Cheat Sheet for EHR Documentation and Data Entry for CRS Version 24.1
Last Updated August 2024

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: https://www.ihs.gov/sites/crs/themes/responsive2017/display_objects/documents/crsv24/GPRA-Measures-V241.pdf.

See Enter Information in EHR on Page 46 for detailed instructions on how to enter information into EHR.

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

Table 1: Cheat Sheet for EHR Documentation and Data Entry for CRS

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes Prevalence **Note**: This is not a GPRA measure; however, it is used in determining patients that have been diagnosed with diabetes.		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-10: E10.*-E13.* Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Glycemic Control	User Population Patients DX with diabetes and with an A1c: Greater than (>) 9 (Poor 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, 3051F, 3052F Quantity: Modifier: Modifier 2:
Diabetes: Blood Pressure Control	User Population 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes	User Population Patients DX with diabetes age 40–75 or any age with documented CVD or age 20 and older with LDL greater than or equal to (≥) 190 or hypercholesterolemia 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Nephropathy Assessment	User Population Patients DX with diabetes with a Nephropathy assessment: • Estimated GFR with result during the Report Period • Urine Albumin-to-Creatinine Ratio during the Report Period • End Stage Renal Disease diagnosis/treatment	Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR: • Date received • Location • Results	**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, M1187, M1188, S2065 or S9339 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Nephropathy Assessment (cont.)			**ESRD POV** Visit Diagnosis Entry Purpose of Visit: ICD-10: I12.0, I13.11, I13.2, N18.5, N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2 Provider Narrative: Modifier: Cause of DX: **ESRD Procedure** Procedure Entry Operation/Procedure: ICD-10: 5A1D70Z, 5A1D80Z, 5A1D90Z Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetic Retinopathy	Patients with diabetes and no bilateral blindness or bilateral eye enucleation 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-ophthalmology 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: 2021F, 2022F-2025F, 2026F, 2033F, G2102-G2104, S0620, S0621, S3000, M1220, M1221 Quantity: Modifier: Modifier 2: **Other Eye Exam CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 67028, 67039, 67040, 92002, 92004, 92012, 92014, 92018, 92019 Quantity: Modifier: Modifier 2: **Other Eye Exam Clinic** Clinic Entry Clinic: A2, 17, 18, 64

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Access to Dental Service	Patients should have annual dental visits/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	**Visit for 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 Visit CPT** Visit Services Entry (includes historical CPTs) Enter CPT: D0110-D0390, D0415-D9952, D9970-D9974, D9995, D9996, D9999 Quantity: Modifier: Modifier 2: **Dental Visit POV** Visit Diagnosis Entry Purpose of Visit: ICD-10: Z01.20, Z01.21, Z13.84, Z29.3 Provider Narrative: Modifier: Cause of DX:
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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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-10: Z29.3 Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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: 123, 125-128, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158, 160, 161, 166, 168, 171, 185, 186, 194, 197, 200-202, 205, 231 (other options are 111, 15, 16, 88) Lot: VFC Eligibility: **Influenza Vaccine CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 90630, 90654-90664, 90666, 90668, 90672-90674, 90682, 90685-90689, 90694, 90756, G0008, Q2034-Q2039 Quantity: Modifier: Modifier 2: **NMI Refusal of Influenza** *NMI Refusals can only be entered in EHR via Reminder Dialogs.* **Contraindication Influenza** Immunization Entry - Contraindications Vaccine: [See codes above] Reason: Anaphylaxis

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Adult Immunizations	All adults ages 19 and older will have age appropriate vaccines. • Ages 19–50: 1 Tdap/Td in the past 10 years, 1 Tdap ever • Ages 51–65: 1 Tdap/Td in the past 10 years, 1 Tdap ever, 2 doses of Shingrix ever • Ages 66+: 1 Tdap/Td in the past 10 years, 1 Tdap ever, 2 doses of Shingrix ever, 1 up-to-date 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 "Immune Deficiency" or "Anaphylaxis" NMI Refusal	**Adult Immunizations** Immunization Entry (includes historical immunizations) Select Immunization Name: Tdap: 115; Td: 9, 113, 138, 139, 196; Shingrix: 187; PPSV23: 33, 109; PCV13: 100, 133, 152; PCV20: 216; PCV15: 215 Lot: VFC Eligibility: **Adult Immunizations CPT** Visit Services Entry (includes historical CPTs) Enter CPT: Tdap: 90715; Td: 90714, 90718; Shingrix: 90750; PPSV23: 90732, G0009, G9279; PCV13: 90669, 90670; PCV20: 90677; PCV15: 90671 Quantity: Modifier: Modifier 2: **NMI Refusal of Adult Immunizations** *NMI Refusals can only be entered in EHR via Reminder Dialogs.* **Contraindication Adult Immunizations** Immunization Entry - Contraindications Vaccine: [See codes above] Reason: [See Contraindications section under the Provider Documentation column]

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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 Hepatitis B 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: • **DTaP**: Encephalopathy due to vaccination with a vaccine adverse-effect • **IPV**: Immunization Package: "Neomycin Allergy" • **OPV**: Immunization Package: "Immune Deficiency" • **MMR**: Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy"; Immunodeficiency; Lymphoreticular cancer, multiple myeloma or leukemia • **Varicella**: Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy;" Immunodeficiency; HIV; Lymphoreticular cancer, multiple myeloma or leukemia • **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, 198; Tdap: 115; DT: 28; Td: 9, 113, 138, 139, 196; 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, 189, 193, 198, 220; HIB: 17, 22, 46-49, 50, 51, 102, 120, 146, 148, 198; Varicella: 21, 94; Pneumococcal: 33, 100, 109, 133, 152, 215, 216 Lot: VFC Eligibility:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations (cont.)		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	**Childhood Immunizations Evidence of Disease POV** Visit Diagnosis Entry Purpose of Visit: IPV: ICD-10: M89.6*; Measles: ICD-10: B05.*; Mumps: ICD-10: B26.*; Rubella: ICD-10: B06.*; Hepatitis B: ICD-10: B16.*, B19.1*; Varicella: ICD-10: B01.*-B02.* Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Immunizations (cont.)			**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, 90697, 90723, 90740, 90743-90748, 90759, G0010; HIB: 90644-90648, 90697, 90698, 90720-90721, 90748; Varicella: 90710, 90716; Pneumococcal: 90669, 90670, 90671, 90677, 90732, G0009, G9279 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]

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Cervical Cancer Screening	Women ages 24–64 should have a Pap Smear every 3 years, or if patient is 30–64 years of age, either a Pap Smear documented in the past 3 years or a Pap Smear and an HPV DNA documented on the same day in the past 5 years or an HPV Primary 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-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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Cervical Cancer Screening (cont.)			**HPV POV** Visit Diagnosis Entry Purpose of Visit: 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, G0476, 0429U Quantity: Modifier: Modifier 2: **HPV Primary V Lab** Lab Test Entry Enter Lab Test Type: [Enter site's defined HPV Primary Lab Test] Clinical Indication: **HPV Primary CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 87624 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Cancer Screening: Mammogram Rates	Women ages 52–74 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-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: 77046-77049, 77052-77059, 77061-77063, 77065-77067, G0206; G0204, G0202, G0279 Quantity: Modifier: Modifier 2: **Mammogram Procedure** Procedure Entry Operation/Procedure: ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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) • FIT-DNA in the past 3 years • Flexible sigmoidoscopy or CT colonography 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-10: C18.*, C19, C20, C21.2, C21.8, C78.5, Z85.030, Z85.038, Z85.048 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-10: 0DTE*ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] **FOBT or FIT CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 82270, 82274, G0328 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening (cont.)			**FIT-DNA CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 81528, G0464 Quantity: Modifier: Modifier 2: **Flexible Sigmoidoscopy CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 45330-45347, 453349, 45350, G0104 Quantity: Modifier: Modifier 2: **Flexible Sigmoidoscopy Procedure** Procedure Entry Operation/Procedure: ICD-10: 0DJD8ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] **CT Colonography CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 74261-74263 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening (cont.)			**Colon Screening CPT** Visit Services Entry (includes historical CPTs) Enter CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398, G0105, G0121, G2204, G9252, G9253 Quantity: Modifier: Modifier 2: **Colon Screening Procedure** Procedure Entry Operation/Procedure: ICD-10: (see logic manual for codes) Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Use and Exposure Assessment **Note**: This is not a GPRA measure; however, it will be used for reducing the incidence of Tobacco Use.	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–Current E-cigarette user w/nicotine • HF–Current E-cig user w/other substance(s) • HF–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Previous (Former) Smoker [or –Smokeless or –E-cigarette] (quit greater 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" • **Note**: Ensure you update the patient’s health factors as they become nontobacco users. Patients who have quit tobacco should have their health factor updated to “Former Smoker,” “Former Smokeless,” or “Former E-cigarette user.”	**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: **Tobacco Users Health Factor** Health Factor Entry Select V Health Factor: Current Smoker (every day, some day, or status unknown), Current Smokeless, Current E-cigarette user w/nicotine, Current E-cig user w/other substance(s) Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Use and Exposure Assessment (cont.)			**Smokers Health Factor** Health Factor Entry Select V Health Factor: Current Smoker (every day, some day, or status unknown) Level/Severity: Provider: Quantity: **Smokeless Health Factor** Health Factor Entry Select V Health Factor: Current Smokeless Level/Severity: Provider: Quantity: **E-Cigarette User Health Factor** Health Factor Entry Select V Health Factor: Current E-cigarette user w/nicotine, Current E-cig user w/other substance(s) Level/Severity: Provider: Quantity: **ETS Health Factor** Health Factor Entry Select V Health Factor: Exp to ETS Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Cessation	User Population 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 Health factors considered to be a tobacco user: • HF–Current Smoker, every day • HF–Current Smoker, some day • HF–Current E-cigarette user w/nicotine • HF–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless 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

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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 become nontobacco users. Patients who have quit tobacco should have their health factor updated to "Former Smoker", "Former Smokeless", or "Former E-cigarette user."	**Tobacco Cessation PED – Diagnosis** Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number or SNOMED code Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment Provider's Narrative: **Tobacco Cessation PED – CPT** Mnemonic PED enter Select CPT Code Number: D1320, 99406, 99407, 4000F, G0030, G9016, G9458 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:

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

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Cessation (cont.)			**Tobacco Cessation Prescription CPT** Visit Services Entry (includes historical CPTs) Enter CPT Code: 4001F Quantity Modifier: Modifier 2: **Quit Tobacco Health Factor** Health Factor Entry Select V Health Factor: Former Smoker, Former Smokeless, Former E-cigarette user Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening	User Population patients ages 9 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, CAGE-AID, or TAPS health factors 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (cont.)		Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen: • Alcohol Screening Exam Code Result: Positive The patient may decline the screen or "Refuse to answer:" • Alcohol Screening Exam Code Result: Refused The provider is unable to conduct the screen: • Alcohol Screening Exam Code Result: Unable To Screen **Note**: Provider should **Note** the screening tool used was the SASQ at the Comment Mnemonic for the Exam code. 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?	**CAGE-AID Health Factor** Health Factor Entry Select Health Factor: CAGE-AID 1. CAGE-AID 0/4 (all No answers) 2. CAGE-AID 1/4 3. CAGE-AID 2/4 4. CAGE-AID 3/4 5. CAGE-AID 4/4 Choose 1-5: [Number from above] Level/Severity: Provider: Quantity: **TAPS-Alcohol Health Factor** Health Factor Entry Select Health Factor: TAPS-Alcohol 1. TAPS-ALCOHOL ALCOHOL-MINIMAL RISK 2. TAPS-ALCOHOL ALCOHOL-PROBLEM USE 3. TAPS-ALCOHOL ALCOHOL-HIGH RISK 4. TAPS-ALCOHOL ALCOHOL-UNDETERMINED RISK 5. TAPS-ALCOHOL ALCOHOL-EARLY REMISSION, BUT AT RISK Choose 1-5: [Number from above] Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (cont.)		Based on how many YES answers were received, document Health Factor in EHR: • HF–CAGE 0/4 (all No answers) • HF–CAGE 1/4 • HF–CAGE 2/4 • HF–CAGE 3/4 • HF–CAGE 4/4 Optional values: • Level/Severity: Minimal, Moderate, or Heavy/Severe • Quantity: # of drinks daily ***or*** T (Tolerance) – # drinks to get high (e.g., T-4) • Comment: used to capture other relevant clinical info e.g., “Non-drinker” Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-" AUDIT Measurements: • **Zone I**: Score 0–7 Low risk drinking or abstinence • **Zone II**: Score 8–15 Alcohol use in excess of low-risk guidelines • **Zone III**: Score 16–19 Harmful and hazardous drinking • **Zone IV**: Score 20–40 Referral to Specialist for Diagnostic Evaluation and Treatment	**Alcohol Screening CPT** Visit Services Entry (includes historical CPTs) Enter CPT Code: 99408, 99409, G0396, G0397, G0442, G0443, G2011, G2196, G2197, H0049, H0050 Quantity Modifier: Modifier 2: **Alcohol-Related Diagnosis POV** Visit Diagnosis Entry Purpose of Visit: ICD-10: F10.1*, F10.20, F10.220-F10.29, F10.920-F10.982, F10.99, G62.1 Provider Narrative: Modifier: Cause of DX: **Alcohol-Related PED - Topic** Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter Alcohol-Related 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (cont.)		AUDIT-C Measurements: How often do you have a drink containing alcohol? • (0) Never (Skip to Questions 9–10) • (1) Monthly or less • (2) 2 to 4 times a month • (3) 2 to 3 times a week • (4) 4 or more times a week How many drinks containing alcohol do you have on a typical day when you are drinking? • (0) 1 or 2 • (1) 3 or 4 • (2) 5 or 6 • (3) 7, 8, or 9 • (4) 10 or more How often do you have 6 or more drinks on one occasion? • (0) Never • (1) Less than monthly • (2) Monthly • (3) Weekly • (4) Daily or almost daily	**Alcohol-Related PED - Diagnosis** Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: F10.1*, F10.20, F10.220-F10.29, F10.920-F10.982, F10.99, or G62.1 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: **Alcohol-Related PED - CPT** Patient Education Entry (includes historical patient education) Select CPT Code Number: 99408, 99409, G0396, G0397, G0442, G2011, G2196, G2197, H0049, or H0050 Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the related text)] Goal Comment: Provider's Narrative:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (cont.)		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). • In men, a score of 4 or more is considered positive. • In women, a score of 3 or more is considered positive. A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence. CRAFFT Measurements: • C–Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? • R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? • A–Do you ever use alcohol/drugs while you are by yourself, ALONE? • F–Do you ever FORGET things you did while using alcohol or drugs? • F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? • T–Have you gotten into TROUBLE while you were using alcohol or drugs? Total CRAFFT score (Range: 0–6). A positive answer to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated.	**Alcohol Screen AUDIT Measurement** Vital Measurements Entry (includes historical Vitals) Value: [Enter 0–40] Select Qualifier: Date/Time Vitals Taken: **Alcohol Screen AUDIT-C Measurement** Vital Measurements Entry (includes historical Vitals) Value: [Enter 0–40] Select Qualifier: Date/Time Vitals Taken: **Alcohol Screen CRAFFT Measurement** Vital Measurements Entry (includes historical Vitals) Value: [Enter 0–6] Select Qualifier: Date/Time Vitals Taken:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	User Population 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, G2011, G2200, G0397, H0050, 96150-96155, 99408, 99409 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Intimate Partner (Domestic) Violence Screening (IPV/DV)	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-10: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, Z91.410; IPV/DV Counseling: ICD-10: Z69.11 Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, or Z91.410 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening	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.	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).	**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, EPDS Provider Performing Exam: **Depression Screen Measurements: PHQ9, PHQT, EPDS** Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Date/Time Vitals Taken: **Depression Screening CPT** Visit Services Entry (includes historical CPTs) Enter CPT Code: 1220F, 3725F, G0444 Quantity Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont.)		Patient Health Questionnaire (PHQ-2 Scaled Version) Over the past two weeks, how often have you been bothered by any of the following problems? 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 PHQ-2 Scaled Version (continued) Total Possible PHQ-2 Score: Range: 0–6 • 0–2: Negative Depression Screening Exam: – Code Result: Normal or Negative • 3–6: Positive; further evaluation indicated Depression Screening Exam – Code Result: **Abnormal or Positive** The patient may decline the screen or "Refuse to answer" Depression Screening Exam • Code Result: **Refused** The provider is unable to conduct the Screen Depression Screening Exam • Code Result: **Unable To Screen**	**Mood Disorder Diagnosis POV** Visit Diagnosis Entry Purpose of Visit: ICD-10: F01.51, 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, F43.21, F43.23 Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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 everyday 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	

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Depression Screening (cont.)		Poor appetite or overeating? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Feeling bad about yourself—or that you are a failure or have let yourself or your family down? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Trouble concentrating on things, such as reading the newspaper or watching television? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 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? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3	

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

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Childhood Weight Control	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 (≥) 95%. 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.	Standard EHR documentation. obtain height and weight during visit and record information in EHR: • 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).	**Height Measurement** Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken: **Weight Measurement** Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Bed Chair Dry Estimated Standing Date/Time Vitals Taken:

<table>
<tr><th>Performance Measure</th><th>Standard</th><th>Provider Documentation</th><th>How to Enter Data in EHR</th></tr>
<tr><td>Childhood Weight Control (cont.)</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.
<table>
<tr><th>Low-High</th><th></th><th>BMI ≥ 85</th><th>BMI ≥ 95</th><th>Data Check Limits</th><th>Data Check Limits</th></tr>
<tr><td>Ages</td><td>Sex</td><td>Over Weight</td><td>Obese</td><td>BMI ></td><td>BMI <</td></tr>
<tr><td>2–2</td><td>M
F</td><td>17.7
17.5</td><td>18.7
18.6</td><td>36.8
37.0</td><td>7.2
7.1</td></tr>
<tr><td>3–3</td><td>M
F</td><td>17.1
17.0</td><td>18.0
18.1</td><td>35.6
35.4</td><td>7.1
6.8</td></tr>
<tr><td>4–4</td><td>M
F</td><td>16.8
16.7</td><td>17.8
18.1</td><td>36.2
36.0</td><td>7.0
6.9</td></tr>
<tr><td>5–5</td><td>M
F</td><td>16.9
16.9</td><td>18.1
18.5</td><td>36.0
39.2</td><td>6.9
6.8</td></tr>
</table></td><td></td></tr>
<tr><td>Controlling High Blood Pressure - Million Hearts</td><td>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).</td><td>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:
Date received
Location
Results</td><td>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:</td></tr>
</table>

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	User Population Patients age 40–75 with diabetes or any age with documented CVD or age 20 and older with LDL greater than or equal to (≥) 190 or hypercholesterolemia 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
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: 80081, 86689, 86701-86703, 87389-87391, 87534-87539, 87806, 87901, 87906 Quantity Modifier: Modifier 2: **HIV Diagnoses POV** Visit Diagnosis Entry Purpose of Visit: ICD-10: B20, B97.35, 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:

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Breastfeeding Rates **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.	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 Mostly Breastfeeding, Some Formula 1/2 & 1/2 Breast and Formula Mostly Formula Mostly Formula, Some Breastfeeding Formula Only

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Patient Education Measures (Patient Education Report) **Note**: This is not a GPRA measure; however, the information is being provided because there are several GPRA measures that do include patient education as meeting the numerator (e.g., alcohol screening). Providers and data entry staff need to know they need to collect and enter all components of patient education.	N/A	*All providers should document all 5 patient education elements and elements #6–7 if a goal was set for the patient:* 1. Education Topic/Diagnosis 2. Readiness to Learn 3. Level of Understanding (see below) 4. Initials of Who Taught 5. Time spent (in minutes) 6. Goal Not Set, Goal Set, Goal Met, Goal Not Met 7. Text relating to the goal or its status 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	**Patient Education Topic** Patient Education Entry (includes historical patient education) Topic: [Enter Topic] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider: Length of Education (minutes): Comment: Goal Code: GS, GM, GNM, GNS Goal Comment: **Patient Education Diagnosis** Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: Category: [Enter Category] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider: Length of Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:

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

Enter Information in EHR

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

> **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.

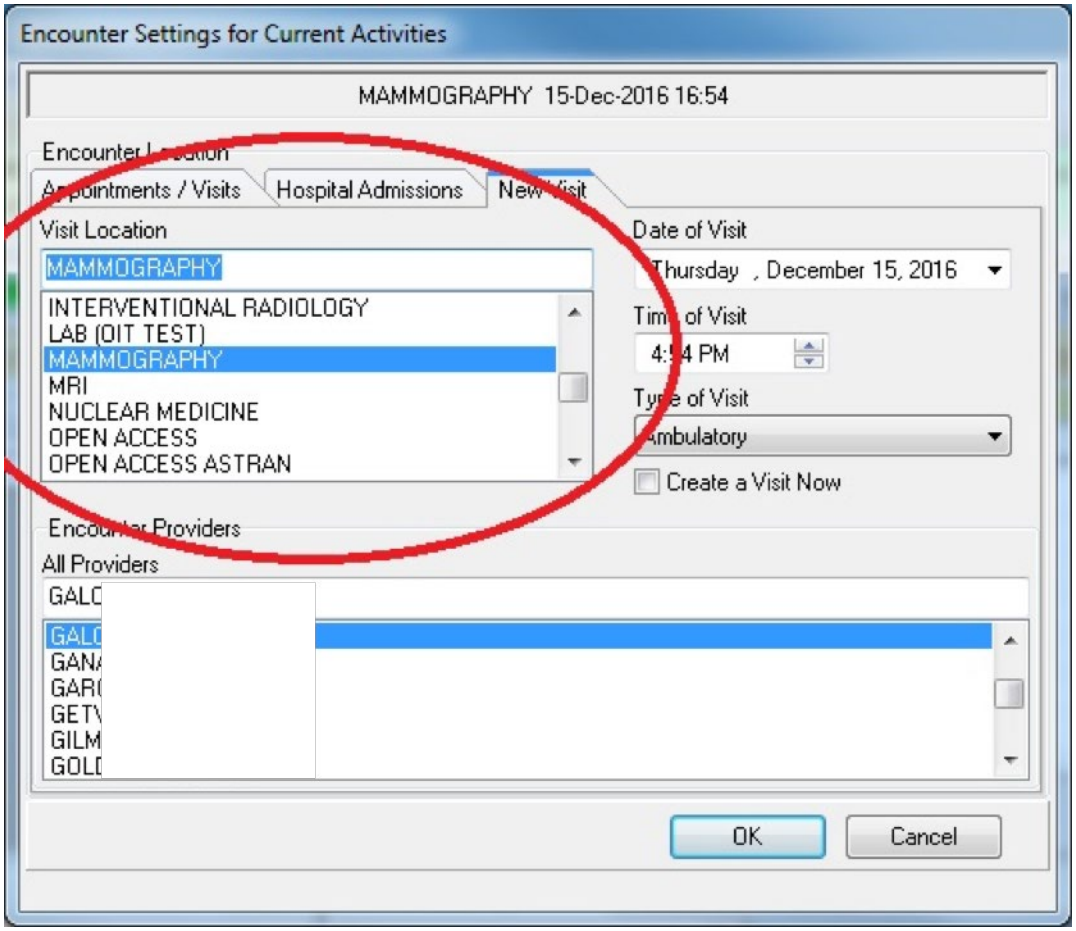

Figure 1: Choosing a clinic code

Purpose of Visit/Diagnosis

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

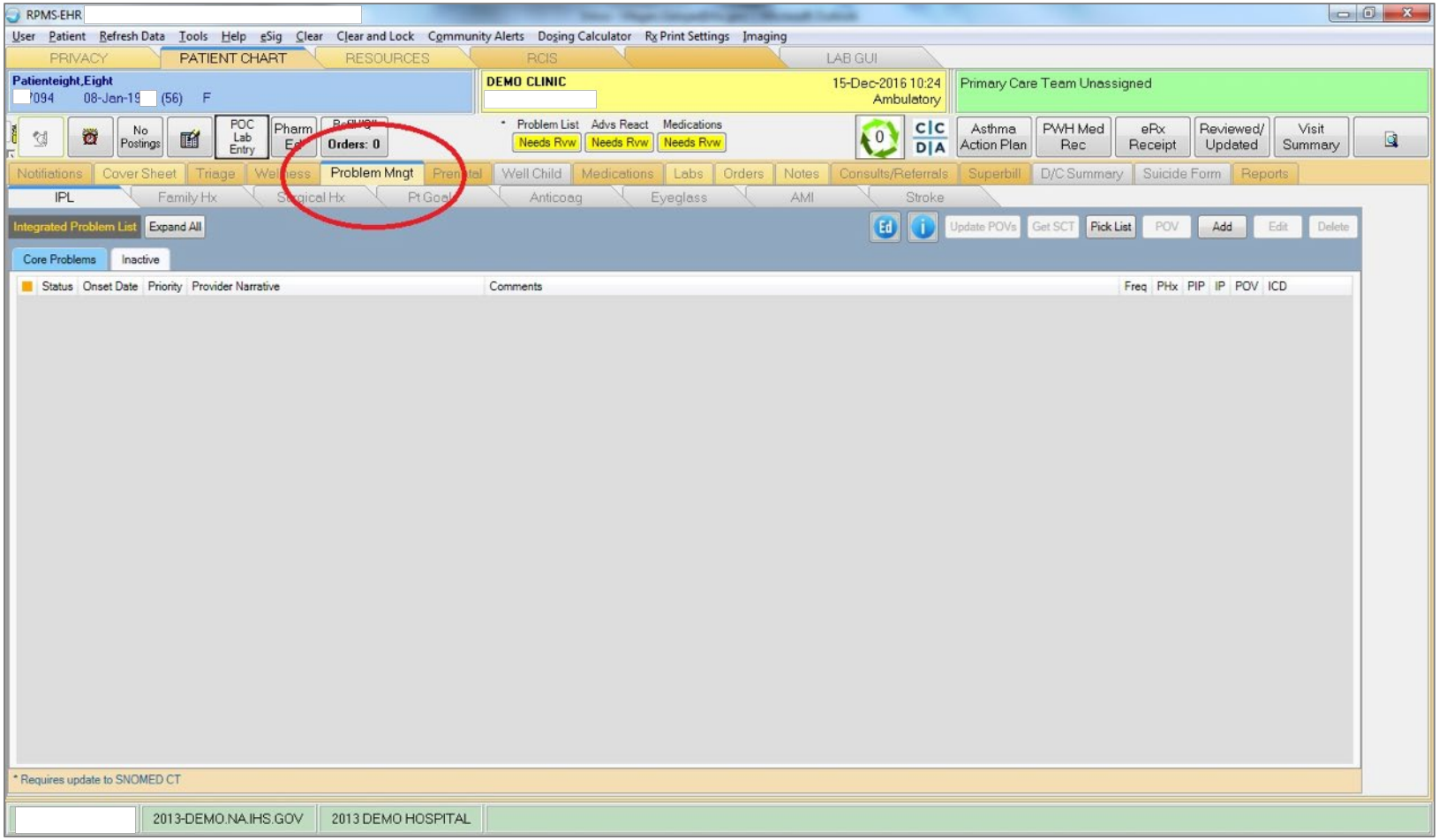

Figure 2: **Problem Mngt** tab

To enter a POV:

