

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: <ul style="list-style-type: none"> • Date received • Location • Results 	Diabetes Prevalence Diagnosis POV Visit Diagnosis Entry Purpose of Visit: ICD-10: E10.*-E13.* Provider Narrative: Modifier: Cause of DX:

Key Clinical Performance Objectives

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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes</p>	<p>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.</p>	<p>Standard EHR documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Dosage 	<p>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:</p> <p>Statin Therapy CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 4013F Quantity: Modifier: Modifier 2:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Diabetes: Nephropathy Assessment</p>	<p>User Population Patients DX with diabetes with a Nephropathy assessment:</p> <ul style="list-style-type: none"> • Estimated GFR with result during the Report Period • Urine Albumin-to-Creatinine Ratio during the Report Period • End Stage Renal Disease diagnosis/treatment 	<p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Estimated GFR Lab Test Lab Test Entry Enter Lab Test Type: [Enter site's defined Est GFR Lab Test] Collect Sample/Specimen: [Blood] Clinical Indication: Urine Albumin-to-Creatinine Ratio CPT Visit Services Entry (includes historical CPTs) Enter CPT: 82043 AND 82570 Quantity: Modifier: Modifier 2: ESRD CPT Visit Services Entry (includes historical CPTs) Enter CPT: 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G9231, M1187, M1188, S2065 or S9339 Quantity: Modifier: Modifier 2:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Diabetes: Nephropathy Assessment (cont.)			<p>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:</p> <p>ESRD Procedure Procedure Entry Operation/Procedure: ICD-10: 5A1D70Z, 5A1D80Z, 5A1D90Z Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Diabetic Retinopathy</p>	<p>Patients with diabetes and no bilateral blindness or bilateral eye enucleation will have a qualified* retinal examination during the report period.</p> <p>*Qualified retinal exam: The following methods are qualifying for this measure:</p> <ul style="list-style-type: none"> • Dilated retinal evaluation by an optometrist or ophthalmologist • Seven standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist • Any photographic method formally validated to seven standard fields (ETDRS). <p>Note: Refusals are not counted toward the GPRM measure but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Exams:</p> <ul style="list-style-type: none"> • Diabetic Retinal Exam <ul style="list-style-type: none"> – Dilated retinal eye exam – Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist – Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos – Routine ophthalmological examination including refraction (new or existing patient) – Diabetic indicator: retinal eye exam, dilated, bilateral • Other Eye Exams <ul style="list-style-type: none"> – Non-DNKA (did not keep appointment) visits to ophthalmology or optometry clinics with an optometrist or ophthalmologist, or visits to formally validated tele-ophthalmology retinal evaluation clinics 	<p>Diabetic Retinopathy Exam Exam Entry (includes historical exams)</p> <p>Select Exam: 03 Result: [Enter Results] Comments: Provider Performing Exam:</p> <p>Retinal Exam CPT Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT: 2021F, 2022F-2025F, 2026F, 2033F, G2102-G2104, S0620, S0621, S3000, M1220, M1221 Quantity: Modifier: Modifier 2:</p> <p>Other Eye Exam CPT Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT: 67028, 67039, 67040, 92002, 92004, 92012, 92014, 92018, 92019 Quantity: Modifier: Modifier 2:</p> <p>Other Eye Exam Clinic Clinic Entry Clinic: A2, 17, 18, 64</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Access to Dental Service	<p>Patients should have annual dental visits/exams. Note: Refusals are not counted toward the GPRA measure but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>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.</p> <p>Dental Visit CPT Visit Services Entry (includes historical CPTs) Enter CPT: D0110-D0390, D0415-D9952, D9970-D9974, D9995, D9996, D9999 Quantity: Modifier: Modifier 2:</p> <p>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:</p>
Dental Sealants	<p>Patients should have one or more intact dental sealants. Note: Refusals are not counted toward the GPRA measure but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Dental Sealants (ADA) <i>ADA codes cannot be entered into EHR.</i></p> <p>Dental Sealants CPT Visit Services Entry (includes historical CPTs) Enter CPT: D1351, D1352, D1353 Quantity: Modifier: Modifier 2:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Topical Fluoride	<p>Patients should have one or more topical fluoride applications.</p> <p>Note: Refusals are not counted toward the GPRA measure but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility, ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Topical Fluoride (ADA code) <i>ADA codes cannot be entered into EHR.</i></p> <p>Topical Fluoride CPT Visit Services Entry (includes historical CPTs) Enter CPT: D1206, D1208, D5986, 99188 Quantity: Modifier: Modifier 2:</p> <p>Topical Fluoride POV Visit Diagnosis Entry Purpose of Visit: ICD-10: Z29.3 Provider Narrative: Modifier: Cause of DX:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Influenza	<p>All patients ages 6 months and older should have an annual influenza (flu) shot. Refusals should be documented.</p> <p>Note: Only Not Medically Indicated (NMI) refusals are counted toward the GPRA Measure.</p>	<p>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • IZ type • Date received • Location <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include: Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal</p>	<p>Influenza Vaccine Immunization Entry (includes historical immunizations)</p> <p>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)</p> <p>Lot: VFC Eligibility:</p> <p>Influenza Vaccine CPT Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT: 90630, 90654-90664, 90666, 90668, 90672-90674, 90682, 90685-90689, 90694, 90756, G0008, Q2034-Q2039</p> <p>Quantity: Modifier: Modifier 2:</p> <p>NMI Refusal of Influenza <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p>Contraindication Influenza Immunization Entry - Contraindications</p> <p>Vaccine: [See codes above] Reason: Anaphylaxis</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Adult Immunizations</p>	<p>All adults ages 19 and older will have age appropriate vaccines.</p> <ul style="list-style-type: none"> • 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 <p>Refusals should be documented. Note: Only NMI refusals are counted toward the GPRA Measure.</p>	<p>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • IZ type • Date received • Location <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include:</p> <p>Immunization Package of "Immune Deficiency" or "Anaphylaxis"</p> <p>NMI Refusal</p>	<p>Adult Immunizations Immunization Entry (includes historical immunizations)</p> <p>Select Immunization Name: Tdap: 115; Td: 9, 113, 138, 139, 196; Shingrix: 187; PPSV23: 33, 109; PCV13: 100, 133, 152; PCV20: 216; PCV15: 215</p> <p>Lot:</p> <p>VFC Eligibility:</p> <p>Adult Immunizations CPT Visit Services Entry (includes historical CPTs)</p> <p>Enter CPT: Tdap: 90715; Td: 90714, 90718; Shingrix: 90750; PPSV23: 90732, G0009, G9279; PCV13: 90669, 90670; PCV20: 90677; PCV15: 90671</p> <p>Quantity:</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>NMI Refusal of Adult Immunizations</p> <p><i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p>Contraindication Adult Immunizations Immunization Entry - Contraindications</p> <p>Vaccine: [See codes above]</p> <p>Reason: [See Contraindications section under the Provider Documentation column]</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Childhood Immunizations</p>	<p>Children age 19–35 months will be up to date for all ACIP recommended immunizations.</p> <p>This is the 4313*314 combo:</p> <p>4 DTaP</p> <p>3 IPV</p> <p>1 MMR</p> <p>3 Hepatitis B</p> <p>3 or 4 Hib</p> <p>1 Varicella</p> <p>4 Pneumococcal</p> <p>Refusals should be documented.</p> <p>Note: Only NMI refusals are counted toward the GPRA Measure.</p>	<p>Standard EHR documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • IZ type • Date received • Location <p>Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization</p> <p>Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include Immunization Package of "Anaphylaxis" for all childhood immunizations. The following additional contraindications are also counted:</p> <ul style="list-style-type: none"> • 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" 	<p>Childhood Immunizations</p> <p>Immunization Entry (includes historical immunizations)</p> <p>Select Immunization Name: DTaP: 20, 50, 102, 106, 107, 110, 120, 130, 146; DTP: 1, 22, 102, 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</p> <p>Lot:</p> <p>VFC Eligibility:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Childhood Immunizations (cont.)</p>		<p>Dosage and types of immunization definitions:</p> <p>4 doses of DTaP:</p> <ul style="list-style-type: none"> • 4 DTaP/DTP/Tdap • 1 DTaP/DTP/Tdap and 3 DT/Td • 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus • 4 DT and 4 Acellular Pertussis • 4 Td and 4 Acellular Pertussis • 4 each of Diphtheria, Tetanus, and Acellular Pertussis <p>3 doses of IPV:</p> <ul style="list-style-type: none"> • 3 OPV • 3 IPV • Combination of OPV and IPV totaling three doses <p>1 dose of MMR:</p> <ul style="list-style-type: none"> • MMR • 1 M/R and 1 Mumps • 1 R/M and 1 Measles • 1 each of Measles, Mumps, and Rubella <p>3 doses of Hepatitis B</p> <ul style="list-style-type: none"> • 3 doses of Hep B <p>3 or 4 doses of Hib, depending on the vaccine administered</p> <p>1 dose of Varicella</p> <p>4 doses of Pneumococcal</p>	<p>Childhood Immunizations Evidence of Disease POV</p> <p>Visit Diagnosis Entry</p> <p>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.*</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Childhood Immunizations (cont.)</p>			<p>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:</p> <p>NMI Refusal of Childhood Immunizations <i>NMI Refusals can only be entered in EHR via Reminder Dialogs.</i></p> <p>Contraindication Childhood Immunizations Immunization Entry - Contraindications Vaccine: [See codes above] Reason: [See Contraindications section under the Provider Documentation column]</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Cervical Cancer Screening	<p>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.</p> <p>Note: Refusals of any above test are not counted toward the GPRA measure but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Pap Smear V Lab Lab Test Entry Enter Lab Test Type: [Enter site's defined Pap Smear Lab Test] Clinical Indication:</p> <p>Pap Smear POV Visit Diagnosis Entry Purpose of Visit: ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4 Provider Narrative: Modifier: Cause of DX:</p> <p>Pap Smear CPT Visit Services Entry (includes historical CPTs) Enter CPT: 88141-88154, 88160-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 Quantity: Modifier: Modifier 2:</p> <p>HPV V Lab Lab Test Entry Enter Lab Test Type: [Enter site's defined HPV Lab Test] Clinical Indication:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Cervical Cancer Screening (cont.)			<p>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:</p> <p>HPV CPT Visit Services Entry (includes historical CPTs) Enter CPT: 87623-87625, G0476, 0429U Quantity: Modifier: Modifier 2:</p> <p>HPV Primary V Lab Lab Test Entry Enter Lab Test Type: [Enter site's defined HPV Primary Lab Test] Clinical Indication:</p> <p>HPV Primary CPT Visit Services Entry (includes historical CPTs) Enter CPT: 87624 Quantity: Modifier: Modifier 2:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Cancer Screening: Mammogram Rates</p>	<p>Women ages 52–74 should have a mammogram every 2 years.</p> <p>Note: Refusals of any above test are not counted toward the GPRA measure but should still be documented.</p>	<p>Standard EHR documentation for Radiology performed at the facility. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Telephone visit with patient Verbal or written lab report Patient's next visit</p>	<p>Mammogram POV Visit Diagnosis Entry Purpose of Visit: ICD-10: R92.0, R92.1, R92.8, Z12.31 Provider Narrative: Modifier: Cause of DX:</p> <p>Mammogram CPT Visit Services Entry (includes historical CPTs) Enter CPT: 77046-77049, 77052-77059, 77061-77063, 77065-77067, G0206; G0204, G0202, G0279 Quantity: Modifier: Modifier 2:</p> <p>Mammogram Procedure Procedure Entry Operation/Procedure: ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Colorectal Cancer Screening</p>	<p>Adults ages 50–75 should be screened for CRC (USPTF). For GPRA, IHS counts any of the following:</p> <ul style="list-style-type: none"> • Annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT) • FIT-DNA in the past 3 years • Flexible sigmoidoscopy or CT colonography in the past 5 years • Colonoscopy every 10 years <p>Note: Refusals of any above test are not counted toward the GPRA measure but should still be documented.</p>	<p>Standard EHR documentation for procedures performed at the facility (Radiology, Lab, provider). Guaiac cards returned by patients to providers should be sent to Lab for processing. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Telephone visit with patient Verbal or written lab report Patient's next visit</p>	<p>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:</p> <p>Total Colectomy CPT Visit Services Entry (includes historical CPTs) Enter CPT: 44150-44151, 44155-44158, 44210-44212 Quantity: Modifier: Modifier 2:</p> <p>Total Colectomy Procedure Procedure Entry Operation/Procedure: ICD-10: 0DTE*ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>FOBT or FIT CPT Visit Services Entry (includes historical CPTs) Enter CPT: 82270, 82274, G0328 Quantity: Modifier: Modifier 2:</p>

