, V45.12, V56.<em>; ICD-10: N18.6, Z48.22, Z49.</em>, Z91.15, Z94.0, Z99.2</td>
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<td>Provider Narrative:</td>
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<td>Cause of DX:</td>
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<td><strong>ESRD Procedure</strong></td>
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<td><strong>Procedure Entry</strong></td>
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<td>Operation/Procedure: ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6*</td>
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<td>Provider Narrative:</td>
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<td>Operating Provider:</td>
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<td>Diagnosis: [Enter appropriate DX (ESRD)]</td>
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| Diabetic Retinopathy      | Patients with diabetes and no bilateral blindness will have a qualified* retinal examination during the report period. *Qualified retinal exam: The following methods are qualifying for this measure:  
  • Dilated retinal evaluation by an optometrist or ophthalmologist  
  • Seven standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist  
  • Any photographic method formally validated to seven standard fields (ETDRS).  
  Note: Refusals are not counted toward the GPRA measure, but should still be documented. | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:  
  • Date received  
  • Location  
  • Results  
  Exams:  
  • Diabetic Retinal Exam  
    - Dilated retinal eye exam  
    - Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist  
    - Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos  
    - Routine ophthalmological examination including refraction (new or existing patient)  
    - Diabetic indicator; retinal eye exam, dilated, bilateral  
  • Other Eye Exams  
    - Non-DNKA (did not keep appointment) visits to ophthalmology or optometry clinics with an optometrist or ophthalmologist, or visits to formally validated tele-opthalmology retinal evaluation clinics | **Diabetic Retinopathy Exam**  
Exam Entry (includes historical exams)  
Select Exam: 03  
Result: [Enter Results]  
Comments:  
Provider Performing Exam:  
**Retinal Exam CPT**  
Visit Services Entry (includes historical CPTs)  
Enter CPT: 2022F, 2024F, 2026F, S0620, S0621, S3000  
Quantity:  
Modifier:  
Modifier 2:  
**Other Eye Exam CPT**  
Visit Services Entry (includes historical CPTs)  
Enter CPT: 67028, 67039, 67040, 92002, 92004, 92012, 92014  
Quantity:  
Modifier:  
Modifier 2:  
**Other Eye Exam POV**  
Visit Diagnosis Entry  
Purpose of Visit: ICD-9: V72.0  
Provider Narrative:  
Modifier:  
Cause of DX:  
**Other Eye Exam Clinic**  
Clinic Entry  
Clinic: A2, 17, 18, 64 |
### Key Clinical Performance Objectives

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| Access to Dental Service     | Patients should have annual dental exams. Note: Refusals are not counted toward the GPRA measure, but should still be documented. | Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:  
  - Date received  
  - Location  
  - Results | Dental Exam  
  **Exam Entry** (includes historical exams)  
  Select Exam: 30  
  Result: [Enter Results]  
  Comments:  
  Provider Performing Exam:  
  Dental Exam (ADA code)  
  ADA codes cannot be entered into EHR.  
  Dental Exam CPT  
  **Visit Services Entry** (includes historical CPTs)  
  Enter CPT: D0190, D0191  
  Quantity:  
  Modifier:  
  Modifier 2:  
  Dental Exam POV  
  **Visit Diagnosis Entry**  
  Purpose of Visit: ICD-9: V72.2; ICD-10: Z01.20, Z01.21  
  Provider Narrative:  
  Modifier:  
  Cause of DX: |
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| Dental Sealants     | Patients should have one or more intact dental sealants. **Note:** Refusals are not counted toward the GPRA measure, but should still be documented. | Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:  
  - Date received  
  - Location  
  - Results | **Dental Sealants (ADA)**  
  *ADA codes cannot be entered into EHR.*  
  **Dental Sealants CPT**  
  *Visit Services Entry* (includes historical CPTs)  
  Enter CPT: D1351, D1352, D1353  
  Quantity:  
  Modifier:  
  Modifier 2: |
| Topical Fluoride    | Patients should have one or more topical fluoride applications. **Note:** Refusals are not counted toward the GPRA measure, but should still be documented. | Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:  
  - Date received  
  - Location  
  - Results | **Topical Fluoride (ADA code)**  
  *ADA codes cannot be entered into EHR.*  
  **Topical Fluoride CPT**  
  *Visit Services Entry* (includes historical CPTs)  
  Enter CPT: D1206, D1208, D5986, 99188  
  Quantity:  
  Modifier:  
  Modifier 2:  
  **Topical Fluoride POV**  
  *Visit Diagnosis Entry*  
  Purpose of Visit: ICD-9: V07.31  
  Provider Narrative:  
  Modifier:  
  Cause of DX: |
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| Influenza           | All patients ages 6 months and older should have an annual influenza (flu) shot. Refusals should be documented. **Note:** Only Not Medically Indicated (NMI) refusals are counted toward the GPRA Measure. | Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:  
  - IZ type  
  - Date received  
  - Location  
Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include:  
Immunization Package of "Egg Allergy" or "Anaphylaxis"  
NMI Refusal | **Influenza Vaccine**  
**Immunization Entry** (includes historical immunizations)  
Select Immunization Name: 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166 (other options are 111, 15, 16, 88)  
Lot:  
VFC Eligibility:  
**Influenza Vaccine POV**  
**Visit Diagnosis Entry**  
Purpose of Visit: ICD-9: *V04.81, *V06.6  
Provider Narrative:  
Modifier:  
Cause of DX:  
* NOT documented with 90663, 90664, 90666-90668, 90470, G9141, G9142  
**Influenza Vaccine CPT**  
**Visit Services Entry** (includes historical CPTs)  
Enter CPT: 90630, 90654-90662, 90672, 90673, 90685-90688, G0008  
Quantity:  
Modifier:  
Modifier 2:  
**NMI Refusal of Influenza**  
*NMI Refusals can only be entered in EHR via Reminder Dialogs.*
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<td>Influenza (cont.)</td>
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<td><strong>Contraindication Influenza</strong></td>
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<td><em>Immunization Entry - Contraindications</em></td>
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<td></td>
<td>Vaccine: [See codes above]</td>
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<td>Reason: Egg Allergy, Anaphylaxis</td>
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| Adult Immunizations      | All adults ages 65 and older will have a pneumococcal vaccine. All adult (18 and older) diabetic patients are strongly recommended to have a pneumococcal vaccine. Refusals should be documented. **Note:** Only NMI refusals are counted toward the GPRA Measure. | Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:  
  - IZ type  
  - Date received  
  - Location  
Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include: Immunization Package of "Egg Allergy" or "Anaphylaxis"  
NMI Refusal | **Pneumococcal Vaccine**  
**Immunization Entry** (includes historical immunizations)  
Select Immunization Name: 33, 100, 109, 133, 152  
Lot:  
VFC Eligibility:  
**Pneumococcal Vaccine POV**  
**Visit Diagnosis Entry**  
Purpose of Visit: ICD-9: V06.6, V03.82  
Provider Narrative:  
Modifier:  
Cause of DX:  
**Pneumococcal Vaccine CPT**  
**Visit Services Entry** (includes historical CPTs)  
Enter CPT: 90669, 90670, 90732, G0009, G9279  
Quantity:  
Modifier:  
Modifier 2:  
**NMI Refusal of Pneumococcal**  
**NMI Refusals can only be entered in EHR via Reminder Dialogs.**  
**Contraindication Pneumococcal**  
**Immunization Entry - Contraindications**  
Vaccine: [See codes above]  
Reason: Egg Allergy, Anaphylaxis |