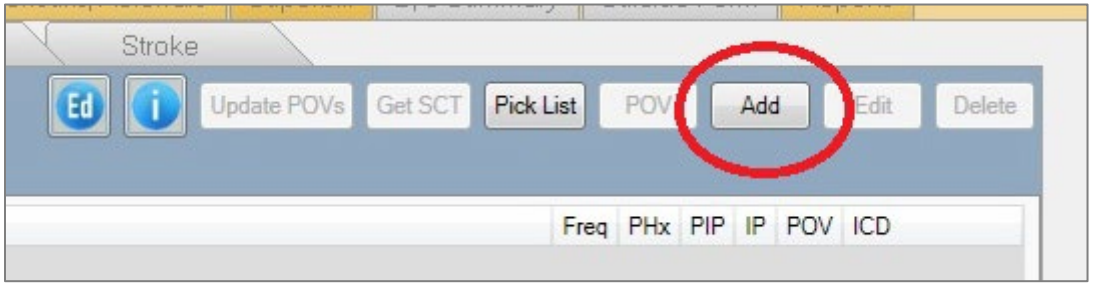

Figure 3: Entering a POV

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

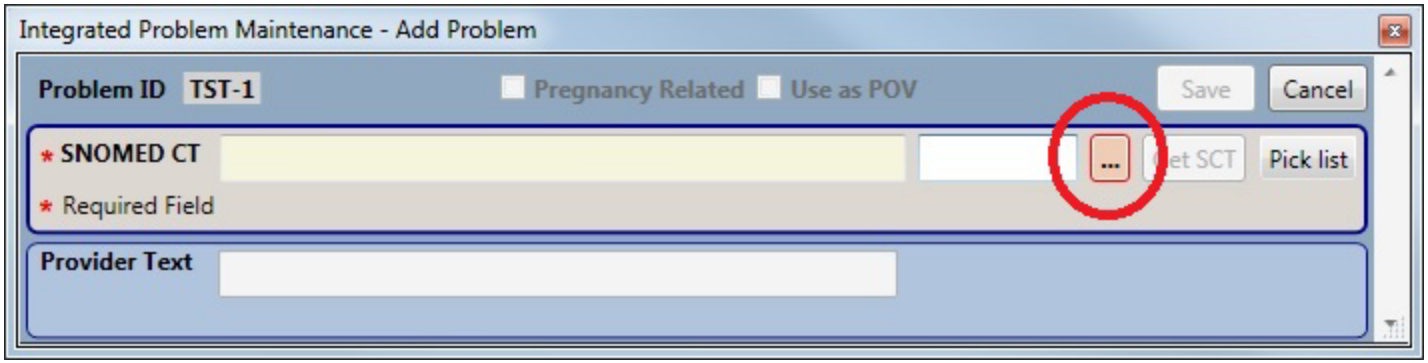

Figure 4: **Integrated Problem Maintenance – Add Problem** dialog

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

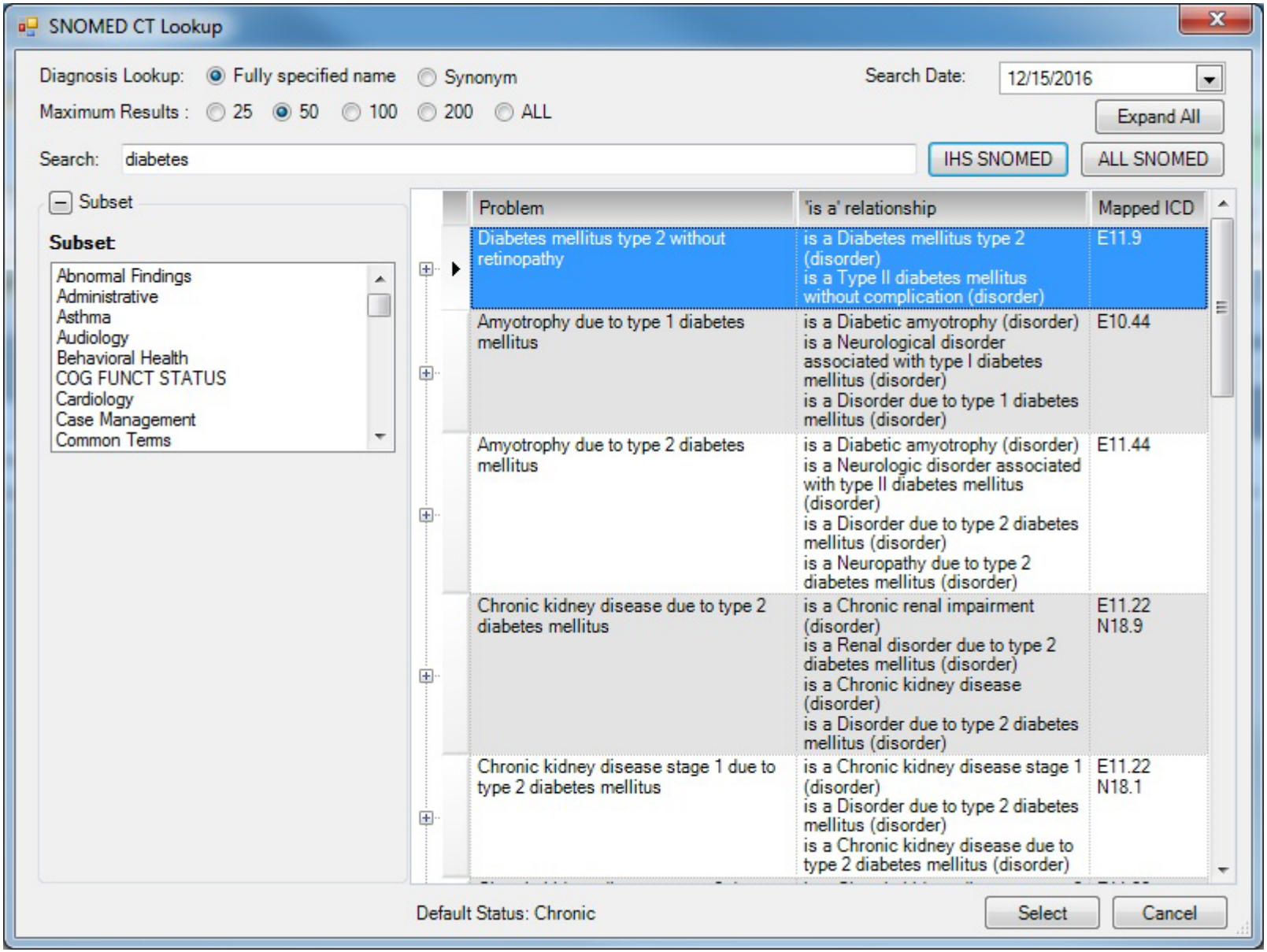

Figure 5: Entering the diagnosis

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

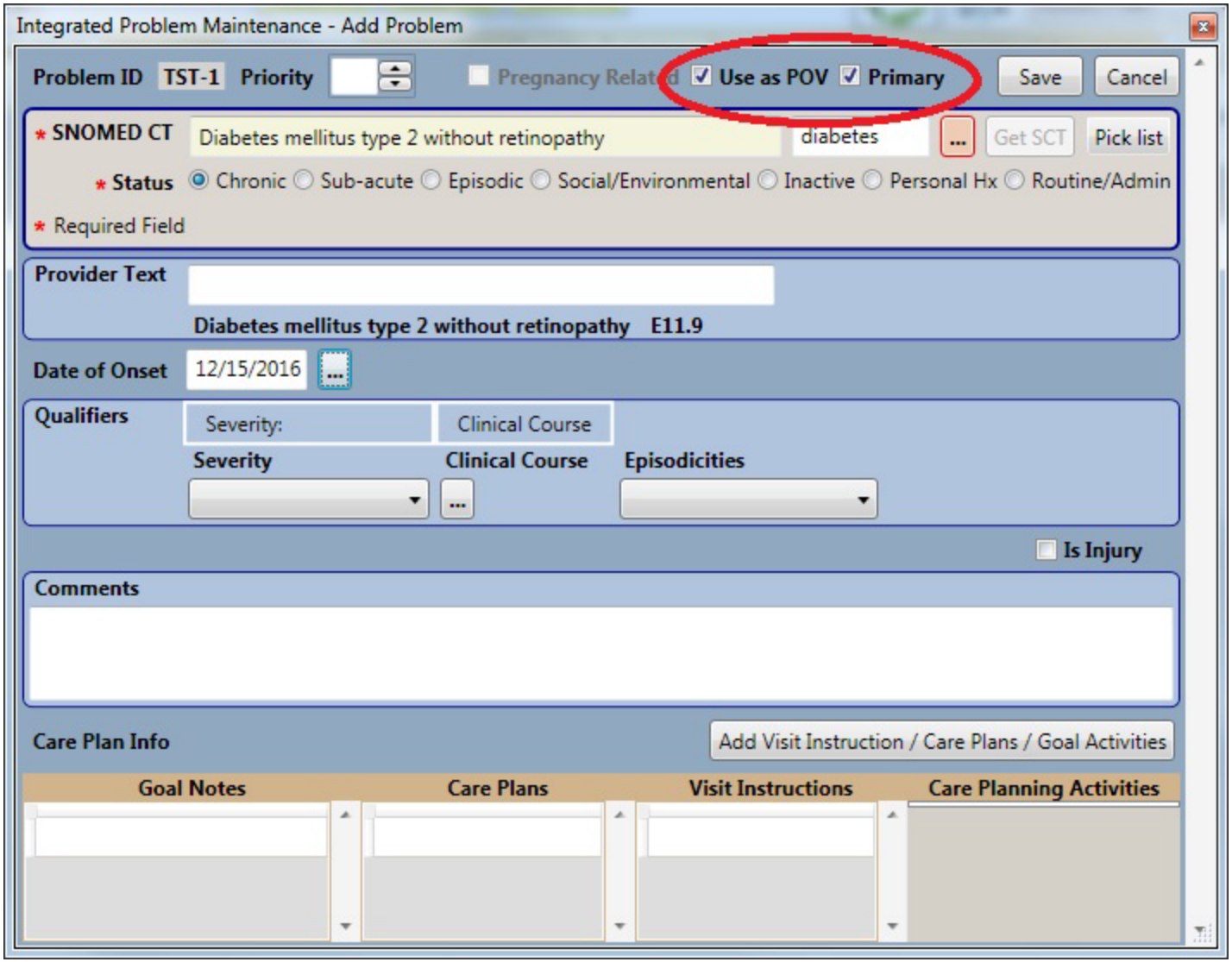

Figure 6: Entering additional POV information

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

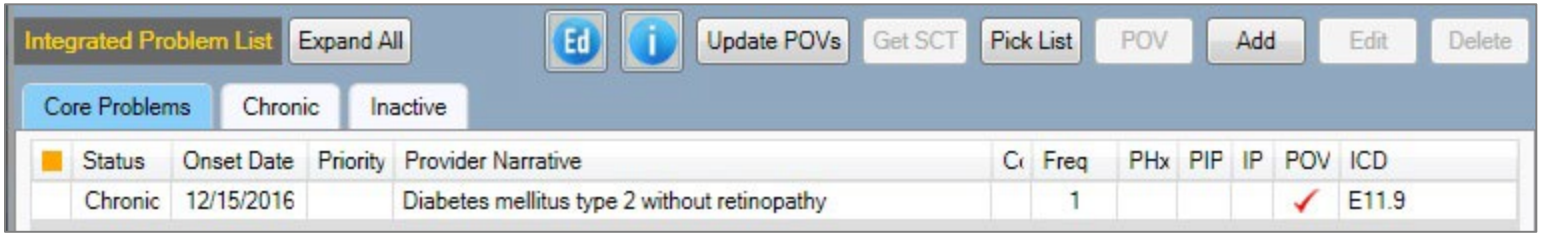

Figure 7: Example of a newly added POV to Integrated Problem List

CPT Codes

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

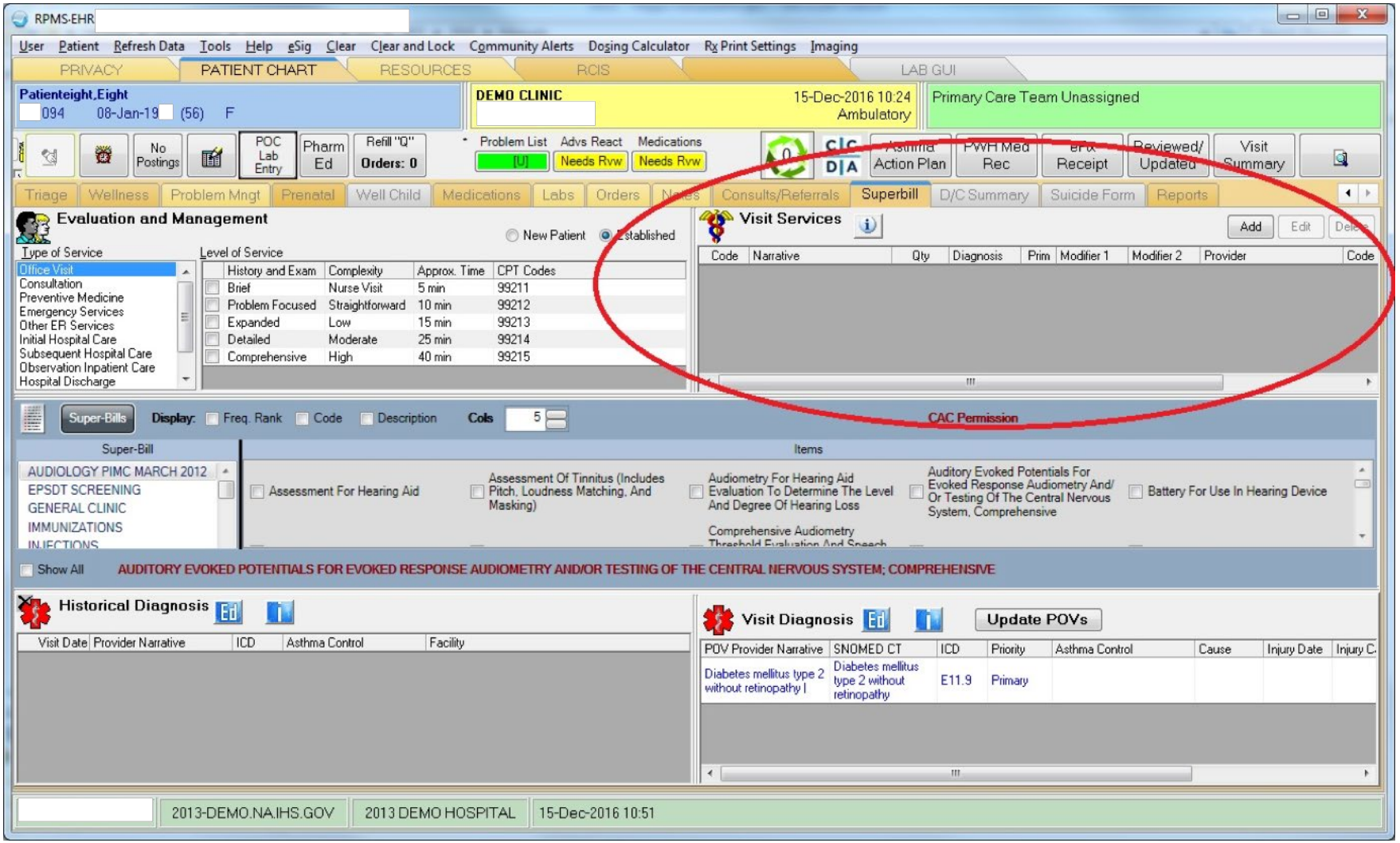

Figure 8: **Visit Services** component

To enter a CPT code:

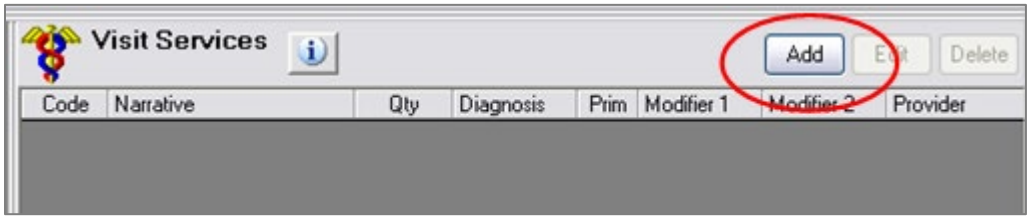

Figure 9: Entering a CPT code

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

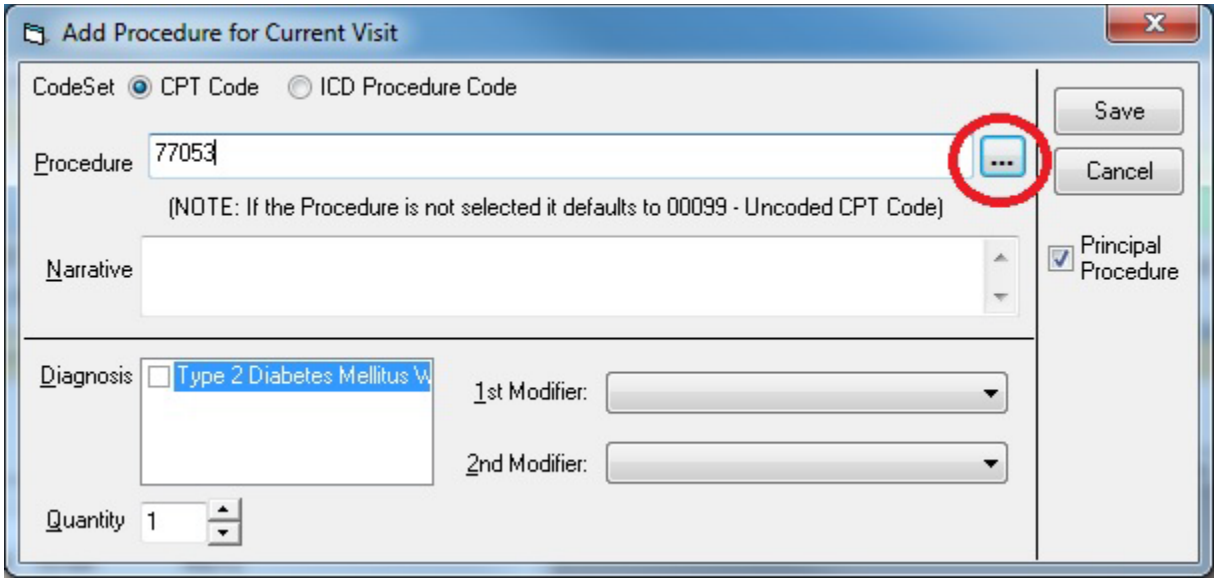

Figure 10: Entering the CPT code

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

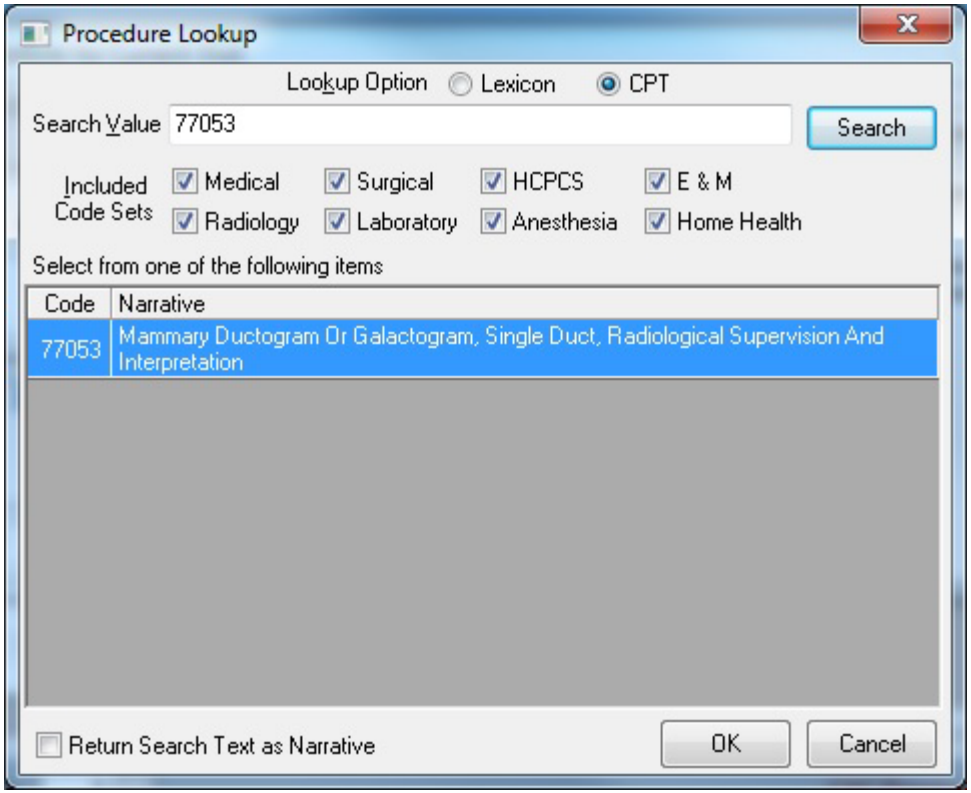

Figure 11: **Procedure Lookup** dialog

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 the **CPT** button is chosen in the **Lookup Option**.

   b. Select additional **Included Code Sets**.

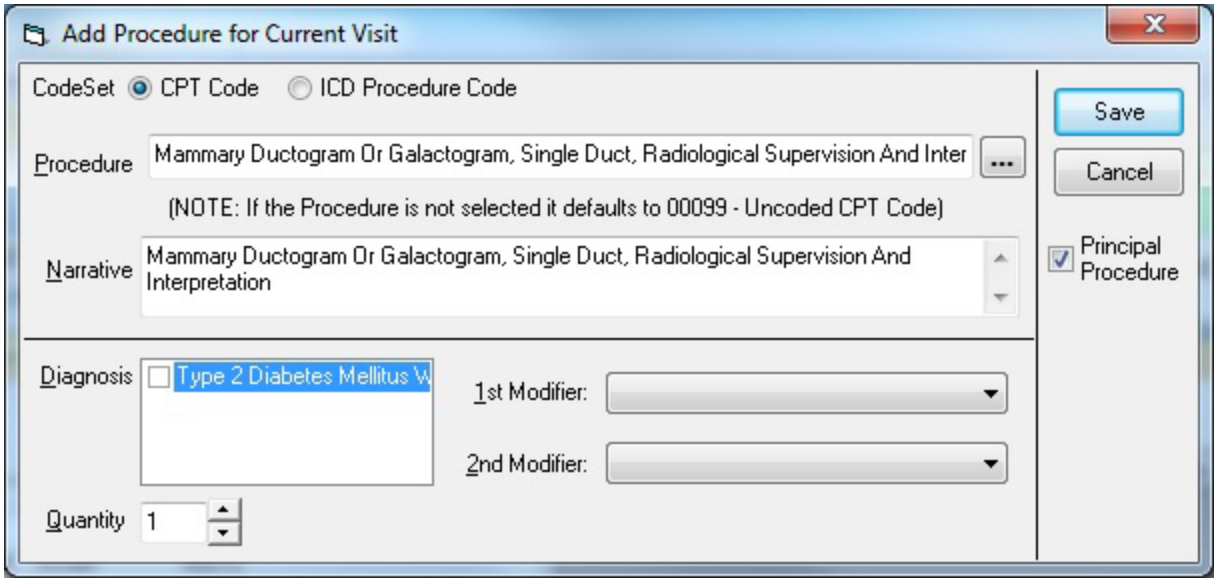

Figure 12: Entering additional Procedure information

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

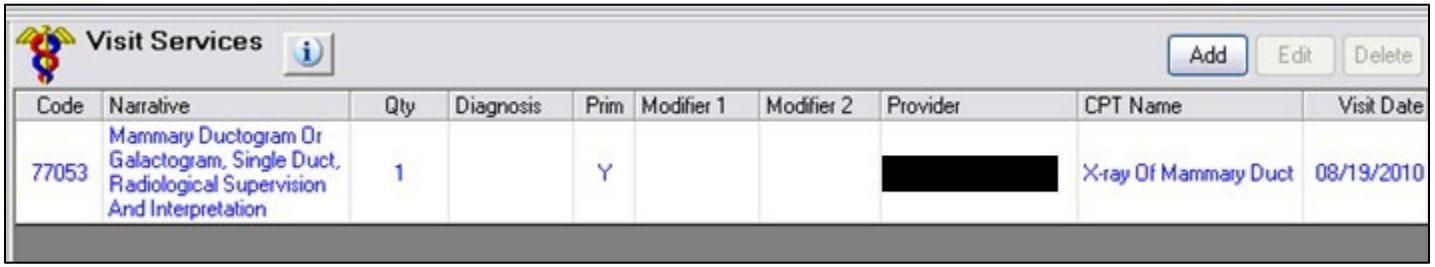

Figure 13: Example of a newly added CPT code

Historical CPT codes are entered in the **Historical Services** component, located on the **Surgical Hx** tab under the **Problem Mngt** tab (Figure 14).