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Colorectal Cancer Screening (cont.)			<p>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:</p> <p>Colon Screening Procedure Procedure Entry Operation/Procedure: ICD-10: (see logic manual for codes) Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Tobacco Use and Exposure Assessment</p> <p>Note: This is not a GPRA measure; however, it will be used for reducing the incidence of Tobacco Use.</p>	<p>Ask all patients age five and over about tobacco use at least annually.</p>	<p>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Document on designated Health Factors section of form:</p> <ul style="list-style-type: none"> • HF–Current Smoker, every day • HF–Current Smoker, some day • HF–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 <p>Note: If your site uses other expressions (e.g., “Chew” instead of “Smokeless;” “Past” instead of “Previous”), be sure Data Entry staff knows how to “translate”</p> <p>Tobacco Patient Education Codes:</p> <ul style="list-style-type: none"> • Codes will contain "TO-", "-TO", "-SHS" • 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.” 	<p>Tobacco Screening Health Factor Health Factor Entry</p> <p>Select V Health Factor: [Enter HF (See the Provider Documentation column)]</p> <p>Level/Severity:</p> <p>Provider:</p> <p>Quantity:</p> <p>Tobacco Screening PED–Topic Patient Education Entry (includes historical patient education)</p> <p>Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Tobacco Users Health Factor Health Factor Entry</p> <p>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)</p> <p>Level/Severity:</p> <p>Provider:</p> <p>Quantity:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Use and Exposure Assessment (cont.)			<p>Smokers Health Factor Health Factor Entry Select V Health Factor: Current Smoker (every day, some day, or status unknown) Level/Severity: Provider: Quantity:</p> <p>Smokeless Health Factor Health Factor Entry Select V Health Factor: Current Smokeless Level/Severity: Provider: Quantity:</p> <p>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:</p> <p>ETS Health Factor Health Factor Entry Select V Health Factor: Exp to ETS Level/Severity: Provider: Quantity:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Tobacco Cessation</p>	<p>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.</p> <p>Note: Refusals are not counted toward the GPRA measure but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Current tobacco users are defined by having any of the following documented prior to the report period:</p> <ul style="list-style-type: none"> • Last documented Tobacco Health Factor <p>Health factors considered to be a tobacco user:</p> <ul style="list-style-type: none"> • HF–Current Smoker, every day • HF–Current Smoker, some day • HF–Current E-cigarette user w/nicotine • HF–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless <p>Tobacco Patient Education Codes:</p> <ul style="list-style-type: none"> • Codes will contain "TO-", "-TO", "-SHS" 	<p>Tobacco Cessation PED - Topic Patient Education Entry (includes historical patient education)</p> <p>Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Tobacco Cessation (cont.)		<p>Prescribe Tobacco Cessation Aids:</p> <ul style="list-style-type: none"> • Predefined Site-Populated Smoking Cessation Meds • Meds containing: <ul style="list-style-type: none"> - “Nicotine Patch” - “Nicotine Polacrilex” - “Nicotine Inhaler” - “Nicotine Nasal Spray” <p>Note: Ensure you update the patient’s health factors as they become nontobacco users. Patients who have quit tobacco should have their health factor updated to “Former Smoker”, “Former Smokeless”, or “Former E-cigarette user.”</p>	<p>Tobacco Cessation PED – Diagnosis</p> <p>Patient Education Entry (includes historical patient education)</p> <p>Select ICD Diagnosis Code Number or SNOMED code</p> <p>Category:</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment</p> <p>Provider’s Narrative:</p> <p>Tobacco Cessation PED – CPT</p> <p>Mnemonic PED enter</p> <p>Select CPT Code Number: D1320, 99406, 99407, 4000F, G0030, G9016, G9458</p> <p>Category:</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Provider’s Narrative:</p>

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Alcohol Screening</p>	<p>User Population patients ages 9 through 75 should be screened for alcohol use at least annually.</p> <p>Note: Refusals are not counted toward the GPRA measure but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Alcohol screening may be documented with either an exam code or the CAGE, CAGE-AID, or TAPS health factors in EHR.</p> <p>Medical Providers: EXAM—Alcohol Screening</p> <ul style="list-style-type: none"> • Negative: Patient’s screening exam does not indicate risky alcohol use. • Positive: Patient’s screening exam indicates potential risky alcohol use. • Refused: Patient declined exam/screen • Unable to screen: Provider unable to screen <p>Note: Recommended Brief Screening Tool: SASQ (below). <i>Single Alcohol Screening Question (SASQ)</i></p> <p><i>For Women:</i></p> <ul style="list-style-type: none"> • When was the last time you had more than 4 drinks in one day? <p><i>For Men:</i></p> <ul style="list-style-type: none"> • When was the last time you had more than 5 drinks in one day? 	<p>Alcohol Screening Exam Exam Entry (includes historical exams)</p> <p>Select Exam: 35, ALC</p> <p>Result: A–Abnormal N–Normal/Negative PR–Resent PAP–Present and Past PA–Past PO–Positive</p> <p>Comments: SASQ Provider Performing Exam:</p> <p>CAGE Health Factor Health Factor Entry</p> <p>Select Health Factor: CAGE</p> <ol style="list-style-type: none"> 1. CAGE 0/4 (all No answers) 2. CAGE 1/4 3. CAGE 2/4 4. CAGE 3/4 5. CAGE 4/4 <p>Choose 1-5: [Number from above]</p> <p>Level/Severity: Provider: Quantity:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (cont.)		<p>Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen:</p> <ul style="list-style-type: none"> Alcohol Screening Exam Code Result: Positive <p>The patient may decline the screen or “Refuse to answer:”</p> <ul style="list-style-type: none"> Alcohol Screening Exam Code Result: Refused <p>The provider is unable to conduct the screen:</p> <ul style="list-style-type: none"> Alcohol Screening Exam Code Result: Unable To Screen <p>Note: Provider should Note the screening tool used was the SASQ at the Comment Mnemonic for the Exam code.</p> <p>All Providers: Use the CAGE questionnaire: Have you ever felt the need to Cut down on your drinking? Have people Annoyed you by criticizing your drinking? Have you ever felt bad or Guilty about your drinking? Have you ever needed an Eye-opener the first thing in the morning to steady your nerves or get rid of a hangover? Tolerance: How many drinks does it take you to get high?</p>	<p>CAGE-AID Health Factor Health Factor Entry Select Health Factor: CAGE-AID</p> <ol style="list-style-type: none"> CAGE-AID 0/4 (all No answers) CAGE-AID 1/4 CAGE-AID 2/4 CAGE-AID 3/4 CAGE-AID 4/4 <p>Choose 1-5: [Number from above] Level/Severity: Provider: Quantity:</p> <p>TAPS-Alcohol Health Factor Health Factor Entry Select Health Factor: TAPS-Alcohol</p> <ol style="list-style-type: none"> TAPS-ALCOHOL ALCOHOL-MINIMAL RISK TAPS-ALCOHOL ALCOHOL-PROBLEM USE TAPS-ALCOHOL ALCOHOL-HIGH RISK TAPS-ALCOHOL ALCOHOL-UNDETERMINED RISK TAPS-ALCOHOL ALCOHOL-EARLY REMISSION, BUT AT RISK <p>Choose 1-5: [Number from above] Level/Severity: Provider: Quantity:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (cont.)		<p>Based on how many YES answers were received, document Health Factor in EHR:</p> <ul style="list-style-type: none"> • HF-CAGE 0/4 (all No answers) • HF-CAGE 1/4 • HF-CAGE 2/4 • HF-CAGE 3/4 • HF-CAGE 4/4 <p>Optional values:</p> <ul style="list-style-type: none"> • Level/Severity: Minimal, Moderate, or Heavy/Severe • Quantity: # of drinks daily or T (Tolerance) – # drinks to get high (e.g., T-4) • Comment: used to capture other relevant clinical info e.g., “Non-drinker” <p>Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-"</p> <p>AUDIT Measurements:</p> <ul style="list-style-type: none"> • Zone I: Score 0–7 Low risk drinking or abstinence • Zone II: Score 8–15 Alcohol use in excess of low-risk guidelines • Zone III: Score 16–19 Harmful and hazardous drinking • Zone IV: Score 20–40 Referral to Specialist for Diagnostic Evaluation and Treatment 	<p>Alcohol 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:</p> <p>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:</p> <p>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:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (cont.)		<p>AUDIT-C Measurements:</p> <p>How often do you have a drink containing alcohol?</p> <ul style="list-style-type: none"> • (0) Never (Skip to Questions 9–10) • (1) Monthly or less • (2) 2 to 4 times a month • (3) 2 to 3 times a week • (4) 4 or more times a week <p>How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <ul style="list-style-type: none"> • (0) 1 or 2 • (1) 3 or 4 • (2) 5 or 6 • (3) 7, 8, or 9 • (4) 10 or more <p>How often do you have 6 or more drinks on one occasion?</p> <ul style="list-style-type: none"> • (0) Never • (1) Less than monthly • (2) Monthly • (3) Weekly • (4) Daily or almost daily 	<p>Alcohol-Related PED - Diagnosis Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: 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:</p> <p>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:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Alcohol Screening (cont.)		<p>The AUDIT-C (the first three AUDIT questions which focus on alcohol consumption) is scored on a scale of 0–12 (scores of 0 reflect no alcohol use).</p> <ul style="list-style-type: none"> In men, a score of 4 or more is considered positive. In women, a score of 3 or more is considered positive. <p>A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence.</p> <p>CRAFFT Measurements:</p> <ul style="list-style-type: none"> C–Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? A–Do you ever use alcohol/drugs while you are by yourself, ALONE? F–Do you ever FORGET things you did while using alcohol or drugs? F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? T–Have you gotten into TROUBLE while you were using alcohol or drugs? <p>Total CRAFFT score (Range: 0–6).</p> <p>A positive answer to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated.</p>	<p>Alcohol Screen AUDIT Measurement Vital Measurements Entry (includes historical Vitals) Value: [Enter 0–40] Select Qualifier: Date/Time Vitals Taken:</p> <p>Alcohol Screen AUDIT-C Measurement Vital Measurements Entry (includes historical Vitals) Value: [Enter 0–40] Select Qualifier: Date/Time Vitals Taken:</p> <p>Alcohol Screen CRAFFT Measurement Vital Measurements Entry (includes historical Vitals) Value: [Enter 0–6] Select Qualifier: Date/Time Vitals Taken:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Screening, Brief Intervention, and Referral to Treatment (SBIRT)</p>	<p>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.</p>	<p>Standard EHR documentation for tests performed at the facility. Ask about off-site tests and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>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:</p> <p>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:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Intimate Partner (Domestic) Violence Screening (IPV/DV)</p>	<p>Adult females should be screened for domestic violence at new encounter and at least annually Prenatal once each trimester (Source: Family Violence Prevention Fund National Consensus Guidelines) Note: Refusals are <i>not</i> counted toward the GPRA measure but should be documented.</p>	<p>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Medical and Behavioral Health Providers: EXAM—IPV/DV Screening</p> <ul style="list-style-type: none"> • Negative—Denies being a current or past victim of IPV/DV • Past—Denies being a current victim, but discloses being a past victim of IPV/DV • Present—Discloses current IPV/DV • Present and Past—Discloses past victimization and current IPV/DV victimization • Refused—Patient declined exam/screen • Unable to screen—Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.) <p>IPV/DV Patient Education Codes:</p> <ul style="list-style-type: none"> • Codes will contain "DV-" or "-DV" 	<p>IPV/DV Screening Exam Exam Entry (includes historical exams) Select Exam: 34, INT Result: A—Abnormal N—Normal/Negative PR—Resent PAP—Present and Past PA—Past PO—Positive Comments: Provider Performing Exam: IPV/DV Diagnosis POV Visit Diagnosis Entry Purpose of Visit: ICD-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:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont.)			<p>IPV/DV–Topic Patient Education Entry (includes historical patient education) Enter Education Topic: [Enter IPV/DV Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p> <p>IPV/DV PED–Diagnosis Patient Education Entry (includes historical patient education) Select ICD Diagnosis Code Number: 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:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Depression Screening</p>	<p>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 <i>not</i> counted toward the GPRA measure but should be documented.</p>	<p>Standard EHR documentation for tests performed at the facility. Ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Medical Providers: EXAM—Depression Screening</p> <ul style="list-style-type: none"> • Normal/Negative—Denies symptoms of depression • Abnormal/Positive—Further evaluation indicated • Refused—Patient declined exam/screen • Unable to screen—Provider unable to screen <p>Note: Refusals are not counted toward the GPRA measure but should be documented.</p> <p>Mood Disorders: Two or more visits with POV related to:</p> <ul style="list-style-type: none"> • Major Depressive Disorder • Dysthymic Disorder • Depressive Disorder NOS • Bipolar I or II Disorder • Cyclothymic Disorder • Bipolar Disorder NOS • Mood Disorder Due to a General Medical Condition • Substance-induced Mood Disorder • Mood Disorder NOS <p>Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</p>	<p>Depression Screening Exam Exam Entry (includes historical exams) 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:</p>

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Childhood Weight Control</p>	<p>Patients ages 2–5 at the beginning of the report period whose BMI could be calculated and have a BMI equal to or greater than (\geq) 95%.</p> <p>Height and weight taken on the same day.</p> <p>Patients that turn 6 years old during the report period are not included in the GPRA measure.</p>	<p>Standard EHR documentation. obtain height and weight during visit and record information in EHR:</p> <ul style="list-style-type: none"> • Height • Weight • Date Recorded <p>BMI is calculated using NHANES II</p> <p>Age in the age groups is calculated based on the date of the most current BMI found.</p> <p>Example, a patient may be 2 at the beginning of the time period but is 3 at the time of the most current BMI found, patient will fall into the age 3 group.</p> <p>The BMI values for this measure are reported differently than in the Obesity Assessment measure as they are Age-Dependent. The BMI values are categorized as Overweight for patients with a BMI in the 85th to 94th percentile and Obese for patients with a BMI at or above the 95th percentile (GPRA).</p>	<p>Height Measurement Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken:</p> <p>Weight Measurement Vital Measurements Entry (includes historical Vitals) Value: Select Qualifier: Actual Bed Chair Dry Estimated Standing Date/Time Vitals Taken:</p>

