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/crsv20/GPRAMeasuresV200.pdf](https://www.ihs.gov/sites/crs/themes/responsive2017/display_objects/documents/crsv20/GPRAMeasuresV200.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

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<thead>
<tr>
<th>Performance Measure</th>
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</thead>
</table>
| Diabetes Prevalence                    | Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:  
**Note:** This is not a GPRA measure; however, it is used in determining patients that have been diagnosed with diabetes. |  
• Date received  
• Location  
• Results                                                                 | Diabetes Prevalence Diagnosis  
POV  
Visit Diagnosis Entry  
Purpose of Visit: ICD-10: E10.*-E13.*  
Provider Narrative:  
Modifier:  
Cause of DX: |
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</table>
| 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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<tbody>
<tr>
<td>Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes</td>
<td>Active Clinical Patients DX with diabetes age 40–75 with LDL = 70–189 mg/dL as the highest LDL in the past 3 years or age 21 and older with documented CVD or LDL greater than or equal to (≥) 190 or hypercholesterolemia who have statin therapy.</td>
<td>Standard EHR documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in EHR: • Date received • Location • Dosage</td>
<td>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&amp;Time: Ordering Provider: Statin Therapy CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 4013F Quantity: Modifier: Modifier 2:</td>
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<td>Provider Documentation</td>
<td>How to Enter Data in EHR</td>
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<td>Diabetes: Nephropathy Assessment</td>
<td>Active Clinical Patients DX with diabetes with a Nephropathy assessment:</td>
<td>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</td>
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<tr>
<td></td>
<td>• Estimated GFR with result during the Report Period</td>
<td>• Date received</td>
<td><strong>Estimated GFR Lab Test</strong></td>
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<td>• Urine Albumin-to-Creatinine Ratio during the Report Period</td>
<td>• Location</td>
<td><strong>Lab Test Entry</strong></td>
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<td>• End Stage Renal Disease diagnosis/treatment</td>
<td>• Results</td>
<td>Enter Lab Test Type: [Enter site’s defined Est GFR Lab Test]</td>
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<td>Collect Sample/Specimen: [Blood]</td>
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<td><strong>Clinical Indication:</strong></td>
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<td><strong>Urine Albumin-to-Creatinine Ratio CPT</strong></td>
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<td><strong>Visit Services Entry</strong> (includes historical CPTs)</td>
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<td>Enter CPT: 82043 AND 82570</td>
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<td><strong>ESRD CPT</strong></td>
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<td><strong>Visit Services Entry</strong> (includes historical CPTs)</td>
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<td>Enter CPT: 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300,</td>
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<td>50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90989,</td>
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<td>90993, 90997, 90999, 99512, 3066F, G0257, G9231, S2065 or S9339</td>
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<td>Modifier 2:</td>
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<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>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-10: 5A1D70Z, 5A1D80Z, 5A1D90Z</td>
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<td>Operating Provider:</td>
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<td>Diagnosis: [Enter appropriate DX]</td>
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<td>Diabetic Retinopathy</td>
<td>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).  <strong>Note:</strong> Refusals are not counted toward the GPRA measure but should still be documented.</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  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</td>
<td><strong>Diabetic Retinopathy Exam</strong>  <strong>Exam Entry</strong> (includes historical exams)  Select Exam: 03  Result: [Enter Results]  Comments:  Provider Performing Exam:  <strong>Retinal Exam CPT</strong>  <strong>Visit Services Entry</strong> (includes historical CPTs)  Enter CPT: 2021F, 2022F, 2024F, 2026F, S0620, S0621, S3000  Quantity:  Modifier:  Modifier 2:  <strong>Other Eye Exam CPT</strong>  <strong>Visit Services Entry</strong> (includes historical CPTs)  Enter CPT: 67028, 67039, 67040, 92002, 92004, 92012, 92014, 92018, 92019  Quantity:  Modifier:  Modifier 2:  <strong>Other Eye Exam Clinic</strong>  <strong>Clinic Entry</strong>  Clinic: A2, 17, 18, 64</td>
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| Access to Dental Service     | Patients should have annual dental exams.                                 | 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: D0110-D0390, D0415-D9952, D9970-D9974, D9999  
  Quantity:  
  Modifier:  
  Modifier 2:  
  **Dental Exam 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.                  | 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: |
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| 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: |
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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, 168, 171, 185, 186 (other options are 111, 15, 16, 88) Lot:  
**VFC Eligibility:**  
**Influenza Vaccine CPT**  
**Visit Services Entry** (includes historical CPTs)  
Enter CPT: 90630, 90654-90662, 90672-90674, 90682, 90685-90688, 90756, G0008  
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 |
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<tbody>
<tr>
<td>Adult Immunizations</td>
<td>All adults ages 19 and older will have age appropriate vaccines.</td>
<td>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</td>
<td><strong>Adult Immunizations</strong>&lt;br&gt;Immunization Entry (includes historical immunizations)&lt;br&gt;Select Immunization Name: Tdap: 115; Td: 9, 113, 138, 139, 196; Zostavax: 121; Shingrix: 187; PPSV23: 33, 109&lt;br&gt;Lot:&lt;br&gt;VFC Eligibility: <strong>Adult Immunizations CPT</strong>&lt;br&gt;Visit Services Entry (includes historical CPTs)&lt;br&gt;Enter CPT: Tdap: 90715; Td: 90714, 90718; Zostavax: 90736; Shingrix: 90750; PPSV23: 90732, G0009, G9279&lt;br&gt;Quantity:&lt;br&gt;Modifier:&lt;br&gt;Modifier 2: <strong>NMI Refusal of Adult Immunizations</strong>&lt;br&gt;NMI Refusals can only be entered in EHR via Reminder Dialogs.&lt;br&gt;<strong>Contraindication Adult Immunizations</strong>&lt;br&gt;Immunization Entry - Contraindications&lt;br&gt;Vaccine: [See codes above]&lt;br&gt;Reason: [See Contraindications section under the Provider Documentation column]</td>