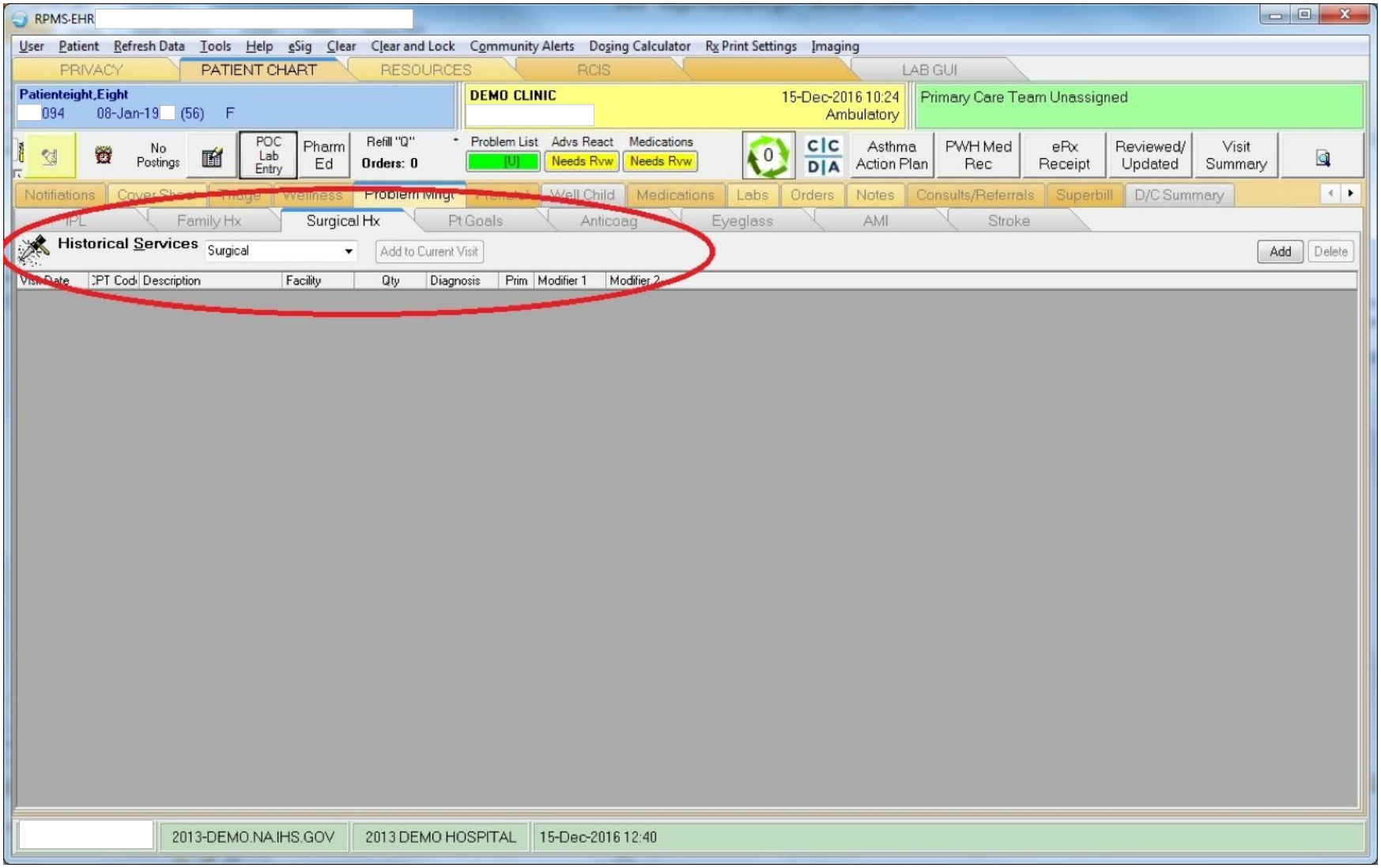

Figure 14: **Historical Services** component

To enter a CPT code:

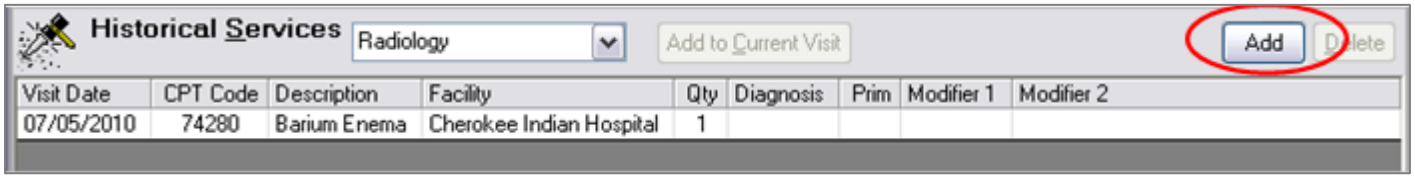

Figure 15: Example of entering a CPT code

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

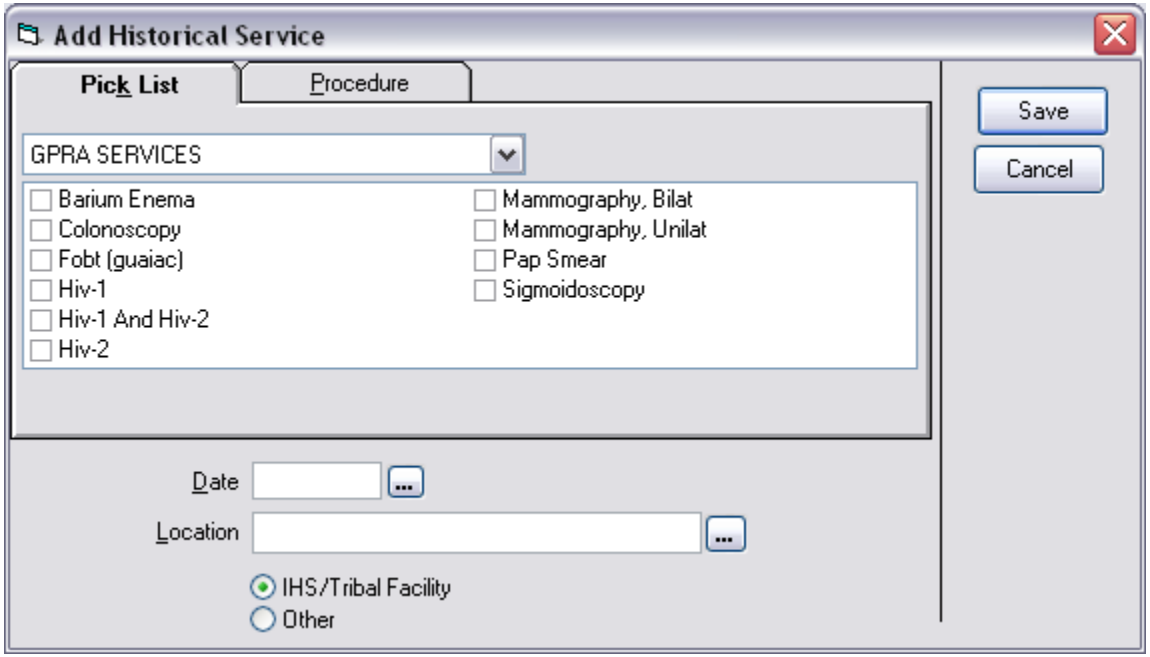

Figure 16: Adding a historical service using the **Pick List**

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

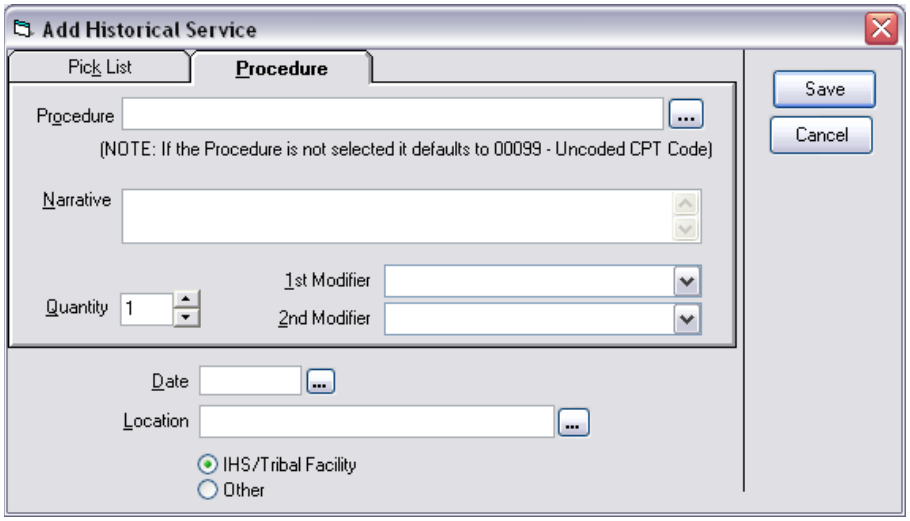

Figure 17: Adding a historical service by **Procedure**

- At the **Procedure** tab in the **Procedure** field (Figure 17), type the CPT code and proceed as in Steps 2–3 starting on Page 54.

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).

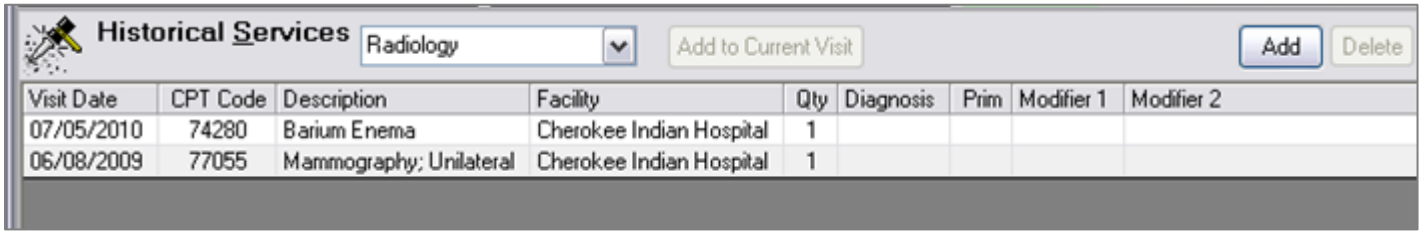

Figure 18: Example of a newly added **Historical Service**

Procedure Codes

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

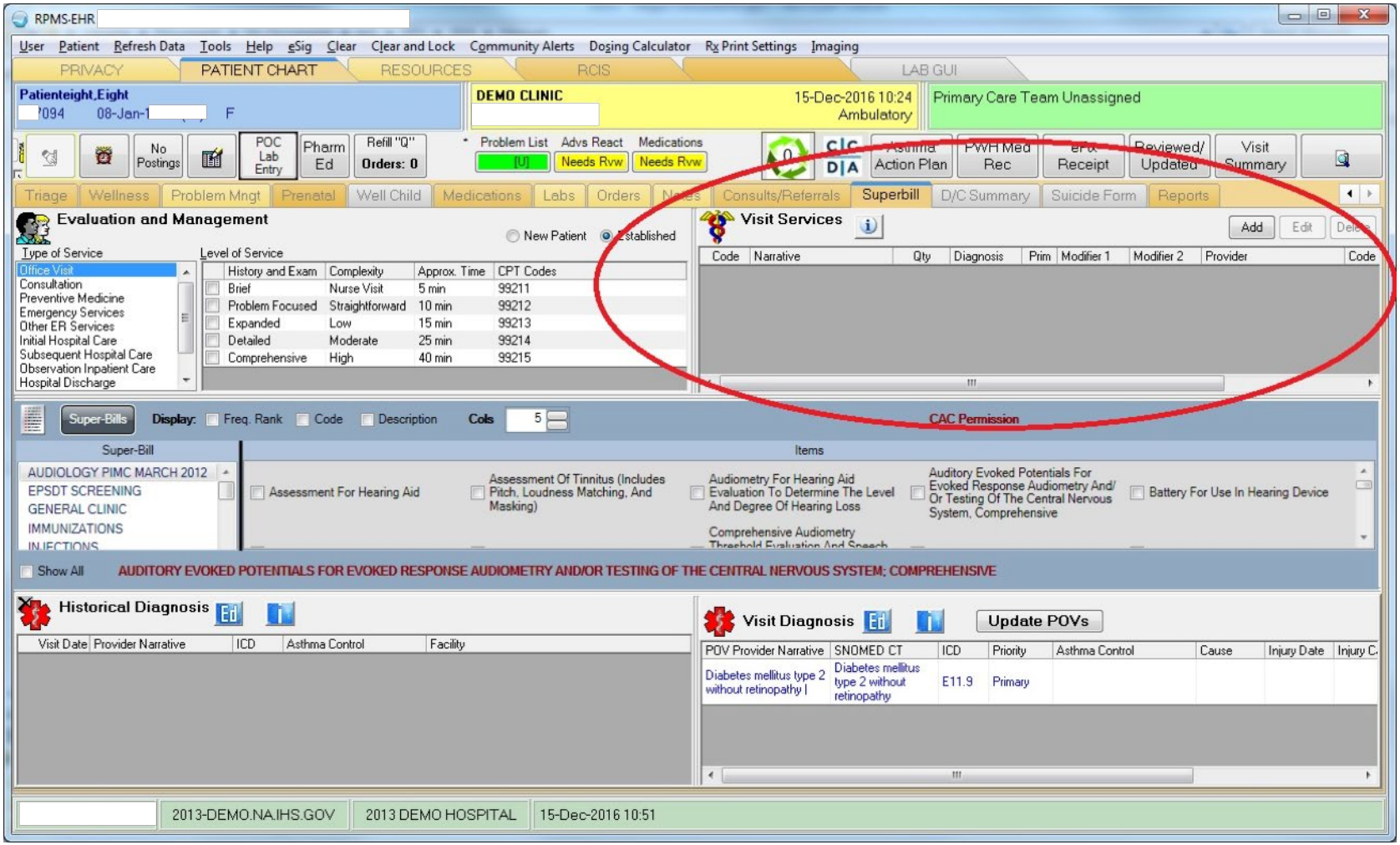

Figure 19: **Visit Services** component

To enter a Procedure code:

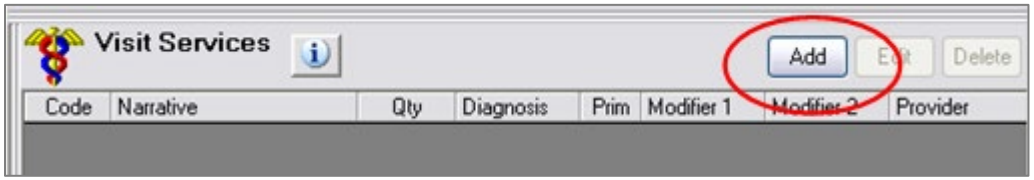

Figure 20: Entering a Procedure code

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

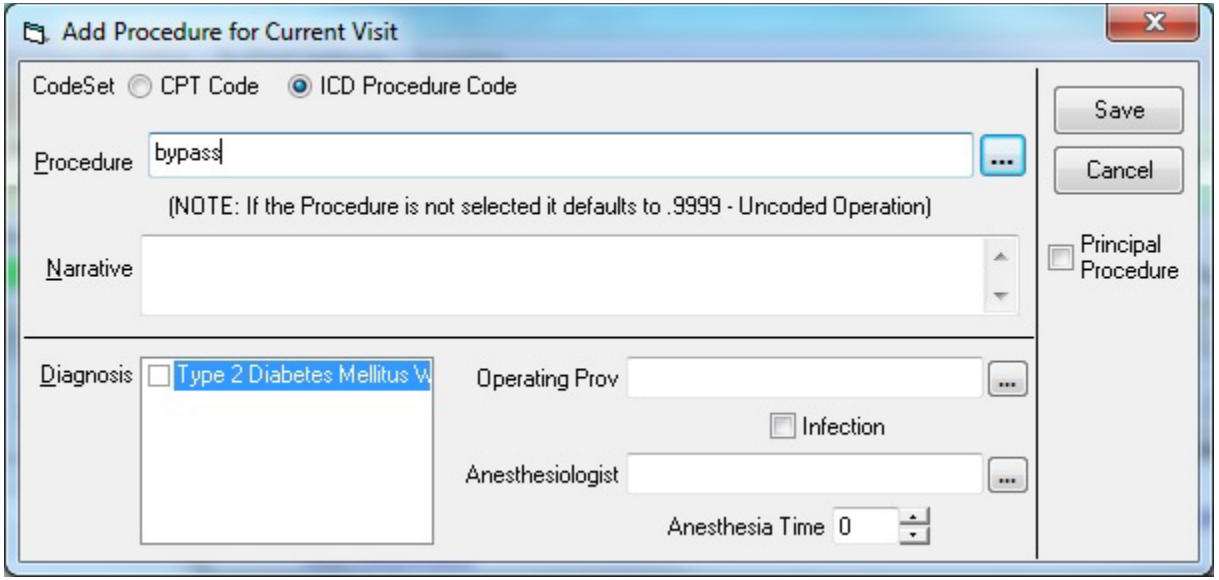

Figure 21: **Add Procedure for Current Visit** dialog

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.

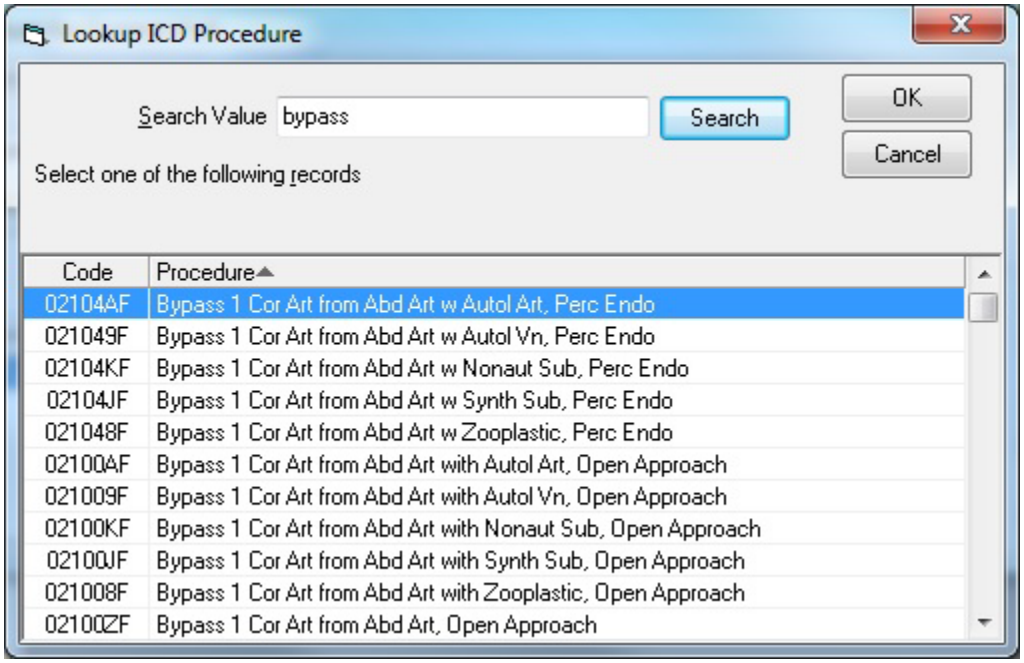

Figure 22: Choosing a Procedure

4. Click to select the **Procedure**.

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

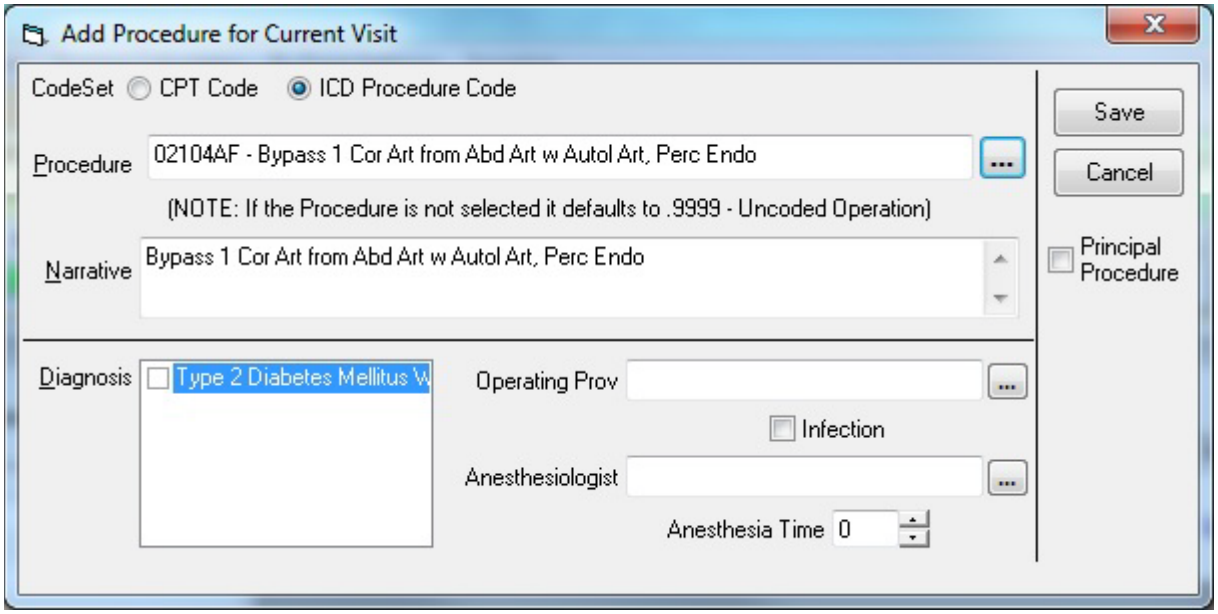

Figure 23: Entering additional Procedure information

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

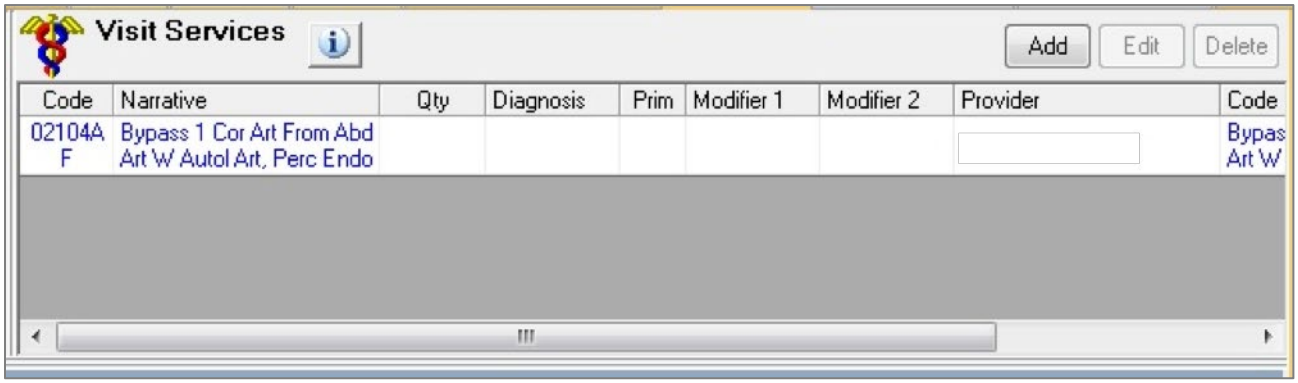

Figure 24: Example of a newly added Procedure code

Exams

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

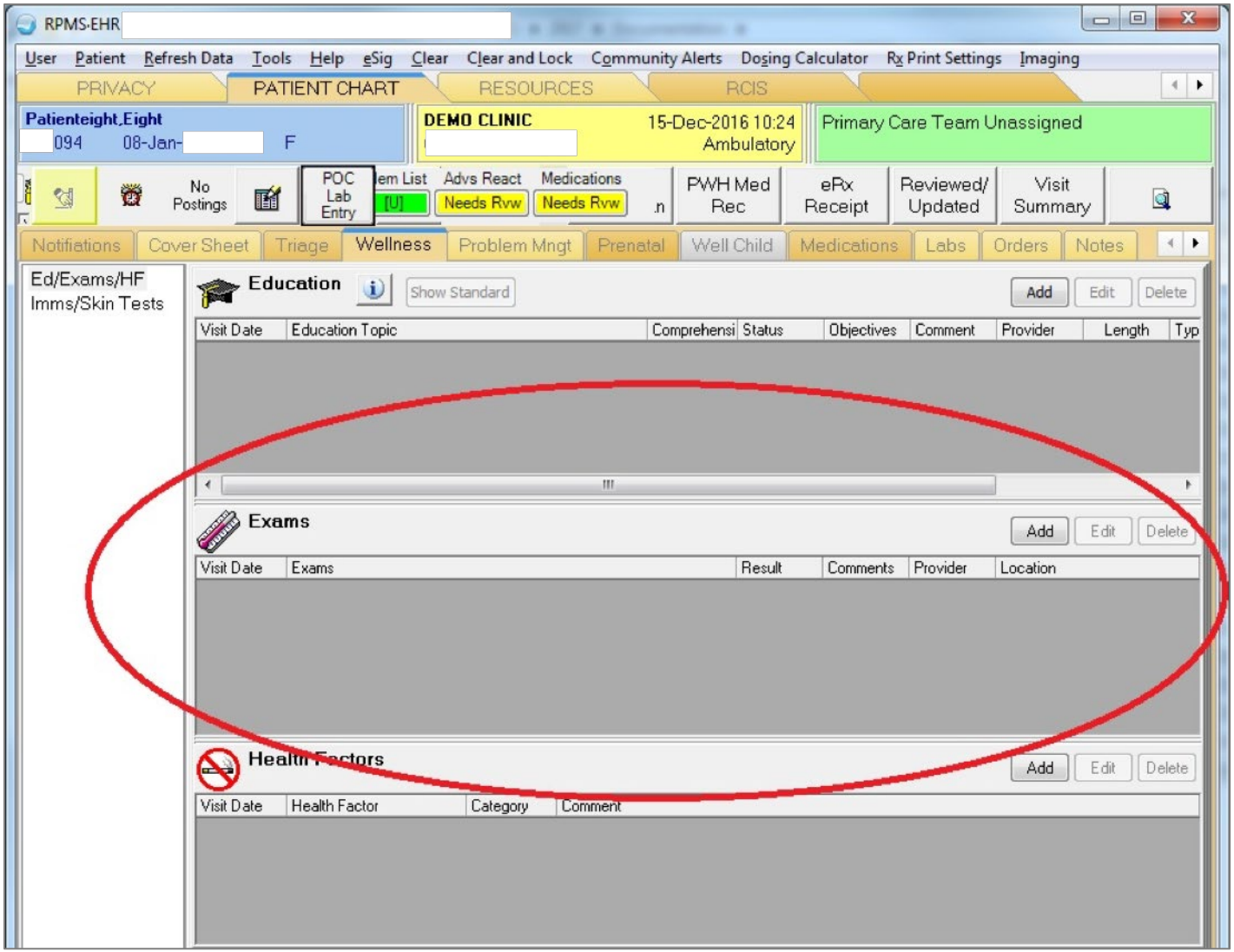

Figure 25: **Exams** component

To enter an Exam code:

Figure 26: Entering an Exam code

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

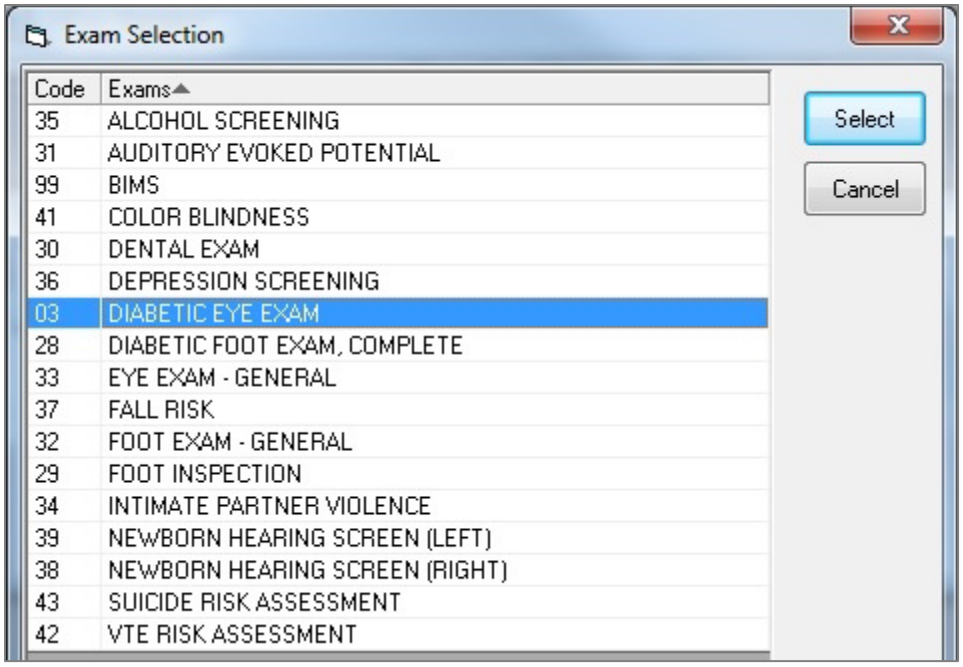

Figure 27: Selecting an exam

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

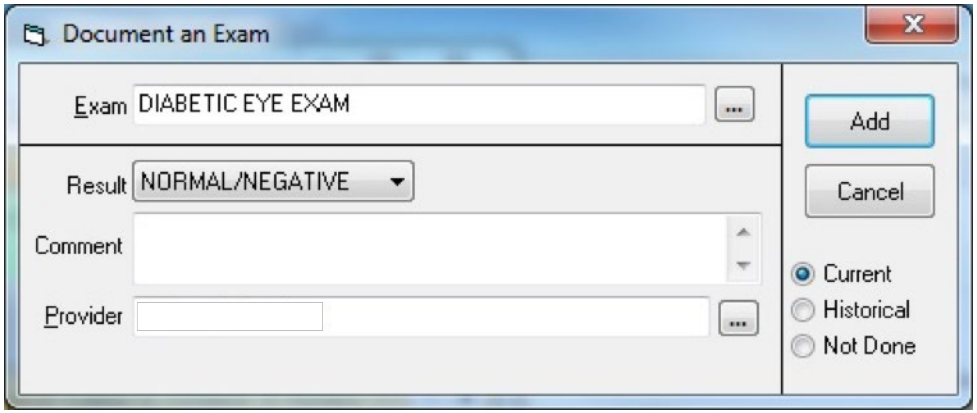

Figure 28: Entering a result and additional comments

3. Select the **Result** and enter any **Comments**.

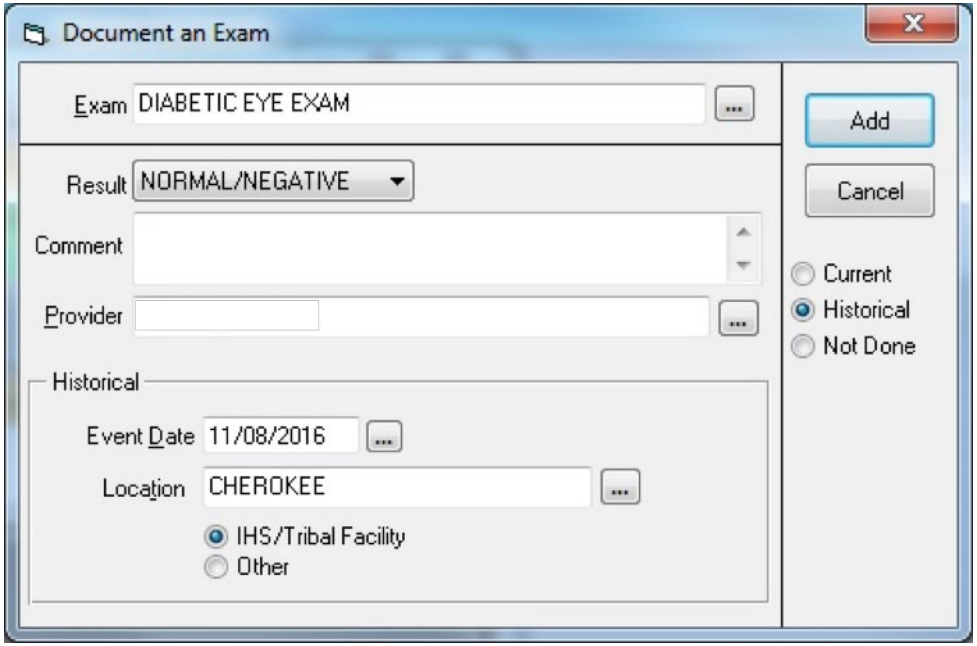

Figure 29: Entering a historical exam

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 display in the **Exams** component (Figure 30).

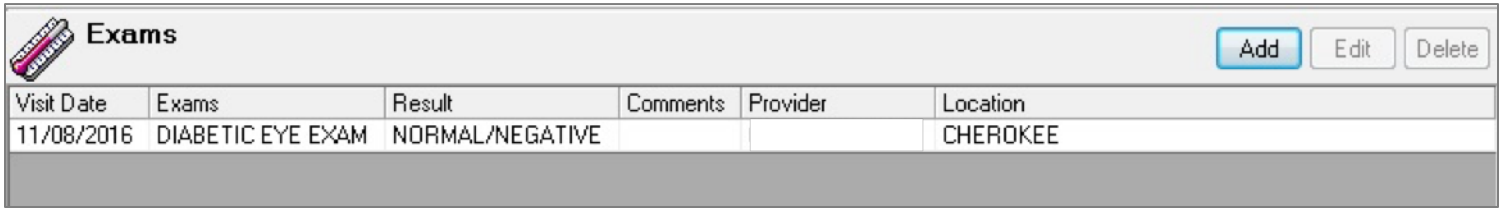

Figure 30: Example of a newly added Exam

Health Factors

Health Factors are entered in the **Health Factors** component, located on the **Wellness** tab under **Ed/Exams/HF** (Figure 31).

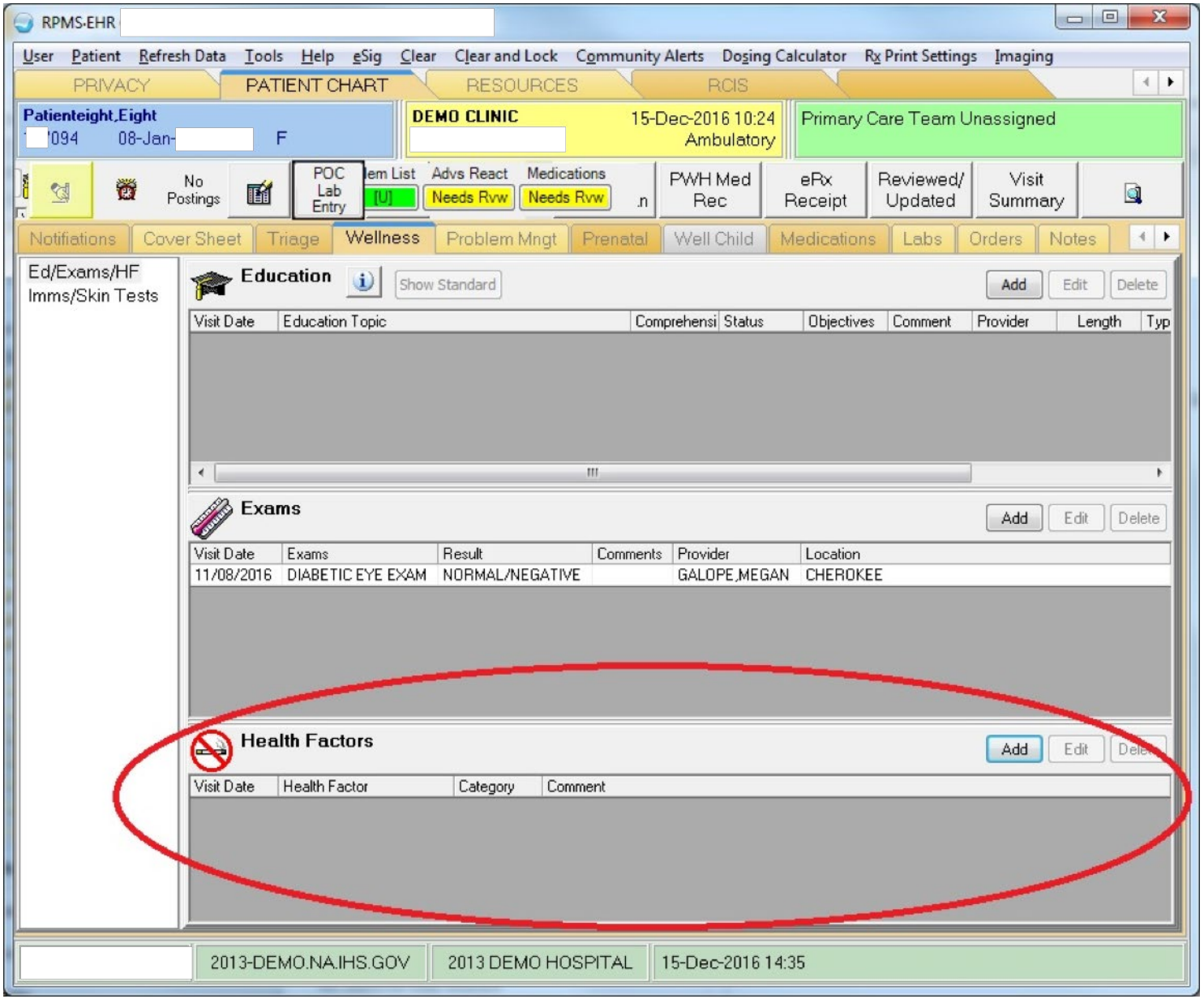

Figure 31: **Health Factors** component

To enter a Health Factor:

Figure 32: Entering a Health Factor

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

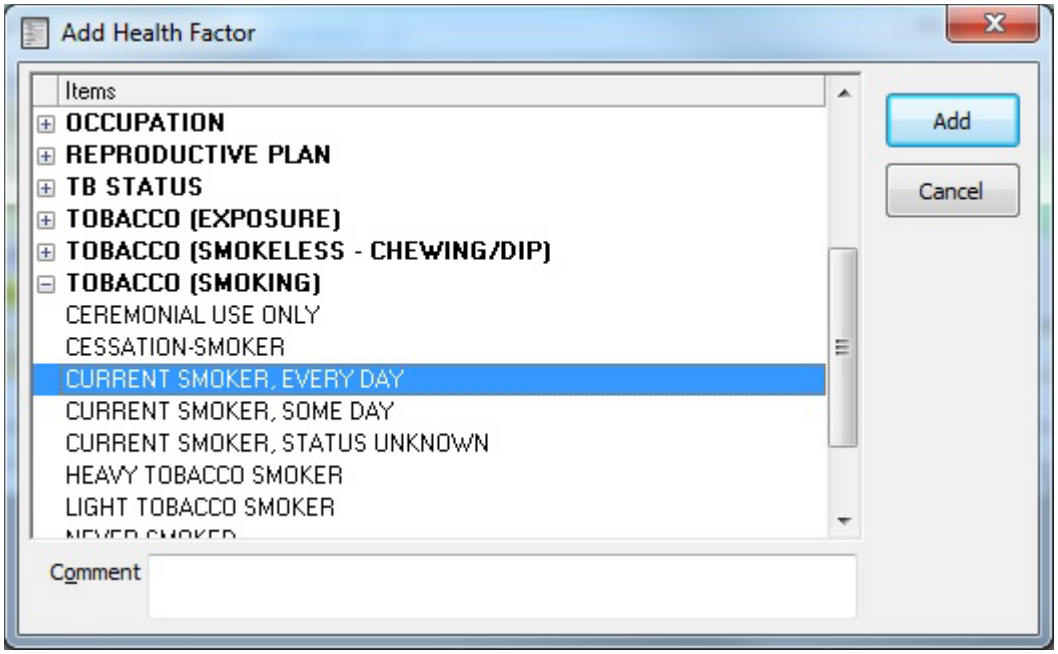

Figure 33: Choosing a **Health Factor**

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

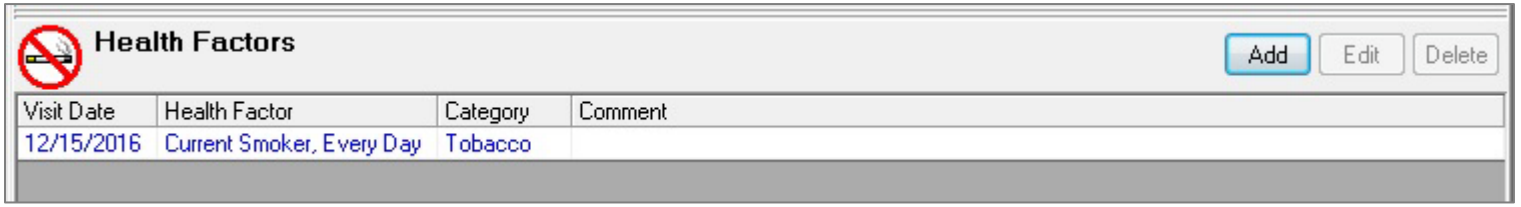

Figure 34: Example of a newly added **Health Factor**

Immunizations

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

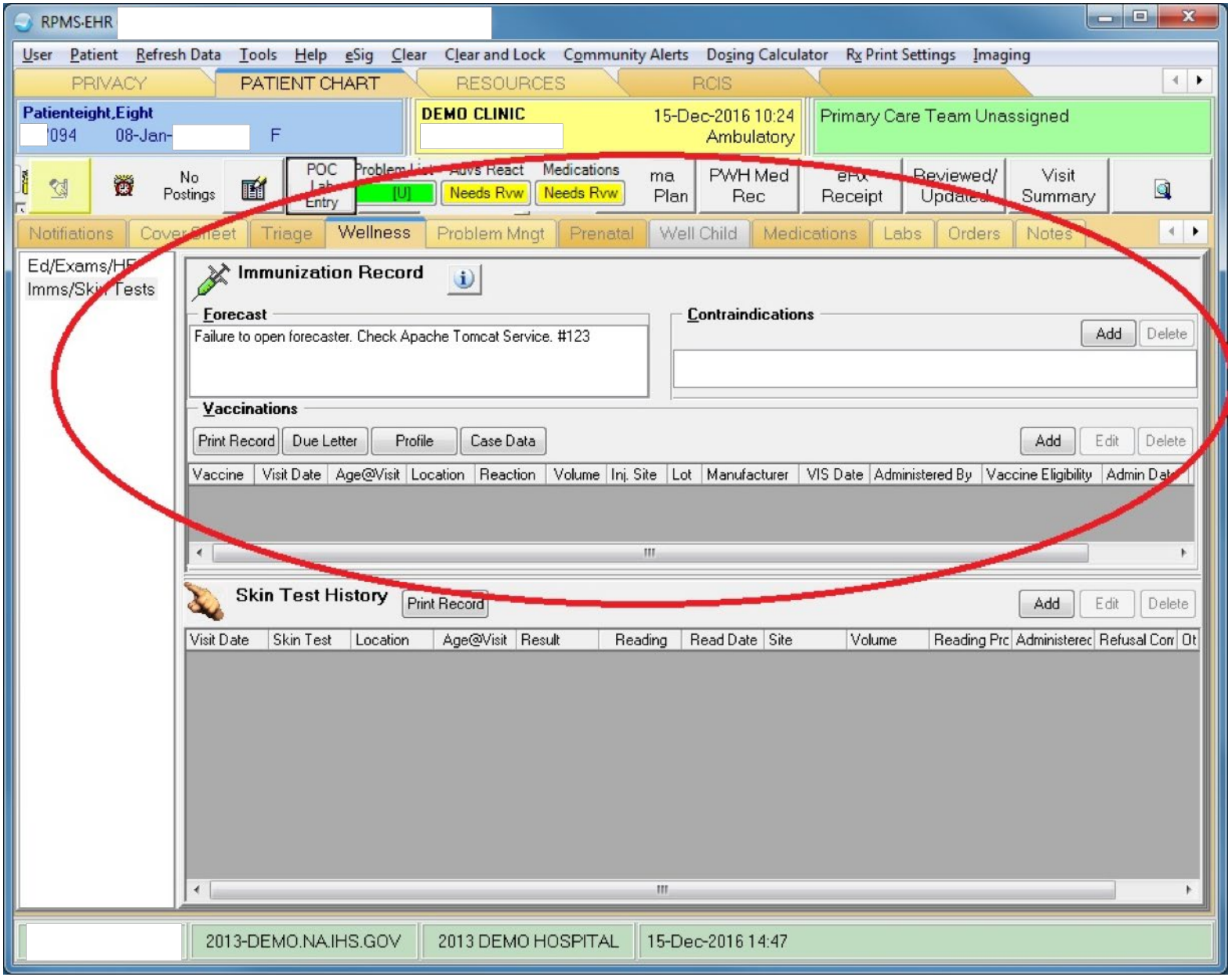

Figure 35: **Immunization Record** component

To enter an Immunization:

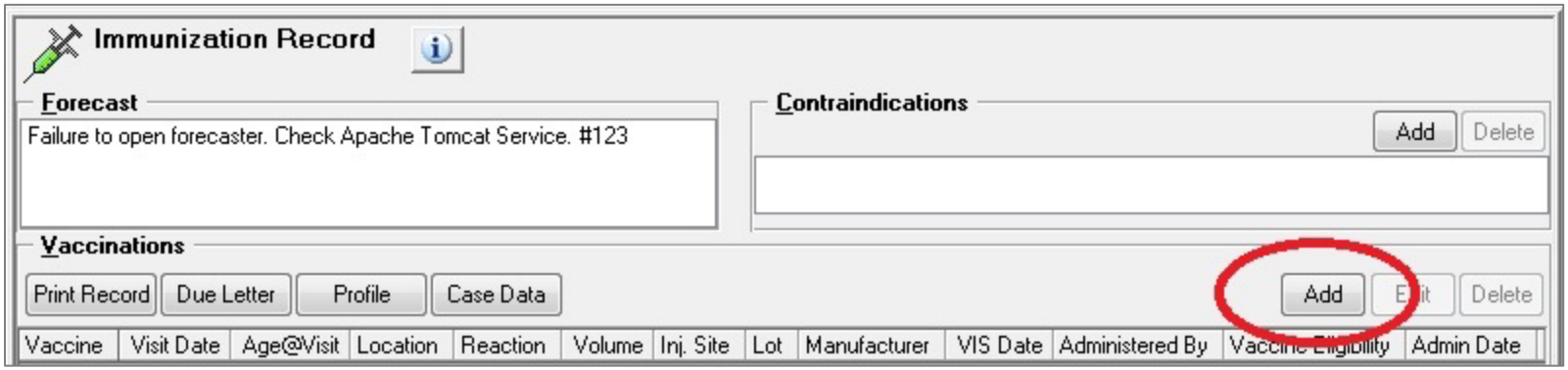

Figure 36: Entering an Immunization

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

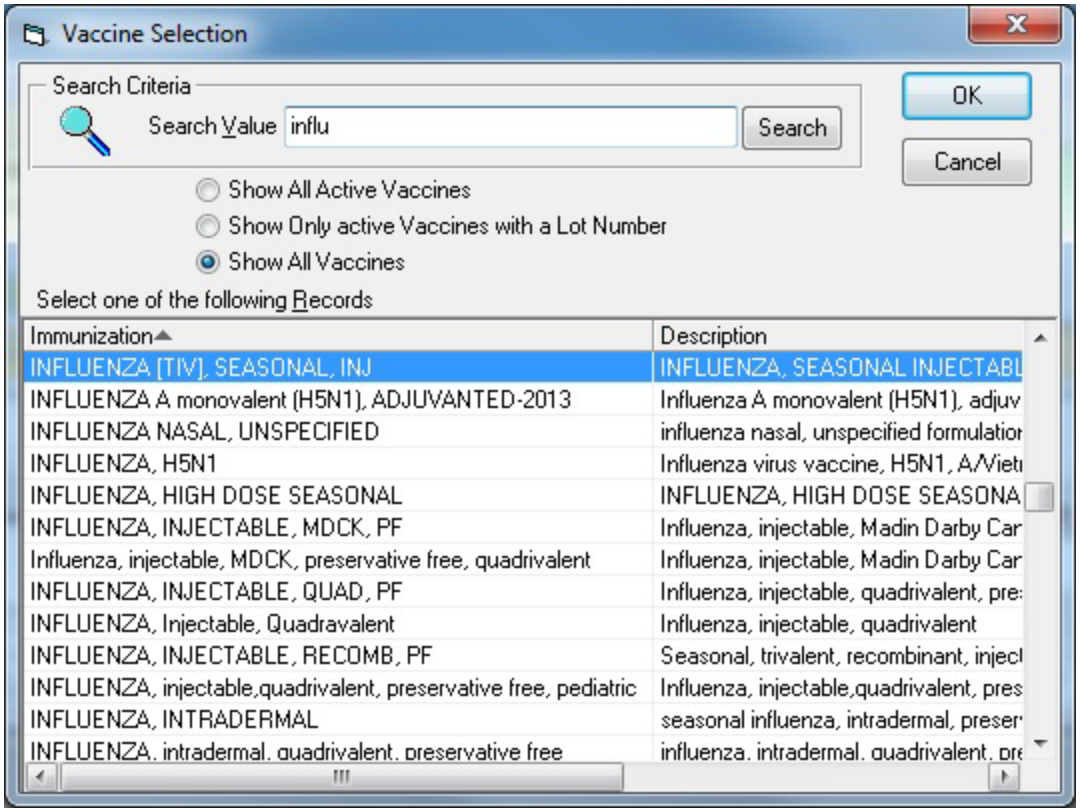

Figure 37: Choosing the Immunization

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

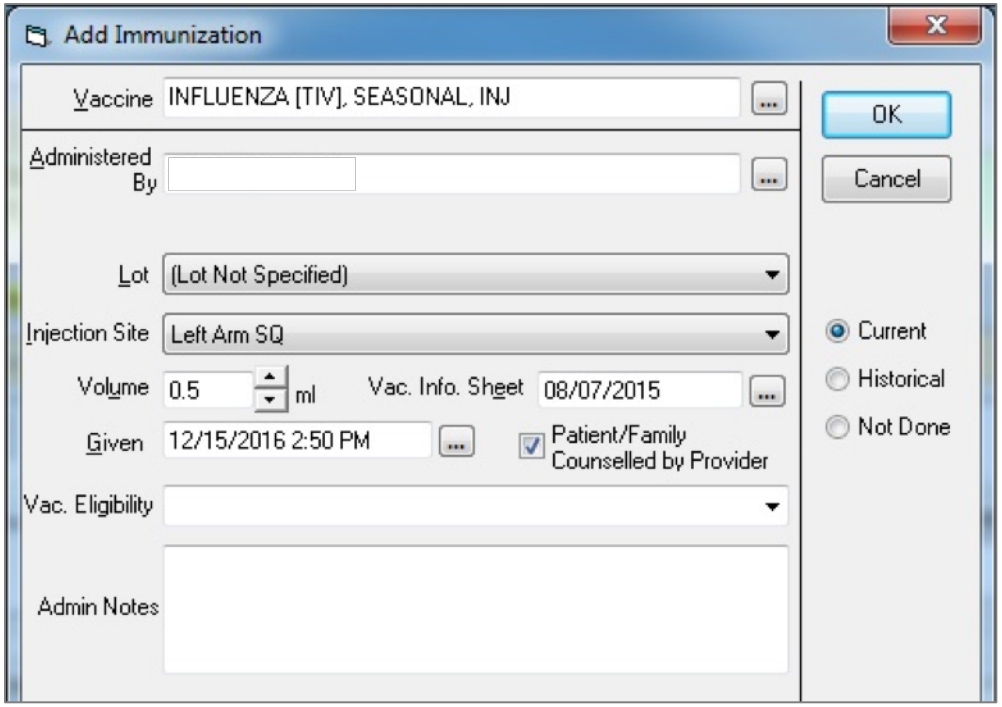

Figure 38: Entering additional immunization information

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

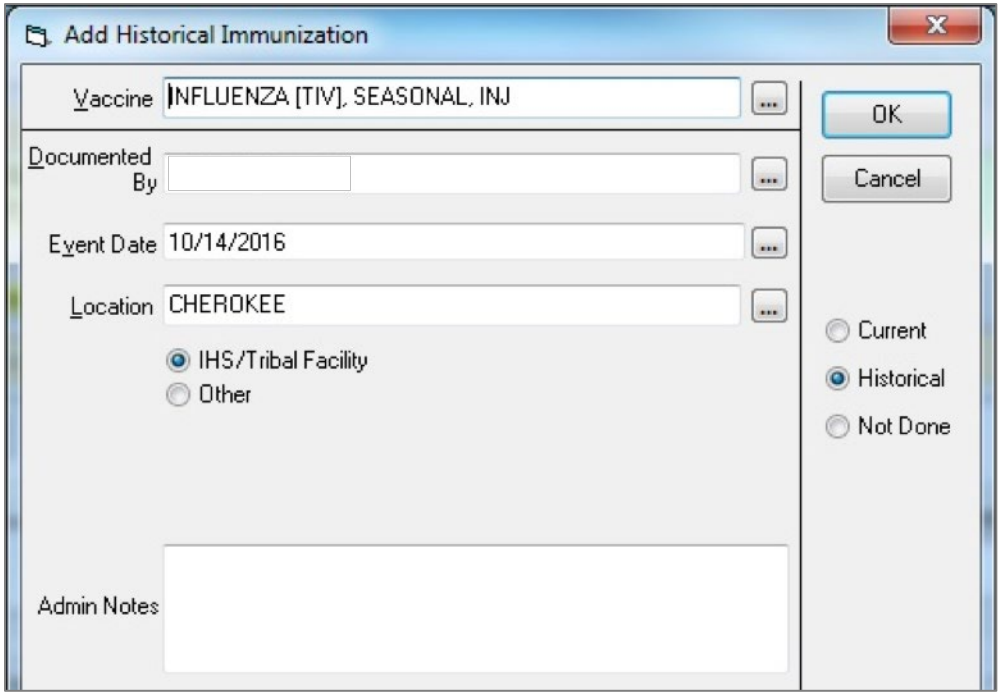

Figure 39: Entering a historical immunization

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

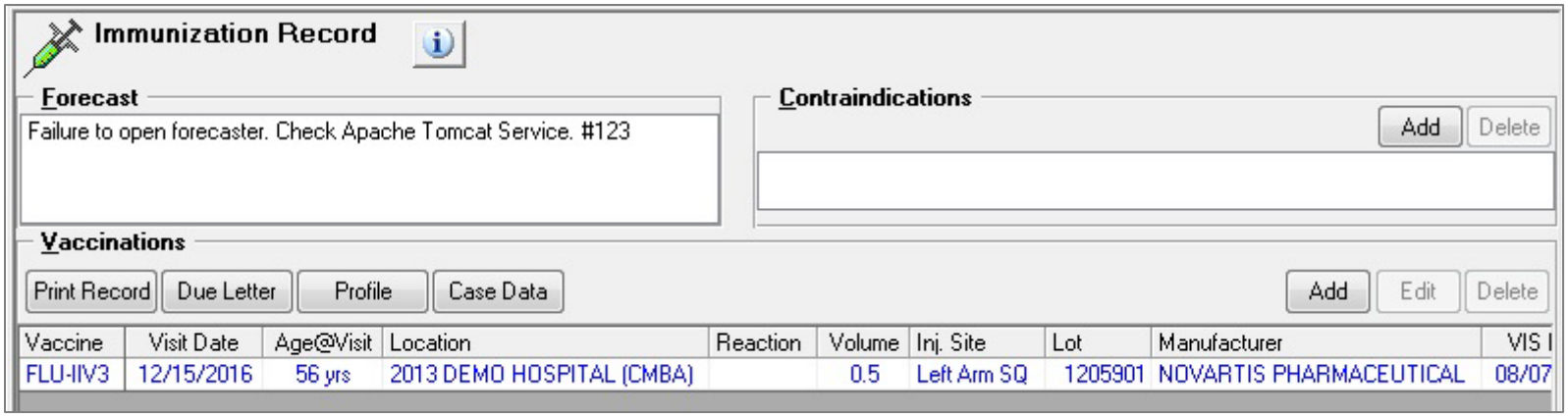

Figure 40: Example of a newly added Immunization

To enter a contraindication for an immunization:

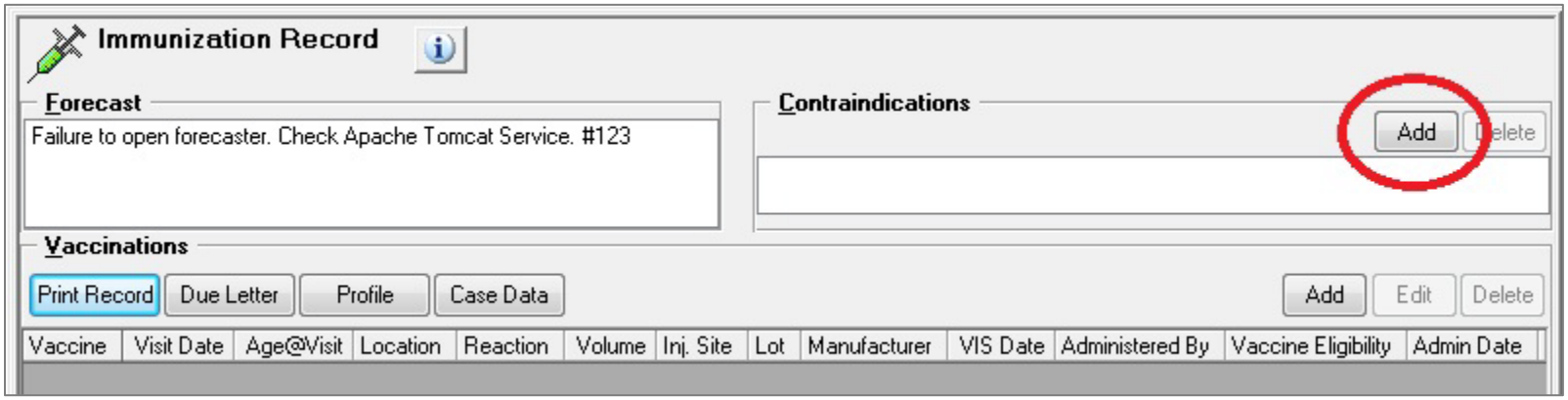

Figure 41: Entering a contraindication

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

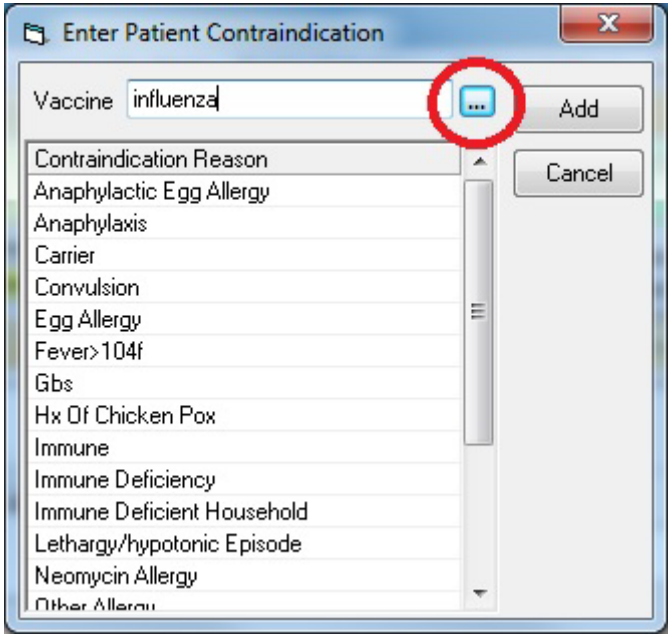

Figure 42: Choosing a contraindication

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

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

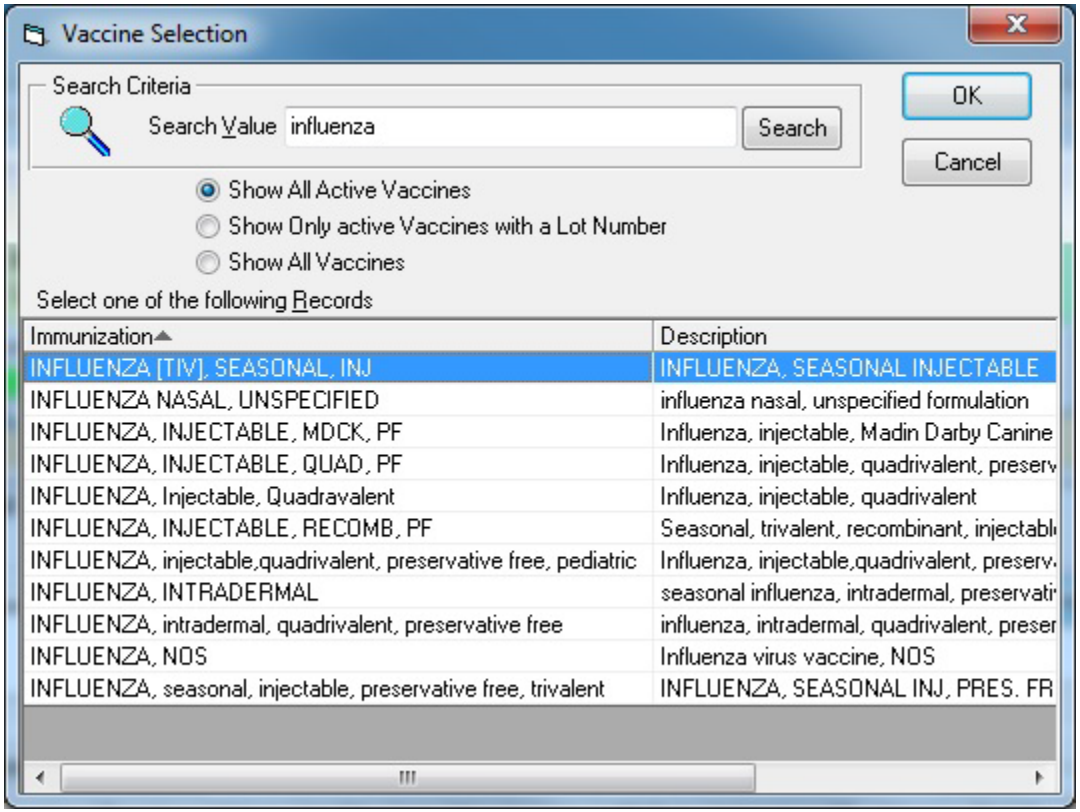

Figure 43: Selecting the immunization

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

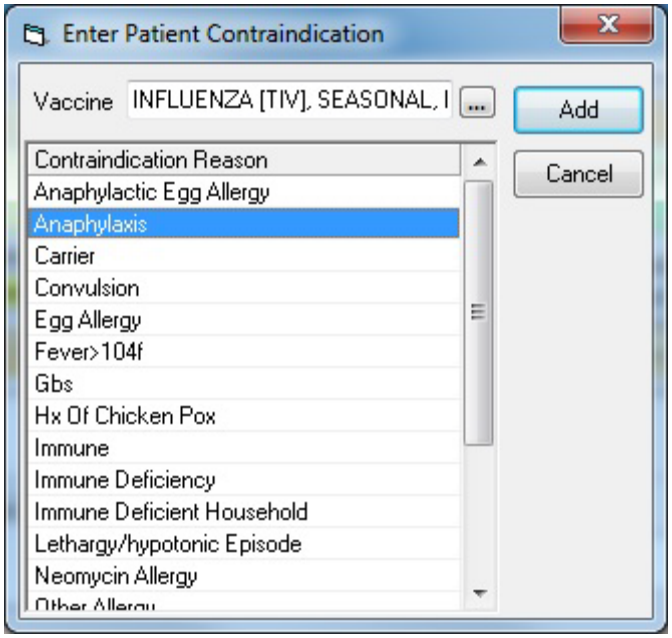

Figure 44: **Enter Patient Contraindication** dialog

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

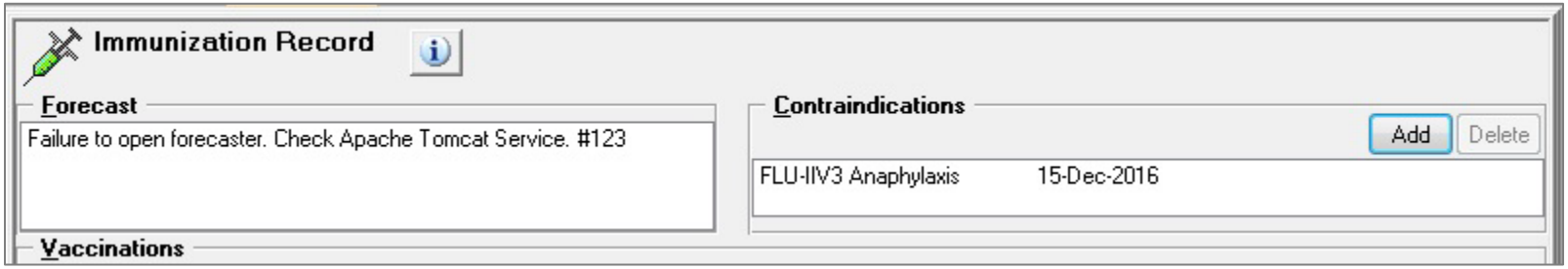

Figure 45: Example of a newly added contraindication

Vital Measurements

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

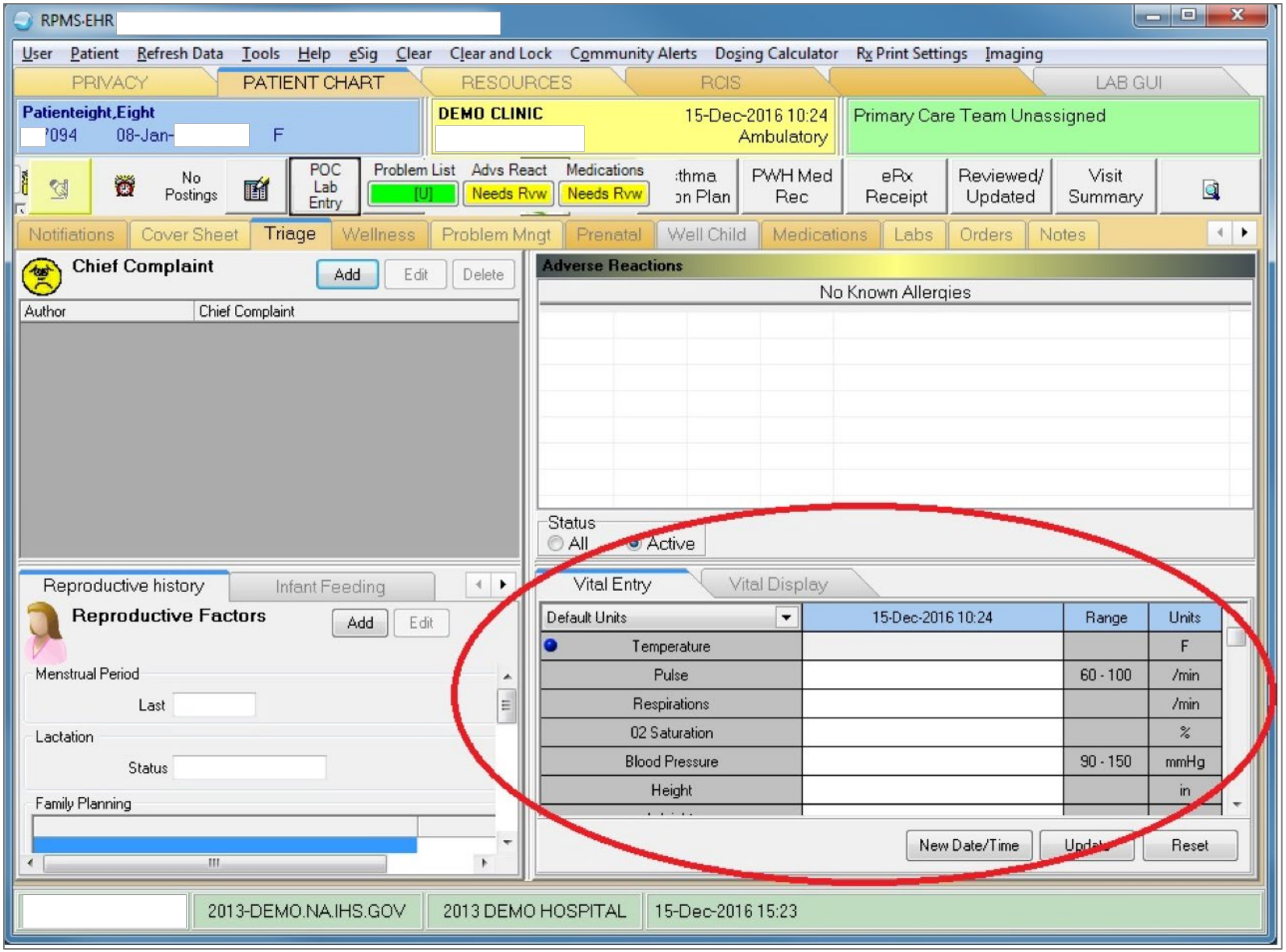

Figure 46: **Vitals** component

To enter Vital Measurements:

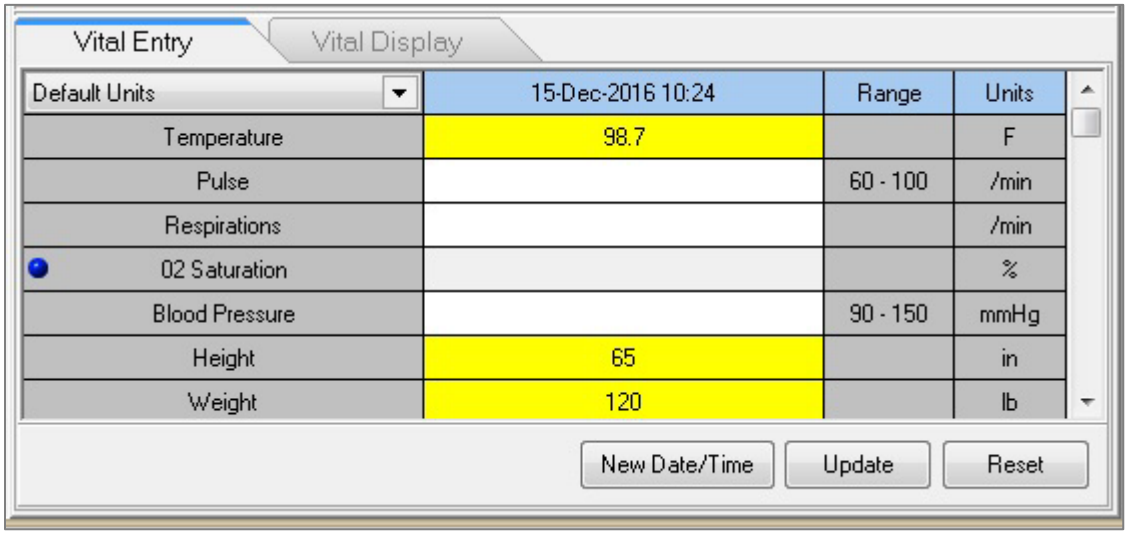

Figure 47: Entering a Vital Measurement

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).

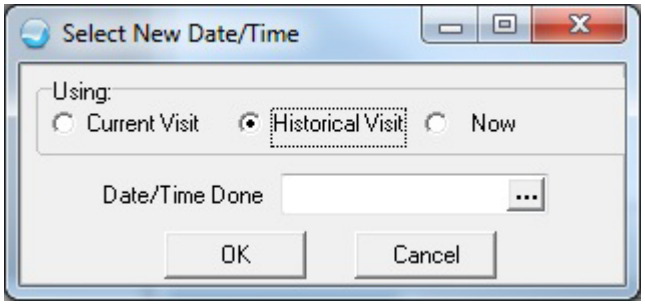

Figure 48: Selecting a new date/time for an historical vital

   c. The **Select Location for Historical Entry** dialog (Figure 49) displays.