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</p>	<p>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 (\geq) 190 or hypercholesterolemia who have statin therapy.</p>	<p>Standard EHR documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Dosage 	<p>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:</p> <p>Statin Therapy CPT Visit Services Entry (includes historical CPTs) Enter CPT Code: 4013F Quantity: Modifier: Modifier 2:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
HIV Screening	<p>Patients should be tested for HIV at least once; education and follow-up provided as appropriate.</p> <p>Note: Refusals are not counted toward the GPRA measure but should still be documented.</p>	<p>Standard EHR documentation for tests performed at the facility, ask and record historical information in EHR:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>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:</p> <p>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:</p> <p>HIV Lab Test Lab Test Entry Enter Lab Test Type: [Enter site's defined HIV Screen Lab Test] Collect Sample/Specimen: [Blood, Serum] Clinical Indication:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Breastfeeding Rates</p> <p>Note: This is not a GPRA measure; however, it will be used in conjunction with the Childhood Weight Control measure for reducing the incidence of childhood obesity. The information is included here to inform providers and data entry staff of how to collect, document, and enter the data.</p>	<p>All providers should assess the feeding practices of all newborns through age 1 year at all well-child visits.</p>	<p>Definitions for Infant Feeding Choice Options:</p> <p>Exclusive Breastfeeding–Breastfed or expressed breast milk only, no formula</p> <p>Mostly Breastfeeding–Mostly breastfed or expressed breast milk, with some formula feeding (1X per week or more, but less than half the time formula feeding.)</p> <p>½ Breastfeeding, ½ Formula Feeding–Half the time breastfeeding/expressed breast milk, half formula feeding</p> <p>Mostly Formula–The baby is mostly formula fed, but breastfeeds at least once a week</p> <p>Formula Only–Baby receives only formula</p> <p>The additional one-time data fields, e.g., birth weight, formula started, and breast stopped, may also be collected and may be entered using the data entry Mnemonic PIF. However, this information is not used or counted in the CRS logic for Breastfeeding Rates.</p>	<p>Infant Breastfeeding</p> <p>Infant Feeding Choice Entry</p> <p>Enter Feeding Choice:</p> <p>Exclusive Breastfeeding</p> <p>Mostly Breastfeeding</p> <p>Mostly Breastfeeding, Some Formula</p> <p>1/2 & 1/2 Breast and Formula</p> <p>Mostly Formula</p> <p>Mostly Formula, Some Breastfeeding</p> <p>Formula Only</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
<p>Patient Education Measures (Patient Education Report)</p> <p>Note: This is not a GPRA measure; however, the information is being provided because there are several GPRA measures that do include patient education as meeting the numerator (e.g., alcohol screening). Providers and data entry staff need to know they need to collect and enter all components of patient education.</p>	<p>N/A</p>	<p><i>All providers should document all 5 patient education elements and elements #6–7 if a goal was set for the patient:</i></p> <ol style="list-style-type: none"> 1. Education Topic/Diagnosis 2. Readiness to Learn 3. Level of Understanding (see below) 4. Initials of Who Taught 5. Time spent (in minutes) 6. Goal Not Set, Goal Set, Goal Met, Goal Not Met 7. Text relating to the goal or its status <p>Readiness to Learn:</p> <ul style="list-style-type: none"> • Distraction • Eager To Learn • Intoxication • Not Ready • Pain • Receptive • Severity of Illness • Unreceptive <p>Levels of Understanding:</p> <ul style="list-style-type: none"> • P–Poor • F–Fair • G–Good • GR–Group-No Assessment • R–Refused <p>Goal Codes:</p> <ul style="list-style-type: none"> • GS–Goal Set • GM–Goal Met • GNM–Goal Not Met • GNS–Goal Not Set 	<p>Patient Education Topic</p> <p>Patient Education Entry (includes historical patient education)</p> <p>Topic: [Enter Topic]</p> <p>Readiness to Learn: D, E, I, N, P, R, S, U</p> <p>Level of Understanding: P, F, G, GR, R</p> <p>Provider:</p> <p>Length of Education (minutes):</p> <p>Comment:</p> <p>Goal Code: GS, GM, GNM, GNS</p> <p>Goal Comment:</p> <p>Patient Education Diagnosis</p> <p>Patient Education Entry (includes historical patient education)</p> <p>Select ICD Diagnosis Code Number:</p> <p>Category: [Enter Category]</p> <p>Readiness to Learn: D, E, I, N, P, R, S, U</p> <p>Level of Understanding: P, F, G, GR, R</p> <p>Provider:</p> <p>Length of Education (Minutes):</p> <p>Comment:</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Provider’s Narrative:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in EHR
Patient Education Measures (Patient Education Report) (cont.)		Diagnosis Categories: <ul style="list-style-type: none"> • Anatomy and Physiology • Complications • Disease Process • Equipment • Exercise • Follow-up • Home Management • Hygiene • Lifestyle Adaptation • Literature • Medical Nutrition Therapy • Medications • Nutrition • Prevention • Procedures • Safety • Tests • Treatment 	

Enter Information in EHR

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

- [Clinic Codes](#): Page 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.

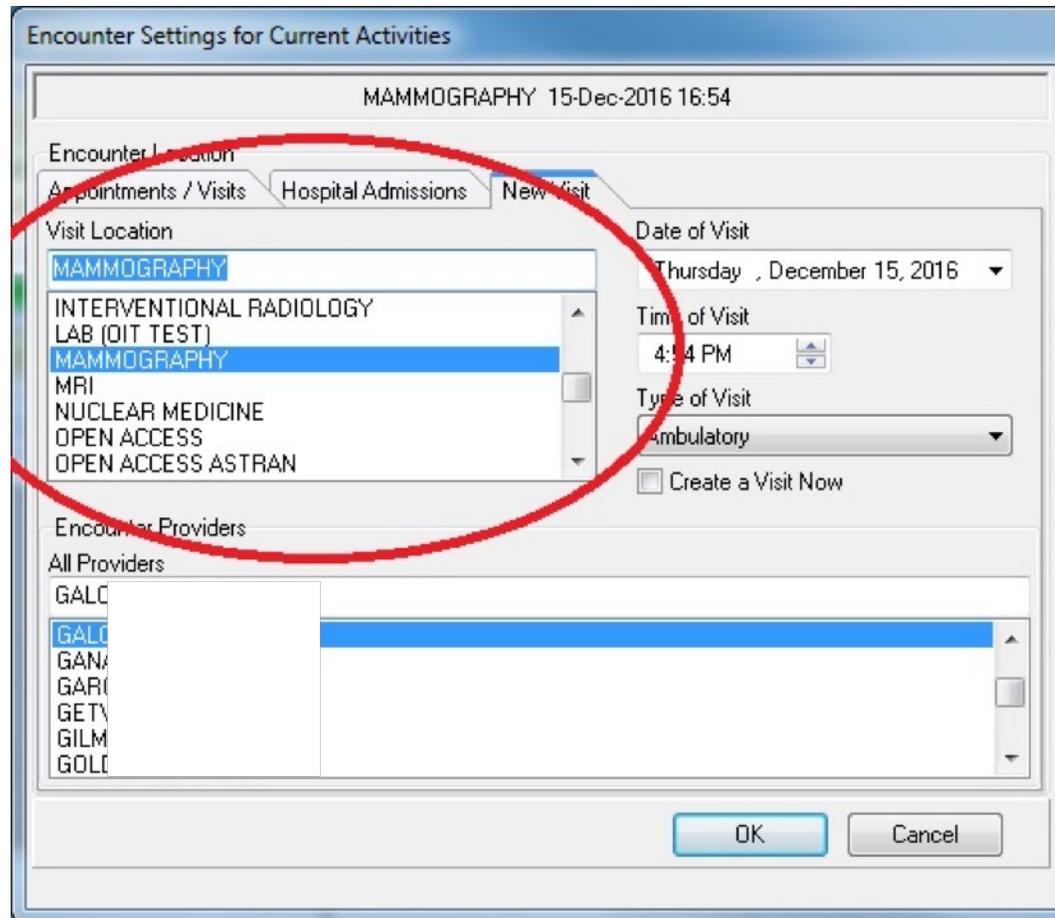


Figure 1: Choosing a clinic code

Purpose of Visit/Diagnosis

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

Key Clinical Performance Objectives

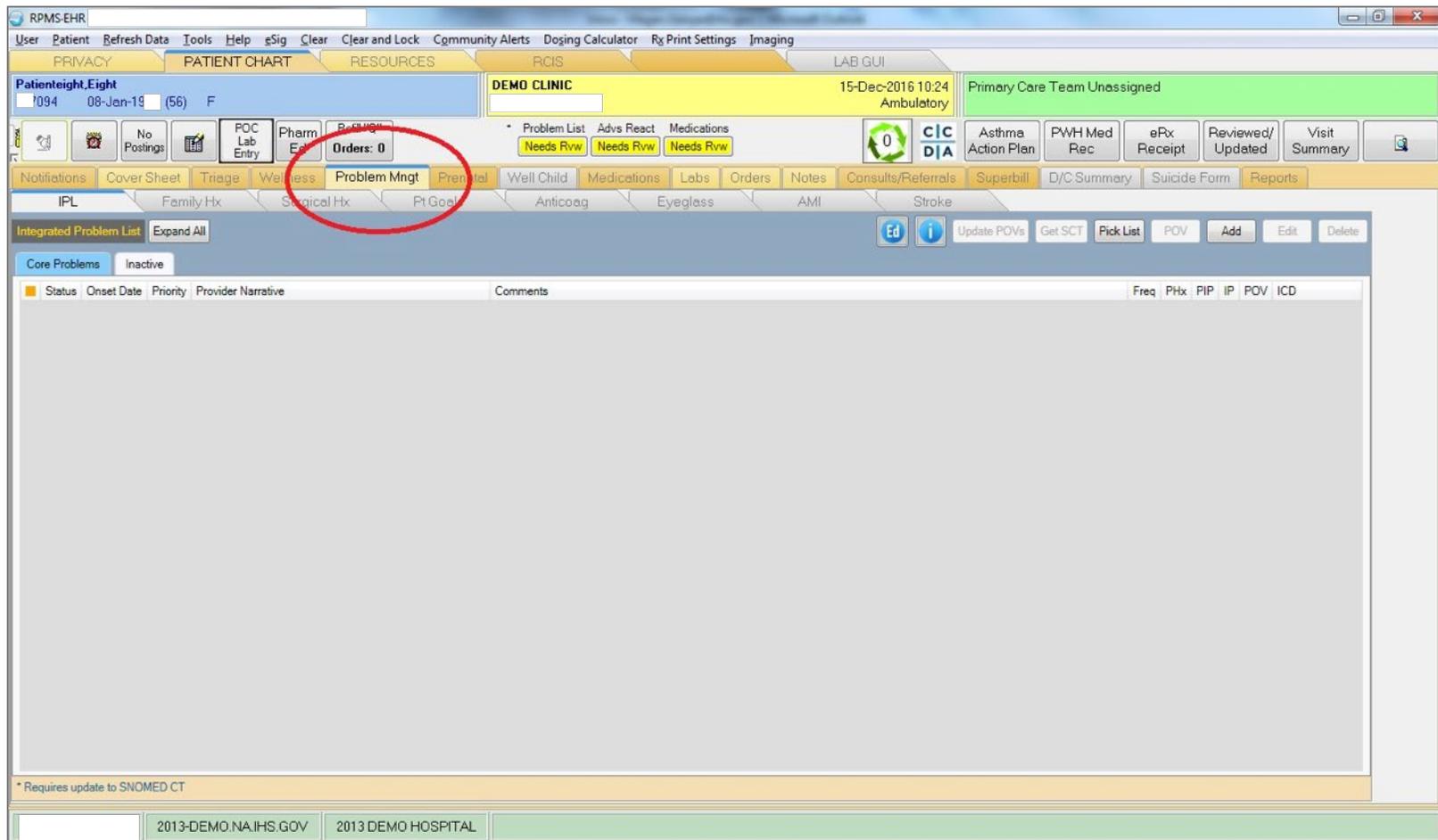


Figure 2: **Problem Mngt** tab

To enter a POV:

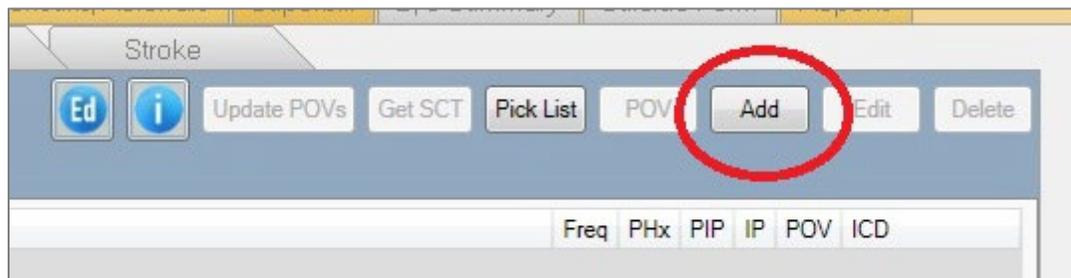


Figure 3: Entering a POV

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

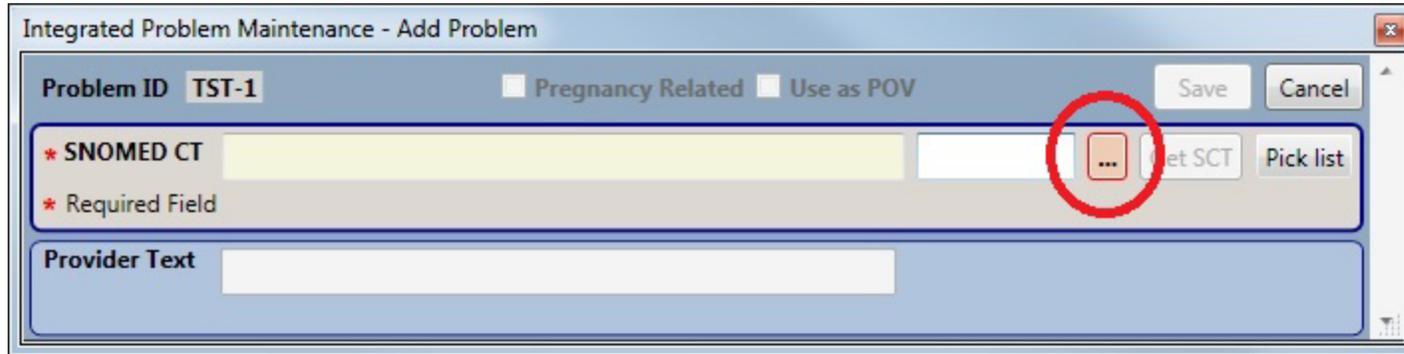


Figure 4: **Integrated Problem Maintenance – Add Problem** dialog

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

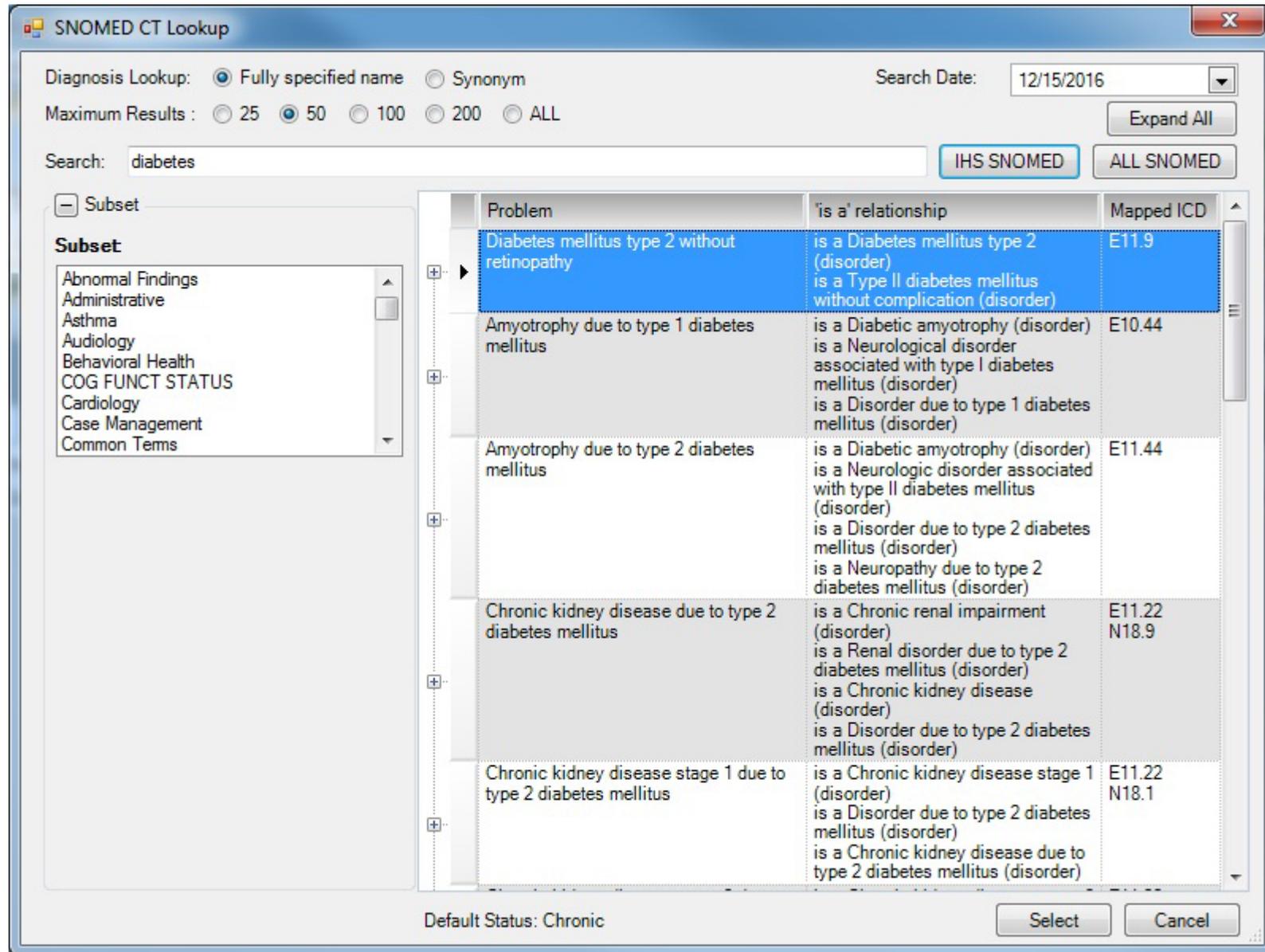


Figure 5: Entering the diagnosis

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

The screenshot shows the 'Integrated Problem Maintenance - Add Problem' dialog box. At the top, there are fields for 'Problem ID' (TST-1), 'Priority', and 'Pregnancy Related'. The 'Use as POV' and 'Primary' checkboxes are checked and highlighted with a red circle. Below this is the 'SNOMED CT' section with the text 'Diabetes mellitus type 2 without retinopathy' and 'diabetes'. The 'Status' section has radio buttons for 'Chronic', 'Sub-acute', 'Episodic', 'Social/Environmental', 'Inactive', 'Personal Hx', and 'Routine/Admin', with 'Chronic' selected. The 'Date of Onset' is set to '12/15/2016'. The 'Qualifiers' section has tabs for 'Severity' and 'Clinical Course', with 'Severity' selected. The 'Is Injury' checkbox is unchecked. The 'Comments' section is empty. The 'Care Plan Info' section has a button 'Add Visit Instruction / Care Plans / Goal Activities' and four columns: 'Goal Notes', 'Care Plans', 'Visit Instructions', and 'Care Planning Activities'.

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).

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

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

CPT Codes

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

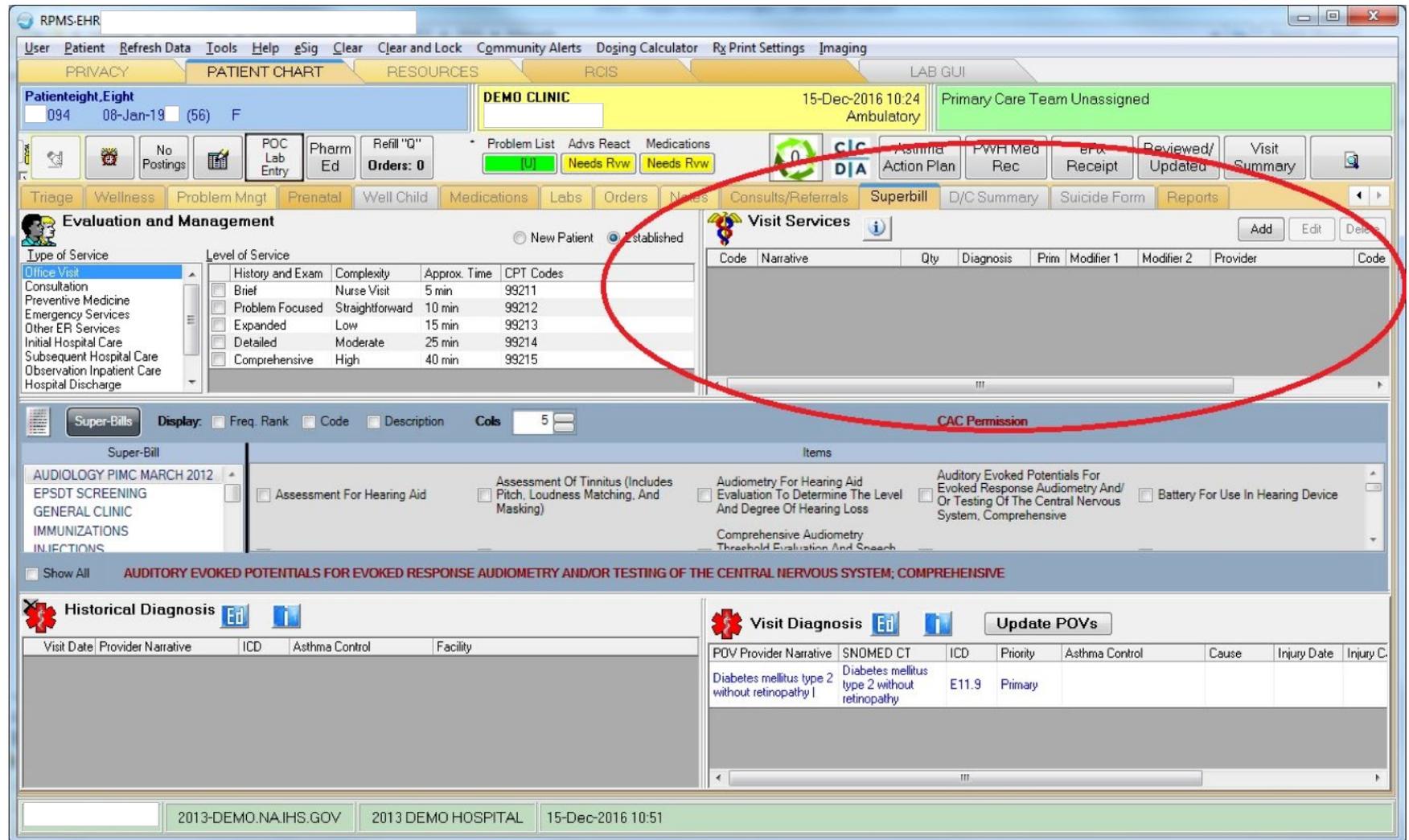


Figure 8: Visit Services component

To enter a CPT code:

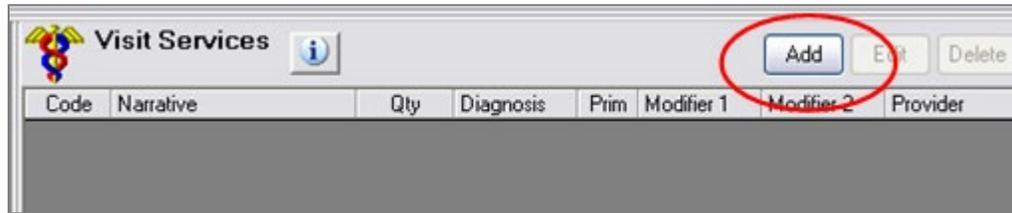


Figure 9: Entering a CPT code

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

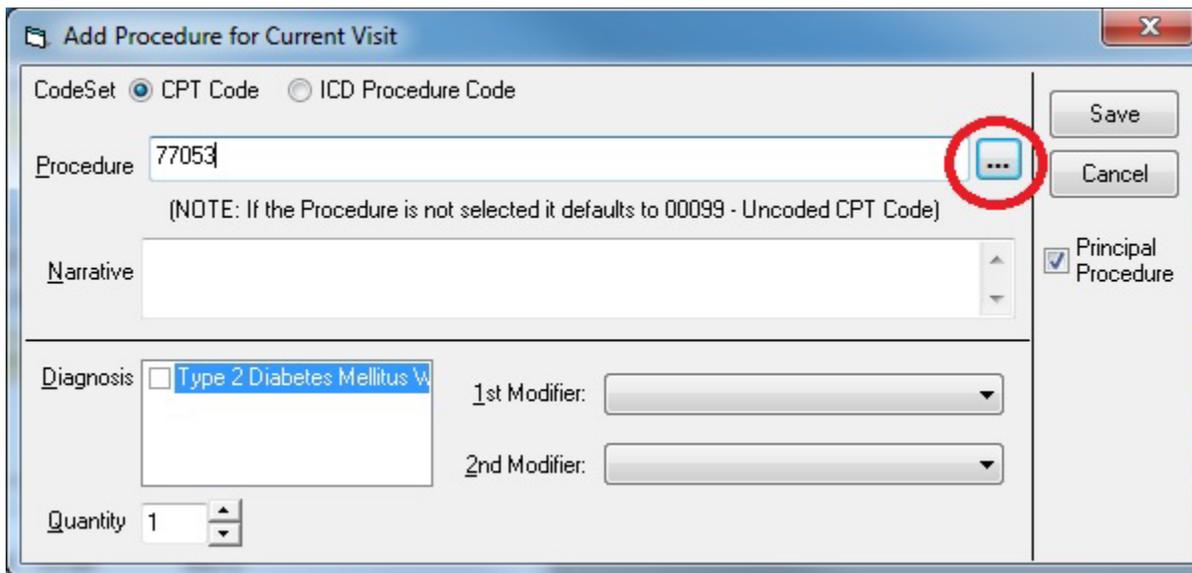


Figure 10: Entering the CPT code

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

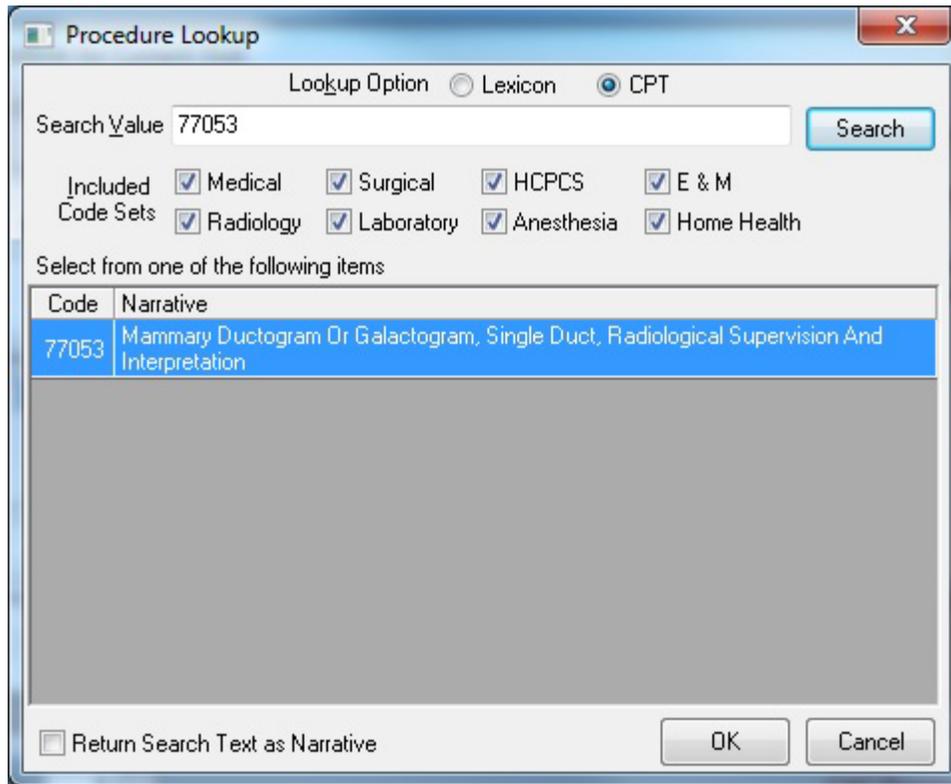


Figure 11: **Procedure Lookup** dialog

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).

Visit Services Add Edit Delete									
Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider	CPT Name	Visit Date
77053	Mammary Ductogram Or Galactogram, Single Duct, Radiological Supervision And Interpretation	1		Y			[REDACTED]	X-ray Of Mammary Duct	08/19/2010

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).

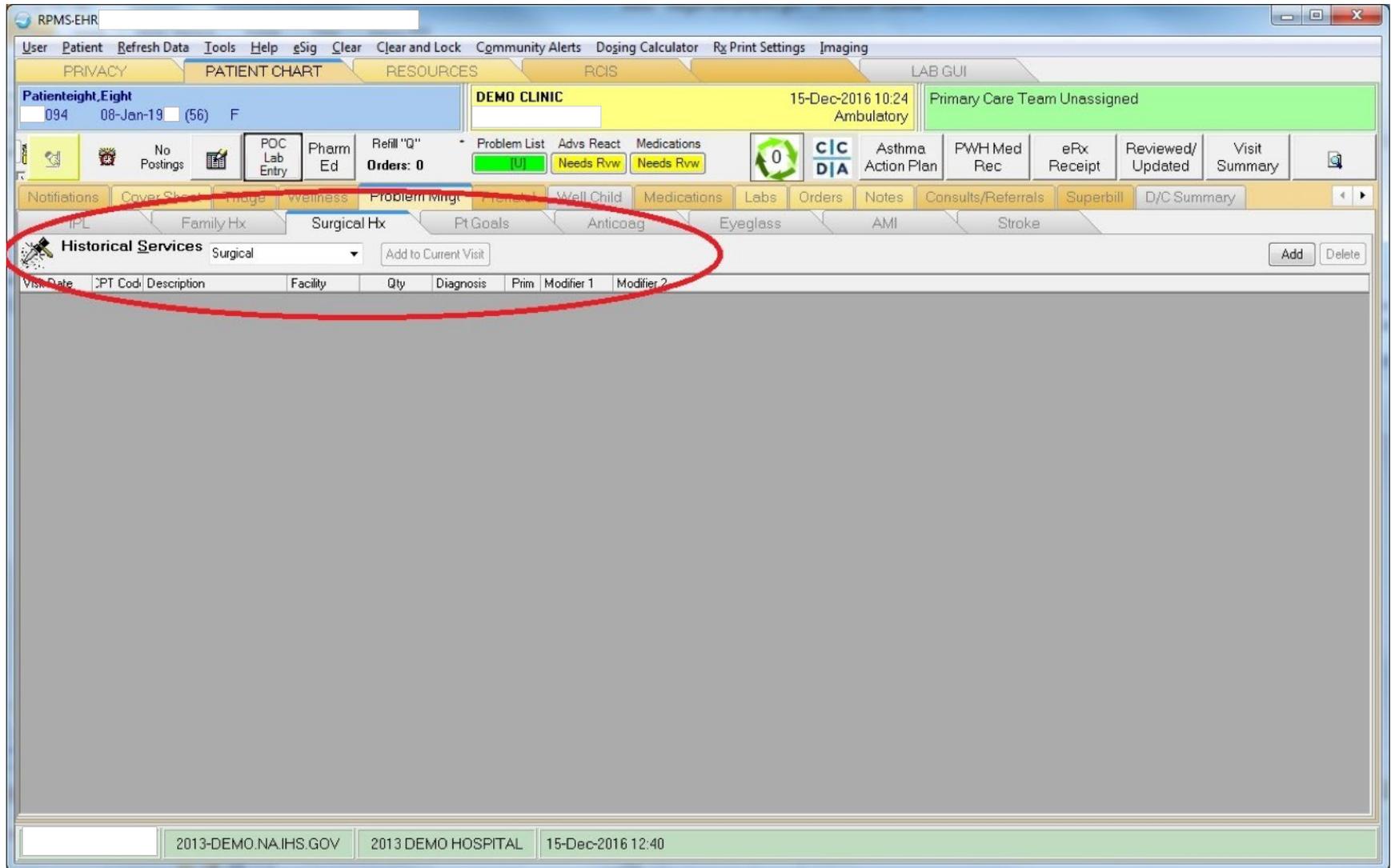


Figure 14: **Historical Services** component

To enter a CPT code:

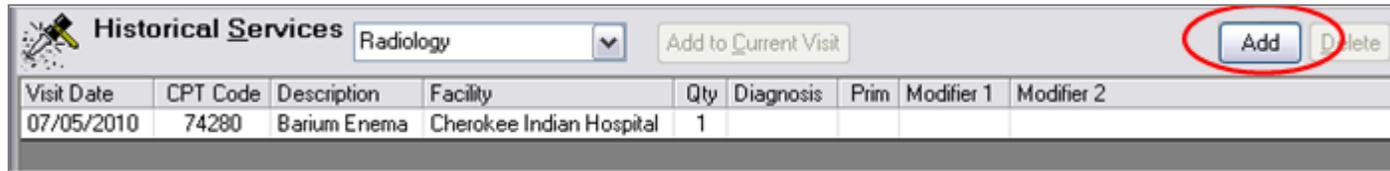


Figure 15: Example of entering a CPT code

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

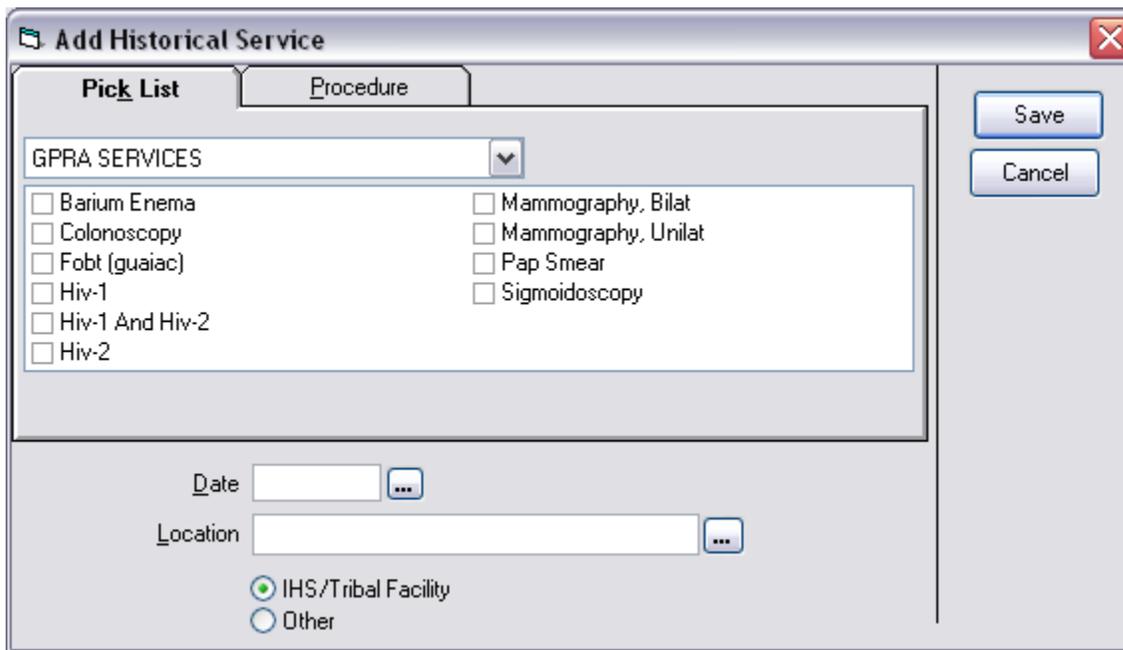


Figure 16: Adding a historical service using the **Pick List**

- 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).

Visit Date	CPT Code	Description	Facility	Qty	Diagnosis	Prim	Modifier 1	Modifier 2
07/05/2010	74280	Barium Enema	Cherokee Indian Hospital	1				
06/08/2009	77055	Mammography; Unilateral	Cherokee Indian Hospital	1				

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

Procedure Codes

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

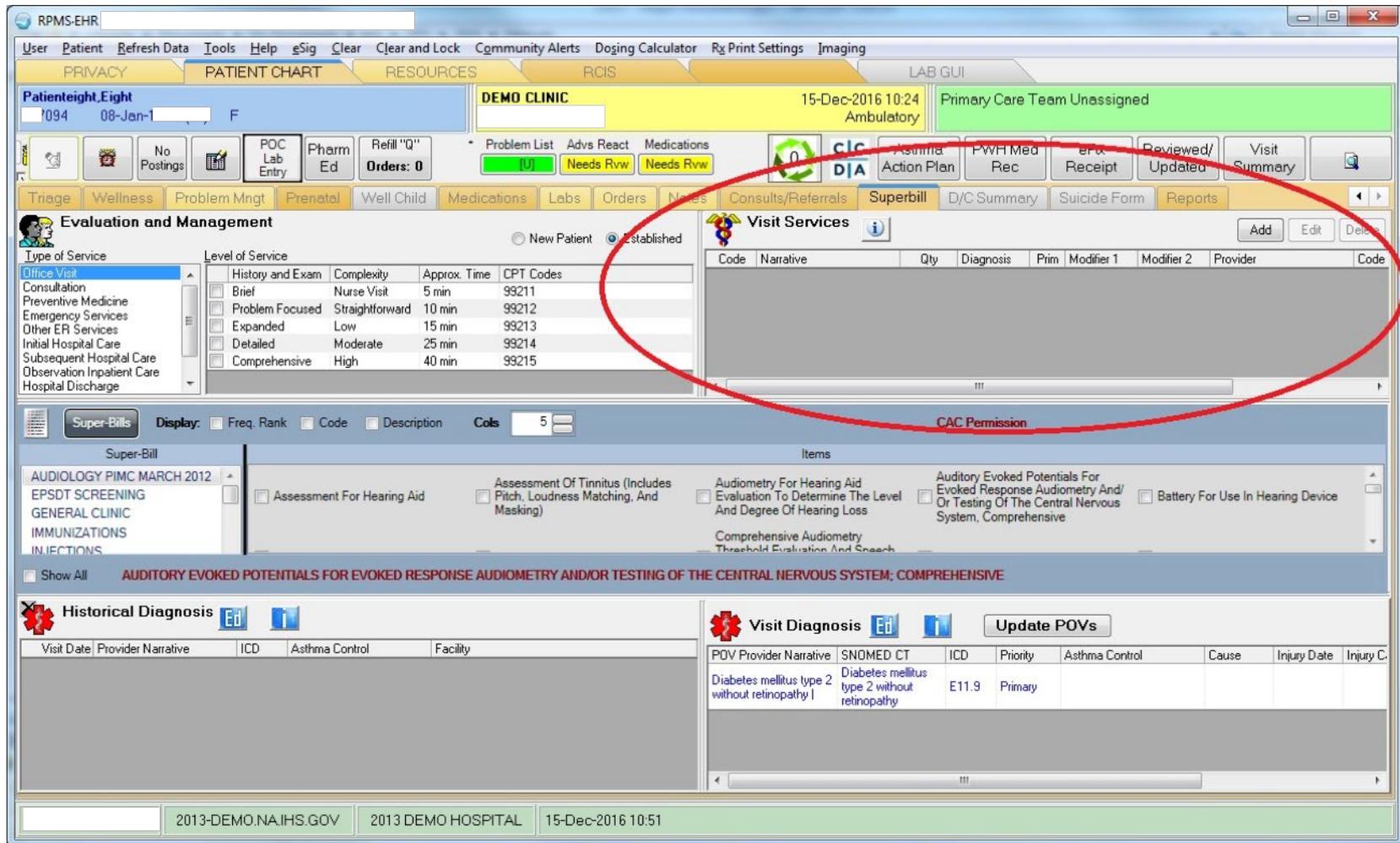


Figure 19: Visit Services component

To enter a Procedure code:

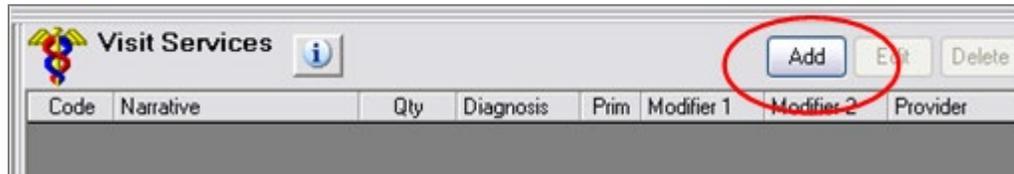


Figure 20: Entering a Procedure code

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

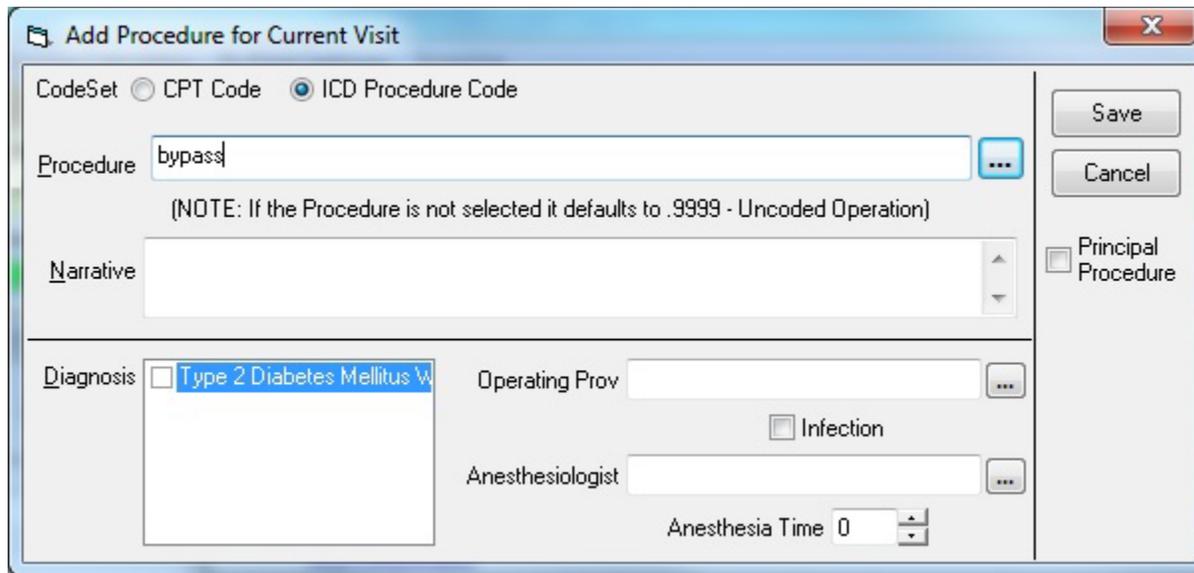


Figure 21: Add Procedure for Current Visit dialog

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.

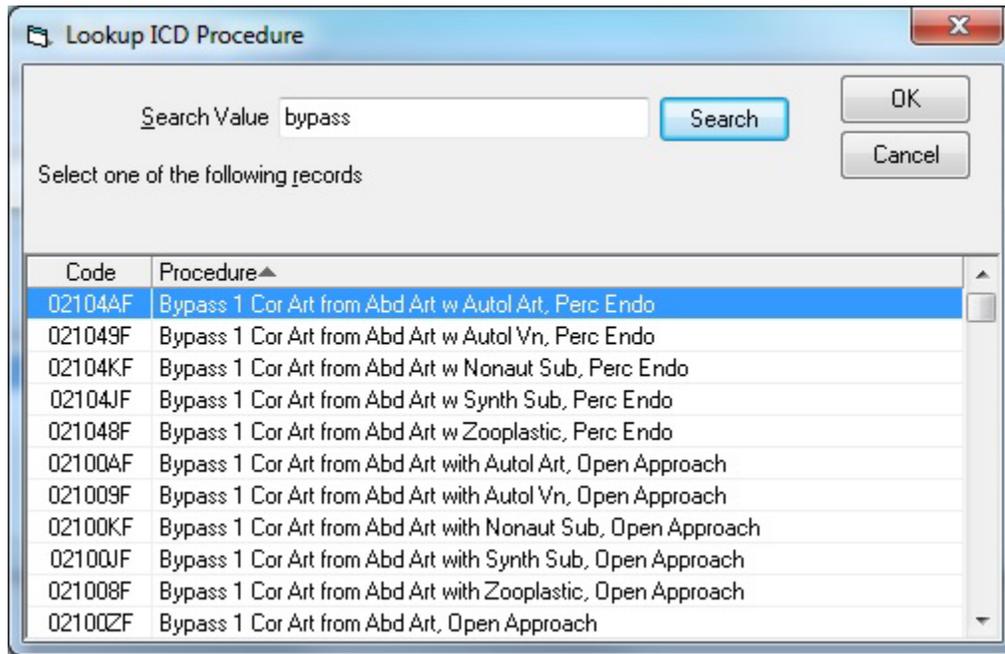


Figure 22: Choosing a Procedure

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).

Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider	Code
02104A F	Bypass 1 Cor Art From Abd Art W Autol Art, Perc Endo							Bypas Art W

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).

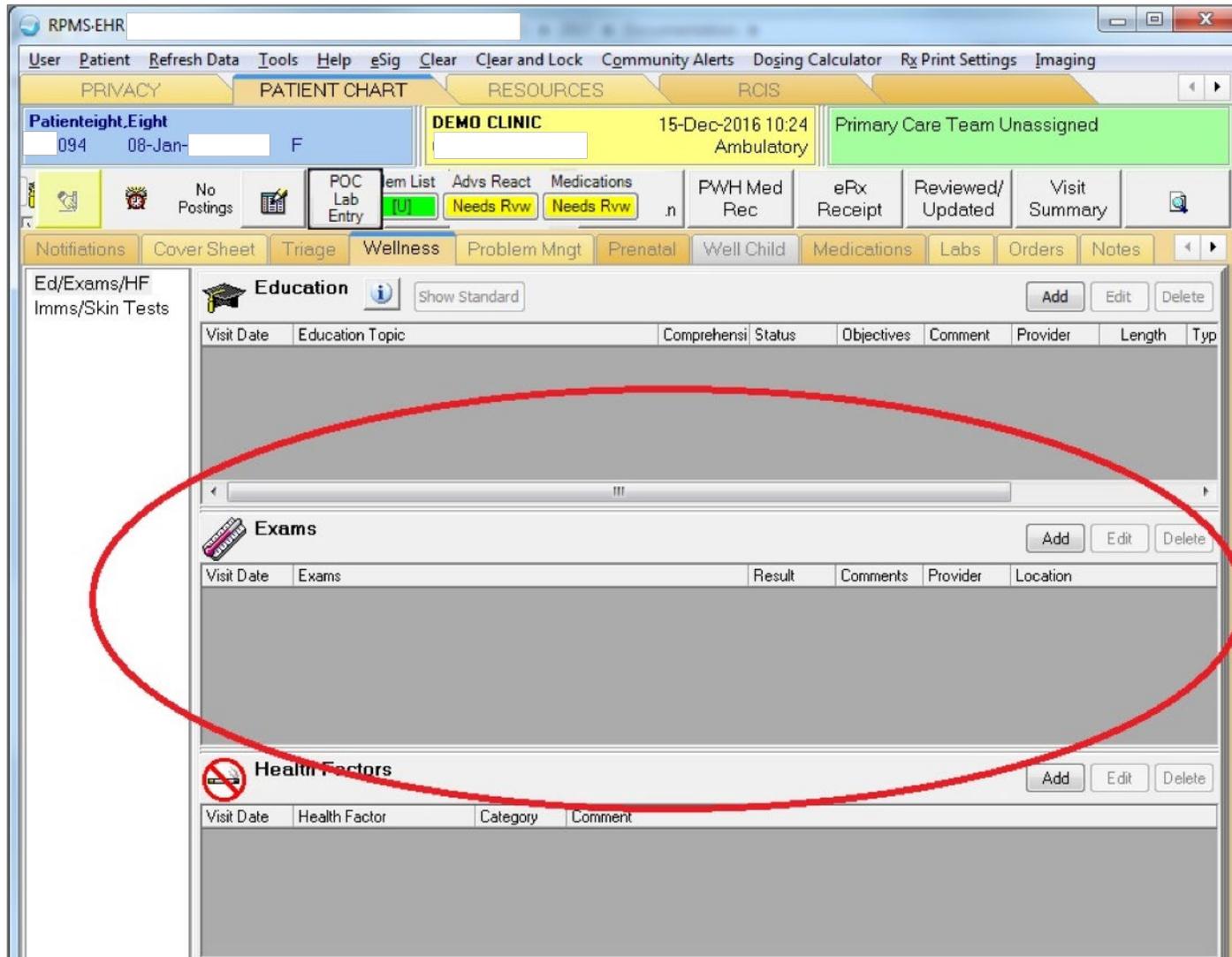


Figure 25: **Exams** component

To enter an Exam code:

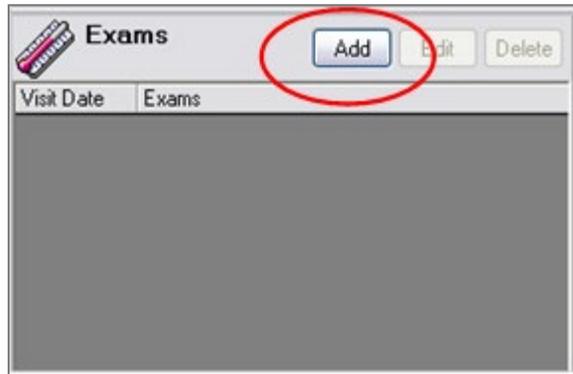


Figure 26: Entering an Exam code

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

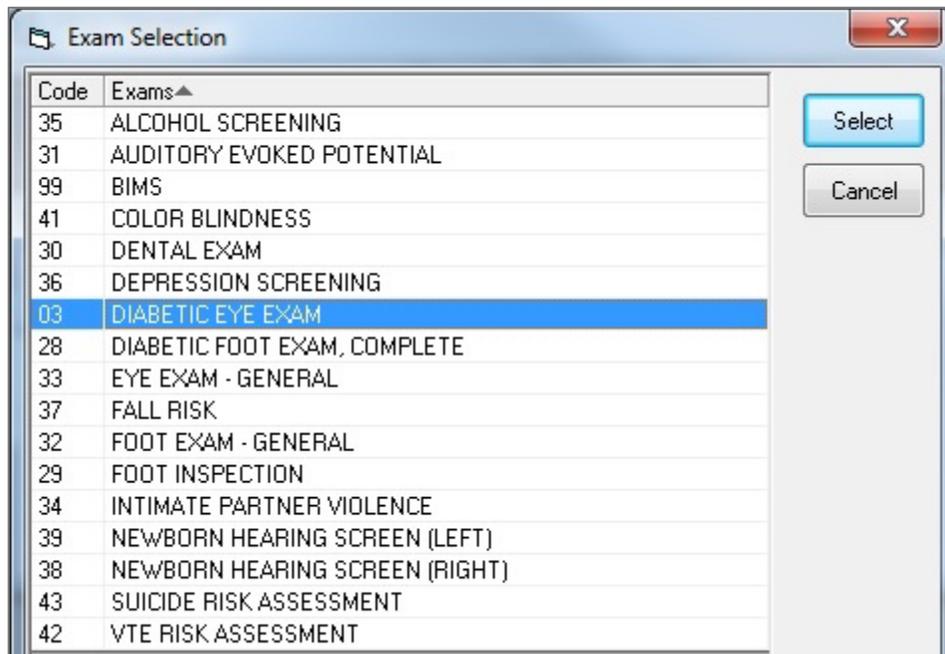


Figure 27: Selecting an exam

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

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

- Exam:** A text input field containing "DIABETIC EYE EXAM" and a dropdown arrow.
- Result:** A dropdown menu showing "NORMAL/NEGATIVE".
- Comment:** A text area with up and down arrow controls.
- Provider:** A text input field with a dropdown arrow.
- Buttons:** "Add" (highlighted in blue) and "Cancel".
- Radio Buttons:** "Current" (selected), "Historical", and "Not Done".