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<td>– Ages 19–49: 1 Tdap/Td in the past 10 years, 1 Tdap ever</td>
<td>• IZ type&lt;br&gt;• Date received&lt;br&gt;• Location&lt;br&gt;Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include:&lt;br&gt;Immunization Package of &quot;Immune Deficiency&quot; or &quot;Anaphylaxis&quot;&lt;br&gt;NMI Refusal</td>
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<td>– Ages 50–64: 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 Zostavax in the past 5 years or 2 doses of Shingrix ever</td>
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<td>– Ages 65+: 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 Zostavax in the past 5 years or 2 doses of Shingrix ever, 1 up-to-date Pneumococcal Polysaccharide vaccine (PPSV23)</td>
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<td>Refusals should be documented. <strong>Note:</strong> Only NMI refusals are counted toward the GPRA Measure.</td>
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<td>Performance Measure</td>
<td>Standard</td>
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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 Hepatitis B 3 or 4 Hib 1 Varicella 4 Pneumococcal | 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, 110, 120, 130, 146; DTP: 1, 22, 102; 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; HIB: 17, 22, 46-49, 50, 51, 102, 120, 146, 148; Varicella: 21, 94; Pneumococcal: 33, 100, 109, 133, 152  
Lot:  
VFC Eligibility: |
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<td>Childhood Immunizations (cont.)</td>
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<td>Dosage and types of immunization definitions:</td>
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<td></td>
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<td>4 doses of DTaP:</td>
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<td>• 4 DTaP/DTP/Tdap</td>
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<td>• 1 DTaP/DTP/Tdap and 3 DT/Td</td>
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<td>• 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus</td>
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<td>• 4 DT and 4 Acellular Pertussis</td>
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<td>• 4 Td and 4 Acellular Pertussis</td>
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<td>• 4 each of Diphtheria, Tetanus, and Acellular Pertussis</td>
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<td>3 doses of IPV:</td>
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<td>• 3 OPV</td>
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<td>• 3 IPV</td>
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<td>• Combination of OPV and IPV totaling three doses</td>
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<td>1 dose of MMR:</td>
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<td>• MMR</td>
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<td>• 1 M/R and 1 Mumps</td>
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<td>• 1 R/M and 1 Measles</td>
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<td>• 1 each of Measles, Mumps, and Rubella</td>
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<td>3 doses of Hepatitis B</td>
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<td>• 3 doses of Hep B</td>
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<td>3 or 4 doses of HIB, depending on the vaccine administered</td>
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<td>1 dose of Varicella</td>
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<td>4 doses of Pneumococcal</td>
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<td>Evidence of Disease POV</td>
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<td>Childhood Immunizations (cont.)</td>
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<td>90721, 90723; DTP: 90701, 90720;</td>
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<td>Tdap: 90715; DT: 90702; Td: 90714,</td>
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<td>90718; Diptheria: 90719; Tetanus: 90703;</td>
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<td>Measles: 90705; Mumps: 90704; Rubella:</td>
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<td>90706; Hepatitis B: 90636, 90697,</td>
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<td>90723, 90740, 90743-90748, G0010;</td>
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<td>90720-90721, 90748; Varicella: 90710,</td>
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<td>90732, G0009, G9279</td>
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<tr>
<td><strong>NMI Refusal of Childhood Immunizations</strong></td>
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<tr>
<td>NMI Refusals can only be entered in</td>
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<td>EHR via Reminder Dialogs.</td>
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<td><strong>Contraindication Childhood Immunizations</strong></td>
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<td>Immunization Entry - Contraindications</td>
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<td>Vaccine: [See codes above]</td>
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<td>Reason: [See Contraindications section under the Provider Documentation column]</td>
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</table>
| Cancer Screening: Pap Smear Rates | 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. | 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: |
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<th>Provider Documentation</th>
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<td>Cancer Screening: Pap Smear Rates (cont.)</td>
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<td>HPV POV</td>
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<td><strong>Visit Diagnosis Entry</strong></td>
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<td>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</td>
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<td>Provider Narrative:</td>
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<td>Cause of DX:</td>
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<td><strong>HPV CPT</strong></td>
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<td><strong>Visit Services Entry</strong> (includes historical CPTs)</td>
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<td>Enter CPT: 87623-87625, G0476</td>
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</table>
| 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, 77065-77067, G0206; G0204, G0202  
Quantity:  
Modifier:  
Modifier 2:  
**Mammogram Procedure**  
**Procedure Entry**  
Operation/Procedure: ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ  
Provider Narrative:  
Operating Provider:  
Diagnosis: [Enter appropriate DX] |
<table>
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<th>How to Enter Data in EHR</th>
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</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) • 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: |
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<tr>
<td>Colorectal Cancer Screening (cont.)</td>
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</table>