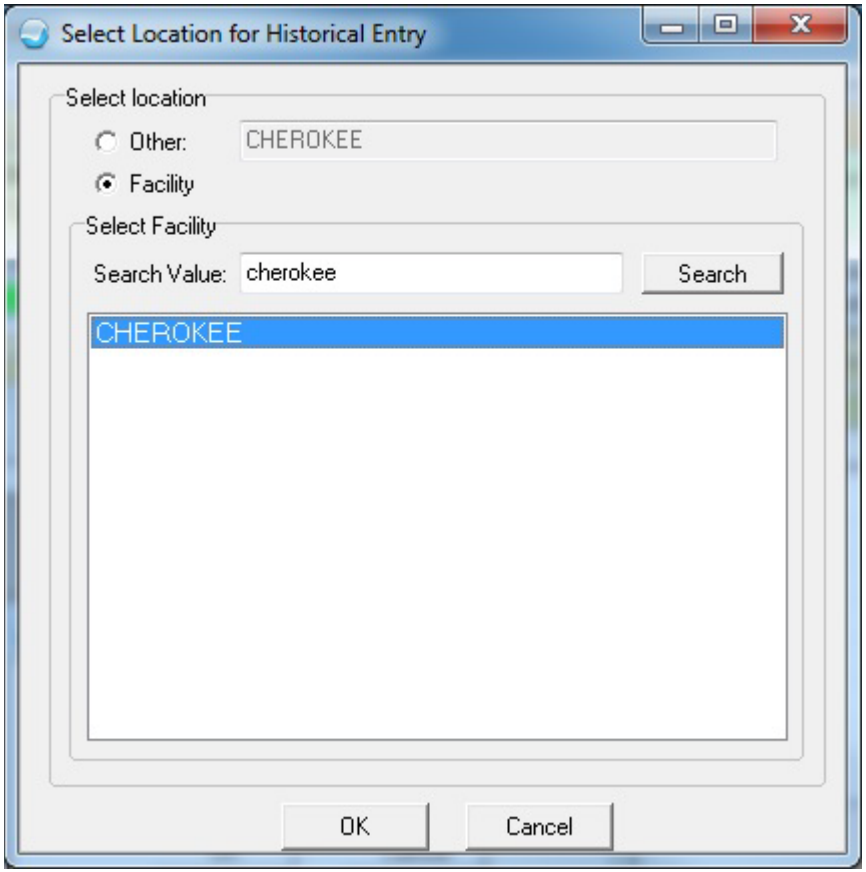

Figure 49: Choosing the historical location

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

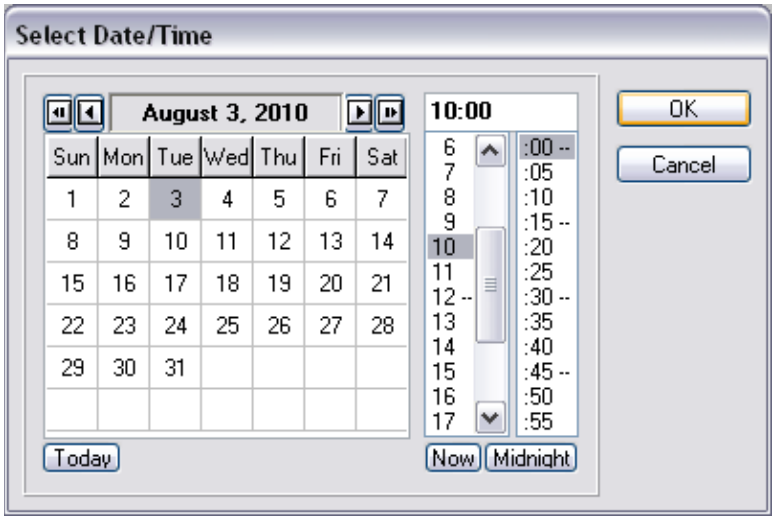

Figure 50: Choosing the historical date

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

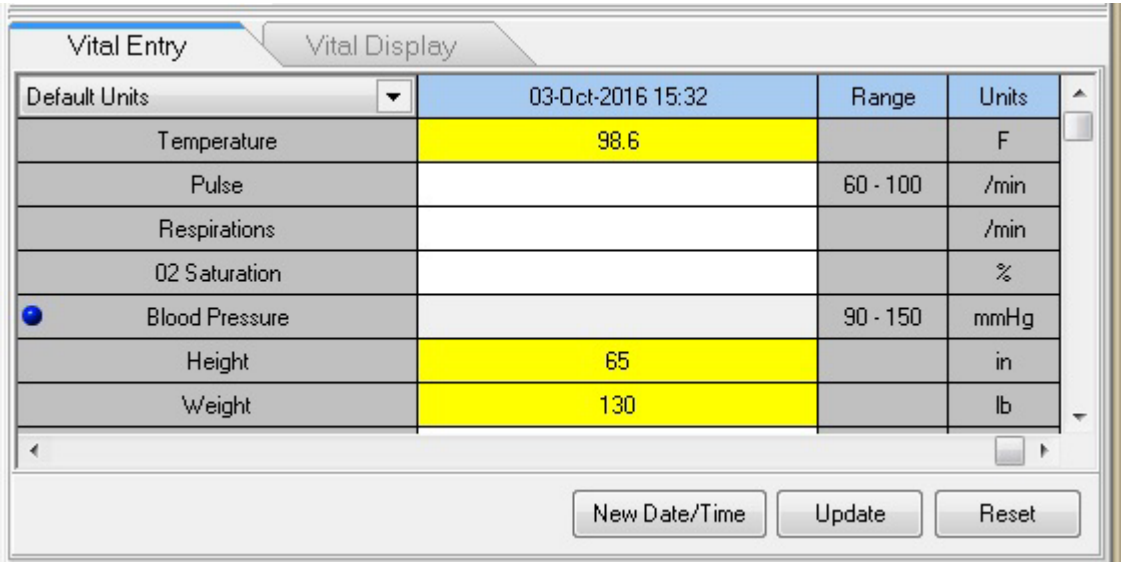

Figure 51: Entering Vital Measurements

Lab Tests

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

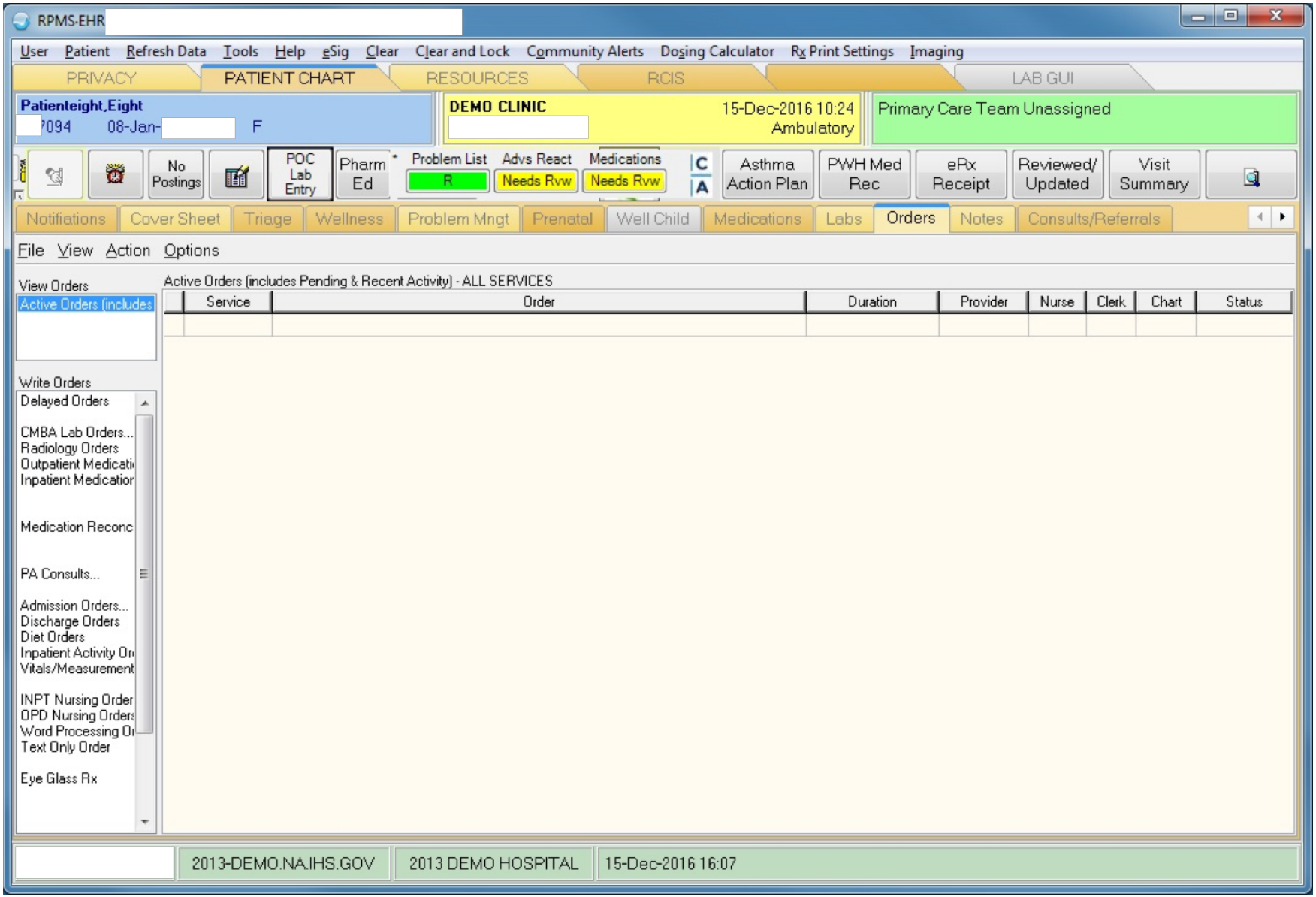

Figure 52: **Orders** component

To enter a Lab test:

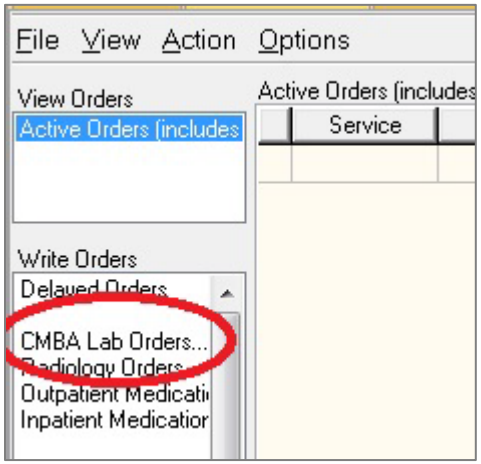

Figure 53: Entering a Lab test

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.

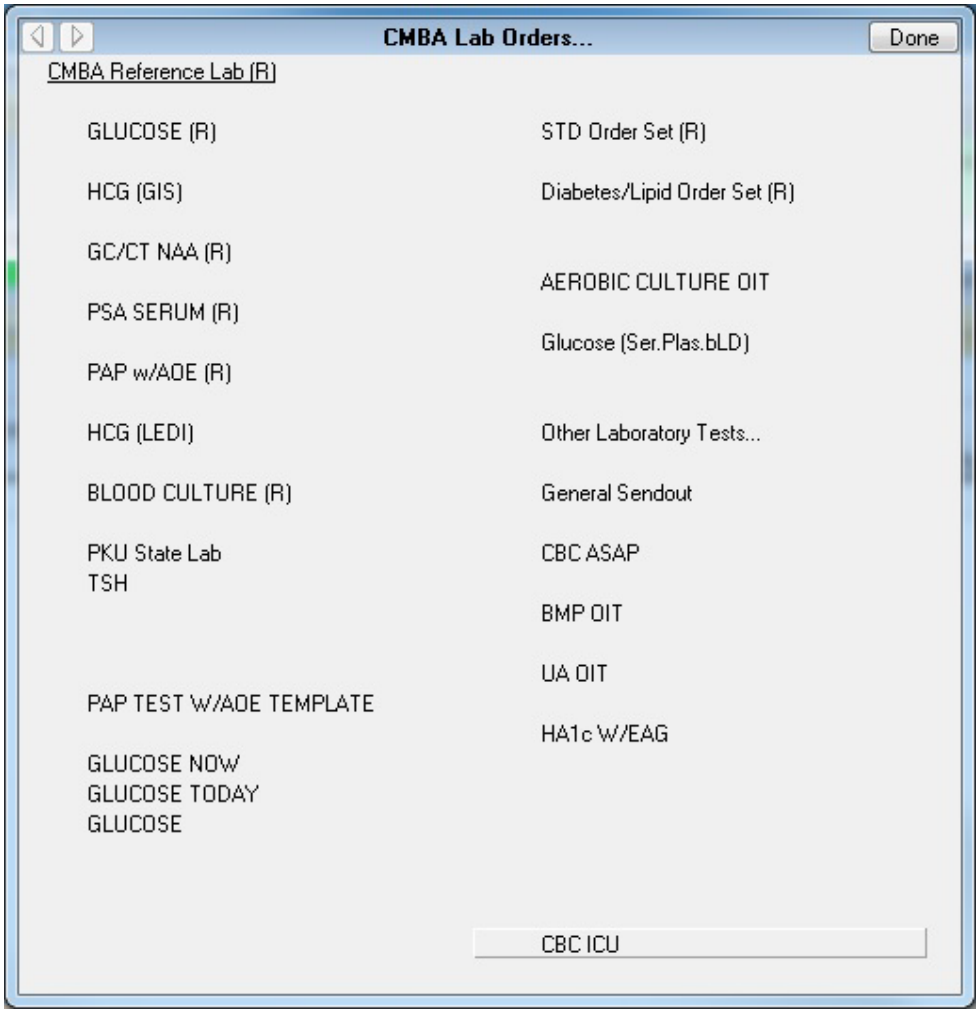

Figure 54: **Lab Orders…** dialog

2. Select the appropriate lab test and the **Order a Lab Test** dialog (Figure 55) displays.

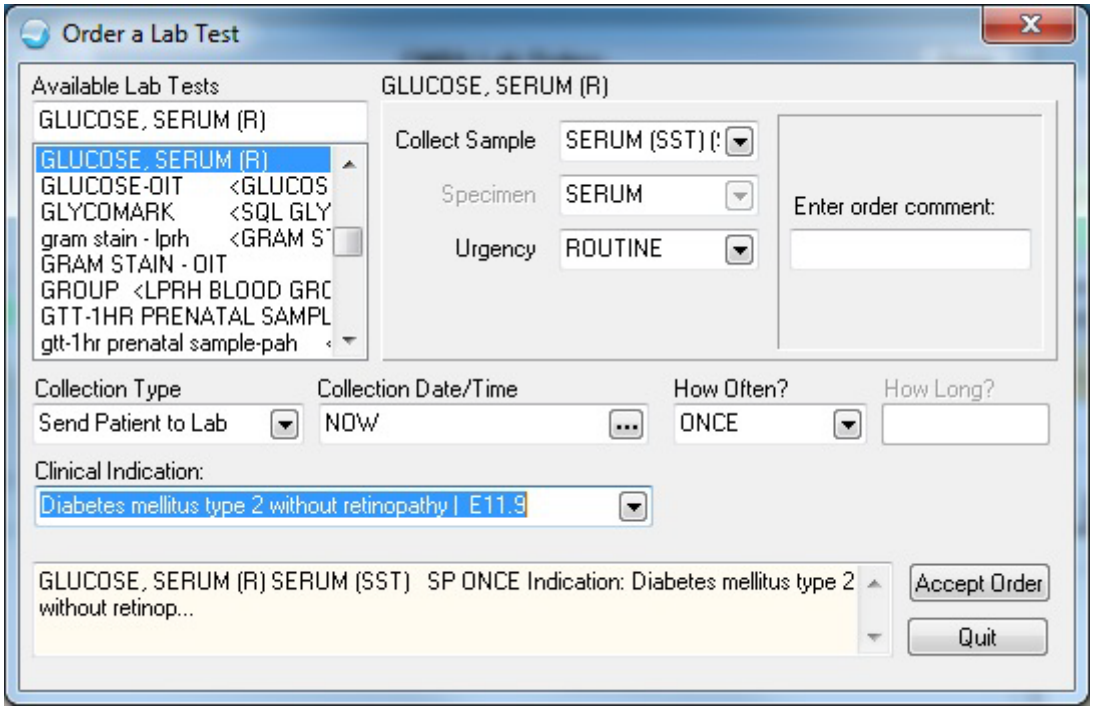

Figure 55: **Order a Lab Test** dialog

3. Select the appropriate lab test and enter any other pertinent information.

Click **Accept Order**. The newly added lab test should display in the **Active Orders** section of the **Orders** component (Figure 56).

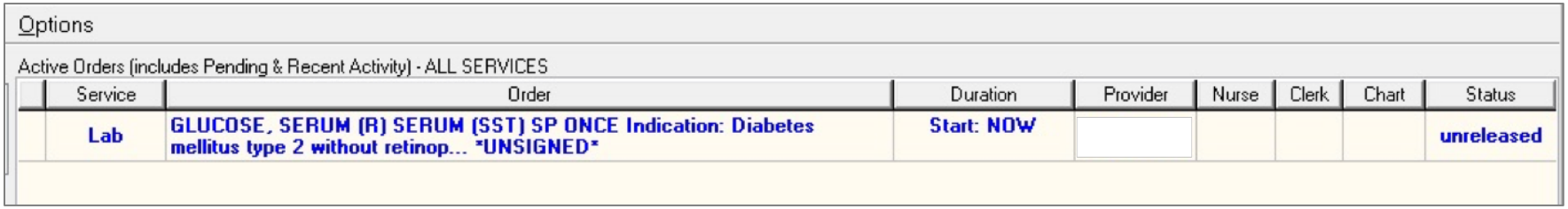

Figure 56: Example of a newly added Lab test

4. 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).

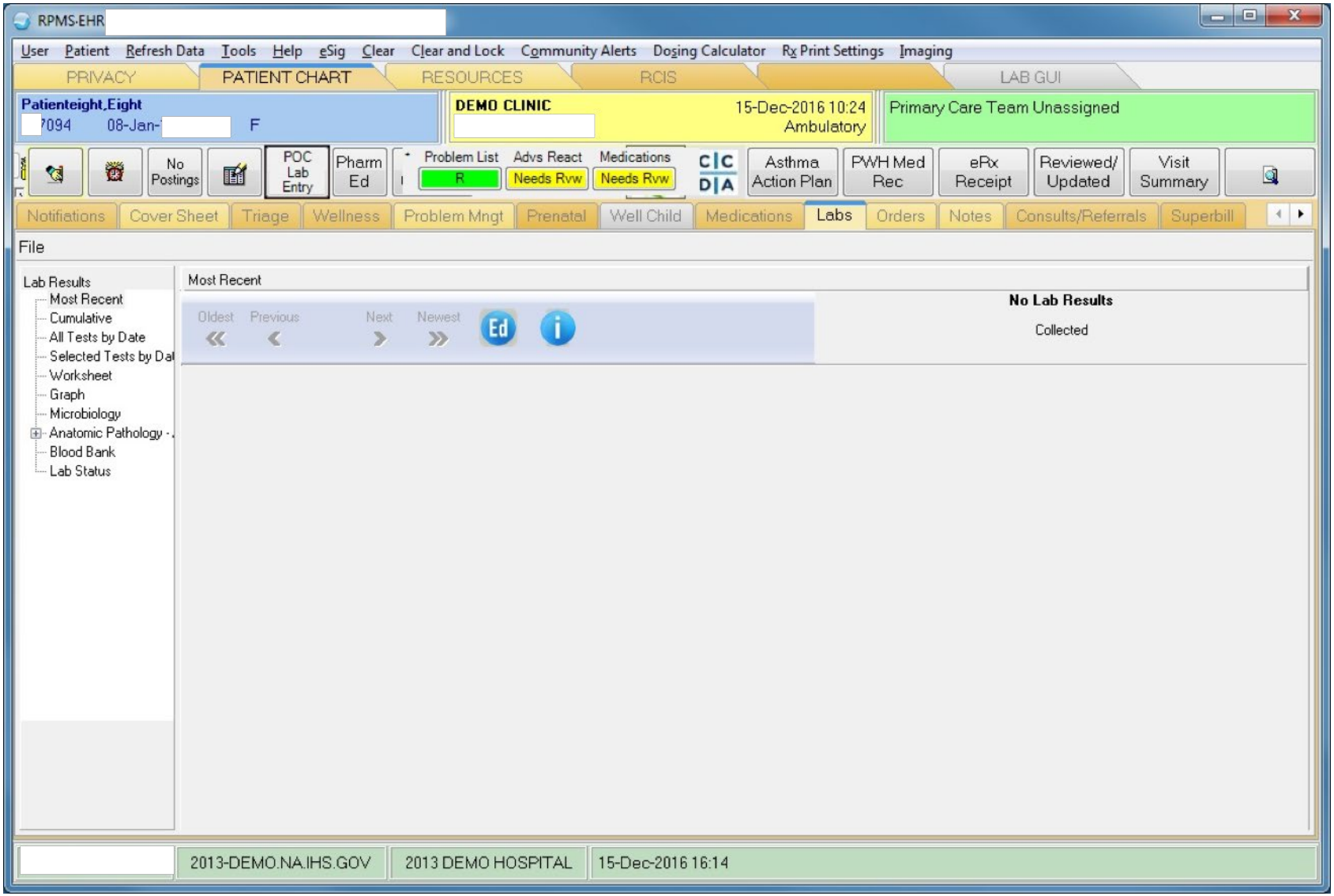

Figure 57: Viewing the lab results

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:

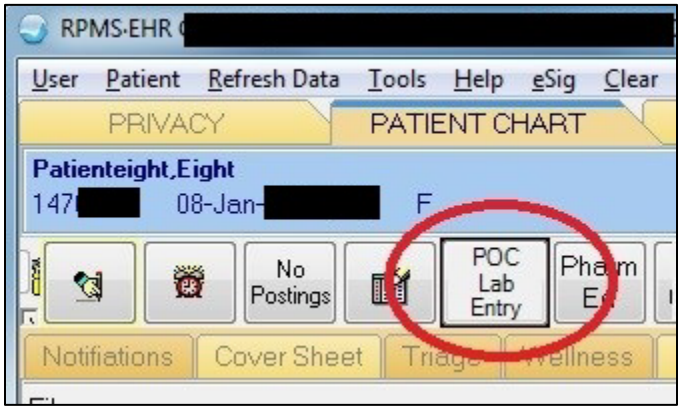

Figure 58: Entering a Point of Care Lab test

1. Click **POC Lab Entry**. If this button is not visible, speak with your Clinical Applications Coordinator (CAC) to see if it can be added. The **Lab Point of Care Data Entry Form** dialog (Figure 59) displays.

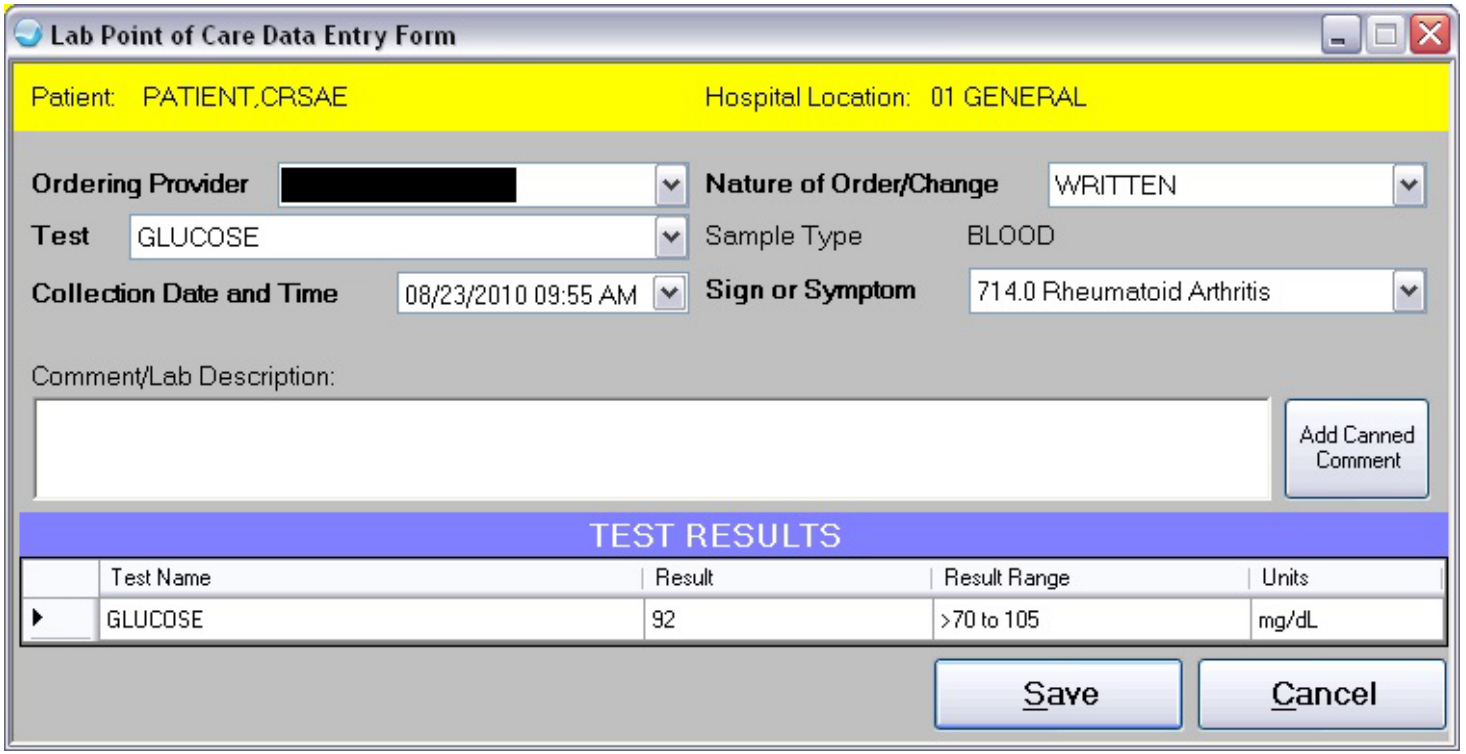

Figure 59: **Lab Point of Care Data Entry Form** dialog

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

Medications

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

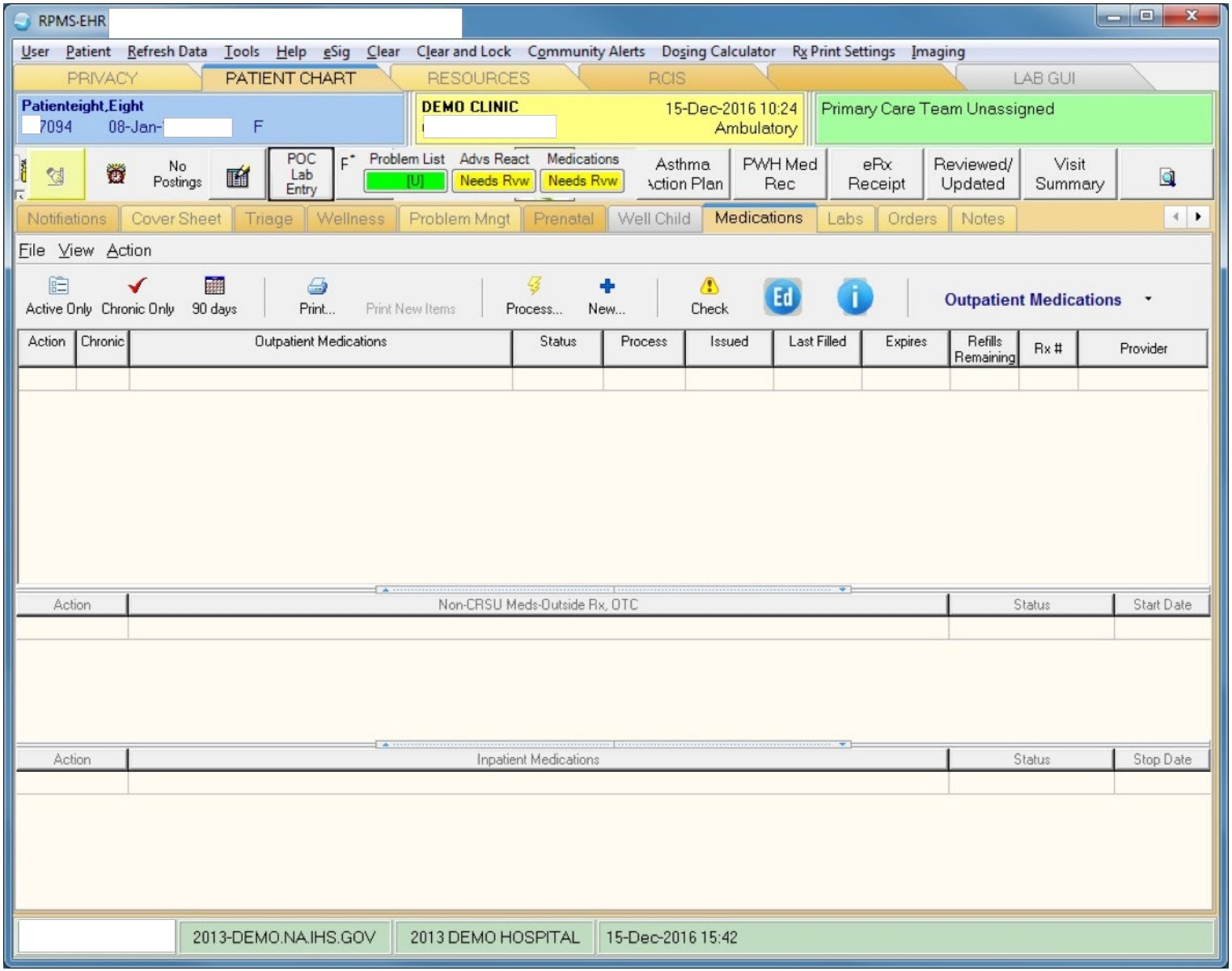

Figure 60: **Medications** component

To enter a prescription for a medication:

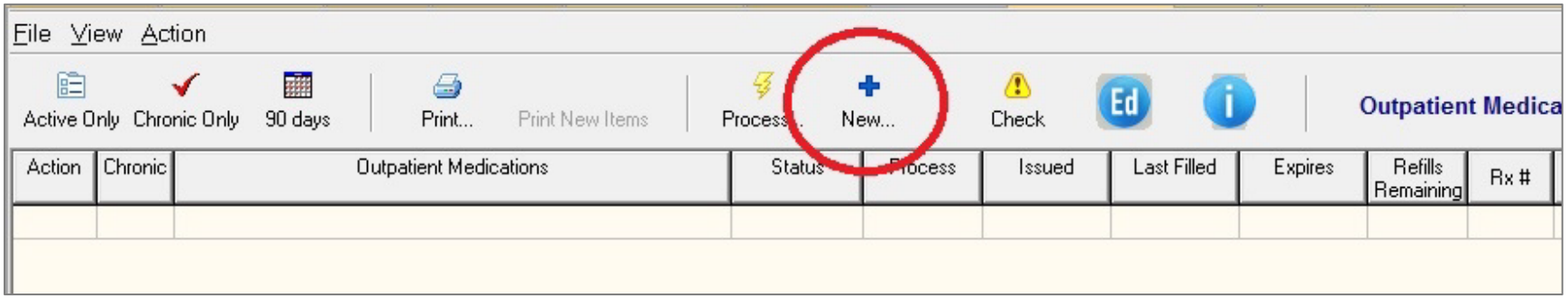

Figure 61: Entering a patient medication

1. Click **New**. The **Medication Order** dialog (Figure 62) displays.

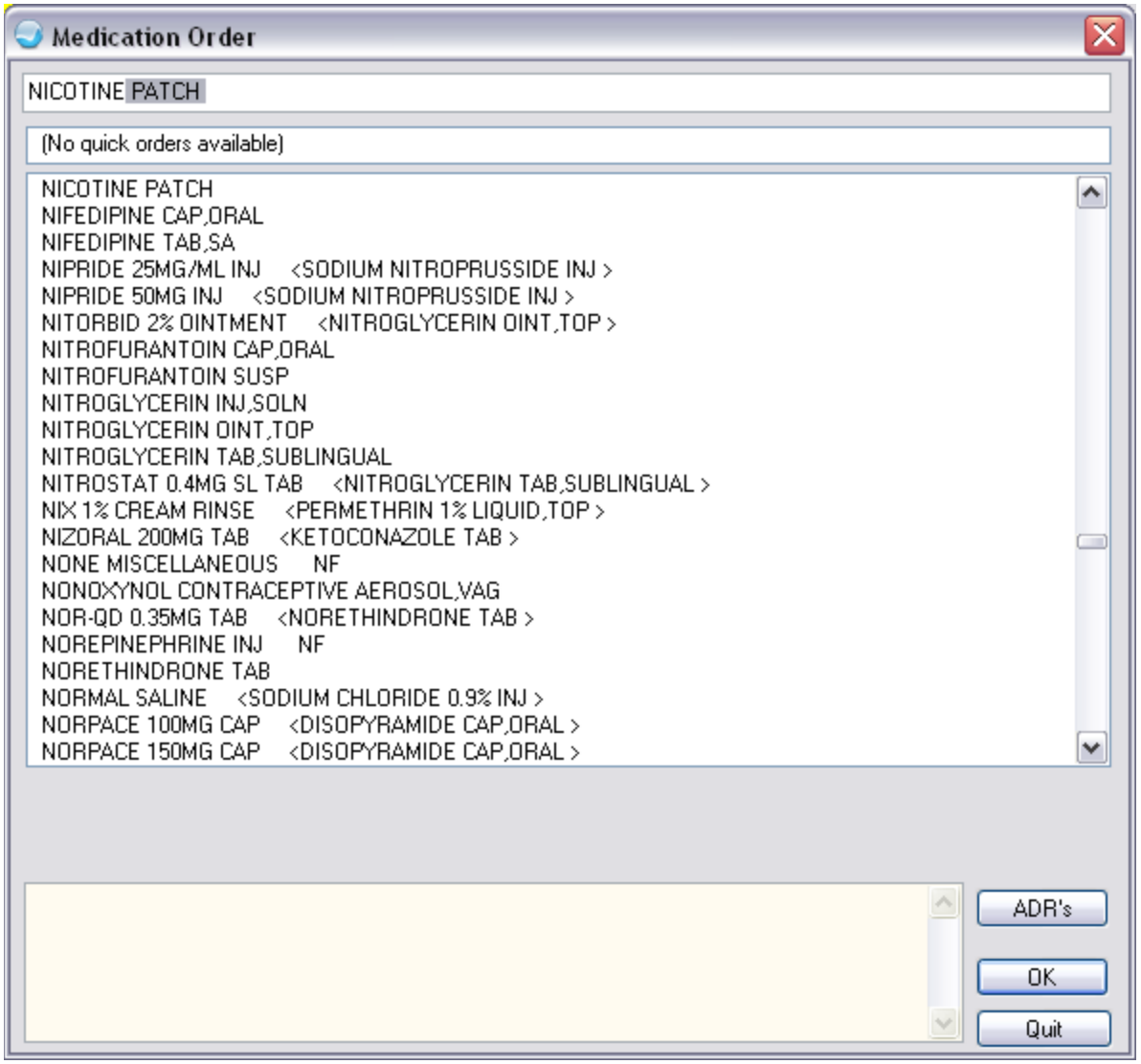

Figure 62: **Medication Order** dialog

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

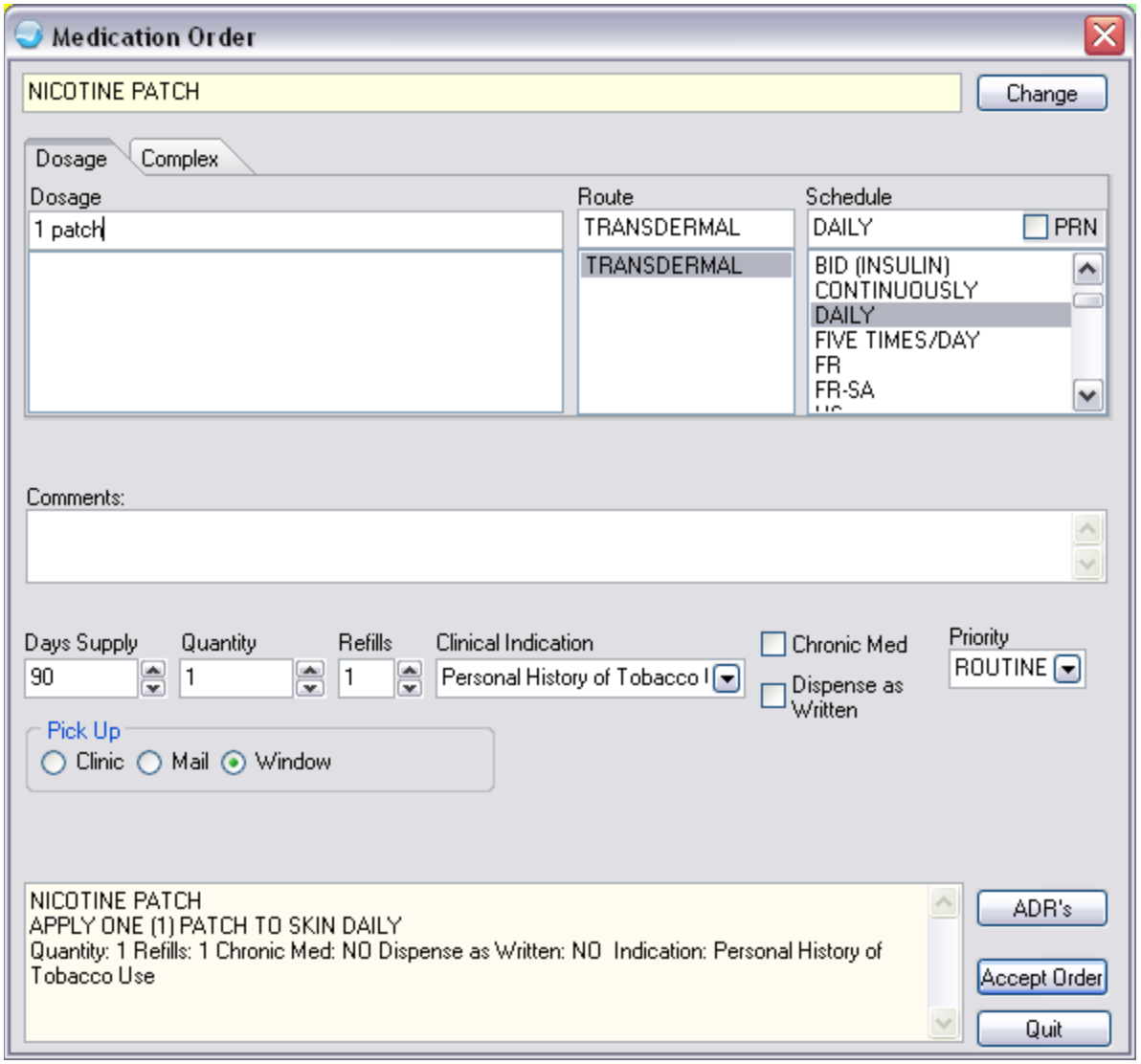

Figure 63: Entering additional medication information

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

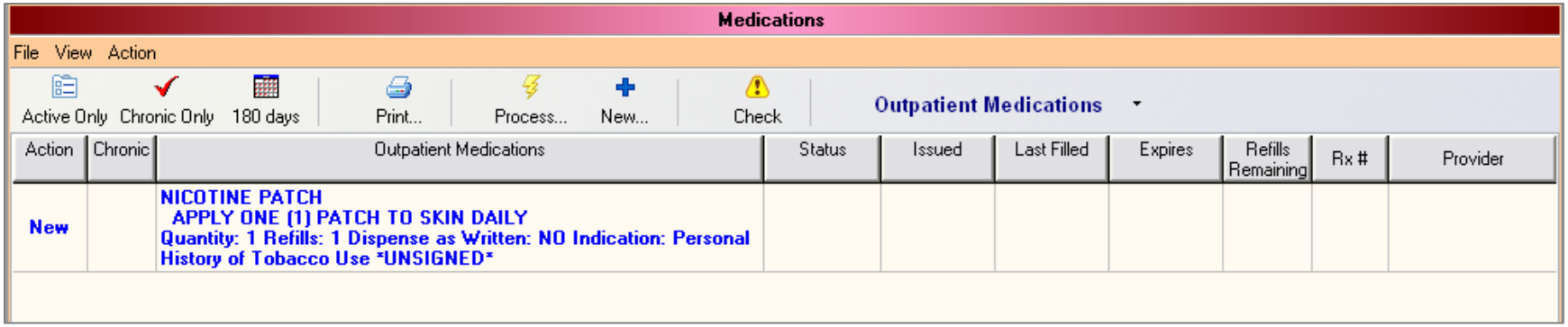

Figure 64: Example of a newly added medication

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).

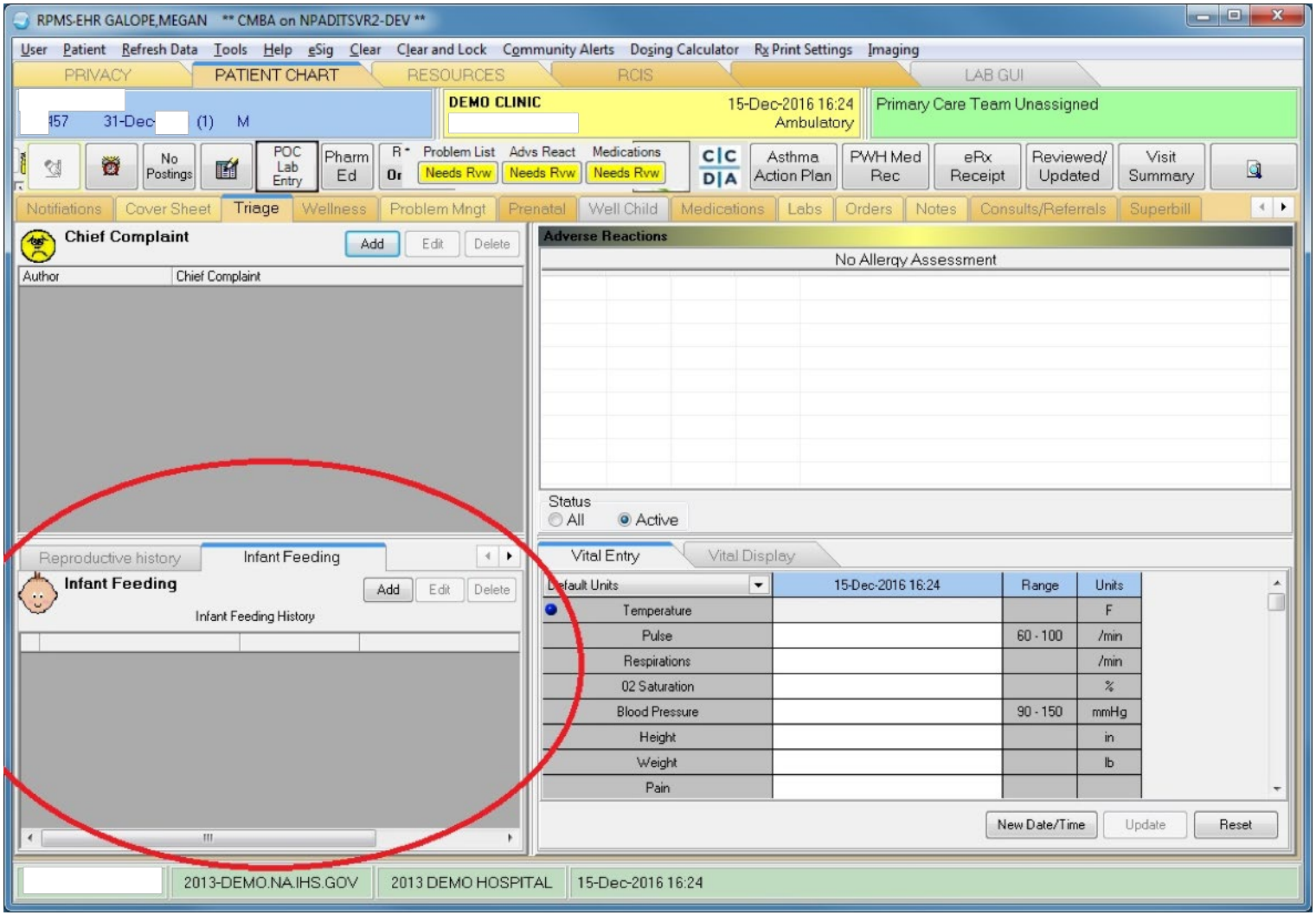

Figure 65: **Infant Feeding** component

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.

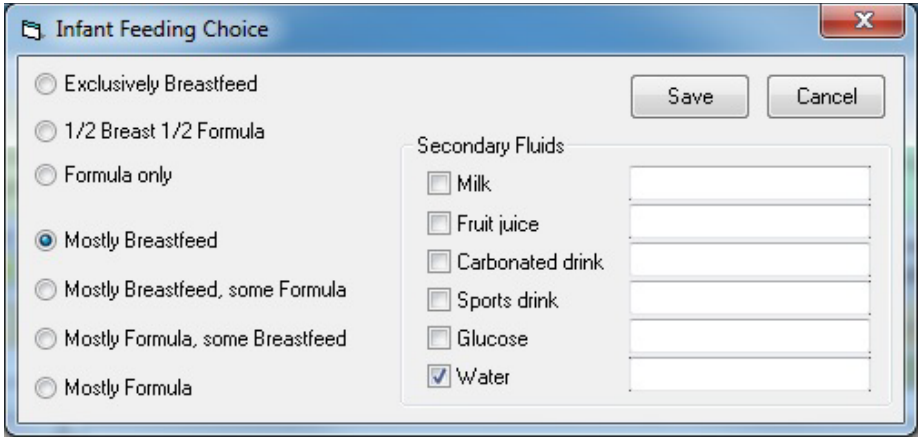

Figure 67: Selecting an Infant Feeding choice

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

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).

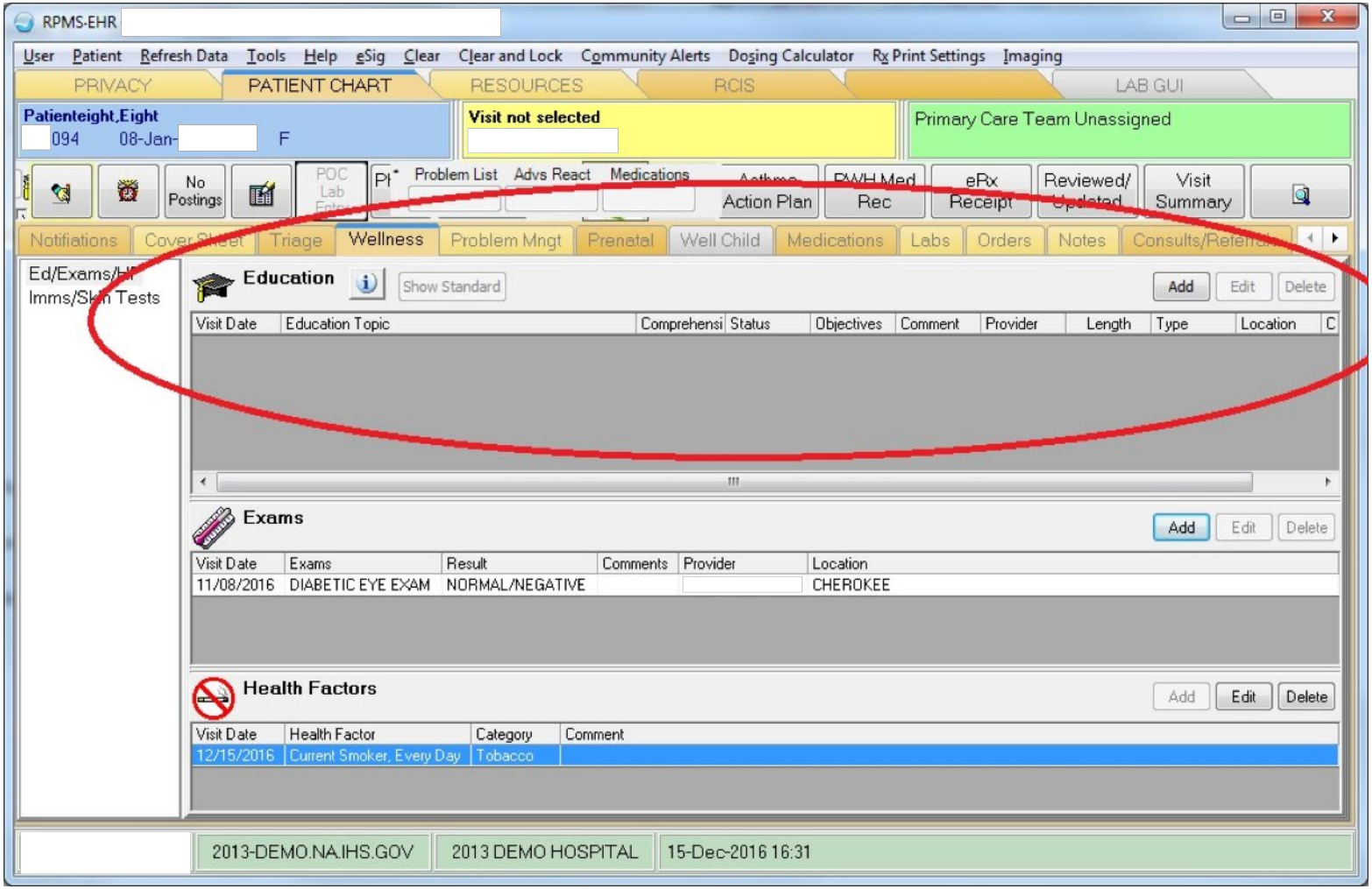

Figure 69: **Education** component

To enter Patient Education:

Figure 70: Entering Patient Education

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

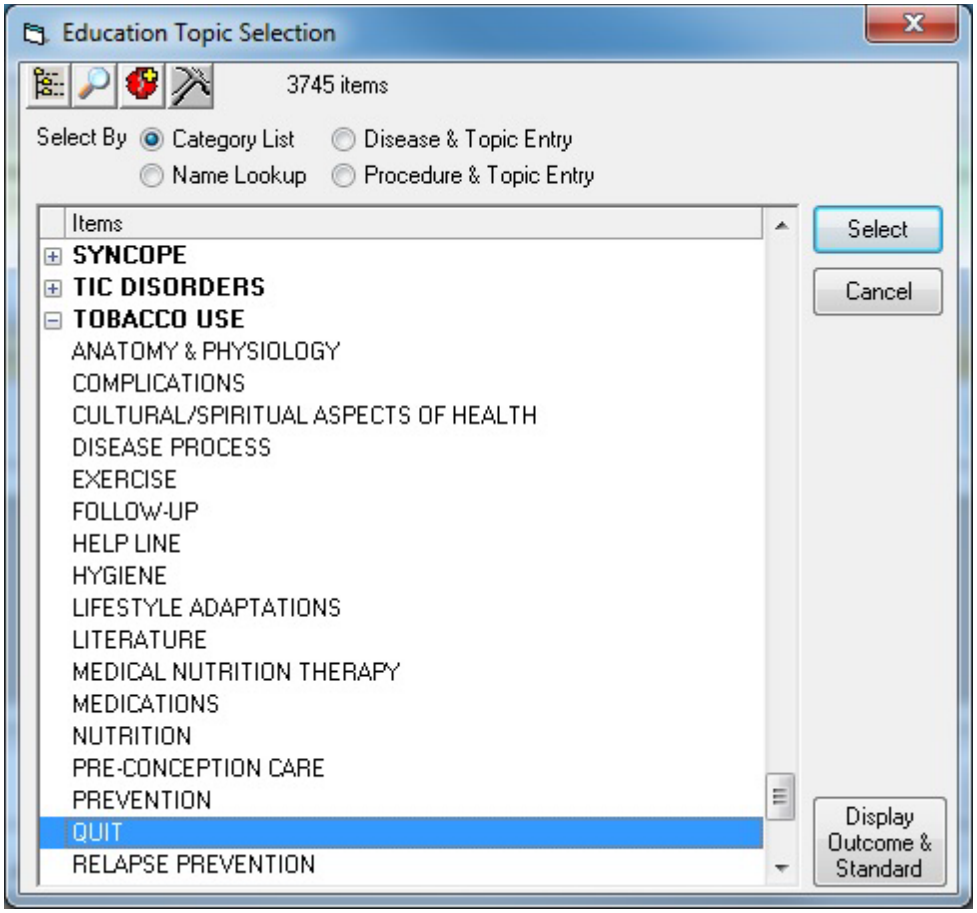

Figure 71: Selecting the education

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:

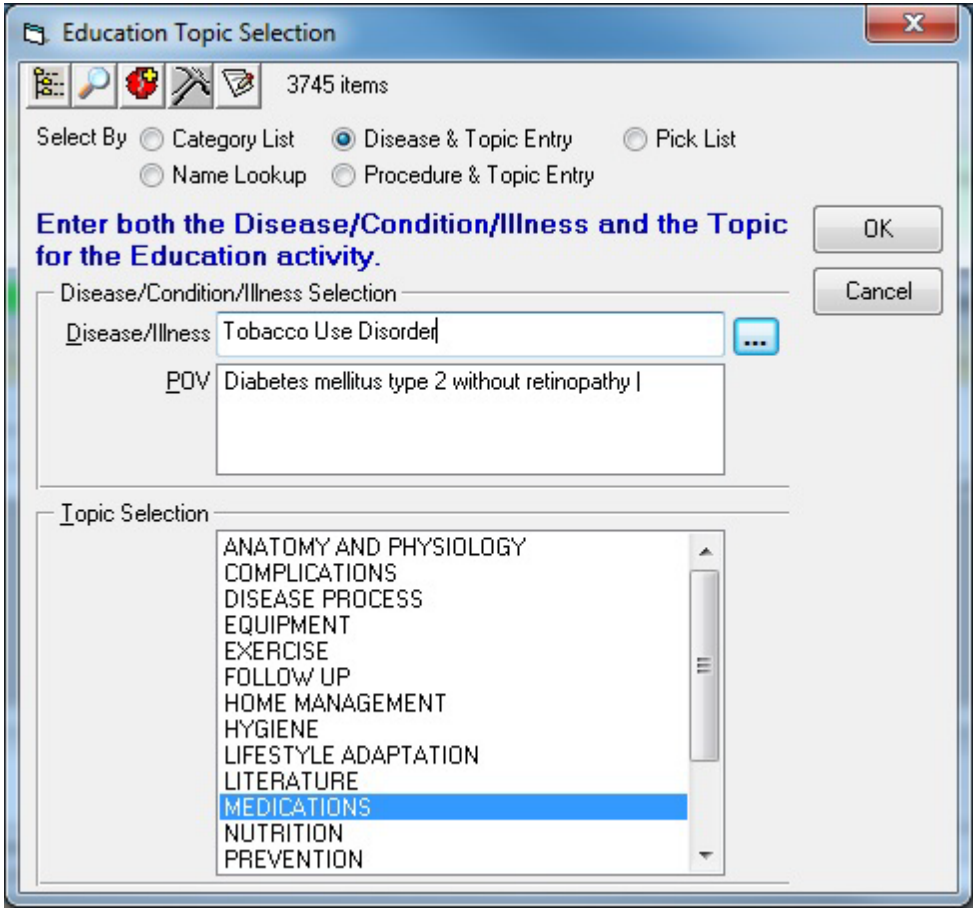

Figure 72: Entering Patient Education by disease

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

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

2. Select values for **Disease/Illness** and **Topic Selection**.
3. Click **OK**. The **Add Patient Education Event** dialog (Figure 73) displays.