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**Clinical Objectives Cheat Sheet**

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| Childhood Immunizations  | Children age 19–35 months will be up-to-date for all ACIP recommended immunizations. This is the 4313*314 combo: 4 DTaP 3 IPV 1 MMR 3 or 4 Hib 1 Varicella 4 Pneumococcal Refusals should be documented. **Note:** Only NMI refusals are counted toward the GPRA Measure. | Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:  
- **IZ type**  
- **Date received**  
- **Location**  
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  
Contraindications should be documented and are counted toward the GPRA Measure.  
Contraindications include Immunization Package of "Anaphylaxis" for all childhood immunizations. The following additional contraindications are also counted:  
- **IPV:** Immunization Package: "Neomycin Allergy."  
- **OPV:** Immunization Package: "Immune Deficiency."  
- **MMR:** Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."  
- **Varicella:** Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."  
- **Pneumococcal:** Immunization Package: "Anaphylaxis" | **Childhood Immunizations**  
Immunization Entry (includes historical immunizations)  
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, 116; Hib: 17, 22, 46-49, 50, 51, 102, 120, 146; Varicella: 21, 94; Pneumococcal: 33, 100, 109, 133, 152  
Lot:  
VFC Eligibility: |
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<tr>
<td><strong>Childhood Immunizations (cont.)</strong></td>
<td>Dosage and types of immunization definitions: 4 doses of DTaP: 4 DTaP/DTP/Tdap 1 DTaP/DTP/Tdap and 3 DT/Td 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus 4 DT and 4 Acellular Pertussis 4 Td and 4 Acellular Pertussis 4 each of Diphtheria, Tetanus, and Acellular Pertussis 3 doses of IPV: 3 OPV 3 IPV Combination of OPV and IPV totaling three doses 1 dose of MMR: MMR 1 M/R and 1 Mumps 1 R/M and 1 Measles 1 each of Measles, Mumps, and Rubella 3 doses of Hepatitis B 3 doses of Hep B 3 or 4 doses of HIB, depending on the vaccine administered 1 dose of Varicella 4 doses of Pneumococcal</td>
<td><strong>Childhood Immunizations POV</strong></td>
<td><strong>Visit Diagnosis Entry</strong>  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.<em>; Mumps: ICD-9: V04.6; Mumps (evidence of disease): ICD-9: 072</em>, ICD-10: B26.<em>; Rubella: ICD-9: V04.3; Rubella (evidence of disease): ICD-9: 056</em>, 771.0, ICD-10: B06.<em>; Hepatitis B (evidence of disease): ICD-9: V02.61, 070.2, 070.3, ICD-10: B16.</em>, 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.<em>-B02.</em>; Pneumococcal: ICD-9: V06.6, V03.82</td>
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<td>Childhood Immunizations (cont.)</td>
<td>Important Note: The GPRA denominator is all User Population patients who are active in the Immunization Package. This means you must be using the Immunization Package and maintaining the active/inactive status field in order to have patients in your denominator for this GPRA measure. Immunization package v8.4 offers a scan function that searches the RPMS Patient Database for children who are less than 36 months old and reside in GPRA communities for the facility, and automatically enters them into the Register with a status of Active. Sites can run this scan at any time, and should run it upon loading 8.4. Children already in the Register or residing outside of the GPRA communities will not be affected.</td>
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<td>Childhood Immunizations CPT Visit Services Entry (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</td>
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<td>Quantity: Modifier: Modifier 2: NMI Refusal of Childhood Immunizations NMI Refusals can only be entered in EHR via Reminder Dialogs. Contraindication Childhood Immunizations Immunization Entry - Contraindications Vaccine: [See codes above] Reason: [See Contraindications section under the Provider Documentation column]</td>
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| Cancer Screening: Pap Smear Rates | 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. **Note:** Refusals of any above test are not counted toward the GPRA measure, but should still be documented. | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:  
- Date received  
- Location  
- Results | **Pap Smear V Lab**  
*Lab Test Entry*  
Enter Lab Test Type: [Enter site’s defined Pap Smear Lab Test]  
Clinical Indication:  
**Pap Smear POV**  
*Visit Diagnosis Entry*  
Purpose of Visit: ICD-9: V72.32, V76.2, 795.0*; ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4  
Provider Narrative:  
Modifier:  
Cause of DX:  
**Pap Smear CPT**  
*Visit Services Entry* (includes historical CPTs)  
Enter CPT: 88141-88154, 88160-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091  
Quantity:  
Modifier:  
Modifier 2:  
**HPV V Lab**  
*Lab Test Entry*  
Enter Lab Test Type: [Enter site’s defined HPV Lab Test]  
Clinical Indication: |
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| Cancer Screening: Pap Smear Rates (cont.) | | | **HPV POV**  
*Visit Diagnosis Entry*  
Purpose of Visit: ICD-9: V73.81, 079.4, 796.75, 795.05, 795.15, 796.79, 795.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51  
Provider Narrative:  
Modifier:  
Cause of DX:  
**HPV CPT**  
*Visit Services Entry* (includes historical CPTs)  
Enter CPT: 87623-87625  
Quantity:  
Modifier:  
Modifier 2: |
<table>
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<tr>
<th>Performance Measure</th>
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</thead>
</table>
| Cancer Screening: Mammogram Rates | Women ages 52–64 should have a mammogram every 2 years **Note**: Refusals of any above test are not counted toward the GPRA measure, but should still be documented. | Standard EHR documentation for Radiology performed at the facility. Ask and record historical information in EHR:  
- Date received  
- Location  
- Results  
Telephone visit with patient  
Verbal or written lab report  
Patient’s next visit | **Mammogram POV**  
**Visit Diagnosis Entry**  
Purpose of Visit: ICD-9: V76.11, V76.12, 793.80, 793.81, 793.89; ICD-10: R92.0, R92.1, R92.8, Z12.31  
Provider Narrative:  
Modifier:  
Cause of DX:  
**Mammogram CPT**  
**Visit Services Entry** (includes historical CPTs)  
Enter CPT: 77053-77059, G0206; G0204, G0202  
Quantity:  
Modifier:  
Modifier 2:  
**Mammogram Procedure**  
**Procedure Entry**  
Operation/Procedure: ICD-9: 87.36, 87.37; ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ  
Provider Narrative:  
Operating Provider:  
Diagnosis: [Enter appropriate DX] |
<table>
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</thead>
</table>
| Colorectal Cancer Screening | Adults ages 50–75 should be screened for CRC (USPTF). For GPRA, IHS counts any of the following:  
  • Annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT)  
  • Flexible sigmoidoscopy in the past 5 years  
  • Colonoscopy every 10 years.  
  **Note:** Refusals of any above test are not counted toward the GPRA measure, but should still be documented. | Standard EHR documentation for procedures performed at the facility (Radiology, Lab, provider). Guaiac cards returned by patients to providers should be sent to Lab for processing.  
  Ask and record historical information in EHR:  
  • Date received  
  • Location  
  • Results  
  Telephone visit with patient  
  Verbal or written lab report  
  Patient’s next visit | **Colorectal Cancer POV**  
  **Visit Diagnosis Entry**  
  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  
  Provider Narrative:  
  Modifier:  
  Cause of DX:  
  **Total Colectomy CPT**  
  **Visit Services Entry** (includes historical CPTs)  
  Enter CPT: 44150-44151, 44155-44158, 44210-44212  
  Quantity:  
  Modifier:  
  Modifier 2:  
  **Total Colectomy Procedure**  
  **Procedure Entry**  
  Operation/Procedure: ICD-9: 45.8*; ICD-10: 0DTE*ZZ  
  Provider Narrative:  
  Operating Provider:  
  Diagnosis: [Enter appropriate DX] |
<table>
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<tbody>
<tr>
<td>Colorectal Cancer Screening (cont.)</td>
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</tbody>
</table>