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:
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<td><strong>Colon Screening CPT</strong></td>
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<td><strong>Visit Services Entry</strong> (includes historical CPTs)</td>
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<td>Enter CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398, G0105, G0121, G9252, G9253</td>
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<tr>
<td>Colon Screening Procedure</td>
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<td><strong>Colon Screening Procedure</strong></td>
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<td>Procedure Entry</td>
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<td>Operation/Procedure: 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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</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–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:
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<td><strong>Smokers Health Factor</strong></td>
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<td><strong>Health Factor Entry</strong></td>
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<td>Select V Health Factor: Current Smoker (every day, some day, or status unknown)</td>
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<td>Level/Severity:</td>
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<td>Quantity:</td>
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<td><strong>Smokeless Health Factor</strong></td>
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<td><strong>Health Factor Entry</strong></td>
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<td>Select V Health Factor: Current Smokeless</td>
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<td>Level/Severity:</td>
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<td><strong>E-Cigarette User Health Factor</strong></td>
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<td><strong>Health Factor Entry</strong></td>
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<td>Select V Health Factor: Current E-cigarette user w/nicotine, Current E-cigarette user w/other substance(s)</td>
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<td><strong>ETS Health Factor</strong></td>
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<td>Select V Health Factor: Exp to ETS</td>
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| 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  
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–Current E-cig user w/other substance(s)  
- 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                                                                                                                                                                                                                                         |
### Tobacco Cessation (cont.)

**Provider Documentation**

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.”

### How to Enter Data in EHR

**Tobacco Cessation PED–Diagnosis**

**Patient Education Entry** (includes historical patient education)

- Select ICD Diagnosis Code Number: 649.00-649.04 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, G8402, G8453, G9016
- 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:
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<td>Tobacco Cessation Clinic</td>
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<td>Clinic Entry</td>
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<td>Clinic: 94</td>
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<td>Tobacco Cessation Dental (ADA)</td>
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<td>ADA codes cannot be entered into EHR.</td>
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<td>Tobacco Cessation CPT</td>
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<td>Visit Services Entry</td>
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<td>(includes historical CPTs)</td>
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<td></td>
<td>Enter CPT Code: D1320, 99406, 99407, 4000F</td>
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<td>Tobacco Cessation Medication</td>
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<td>Medication Entry</td>
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<td>Select Medication: [Enter Tobacco Cessation Prescribed Medication]</td>
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<td>Outside Drug Name (Optional): [Enter any additional name for the drug]</td>
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<td>Event Date&amp;Time:</td>
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<td>Tobacco Cessation (cont.)</td>
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<td>Tobacco Cessation Prescription CPT</td>
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<td>Visit Services Entry (includes historical CPTs)</td>
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<td>Enter CPT Code: 4001F</td>
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<td>Quit Tobacco Health Factor</td>
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<td>Health Factor Entry</td>
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<td>Select V Health Factor: Former Smoker, Former Smokeless, Former E-cigarette user</td>
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<td>Level/Severity:</td>
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| Alcohol Screening   | Adult 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 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: |
### Key Clinical Performance Objectives