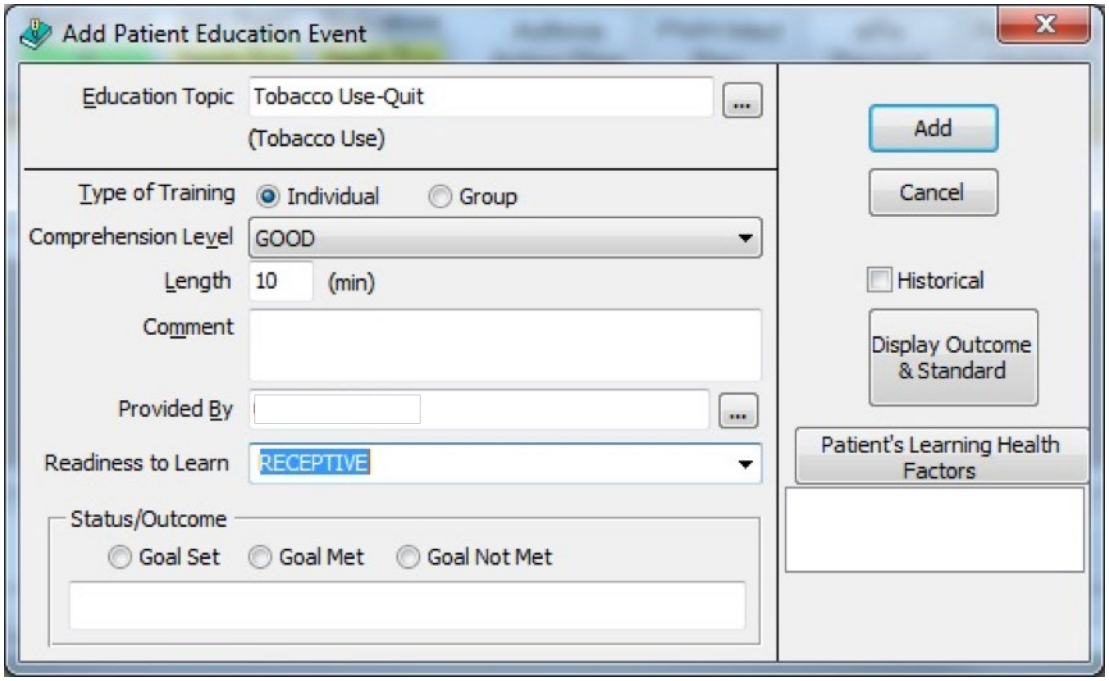

Figure 73: **Add Patient Education Event** dialog

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

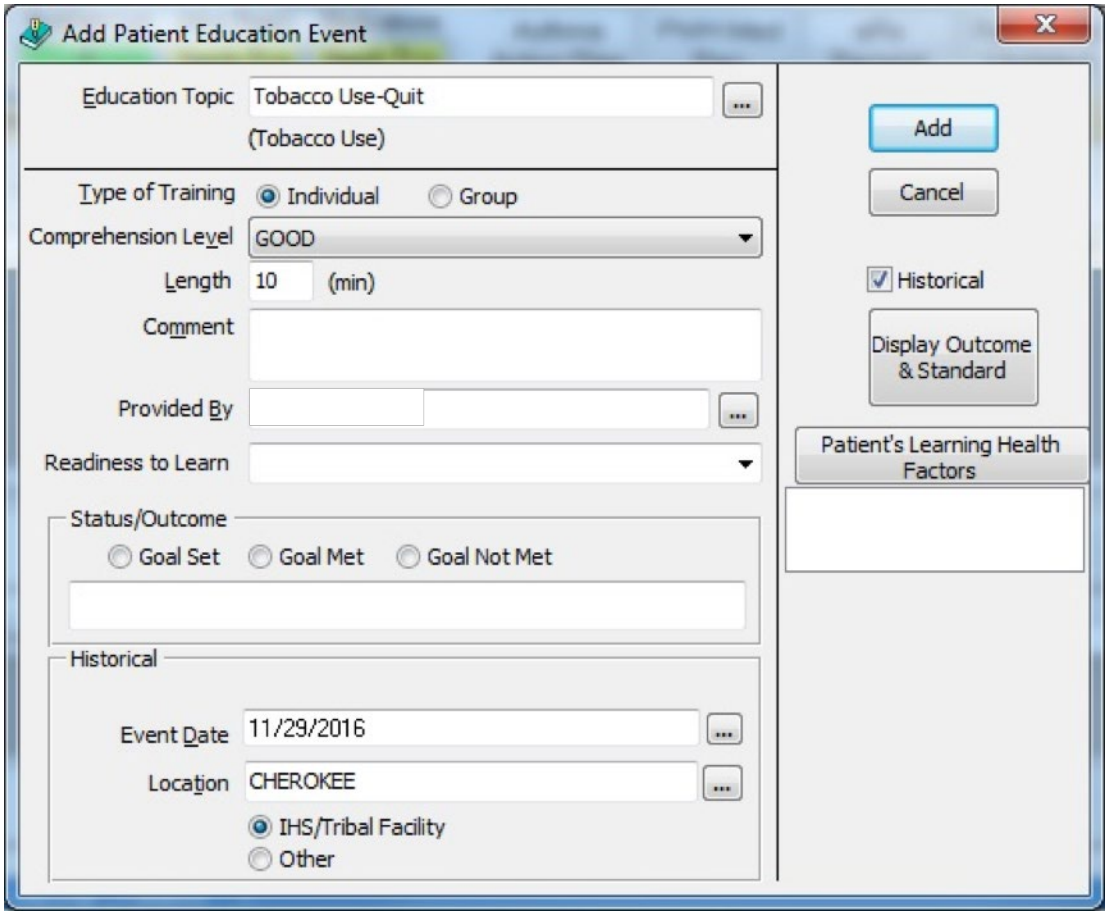

Figure 74: Entering historical education

5. If this is historical education:

   a. Select **Historical**.

   b. Type the **Event Date** and **Location** of the education.

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

Figure 75: Example of a newly added Patient Education

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

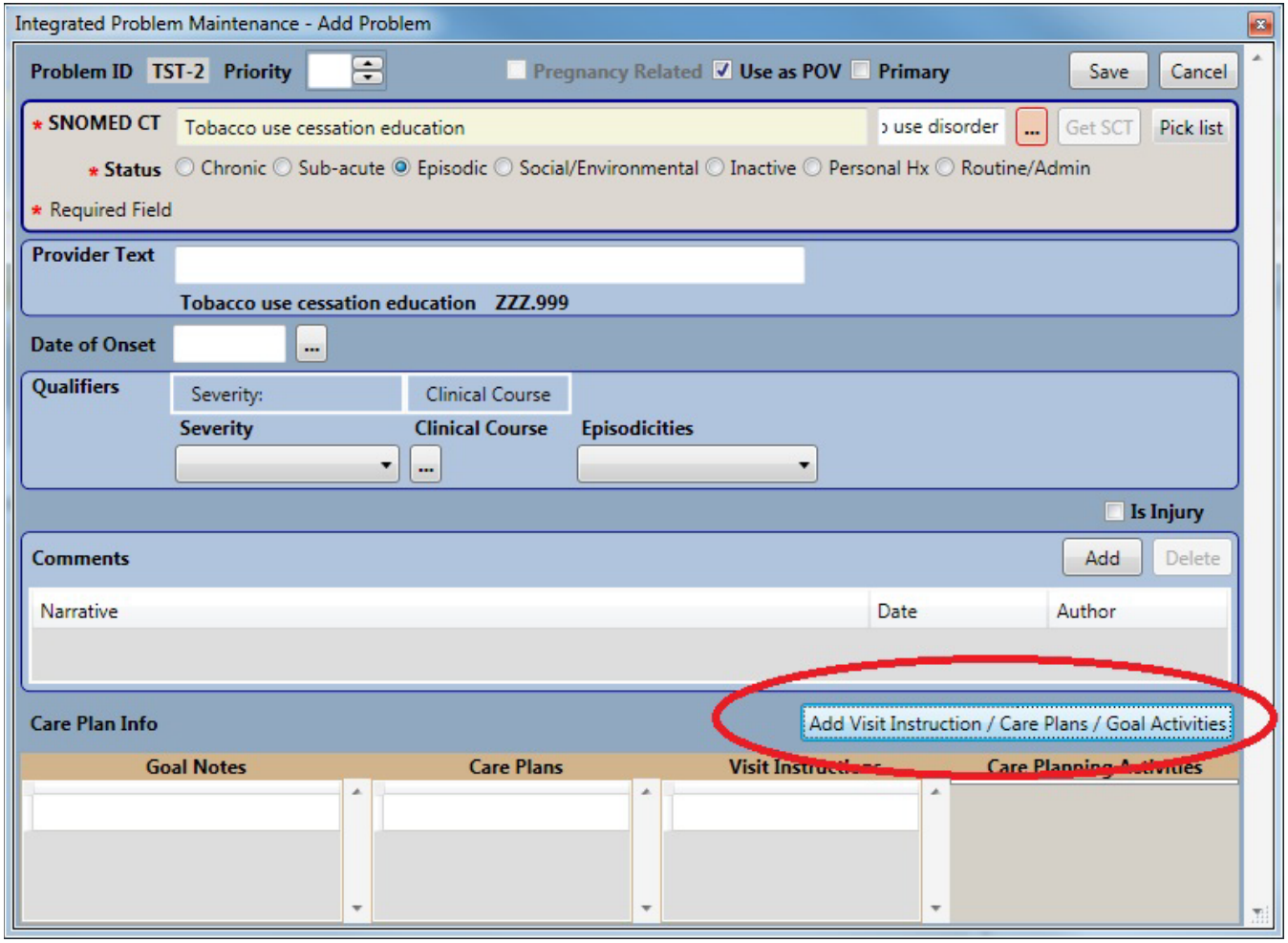

Figure 76: Entering the Patient Education

6. 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.

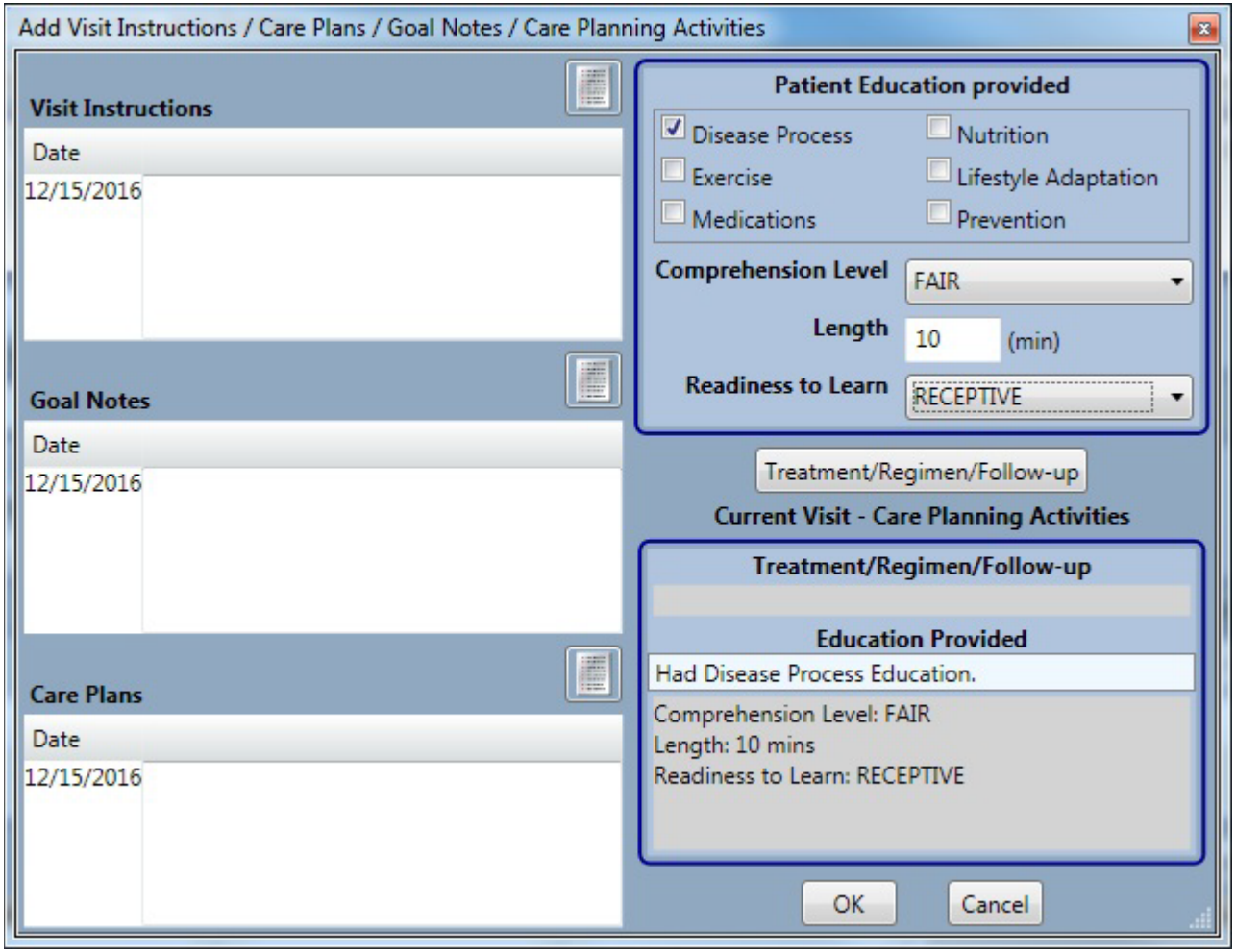

Figure 77: **Add Visit Instruction/Care Plans/Goal Activities** dialog

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

Refusals

Refusals are entered in the **Personal Health** component, located on the **Triage** tab (Figure 78).

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

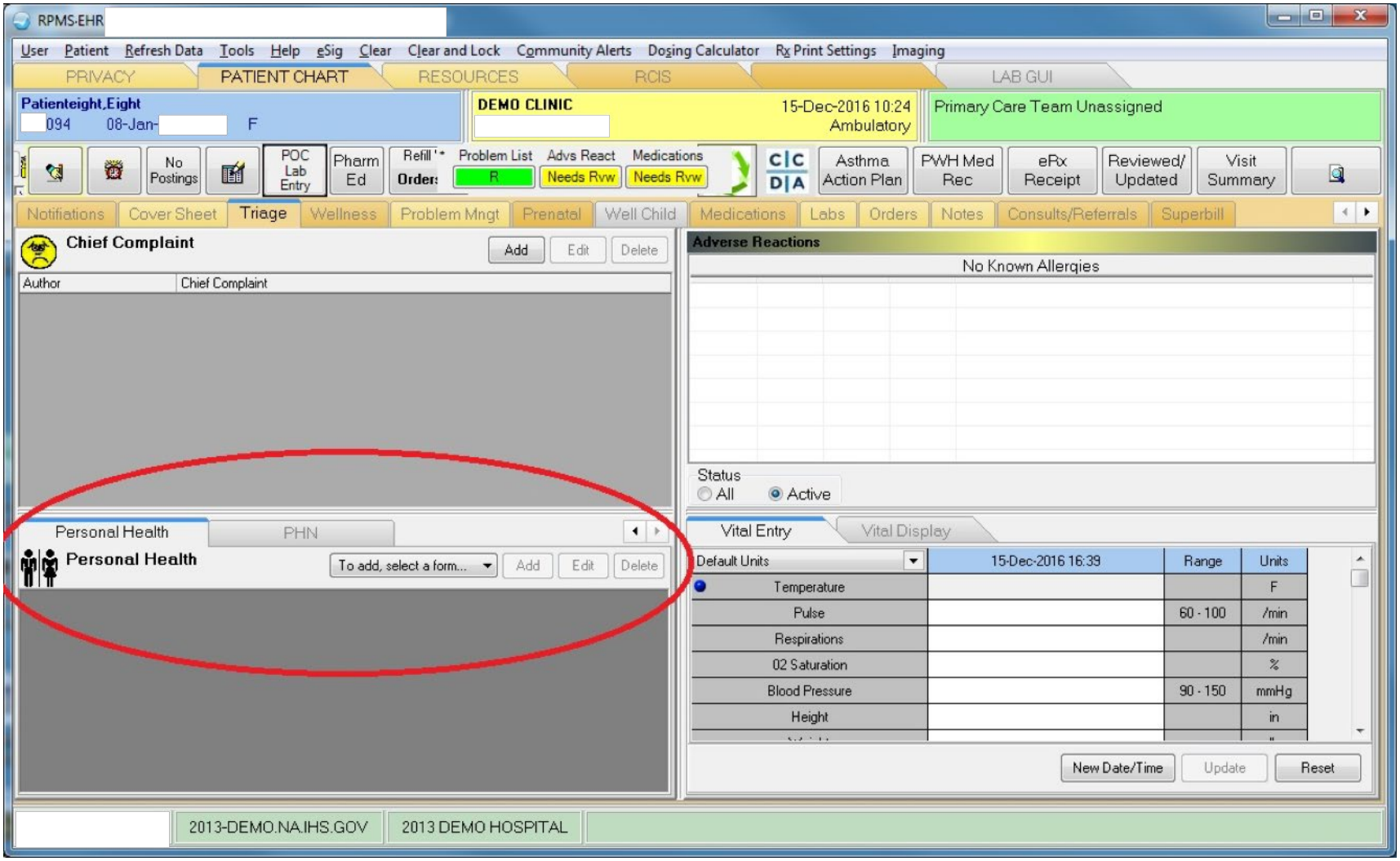

Figure 78: **Personal Health** component

To enter a Refusal:

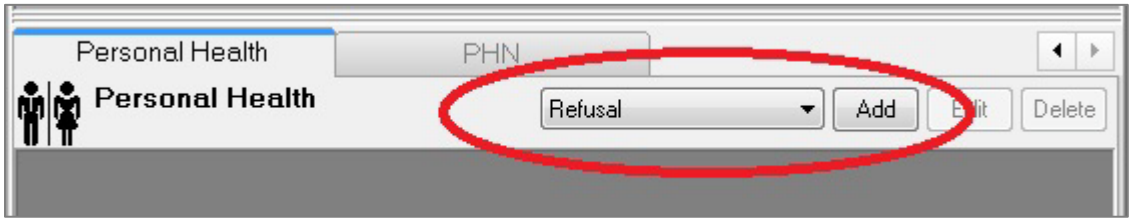

Figure 79: Entering a Refusal

1. Select **Refusal** from the drop-down list.
2. Click **Add**. The **Enter Service Not Provided/Refusal** dialog (Figure 80) displays.

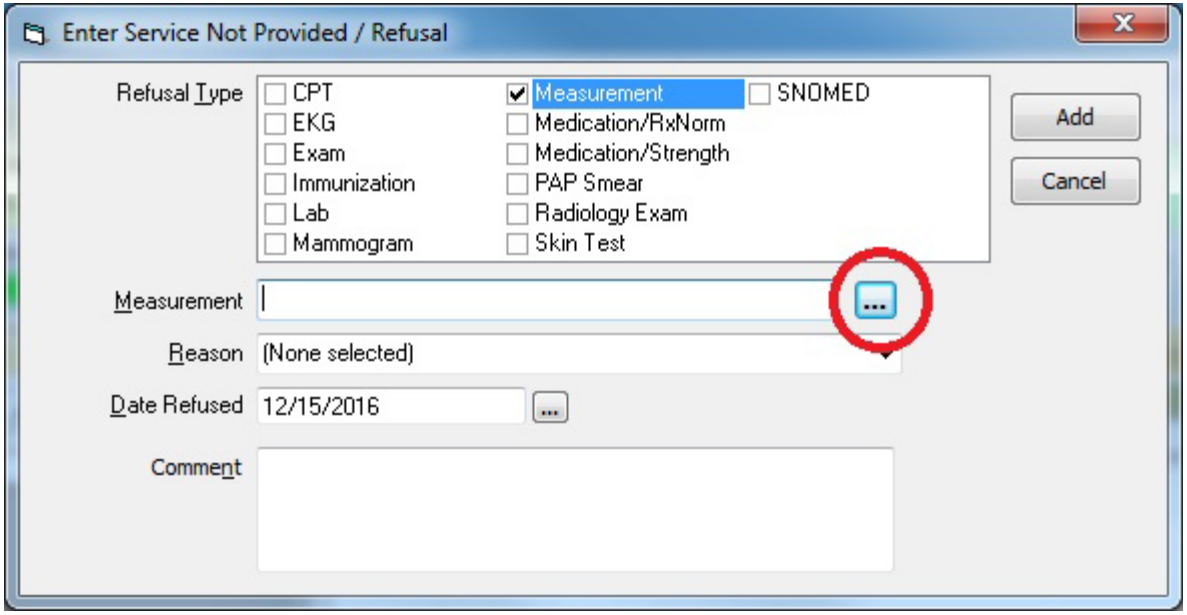

Figure 80: Selecting the Refusal Type

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

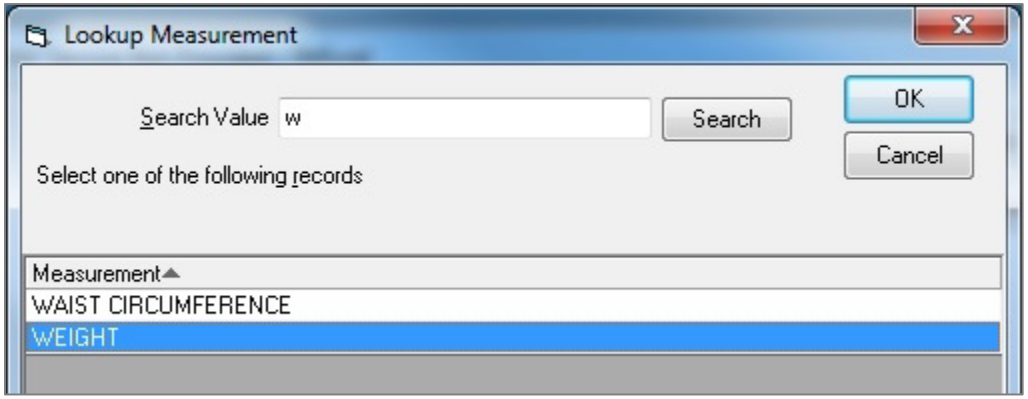

Figure 81: **Lookup Measurement** dialog

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 Service Not Provided/ Refusal** dialog (Figure 82) displays.

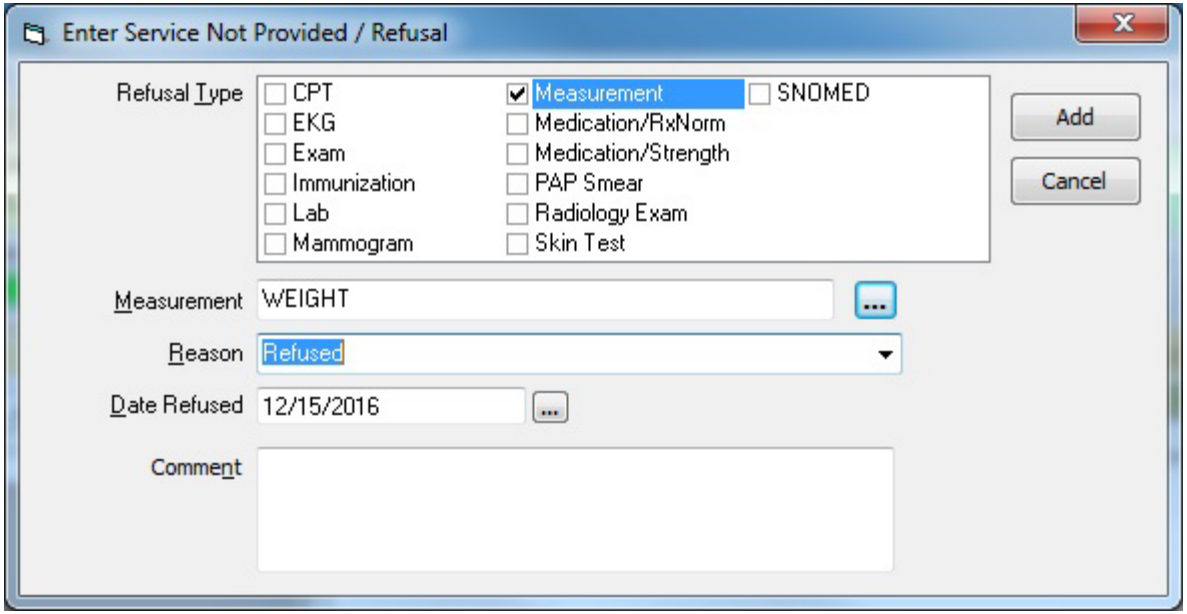

Figure 82: Entering a comment

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

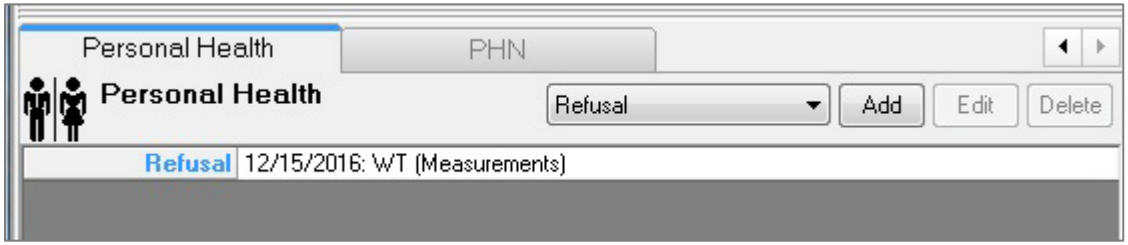

Figure 83: Example of a newly added Refusal

Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS IT Service Desk.

Phone: (888) 830-7280 (toll free)

Web: https://www.ihs.gov/itsupport/

Email: itsupport@ihs.gov