**FOBT or FIT CPT**

*Visit Services Entry* (includes historical CPTs)
- Enter CPT: 82270, 82274, G0328
- Quantity:
- Modifier:
- Modifier 2:

**Flexible Sigmoidoscopy CPT**

*Visit Services Entry* (includes historical CPTs)
- Enter CPT: 45330–45345, G0104
- Quantity:
- Modifier:
- Modifier 2:

**Flexible Sigmoidoscopy Procedure**

*Procedure Entry*
- Operation/Procedure: ICD-9: 45.24; ICD-10: 0DJD8ZZ
- Provider Narrative:
- Operating Provider:
- Diagnosis: [Enter appropriate DX]

**Colon Screening CPT**

*Visit Services Entry* (includes historical CPTs)
- Enter CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121, G9252, G9253
- Quantity:
- Modifier:
- Modifier 2:
## Key Clinical Performance Objectives

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<tr>
<td>Colorectal Cancer Screening (cont.)</td>
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<td></td>
<td><strong>Colon Screening Procedure</strong></td>
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<td></td>
<td><em>Procedure Entry</em></td>
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<td>Operation/Procedure: ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; ICD-10: (see logic manual for codes)</td>
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<td>Provider Narrative:</td>
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<td>Operating Provider:</td>
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<td>Diagnosis: [Enter appropriate DX]</td>
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<td>Performance Measure</td>
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</tbody>
</table>
| Tobacco Use and Exposure Assessment | Ask all patients age five and over about tobacco use at least annually. | Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:  
  - Date received  
  - Location  
  - Results  
Document on designated Health Factors section of form:  
  - HF–Current Smoker, every day  
  - HF–Current Smoker, some day  
  - HF–Heavy Tobacco Smoker  
  - HF–Light Tobacco Smoker  
  - HF–Current Smoker, status unknown  
  - HF–Current Smokeless  
  - HF–Previous (Former) Smoker [or -Smokeless] (quit greater than (>)) 6 months)  
  - HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 6 months)  
  - HF–Smoker in Home  
  - HF–Ceremonial Use Only  
  - HF–Exp to ETS (Second Hand Smoke)  
  - HF–Smoke Free Home  
**Note:** If your site uses other expressions (e.g., "Chew" instead of "Smokeless;" "Past" instead of "Previous"), be sure Data Entry staff knows how to "translate"  
Tobacco Patient Education Codes:  
  - Codes will contain "TO-", "-TO", "-SHS" | **Tobacco Screening Health Factor**  
*Health Factor Entry*  
Select V Health Factor: [Enter HF (See the Provider Documentation column)]  
Level/Severity:  
Provider:  
Quantity:  
**Tobacco Screening PED–Topic**  
*Patient Education Entry* (includes historical patient education)  
Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]  
Readiness to Learn:  
Level of Understanding:  
Provider:  
Length of 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:
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Tobacco Use and Exposure Assessment (cont.)</td>
<td>Note: Ensure you update the patient’s health factors as they enter a cessation program and eventually become non-tobacco users. Patients who are in a tobacco cessation program should have their health factor changed from “Smoker” or “Smokeless” to “Cessation-Smoker” or “Cessation-Smokeless” until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to “Previous Smoker” or “Previous Smokeless.”</td>
<td></td>
<td>Tobacco Users Health Factor</td>
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<td>Health Factor Entry</td>
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<td></td>
<td>Select V Health Factor: Current Smoker (every day, some day, or status unknown), Current Smokeless, Cessation-Smoker, Cessation-Smokeless</td>
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<td></td>
<td></td>
<td></td>
<td>Level/Severity:</td>
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<td></td>
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<td></td>
<td>Provider:</td>
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<td></td>
<td></td>
<td></td>
<td>Quantity:</td>
</tr>
<tr>
<td>Smokers Health Factor</td>
<td>Health Factor Entry</td>
<td>Select V Health Factor: Current Smoker (every day, some day, or status unknown), or Cessation-Smoker</td>
<td>Level/Severity:</td>
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<td>Provider:</td>
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<td></td>
<td>Quantity:</td>
</tr>
<tr>
<td>Smokeless Health Factor</td>
<td>Health Factor Entry</td>
<td>Select V Health Factor: Current Smokeless or Cessation-Smokeless</td>
<td>Level/Severity:</td>
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<td></td>
<td>Provider:</td>
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<td>Quantity:</td>
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<tr>
<td>ETS Health Factor</td>
<td>Health Factor Entry</td>
<td>Select V Health Factor: Exp to ETS</td>
<td>Level/Severity:</td>
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<td>Provider:</td>
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</table>
| Tobacco Cessation         | Active clinical patients identified as current tobacco users prior to report period and who have received tobacco cessation counseling or a Rx for smoking cessation aid or quit tobacco use. 
**Note:** Refusals are not counted toward the GPRA measure, but should still be documented.                                                                   | Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:  
• Date received  
• Location  
• Results  
Current tobacco users are defined by having any of the following documented prior to the report period:  
• Last documented Tobacco Health Factor  
• Last documented Tobacco related POV  
• Last documented Tobacco related CPT  
Health factors considered to be a tobacco user:  
• HF–Current Smoker, every day  
• HF–Current Smoker, some day  
• HF–Heavy Tobacco Smoker  
• HF–Light Tobacco Smoker  
• HF–Current Smoker, status unknown  
• HF–Current Smokeless  
• HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 6 months)  
Tobacco Patient Education Codes:  
• Codes will contain "TO-", "-TO", "-SHS" | **Tobacco Cessation PED - Topic Patient Education Entry** (includes historical patient education)  
Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]  
Readiness to Learn:  
Level of Understanding:  
Provider:  
Length of 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:
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</tr>
</thead>
</table>
| Tobacco Cessation (cont.) | | Prescribe Tobacco Cessation Aids:  
- Predefined Site-Populated Smoking Cessation Meds  
- Meds containing:  
  - “Nicotine Patch”  
  - “Nicotine Polacrilex”  
  - “Nicotine Inhaler”  
  - “Nicotine Nasal Spray”  
  