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| 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 CPT**  
Visit Services Entry (includes historical CPTs)  
Enter CPT Code: 99408, 99409, G0396, G0397, G0442, G2011, H0049, H0050  
Quantity  
Modifier:  
Modifier 2:  
**Alcohol-Related Diagnosis POV**  
Visit Diagnosis Entry  
Provider Narrative:  
Modifier:  
Cause of DX: |
| | | • 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? |  |
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| 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-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)]  
<p>|                              |          | Goal Comment:  |</p>
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<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 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:</td>
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<td>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</td>
<td>Alcohol-Related PED - CPT Patient Education Entry (includes historical patient education) Select CPT Code Number: 99408, 99409, G0396, G0397, G0442, G2011, 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 text relating to the goal)] Goal Comment: Provider's Narrative:</td>
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<td>Performance Measure (cont.)</td>
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<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). • 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 &quot;high&quot; 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.</td>
<td>Alcohol Screen AUDIT Measurement <strong>Vital Measurements Entry</strong> (includes historical Vitals) Value: [Enter 0–40] Select Qualifier: Date/Time Vitals Taken: Alcohol Screen AUDIT-C Measurement <strong>Vital Measurements Entry</strong> (includes historical Vitals) Value: [Enter 0–40] Select Qualifier: Date/Time Vitals Taken: Alcohol Screen CRAFFT Measurement <strong>Vital Measurements Entry</strong> (includes historical Vitals) Value: [Enter 0–6] Select Qualifier: Date/Time Vitals Taken:</td>
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| 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, 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: |
### 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.

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</table>
| 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: |
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</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: 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: |
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<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) <strong>Note:</strong> Refusals are <em>not</em> 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  - <strong>Normal/Negative</strong>—Denies symptoms of depression  - <strong>Abnormal/Positive</strong>—Further evaluation indicated  - <strong>Refused</strong>—Patient declined exam/screen  - <strong>Unable to screen</strong>—Provider unable to screen <strong>Note:</strong> 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 <strong>Note:</strong> Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</td>
<td><strong>Depression Screening Exam</strong>  <strong>Exam Entry</strong> (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: <strong>Depression Screening CPT</strong>  <strong>Visit Services Entry</strong> (includes historical CPTs)  - Enter CPT Code: 1220F, 3725F, G0444  - Quantity  - Modifier: Modifier 2:</td>
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| 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  
Provider Narrative:  
Modifier:  
Cause of DX: |
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<td>Depression Screening</td>
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<td>Provider should Note the screening tool used was the PHQ-2 Scaled at the Comment Mnemonic for the Exam Code. PHQ9 Questionnaire Screening Tool</td>
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<td>Little interest or pleasure in doing things?</td>
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<td></td>
<td></td>
<td>- Not at all Value: 0</td>
<td>How to Enter Data in EHR</td>
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<td>- Several days Value: 1</td>
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<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>Feeling down, depressed, or hopeless?</td>
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<td>- Not at all Value: 0</td>
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<td>- Several days Value: 1</td>
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<td>- More than half the days Value: 2</td>
<td>How to Enter Data in EHR</td>
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<td>- Nearly every day Value: 3</td>
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<td>Trouble falling or staying asleep, or sleeping too much?</td>
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<td>- Not at all Value: 0</td>
<td>How to Enter Data in EHR</td>
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<tr>
<td>- Several days Value: 1</td>
<td>How to Enter Data in EHR</td>
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<td>- More than half the days Value: 2</td>
<td>How to Enter Data in EHR</td>
<td>How to Enter Data in EHR</td>
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<td>- Nearly every day Value: 3</td>
<td>How to Enter Data in EHR</td>
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<td>Feeling tired or having little energy?</td>
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<td>- Not at all Value: 0</td>
<td>How to Enter Data in EHR</td>
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<tr>
<td>- Several days Value: 1</td>
<td>How to Enter Data in EHR</td>
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<td>- More than half the days Value: 2</td>
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<tr>
<td>- Nearly every day Value: 3</td>
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<tr>
<td>Depression Screening (cont.)</td>
<td>Poor appetite or overeating?</td>
<td>• Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3</td>
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<td>Feeling bad about yourself—or that you are a failure or have let yourself or your family down?</td>
<td>• Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3</td>
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<td>Trouble concentrating on things, such as reading the newspaper or watching television?</td>
<td>• Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3</td>
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<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>• Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3</td>
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<td>Depression Screening (cont.)</td>
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<td>Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
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<td></td>
<td></td>
<td>• Not at all Value: 0</td>
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<td></td>
<td></td>
<td>• Several days Value: 1</td>
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<td></td>
<td>• More than half the days Value: 2</td>
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<td></td>
<td>• Nearly every day Value: 3</td>
<td></td>
</tr>
<tr>
<td>PHQ9 Questionnaire (Continued)</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>
<tr>
<td>Performance Measure</td>
<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>
</tbody>
</table>
| 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>
<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 (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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>**</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>**</td>
<td>Ages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2–2</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3–3</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4–4</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5–5</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></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 | **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: |
<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 with diabetes with LDL = 70–189 mg/dL as the highest LDL in the past 3 years or age 21 and older with documented CVD or 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: |
<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: 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, 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  
Mostly Breastfeeding, Some Formula  
1/2 & 1/2 Breast and Formula  
Mostly Formula  
Mostly Formula, Some Breastfeeding  
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.
<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)</td>
<td>N/A</td>
<td>All providers should document all 5 patient education elements and elements #6–7 if a goal was set for the patient:</td>
<td>Patient Education Topic</td>
</tr>
</tbody>
</table>
| 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. | | 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 | Patient Education Entry (includes historical patient education) |
| Readiness to Learn: | | • Distraction  
• Eager To Learn  
• Intoxication  
• Not Ready  
• Pain  
• Receptive  
• Severity of Illness  
• Unreceptive | Topic: [Enter Topic]  
Readiness to Learn: D, E, I, N, P, R, S, U  
Level of Understanding: P, F, G, GR, R  
Provider: |
| Levels of Understanding: | | • P–Poor  
• F–Fair  
• G–Good  
• GR–Group-No Assessment  
• R–Refused | Length of Education (minutes):  
Comment:  
Goal Code: GS, GM, GNM, GNS  
Goal Comment: |
| Goal Codes: | | • GS–Goal Set  
• GM–Goal Met  
• GNM–Goal Not Met  
• GNS–Goal Not Set | Provider’s Narrative: |
<p>| Patient Education Diagnosis | | | |
| Patient Education Entry (includes historical patient education) | | | |
| Select ICD Diagnosis Code Number: | | | |
| Category: [Enter Category] | | | |
| Readiness to Learn: D, E, I, N, P, R, S, U | | | |
| Level of Understanding: P, F, G, GR, R | | | |
| Provider: | | | |
| Length of Education (Minutes): | | | |
| Comment: | | | |
| Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] | | | |
| Goal Comment: | | | |
| Provider’s Narrative: | | | |</p>
<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>
| 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:

- **Clinic Codes**: Page 47.
- **Purpose of Visit/Diagnosis**: Page 47.
- **CPT Codes**: Page 53.
- **Procedure Codes**: Page 60.
- **Exams**: Page 64.
- **Health Factors**: Page 68.
- **Immunizations**: Page 71, including contraindications: Page 76.
- **Vital Measurements**: Page 79.
- **Lab Tests**: Page 83.
- **Medications**: Page 89.
- **Infant Feeding**: Page 95.
- **Patient Education**: Page 97.
- **Refusals**: Page 104.

**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.

![Choosing a clinic code](image)

**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:

Figure 3: Entering a POV
1. Click **Add** on the **Problem Mgmt** tab. The **Integrated Problem Maintenance – Add Problem** dialog (Figure 4) displays.

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

**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).

![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).

Figure 8: **Visit Services** component
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 the CPT button is chosen in the Lookup Option.
   b. Select additional Included Code Sets.
Key Clinical Performance Objectives

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

![Add Procedure for Current Visit](image)

Figure 12: Entering additional Procedure information

![Visit Services](image)

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:

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:
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](image-url)
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.
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 display in the Visit Services component (Figure 24).
Exams

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

![Figure 25: Exams component](image-url)
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).
Figure 30: Example of a newly added Exam

<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></td>
<td>CHEROKEE</td>
</tr>
</tbody>
</table>
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).
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-url)
To enter 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 display 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).

![Enter Patient Contraindication dialog](image)

**Figure 44: Enter Patient Contraindication dialog**

![Immunization Record component](image)

**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).

![Vitals component](image-url)
To enter Vital Measurements:

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 49) 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.
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:

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

![Figure 61: Entering a patient medication](image-url)
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 choices are entered in the **Infant Feeding** component, located on the **Triage** tab (Figure 65).
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).

![Education component](image-url)
To enter Patient Education:

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

![Education Topic Selection](image)

**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:

![Education Topic Selection](image)

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.
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.

![Education component](image)

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

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

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

*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.

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

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.
To enter a Refusal:

1. Select **Refusal** from the drop-down list.

2. Click **Add**. The **Enter Service Not Provided/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 Service Not Provided/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](image)

Figure 83: Example of a newly added Refusal