Figure 28: Entering a result and additional comments

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

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

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

Figure 29: Entering a historical exam

4. If this is a historical exam, select **Historical** and type the **Date** and **Location** of the exam (Figure 29).

5. Click **Save**. The newly added Exam code should display in the **Exams** component (Figure 30).

Exams <input type="button" value="Add"/> <input type="button" value="Edit"/> <input type="button" value="Delete"/>					
Visit Date	Exams	Result	Comments	Provider	Location
11/08/2016	DIABETIC EYE EXAM	NORMAL/NEGATIVE			CHEROKEE

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).

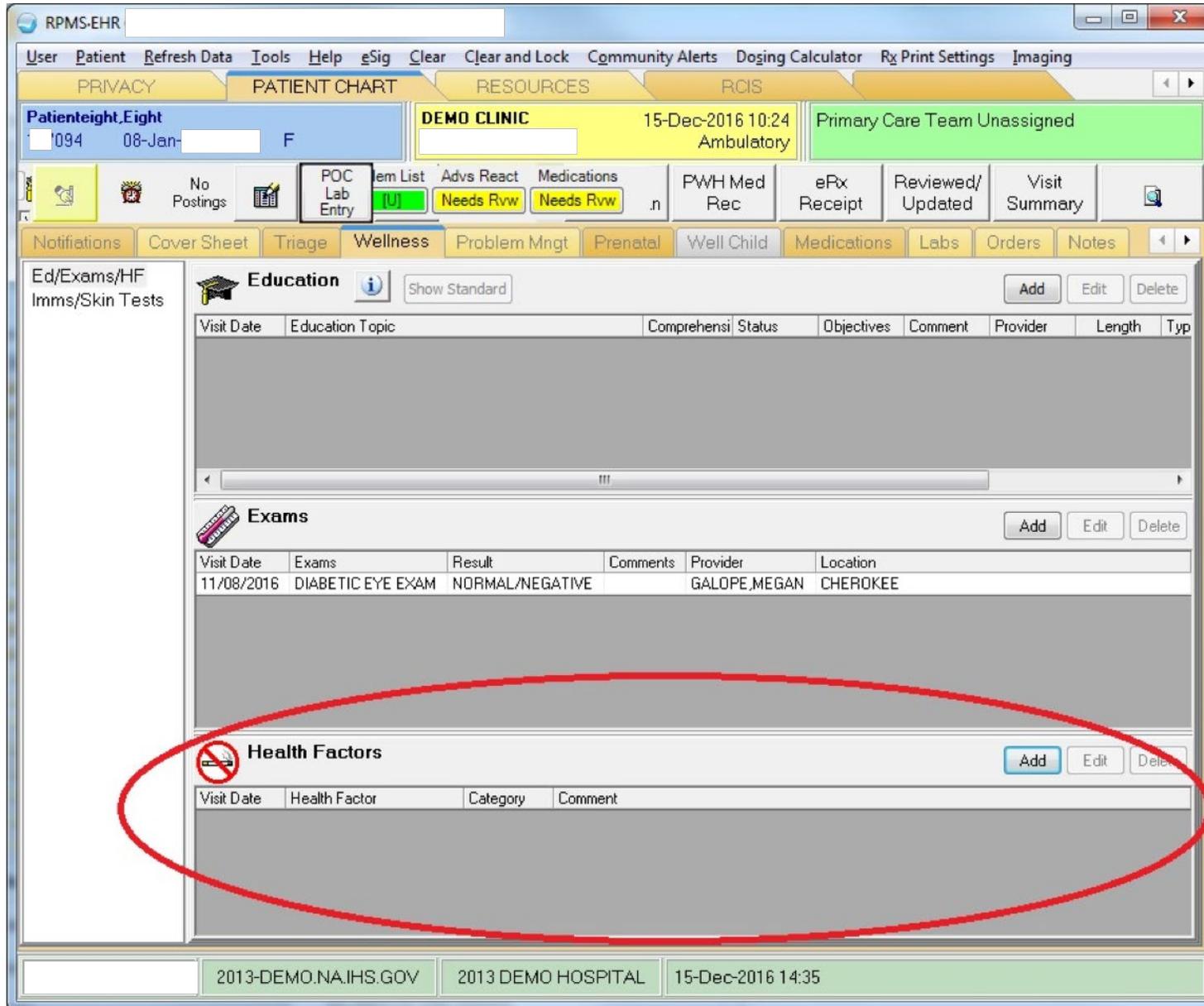


Figure 31: **Health Factors** component

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.

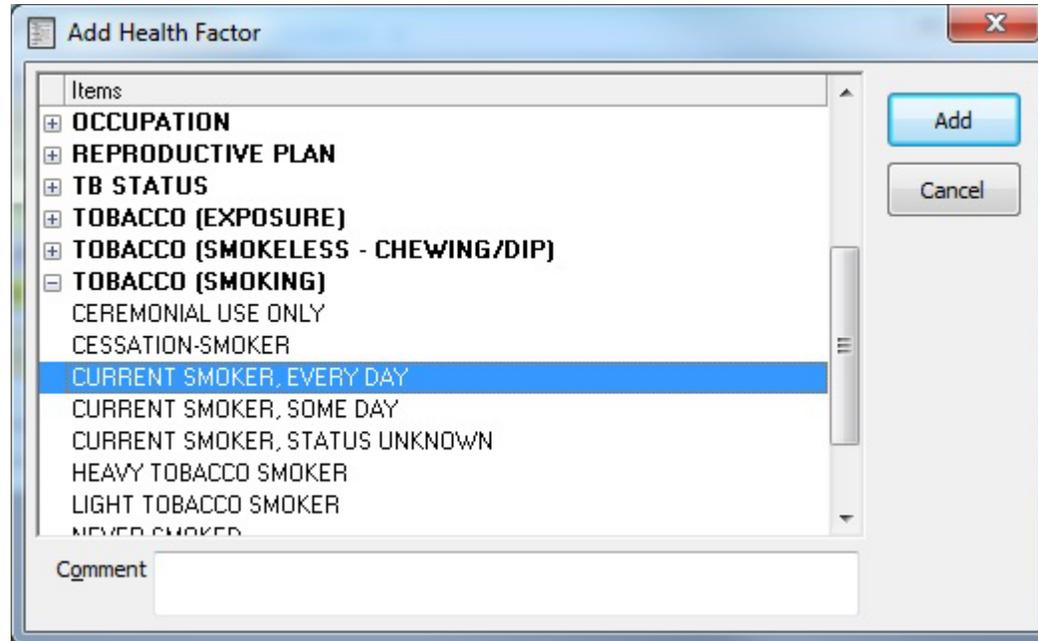
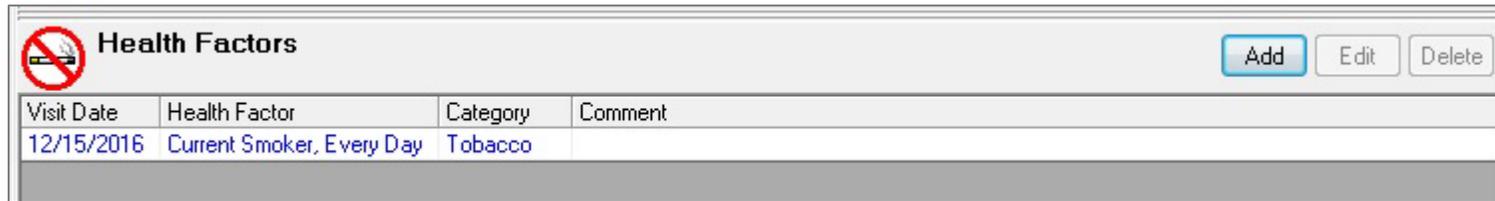


Figure 33: Choosing a **Health Factor**

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



The screenshot shows a window titled "Health Factors" with a "No Smoking" icon. It contains a table with the following data:

Visit Date	Health Factor	Category	Comment
12/15/2016	Current Smoker, Every Day	Tobacco	

Buttons for "Add", "Edit", and "Delete" are visible in the top right corner of the window.

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).

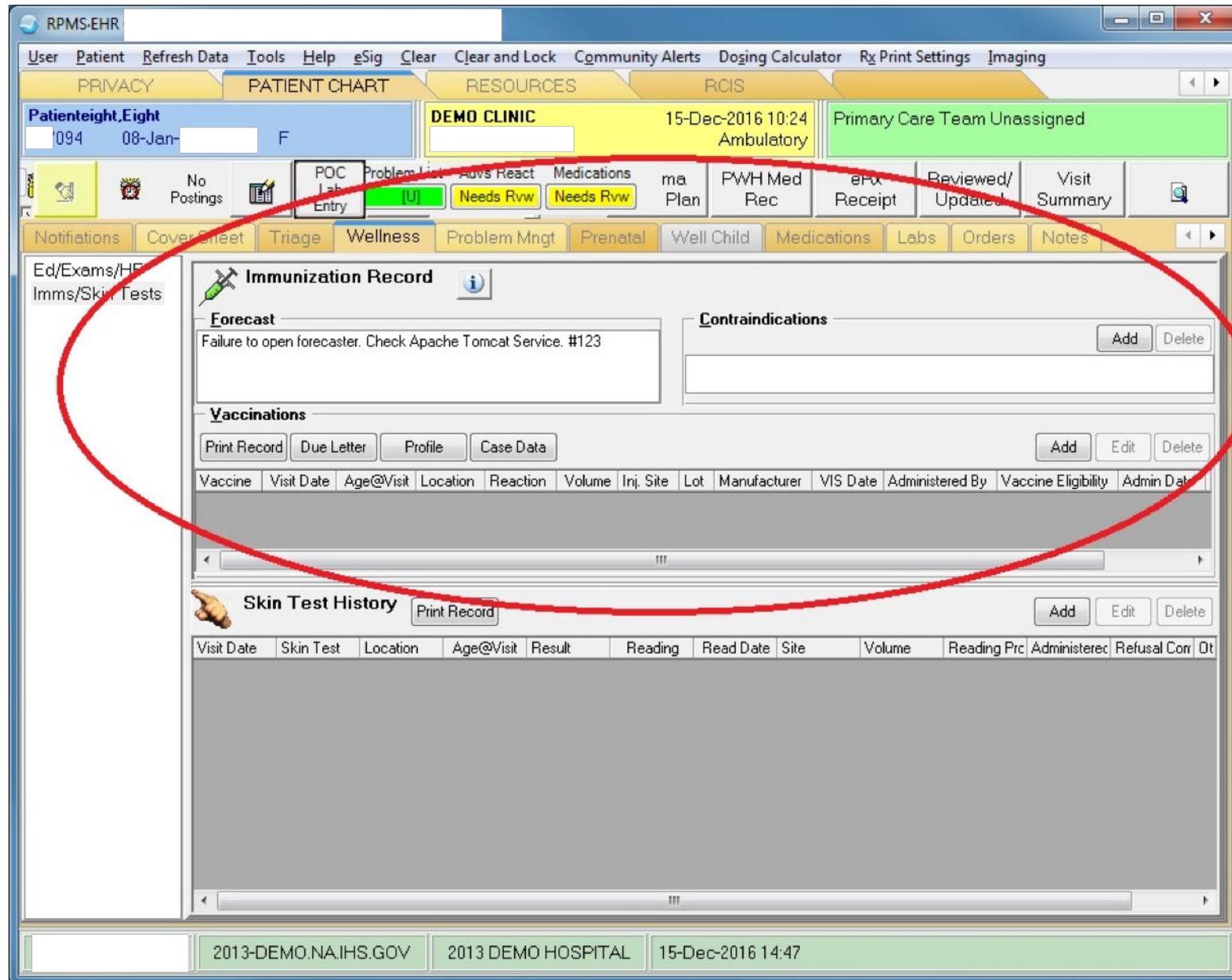


Figure 35: Immunization Record component

To enter an Immunization:

The screenshot shows a web application window titled "Immunization Record". It features a syringe icon and an information icon. The interface is divided into several sections: "Forecast" with a text area containing "Failure to open forecaster. Check Apache Tomcat Service. #123"; "Contraindications" with an empty text area and "Add" and "Delete" buttons; and "Vaccinations" with a row of buttons: "Print Record", "Due Letter", "Profile", "Case Data", "Add", "Edit", and "Delete". The "Add" button in the "Vaccinations" section is circled in red. Below these sections is a table header with columns: Vaccine, Visit Date, Age@Visit, Location, Reaction, Volume, Inj. Site, Lot, Manufacturer, VIS Date, Administered By, Vaccine Eligibility, and Admin Date.