**Note:**  
Ensure you update the patient’s health factors as they enter a cessation program and eventually become nontobacco users. Patients who are in a tobacco cessation program should have their health factor changed from “Smoker” or “Smokeless” to “Cessation-Smoker” or “Cessation-Smokeless” until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to “Previous Smoker” or “Previous Smokeless.” | | **Tobacco Cessation PED–Diagnosis**  
[Patient Education Entry](#) (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: |

**Tobacco Cessation PED - CPT**  
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:
### Tobacco Cessation (cont.)

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<tbody>
<tr>
<td>Tobacco Cessation Clinic</td>
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<td><strong>Tobacco Cessation Clinic</strong></td>
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<tr>
<td>Tobacco Cessation Dental</td>
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<td></td>
<td><strong>Clinic Entry</strong></td>
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<td><strong>Tobacco Cessation Dental</strong></td>
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<td><strong>Tobacco Cessation CPT</strong></td>
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<td><strong>Visit Services Entry</strong> (includes historical CPTs)**</td>
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<td><strong>Enter CPT Code: D1320, 99406, 99407, 4000F</strong></td>
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<tr>
<td>ADA codes cannot be entered into EHR.</td>
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<td><strong>Quantity</strong></td>
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<td><strong>Modifier:</strong></td>
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<td><strong>Modifier 2:</strong></td>
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<td><strong>Tobacco Cessation Medication</strong></td>
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<td><strong>Medication Entry</strong></td>
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<td><strong>Select Medication: [Enter Tobacco Cessation Prescribed Medication]</strong></td>
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<td></td>
<td><strong>Outside Drug Name (Optional): [Enter any additional name for the drug]</strong></td>
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<td><strong>SIG</strong></td>
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<td><strong>Quantity:</strong></td>
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<td><strong>Event Date&amp;Time:</strong></td>
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<td><strong>Ordering Provider:</strong></td>
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**Clinical Objectives Cheat Sheet 25**

Last Edited: 12/30/2016
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<td></td>
<td><strong>Tobacco Cessation Prescription CPT</strong></td>
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<td><strong>Visit Services Entry</strong> (includes historical CPTs)</td>
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<td>- Enter CPT Code: 4001F</td>
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<td>- Modifier 2:</td>
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<td></td>
<td><strong>Quit Tobacco POV</strong></td>
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<td><strong>Visit Diagnosis Entry</strong></td>
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<td></td>
<td>- Purpose of Visit: ICD-9: 305.13, V15.82; ICD-10: F17.2*1, Z87.891</td>
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<td>- Provider Narrative:</td>
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<td>- Cause of DX:</td>
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| Alcohol Screening       | Adult patients ages 12 through 75 should be screened for alcohol use at least annually. **Note:** Refusals are not counted toward the GPRA measure, but should still be documented. | Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:  
  - Date received  
  - Location  
  - Results  
Alcohol screening may be documented with either an exam code or the CAGE health factor in EHR.  
Medical Providers:  
EXAM—Alcohol Screening  
  - **Negative**—Patient’s screening exam does not indicate risky alcohol use.  
  - **Positive**—Patient’s screening exam indicates potential risky alcohol use.  
  - **Refused**—Patient declined exam/screen  
  - **Unable to screen** - Provider unable to screen  
**Note:** Recommended Brief Screening Tool: SASQ (below).  
**Single Alcohol Screening Question (SASQ)**  
**For Women:**  
  - When was the last time you had more than 4 drinks in one day?  
**For Men:**  
  - When was the last time you had more than 5 drinks in one day? | **Alcohol Screening Exam**  
*Exam Entry* (includes historical exams)  
Select Exam: 35, ALC  
Result:  
A—Abnormal  
N—Normal/Negative  
PR—Resent  
PAP—Present and Past  
PA—Past  
PO—Positive  
Comments: SASQ  
Provider Performing Exam:  
**Cage Health Factor**  
*Health Factor Entry*  
Select Health Factor: CAGE  
1. CAGE 0/4 (all No answers)  
2. CAGE 1/4  
3. CAGE 2/4  
4. CAGE 3/4  
5. CAGE 4/4  
Choose 1-5: [Number from above]  
Level/Severity:  
Provider:  
Quantity: |
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<tr>
<td>Alcohol Screening (cont.)</td>
<td>Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen:</td>
<td>• Alcohol Screening Exam Code Result: Positive</td>
<td><strong>Alcohol Screening POV</strong></td>
</tr>
<tr>
<td></td>
<td>The patient may decline the screen or “Refuse to answer”:</td>
<td>• Alcohol Screening Exam Code Result: Refused</td>
<td><strong>Visit Diagnosis Entry</strong></td>
</tr>
<tr>
<td></td>
<td>The provider is unable to conduct the screen:</td>
<td>• Alcohol Screening Exam Code Result: Unable To Screen</td>
<td>Purpose of Visit: ICD-9: V11.3, V79.1</td>
</tr>
<tr>
<td></td>
<td><strong>Note</strong>: Provider should <strong>Note</strong> the screening tool used was the SASQ at the Comment Mnemonic for the Exam code.</td>
<td><strong>Alcohol-Related Diagnosis POV</strong></td>
<td>Provider Narrative:</td>
</tr>
<tr>
<td></td>
<td>All Providers: Use the CAGE questionnaire:</td>
<td><strong>Visit Diagnosis Entry</strong> (includes historical CPTs)</td>
<td>Modifier:</td>
</tr>
<tr>
<td></td>
<td>Have you ever felt the need to Cut down on your drinking?</td>
<td>Enter CPT Code: 99408, 99409, G0396, G0397, H0049, H0050</td>
<td>Cause of DX:</td>
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<td></td>
<td>Have people Annoyed you by criticizing your drinking?</td>
<td>Quantity</td>
<td><strong>Alcohol-Related Procedure</strong></td>
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<td></td>
<td>Have you ever felt bad or Guilty about your drinking?</td>
<td>Modifier:</td>
<td><strong>Procedure Entry</strong></td>
</tr>
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<td></td>
<td>Have you ever needed an Eye-opener the first thing in the morning to steady your nerves or get rid of a hangover?</td>
<td>Modifier 2:</td>
<td>Operation/Procedure: ICD-9: 94.46, 94.53, 94.61-94.63, 94.67-94.69</td>
</tr>
<tr>
<td></td>
<td>Tolerance: How many drinks does it take you to get high?</td>
<td><strong>Alcohol-Related Procedure</strong></td>
<td>Provider Narrative:</td>
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<td></td>
<td><strong>Procedure Entry</strong></td>
<td>Operating Provider:</td>
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<td>Diagnosis: [Enter appropriate DX]</td>
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<tbody>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>Based on how many YES answers were received, document Health Factor in EHR:</td>
<td></td>
<td>Alcohol-Related PED - Topic Patient Education Entry (includes historical patient education)</td>
</tr>
<tr>
<td></td>
<td>- HF–CAGE 0/4 (all No answers)</td>
<td></td>
<td>Enter Education Topic: [Enter Alcohol-Related Education Code (See the Provider Documentation column)]</td>
</tr>
<tr>
<td></td>
<td>- HF–CAGE 1/4</td>
<td></td>
<td>Readiness to Learn:</td>
</tr>
<tr>
<td></td>
<td>- HF–CAGE 2/4</td>
<td></td>
<td>Level of Understanding:</td>
</tr>
<tr>
<td></td>
<td>- HF–CAGE 3/4</td>
<td></td>
<td>Provider:</td>
</tr>
<tr>
<td></td>
<td>- HF–CAGE 4/4</td>
<td></td>
<td>Length of Education (Minutes):</td>
</tr>
<tr>
<td>Optional values:</td>
<td></td>
<td></td>
<td>Comment</td>
</tr>
<tr>
<td></td>
<td>- Level/Severity: Minimal, Moderate, or Heavy/Severe</td>
<td></td>
<td>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</td>
</tr>
<tr>
<td>Alcohol-Related Patient Education Codes:</td>
<td>Codes will contain &quot;AOD-&quot;, &quot;-AOD&quot;, &quot;CD-&quot;</td>
<td></td>
<td>Goal Comment:</td>
</tr>
<tr>
<td>AUDIT Measurements:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- <strong>Zone I</strong>: Score 0–7</td>
<td>Low risk drinking or abstinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- <strong>Zone II</strong>: Score 8–15</td>
<td>Alcohol use in excess of low-risk guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- <strong>Zone III</strong>: Score 16–19</td>
<td>Harmful and hazardous drinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- <strong>Zone IV</strong>: Score 20–40</td>
<td>Referral to Specialist for Diagnostic Evaluation and Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Measure</td>
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<td>Provider Documentation</td>
<td>How to Enter Data in EHR</td>
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<tr>
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<td>--------------------------</td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>AUDIT-C Measurements: How often do you have a drink containing alcohol?</td>
<td>Alcohol-Related PED - Diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (0) Never (Skip to Questions 9-10)</td>
<td>Patient Education Entry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (1) Monthly or less</td>
<td>(includes historical patient education)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (2) 2 to 4 times a month</td>
<td>Select ICD Diagnosis Code</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (3) 2 to 3 times a week</td>
<td>Number: V11.3, V79.1, 303.*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (4) 4 or more times a week</td>
<td>305.0*, 291.* or 357.5*</td>
<td>Category:</td>
</tr>
<tr>
<td></td>
<td>How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>Readiness to Learn:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (0) 1 or 2</td>
<td>Level of Understanding:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (1) 3 or 4</td>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (2) 5 or 6</td>
<td>Length of Education (Minutes):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (3) 7, 8, or 9</td>
<td>Comment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (4) 10 or more</td>
<td>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How often do you have 6 or more drinks on one occasion?</td>
<td>Goal Comment:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (0) Never</td>
<td>Provider's Narrative:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (1) Less than monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (2) Monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (3) Weekly</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (4) Daily or almost daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>AUDIT-C Measurements: How often do you have a drink containing alcohol?</td>
<td>Alcohol-Related PED - CPT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (0) Never (Skip to Questions 9-10)</td>
<td>Patient Education Entry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (1) Monthly or less</td>
<td>(includes historical patient education)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (2) 2 to 4 times a month</td>
<td>Select CPT Code Number:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (3) 2 to 3 times a week</td>
<td>99408, 99409, G0396, G0397,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (4) 4 or more times a week</td>
<td>H0049, or H0050</td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>Category:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (0) 1 or 2</td>
<td>Readiness to Learn:</td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>- (1) 3 or 4</td>
<td>Level of Understanding:</td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>- (2) 5 or 6</td>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>- (3) 7, 8, or 9</td>
<td>Length of Education (Minutes):</td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>- (4) 10 or more</td>
<td>Comment</td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>How often do you have 6 or more drinks on one occasion?</td>
<td>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the related text)]</td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>- (0) Never</td>
<td>Goal Comment:</td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>- (1) Less than monthly</td>
<td>Provider's Narrative:</td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>- (2) Monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>- (3) Weekly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>- (4) Daily or almost daily</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinical Objectives Cheat Sheet 30 Last Edited: 12/30/2016
## Key Clinical Performance Objectives

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Alcohol Screening (cont.)</td>
<td>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).</td>
<td></td>
<td>Alcohol Screen AUDIT Measurement</td>
</tr>
<tr>
<td></td>
<td>• In men, a score of 4 or more is considered positive</td>
<td></td>
<td>Vital Measurements Entry</td>
</tr>
<tr>
<td></td>
<td>• In women, a score of 3 or more is considered positive.</td>
<td></td>
<td>(includes historical Vitals)</td>
</tr>
<tr>
<td></td>
<td>A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence.</td>
<td></td>
<td>Value: [Enter 0-40]</td>
</tr>
<tr>
<td></td>
<td>CRAFFT Measurements:</td>
<td></td>
<td>Select Qualifier:</td>
</tr>
<tr>
<td></td>
<td>• C–Have you ever ridden in a CAR driven by someone (including yourself) who was &quot;high&quot; or had been using alcohol or drugs?</td>
<td></td>
<td>Date/Time Vitals Taken:</td>
</tr>
<tr>
<td></td>
<td>• R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A–Do you ever use alcohol/drugs while you are by yourself, ALONE?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• F–Do you ever FORGET things you did while using alcohol or drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• T–Have you gotten into TROUBLE while you were using alcohol or drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total CRAFFT score (Range: 0–6).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A positive answer to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated.</td>
<td></td>
<td></td>
</tr>
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</tr>
</tbody>
</table>
| Screening, Brief Intervention, and Referral to Treatment (SBIRT) | 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. | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:  
  - Date received  
  - Location  
  - Results | **BNI/BI CPT**  
  **Visit Services Entry** (includes historical CPTs)  
  Enter CPT Code: G0396, G0397, H0050, 96150-96155  
  Quantity  
  Modifier:  
  Modifier 2: **BNI/BI PED - Topic**  
  **Patient Education Entry** (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: |
### Intimate Partner (Domestic) Violence Screening (IPV/DV)

<table>
<thead>
<tr>
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</thead>
</table>
| Adult females should be screened for domestic violence at new encounter and at least annually Prenatal once each trimester (Source: Family Violence Prevention Fund National Consensus Guidelines) **Note:** Refusals are NOT counted toward the GPRA measure, but should be documented. | Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:  
- Date received  
- Location  
- Results  
Medical and Behavioral Health Providers: EXAM—IPV/DV Screening  
- **Negative**—Denies being a current or past victim of IPV/DV  
- **Past**—Denies being a current victim, but discloses being a past victim of IPV/DV  
- **Present**—Discloses current IPV/DV  
- **Present and Past**—Discloses past victimization and current IPV/DV victimization  
- **Refused**—Patient declined exam/screen  
- **Unable to screen**—Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.)  
IPV/DV Patient Education Codes:  
- Codes will contain "DV-" or ":DV"
| **IPV/DV Screening Exam**  
**Exam Entry** (includes historical exams)  
Select Exam: 34, INT  
Result:  
- A—Abnormal  
- N—Normal/Negative  
- PR—Resent  
- PAP—Present and Past  
- PA—Past  
- PO—Positive  
Comments:  
Provider Performing Exam:  
**IPV/DV Diagnosis POV**  
**Visit Diagnosis Entry**  
Purpose of Visit: ICD-9: 995.80-83, 995.85, V15.41, V15.42, V15.49; ICD-10: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, Z91.410; IPV/DV Counseling: ICD-9: V61.11; ICD-10: Z69.11  
Provider Narrative:  
Modifier:  
Cause of DX: |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont.) | | | **IPV/DV–Topic**  
*Patient Education Entry* (includes historical patient education)  
Enter Education Topic: [Enter IPV/DV Patient Education Code (See the Provider Documentation column)]  
Readiness to Learn:  
Level of Understanding:  
Provider:  
Length of Education (Minutes):  
Comment  
Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]  
Goal Comment: |
| | | | **IPV/DV PED–Diagnosis**  
*Patient Education Entry* (includes historical patient education)  
Select ICD Diagnosis Code Number: 995.80-83, 995.85, V15.41, V15.42, V15.49  
Category:  
Readiness to Learn:  
Level of Understanding:  
Provider:  
Length of Education (Minutes):  
Comment  
Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]  
Goal Comment:  
Provider’s Narrative: |
### Key Clinical Performance Objectives

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<tbody>
<tr>
<td>Depression Screening</td>
<td>All patients 12 years of age and older should be screened for depression at least annually. (Source: United States Preventive Services Task Force) Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</td>
<td>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR: • Date received • Location • Results Medical Providers: EXAM—Depression Screening • Normal/Negative—Denies symptoms of depression • Abnormal/Positive—Further evaluation indicated • Refused—Patient declined exam/screen • Unable to screen—Provider unable to screen Note: Refusals are not counted toward the GPRA measure, but should be documented. Mood Disorders: Two or more visits with POV related to: • Major Depressive Disorder • Dysthymic Disorder • Depressive Disorder NOS • Bipolar I or II Disorder • Cyclothymic Disorder • Bipolar Disorder NOS • Mood Disorder Due to a General Medical Condition • Substance-induced Mood Disorder • Mood Disorder NOS Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</td>
<td>Depression Screening Exam Exam Entry (includes historical exams) 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: Depression Screen Diagnosis POV Visit Diagnosis Entry Purpose of Visit: ICD-9: V79.0 Provider Narrative: Modifier: Cause of DX: Depression Screening CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 1220F, 3725F, G0444 Quantity Modifier: Modifier 2:</td>
</tr>
</tbody>
</table>
### Key Clinical Performance Objectives

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<tbody>
<tr>
<td>Depression Screening (cont.)</td>
<td><strong>Patient Health Questionnaire (PHQ-2 Scaled Version)</strong></td>
<td>Over the past two weeks, how often have you been bothered by any of the following problems?</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Little interest or pleasure in doing things</strong></td>
<td>• Not at all Value: 0</td>
<td><strong>Mood Disorder Diagnosis POV</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Feeling down, depressed, or hopeless</strong></td>
<td>• Several days Value: 1</td>
<td><strong>Visit Diagnosis Entry</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nearly every day Value: 3</td>
<td><strong>Provider Narrative:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>PHQ-2 Scaled Version (continued)</strong></td>
<td></td>
<td><strong>Modifier:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total Possible PHQ-2 Score: Range: 0-6</strong></td>
<td></td>
<td><strong>Cause of DX:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>0-2: Negative Depression Screening Exam:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Code Result: Normal or Negative</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>3-6: Positive; further evaluation indicated Depression Screening Exam</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Code Result: Abnormal or Positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The patient may decline the screen or “Refuse to answer” Depression Screening Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Code Result: Refused</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The provider is unable to conduct the Screen Depression Screening Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Code Result: Unable To Screen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Measure</td>
<td>Standard</td>
<td>Provider Documentation</td>
<td>How to Enter Data in EHR</td>
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</tbody>
</table>
| Depression Screening (cont.)|          | Provider should **Note** the screening tool used was the PHQ-2 Scaled at the Comment Mnemonic for the Exam Code. PHQ9 Questionnaire Screening Tool  
 Little interest or pleasure in doing things?  
  - Not at all Value: 0  
  - Several days Value: 1  
  - More than half the days Value: 2  
  - Nearly every day Value: 3  
 Feeling down, depressed, or hopeless?  
  - Not at all Value: 0  
  - Several days Value: 1  
  - More than half the days Value: 2  
  - Nearly every day Value: 3  
 Trouble falling or staying asleep, or sleeping too much?  
  - Not at all Value: 0  
  - Several days Value: 1  
  - More than half the days Value: 2  
  - Nearly every day Value: 3  
 Feeling tired or having little energy?  
  - Not at all Value: 0  
  - Several days Value: 1  
  - More than half the days Value: 2  
  - Nearly every day Value: 3 |
<table>
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<tr>
<td>Depression Screening (cont.)</td>
<td></td>
<td>Poor appetite or overeating?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not at all Value: 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Several days Value: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More than half the days Value: 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nearly every day Value: 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feeling bad about yourself—or that you are a failure or have let yourself or your family down?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not at all Value: 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Several days Value: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More than half the days Value: 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nearly every day Value: 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trouble concentrating on things, such as reading the newspaper or watching television?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not at all Value: 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Several days Value: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More than half the days Value: 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nearly every day Value: 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>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?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not at all Value: 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Several days Value: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More than half the days Value: 2</td>
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<td>• Nearly every day Value: 3</td>
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<td>Standard</td>
<td>Provider Documentation</td>
<td>How to Enter Data in EHR</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Depression Screening (cont.)</td>
<td></td>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not at all Value: 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Several days Value: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More than half the days Value: 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nearly every day Value: 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PHQ9 Questionnaire (Continued)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Possible PHQ-2 Score: Range: 0–27</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0-4 Negative/None Depression Screening Exam: Code Result: <strong>None</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5-9 Mild Depression Screening Exam: Code Result: <strong>Mild depression</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-14 Moderate Depression Screening Exam: Code Result: <strong>Moderate depression</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>15-19 Moderately Severe Depression Screening Exam: Code Result: <strong>Moderately Severe depression</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>20-27 Severe Depression Screening Exam: Code Result: <strong>Severe depression</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provider should <strong>Note</strong> the screening tool used was the PHQ9 Scaled at the Comment Mnemonic for the Exam Code.</td>
<td></td>
</tr>
</tbody>
</table>
## Key Clinical Performance Objectives

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Standard</th>
<th>Provider Documentation</th>
<th>How to Enter Data in EHR</th>
</tr>
</thead>
</table>
| **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). | Standard EHR documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in EHR:  
  - Date received  
  - Location  
  - Dosage                                                                                                                                                                                                 | **Antidepressant Medication**  
  **Medication Entry**  
  Select Medication: [Enter Antidepressant Prescribed Medication]  
  Outside Drug Name (Optional): [Enter any additional name for the drug]  
  SIG  
  Quantity:  
  Day Prescribed:  
  Event Date&Time:  
  Ordering Provider: |
<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Standard</th>
<th>Provider Documentation</th>
<th>How to Enter Data in EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Weight Control</td>
<td>Patients ages 2–5 at the beginning of the report period whose BMI could</td>
<td>Standard EHR documentation. obtain height and weight during visit and record information in EHR:</td>
<td><strong>Height Measurement</strong></td>
</tr>
</tbody>
</table>
|                             | be calculated and have a BMI equal to or greater than (=>) 95%.          | • Height  
• Weight  
• Date Recorded  
BMI is calculated using NHANES II  
Age in the age groups is calculated based on the date of the most current BMI found.  
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.  
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). | **Vital Measurements Entry**  
(includes historical Vitals)  
Value:  
Select Qualifier:  
Actual  
Estimated  
Date/Time Vitals Taken: |
|                             | Height and weight taken on the same day.  
Patients that turn 6 years old during the report period are not included in the GPRA measure. | | **Weight Measurement**  
**Vital Measurements Entry**  
(includes historical Vitals)  
Value:  
Select Qualifier:  
Actual  
Bed  
Chair  
Dry  
Estimated  
Standing  
Date/Time Vitals Taken: |
### Key Clinical Performance Objectives

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Standard</th>
<th>Provider Documentation</th>
<th>How to Enter Data in EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childhood Weight Control (cont.)</strong></td>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Low-High</strong></td>
<td><strong>BMI &gt;= 85</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Ages</strong></td>
<td><strong>Sex</strong></td>
<td><strong>Over Weight</strong></td>
</tr>
<tr>
<td>2-2</td>
<td>M</td>
<td>F</td>
<td>17.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>17.5</td>
</tr>
<tr>
<td>3-3</td>
<td>M</td>
<td>F</td>
<td>17.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>17.0</td>
</tr>
<tr>
<td>4-4</td>
<td>M</td>
<td>F</td>
<td>16.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>16.7</td>
</tr>
<tr>
<td>5-5</td>
<td>M</td>
<td>F</td>
<td>16.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>16.9</td>
</tr>
</tbody>
</table>
| **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). | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:  
  - Date received  
  - Location  
  - Results |                          |
<p>|                                             | Blood Pressure Data Entry                                                | <strong>Vital Measurements Entry</strong> (includes historical Vitals) |                          |
|                                             |                                                                          | Value: [Enter as Systolic/Diastolic (e.g., 140/90)] |                          |
|                                             |                                                                          | Select Qualifier: |                          |
|                                             |                                                                          | Date/Time Vitals Taken: |                          |</p>
<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Standard</th>
<th>Provider Documentation</th>
<th>How to Enter Data in EHR</th>
</tr>
</thead>
</table>
| Statin Therapy for the Prevention and Treatment of Cardiovascular Disease | Active Clinical Patients age 40 - 75 DX with diabetes or age 21 and older with documented CVD or LDL greater than or equal to (>=) 190 who have statin therapy. | Standard EHR documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in EHR:  
- Date received  
- Location  
- Dosage | **Statin Therapy Medication**  
**Medication Entry**  
Select Medication: [Enter Statin Therapy Prescribed Medication]  
Outside Drug Name (Optional): [Enter any additional name for the drug]  
SIG  
Quantity:  
Day Prescribed:  
Event Date&Time:  
Ordering Provider:  
**Statin Therapy CPT**  
**Visit Services Entry** (includes historical CPTs)  
Enter CPT Code: 4013F  
Quantity:  
Modifier:  
Modifier 2: |
<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Standard</th>
<th>Provider Documentation</th>
<th>How to Enter Data in EHR</th>
</tr>
</thead>
</table>
| HIV Screening       | Patients should be tested for HIV at least once; education and follow-up provided as appropriate. **Note:** Refusals are not counted toward the GPRA measure, but should still be documented. | Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:  
  - Date received  
  - Location  
  - Results | **HIV Screen CPT**  
  **Visit Services Entry** (includes historical CPTs)  
  Enter CPT Code: 86689, 86701-86703, 87390, 87391, 87534-87539  
  Quantity  
  Modifier:  
  Modifier 2:  
  **HIV Diagnoses POV**  
  **Visit Diagnosis Entry**  
  Purpose of Visit: ICD-9: 042, 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711-O98.73  
  Provider Narrative:  
  Modifier:  
  Cause of DX:  
  **HIV Lab Test**  
  **Lab Test Entry**  
  Enter Lab Test Type: [Enter site’s defined HIV Screen Lab Test]  
  Collect Sample/Specimen: [Blood, Serum]  
  Clinical Indication: |
<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Standard</th>
<th>Provider Documentation</th>
<th>How to Enter Data in EHR</th>
</tr>
</thead>
</table>
| Breastfeeding Rates         | All providers should assess the feeding practices of all newborns through age 1 year at all well-child visits. | Definitions for Infant Feeding Choice Options: Exclusive Breastfeeding–Breastfed or expressed breast milk only, no formula 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.) ½ Breastfeeding, ½ Formula Feeding–Half the time breastfeeding/expressed breast milk, half formula feeding Mostly Formula–The baby is mostly formula fed, but breastfeeds at least once a week Formula Only–Baby receives only formula 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. | Infant Breastfeeding  
Infant Feeding Choice Entry  
Enter Feeding Choice:  
Exclusive Breastfeeding  
Mostly Breastfeeding  
1/2 & 1/2 Breast and Formula  
Mostly Formula  
Formula Only |

**Note:** This is not a GPRA measure; however, it will be used in conjunction with the Childhood Weight Control measure for reducing the incidence of childhood obesity. The information is included here to inform providers and data entry staff of how to collect, document, and enter the data.
### Patient Education

- **N/A**

<table>
<thead>
<tr>
<th>How to Enter Data in EHR</th>
<th>Provider Documentation</th>
</tr>
</thead>
</table>
| **Note**                | All providers should document all 5 patient education elements and elements #6–7 if a goal was set, goal was met, or goal was not met. Providers and data entry staff need to know they need to collect and enter all components of patient education.

**Goal Code:**

- GNS – Goal Not Set
- GNM – Goal Not Met
- GM – Goal Met
- GS – Goal Set

**Goal Codes:**

- R – Released
- GR – Group-No Assessment
- G – Good
- F – Fair
- P – Poor

**Readiness to Learn:**

- Distraction
- Eager To Learn
- Intoxication
- Not Ready
- Pain
- Receptive
- Severity Of Illness
- Unreceptive

**Levels of Understanding:**

- P – Poor
- F – Fair
- G – Good
- GR – Group-No Assessment
- R – Refused

**Goal Codes:**

- GS – Goal Set
- GM – Goal Met
- GNM – Goal Not Met
- GNS – Goal Not Set
### Key Clinical Performance Objectives

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Standard</th>
<th>Provider Documentation</th>
<th>How to Enter Data in EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Education Measures (Patient Education Report) (cont.)</td>
<td></td>
<td>Diagnosis Categories:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Anatomy and Physiology</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Complications</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Disease Process</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Equipment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Exercise</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Follow-up</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Home Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hygiene</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lifestyle Adaptation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Literature</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical Nutrition Therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nutrition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Procedures</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Safety</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tests</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Treatment</td>
<td></td>
</tr>
</tbody>
</table>
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. |
Clinic Codes

Clinic codes are chosen when a visit is created.

Figure 1: Choosing a clinic code
Purpose of Visit/Diagnosis

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

To enter a POV:

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

<table>
<thead>
<tr>
<th>Problem</th>
<th>is a relationship</th>
<th>Mapped ICD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes mellitus type 2 without retinopathy</td>
<td>is a Diabetes mellitus type 2 (disorder)</td>
<td>E11.9</td>
</tr>
<tr>
<td>Amyotrophy due to type 1 diabetes mellitus</td>
<td>is a Diabetic amyotrophy (disorder)</td>
<td>E10.44</td>
</tr>
<tr>
<td>Amyotrophy due to type 2 diabetes mellitus</td>
<td>is a Diabetic amyotrophy (disorder)</td>
<td>E11.44</td>
</tr>
<tr>
<td>Chronic kidney disease due to type 2 diabetes mellitus</td>
<td>is a Chronic renal impairment (disorder)</td>
<td>E11.22 N18.9</td>
</tr>
<tr>
<td>Chronic kidney disease stage 1 due to type 2 diabetes mellitus</td>
<td>is a Chronic kidney disease stage 1 (disorder)</td>
<td>E11.22 N18.1</td>
</tr>
</tbody>
</table>

[Image of SNOMED CT Lookup interface with search results for diabetes mellitus and related conditions.]
3. Click to highlight the diagnosis and click Select. The **Integrated Problem Maintenance – Add Problem** dialog (Figure 6) displays.

![Integrated Problem Maintenance - Add Problem](image)

**Figure 6: Entering additional POV information**
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).

![Integrated Problem List](image)

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

CPT codes are entered in the Visit Services component, located on the Superbill tab (Figure 8).
To enter a CPT code:

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

2. In the Procedure field, type the CPT code and click the ellipses (…) button. The Procedure Lookup dialog (Figure 11) displays.
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.
4. Enter any other pertinent information and click Save. The newly added CPT code should display in the Visit Services component (Figure 13).
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
To enter 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:

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

- 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).

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

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).

![Visit Services component](image-url)

Figure 19: **Visit Services** component
To enter a Procedure code:

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

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

![Visit Services](image)

**Figure 24: Example of a newly added Procedure code**
Exams

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

Figure 25: **Exams** component
To enter an Exam code:

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

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

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

#### Exams

<table>
<thead>
<tr>
<th>Visit Date</th>
<th>Exams</th>
<th>Result</th>
<th>Comments</th>
<th>Provider</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/08/2016</td>
<td>DIABETIC EYE EXAM</td>
<td>NORMAL/NEGATIVE</td>
<td></td>
<td>GALOF MEGAN</td>
<td>CHEROKEE</td>
</tr>
</tbody>
</table>

Figure 30: Example of a newly added Exam
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
To enter a Health Factor:

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

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

<table>
<thead>
<tr>
<th>Visit Date</th>
<th>Health Factor</th>
<th>Category</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/15/2016</td>
<td>Current Smoker, Every Day</td>
<td>Tobacco</td>
<td></td>
</tr>
</tbody>
</table>

Figure 34: Example of a newly added Health Factor
Immunizations

Immunizations are entered in the **Immunization Record** component, located on the **Wellness** tab under **Imms/Skin Tests** (Figure 35).

![Immunization Record component](image)

Figure 35: *Immunization Record* component
To enter an Immunization:

![Image of Immunization Record](image)

Figure 36: Entering an Immunization

1. Click **Add** in the **Vaccinations** section of the **Immunization Record** component. The **Vaccine Selection** dialog (Figure 37) displays.
2. Highlight the chosen Immunization and click OK. The Add Immunization dialog (Figure 38) displays.
3. Type any other pertinent information and click OK.
4. If this is a historical immunization, select [Historical] and enter the [Date] and [Location] of the immunization. The newly added Immunization should appear in the [Immunization Record] component (Figure 40).

Figure 39: Entering a historical immunization

Figure 40: Example of a newly added Immunization
To enter a contraindication for an immunization:

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

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

![Vaccine Selection dialog](image)

Figure 43: Selecting the immunization

4. Click to highlight the **Immunization** and click **OK**. The **Enter Patient Contraindication** dialog (Figure 44) displays.
5. Click **Add**. The newly added contraindication should appear in the **Immunization Record** component (Figure 45).

![Figure 44: Enter Patient Contraindication dialog](Image)

![Figure 45: Example of a newly added contraindication](Image)
Vital Measurements

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

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)
   c. The **Select Location for Historical Entry** dialog (Figure 50) displays.
d. Choose the location and click **OK**. Click the ellipses (…) button. The **Select Date/Time** dialog (Figure 50) displays.
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
Lab Tests

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

![Figure 52: Orders component](image-url)
To enter 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.
2. Select the appropriate lab test and the **Order a Lab Test** dialog (Figure 54) displays.
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).

5. You must sign the order before it can be released.
Lab results can be viewed in the **Laboratory Results** component, located on the **Labs** tab (Figure 57).

![Lab Results Component](image)

**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.
To enter Point of Care Lab tests and results:

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.

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

3. Click **Save**.
Medications

Medications are entered in the **Medications** component, located on the **Medications** tab (Figure 60).

Figure 60: **Medications** component
To enter a prescription for a medication:

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

![Figure 61: Entering a patient medication](image)
2. Click to highlight the appropriate medication and click **OK**. The dialog redisplay with new fields (Figure 63).
3. Type other pertinent information about the prescription.
4. Click **Accept Order**. The updated **Medications** component (Figure 64) displays.
Figure 64: Example of a newly added medication

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

Infant Feeding choices are entered in the **Infant Feeding** component, located on the **Triage** tab (Figure 65).

![Infant Feeding component](image)

**Figure 65: Infant Feeding component**
Key Clinical Performance Objectives

To enter Infant Feeding:

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

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).
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](image-url)
To enter Patient Education:

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

![Figure 71: Selecting the education](image_url)
To enter 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.
Figure 73: **Add Patient Education Event** dialog

4. Type any pertinent information and click **Add**.
5. If this is historical education:
   a. Select \textbf{Historical}.
   b. Type the \textbf{Event Date} and \textbf{Location} of the education.
The newly added Patient Education should display in the **Education** component.

**Figure 75:** Example of a newly added Patient Education

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

**Figure 76:** Entering the Patient Education
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.

![Figure 77: Add Visit Instruction/Care Plans/Goal Activities dialog](image)

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

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Figure 78: **Personal Health** component
To enter a Refusal:

1. Select **Refusal** from the drop-down list.
2. Click **Add**. The **Enter Refusal** dialog (Figure 80) displays.
3. Select the **Refusal Type** and click the ellipses (…) button. The Lookup Measurement dialog (Figure 81) displays.
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.

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