Figure 36: Entering an Immunization

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

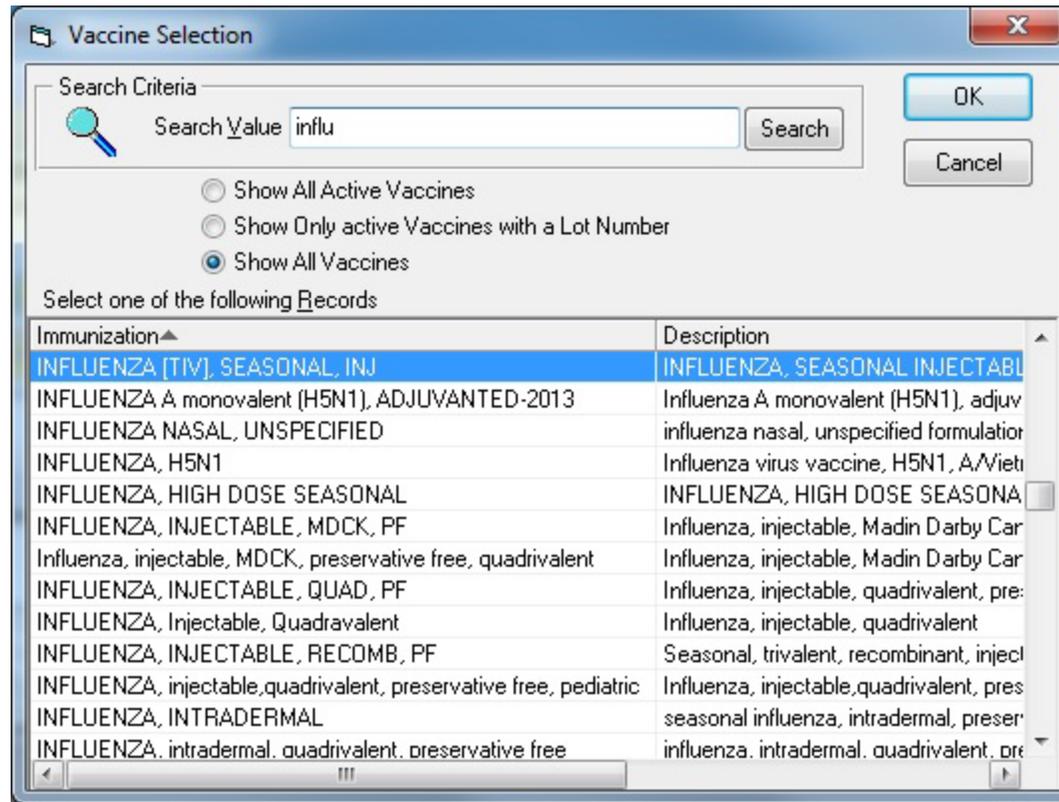


Figure 37: Choosing the Immunization

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

The screenshot shows a software window titled "Add Immunization". The window contains several input fields and controls:

- Vaccine:** A text box containing "INFLUENZA [TIV], SEASONAL, INJ" with a dropdown arrow.
- Administered By:** A text box with a dropdown arrow.
- Lot:** A dropdown menu showing "(Lot Not Specified)".
- Injection Site:** A dropdown menu showing "Left Arm SQ".
- Volume:** A spinner box set to "0.5" with "ml" next to it.
- Vac. Info. Sheet:** A text box containing "08/07/2015" with a dropdown arrow.
- Given:** A text box containing "12/15/2016 2:50 PM" with a dropdown arrow.
- Checkboxes:** A checked checkbox labeled "Patient/Family Counseled by Provider".
- Radio Buttons:** Three radio buttons labeled "Current" (selected), "Historical", and "Not Done".
- Buttons:** "OK" and "Cancel" buttons.
- Other:** A "Vac. Eligibility" dropdown menu and an "Admin Notes" text area.

Figure 38: Entering additional immunization information

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

Add Historical Immunization

Vaccine: INFLUENZA [TIV], SEASONAL, INJ

Documented By: []

Event Date: 10/14/2016

Location: CHEROKEE

IHS/Tribal Facility
 Other

Current
 Historical
 Not Done

Admin Notes: []

Buttons: OK, Cancel

Figure 39: Entering a historical immunization

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

Immunization Record

Forecast
 Failure to open forecaster. Check Apache Tomcat Service. #123

Contraindications
 Add Delete

Vaccinations
 Print Record Due Letter Profile Case Data Add Edit Delete

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

Figure 40: Example of a newly added Immunization

To enter a contraindication for an immunization:

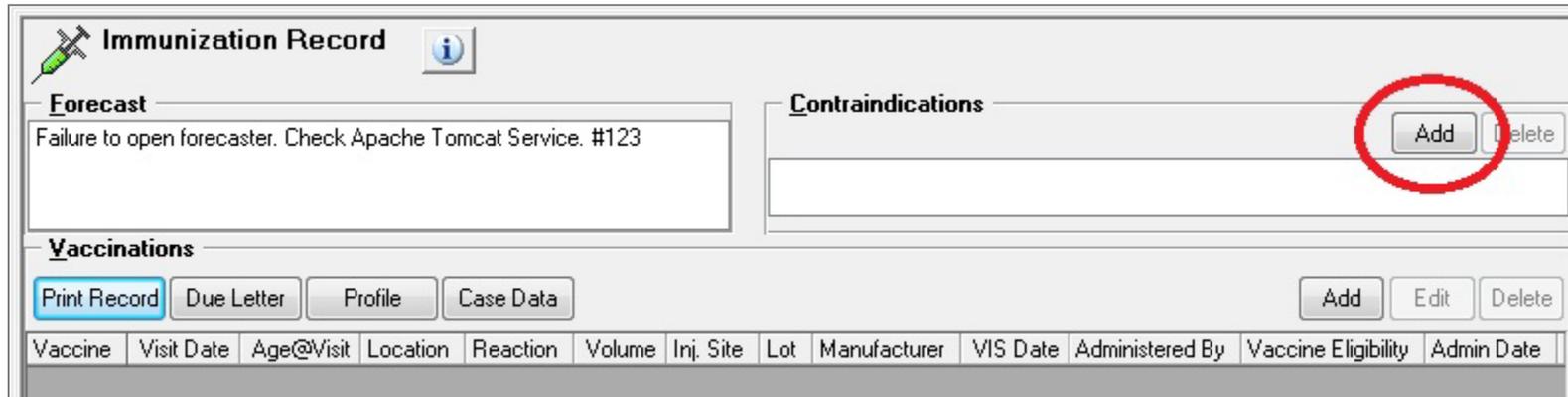


Figure 41: Entering a contraindication

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

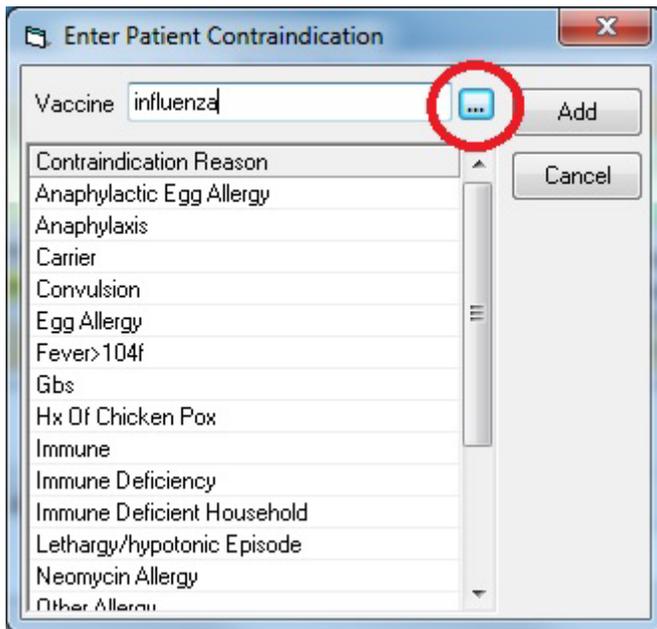


Figure 42: Choosing a contraindication

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

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

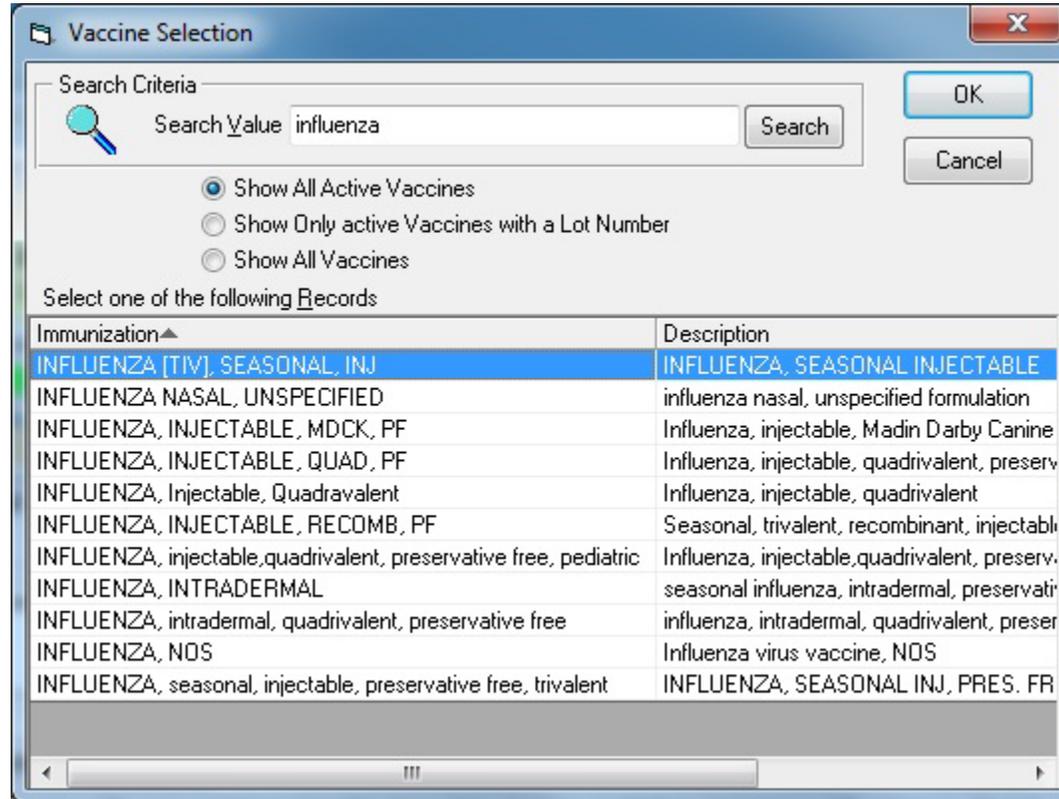


Figure 43: Selecting the immunization

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

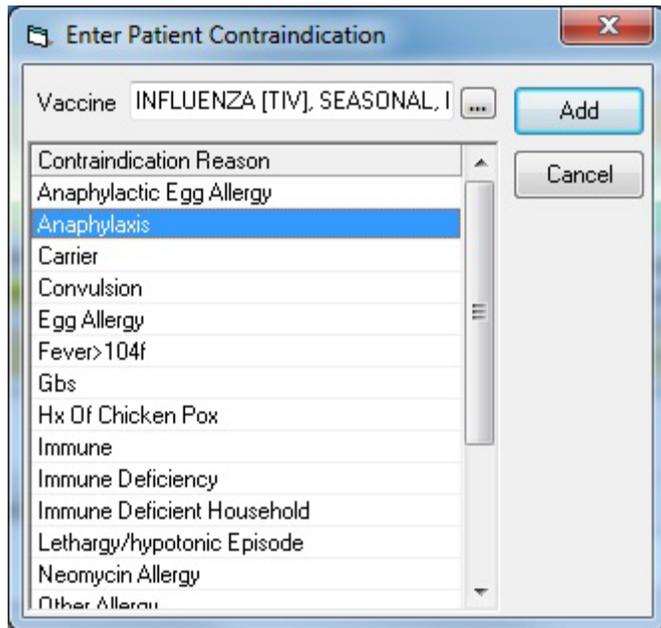


Figure 44: Enter Patient Contraindication dialog

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

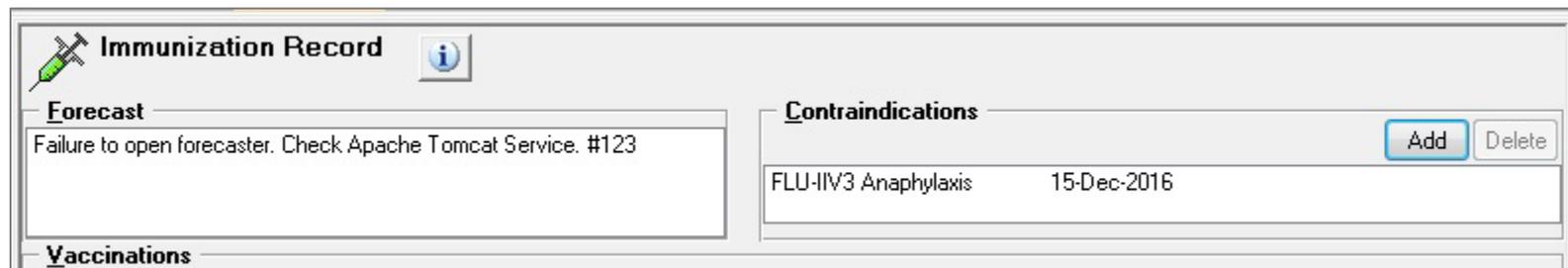


Figure 45: Example of a newly added contraindication

Vital Measurements

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

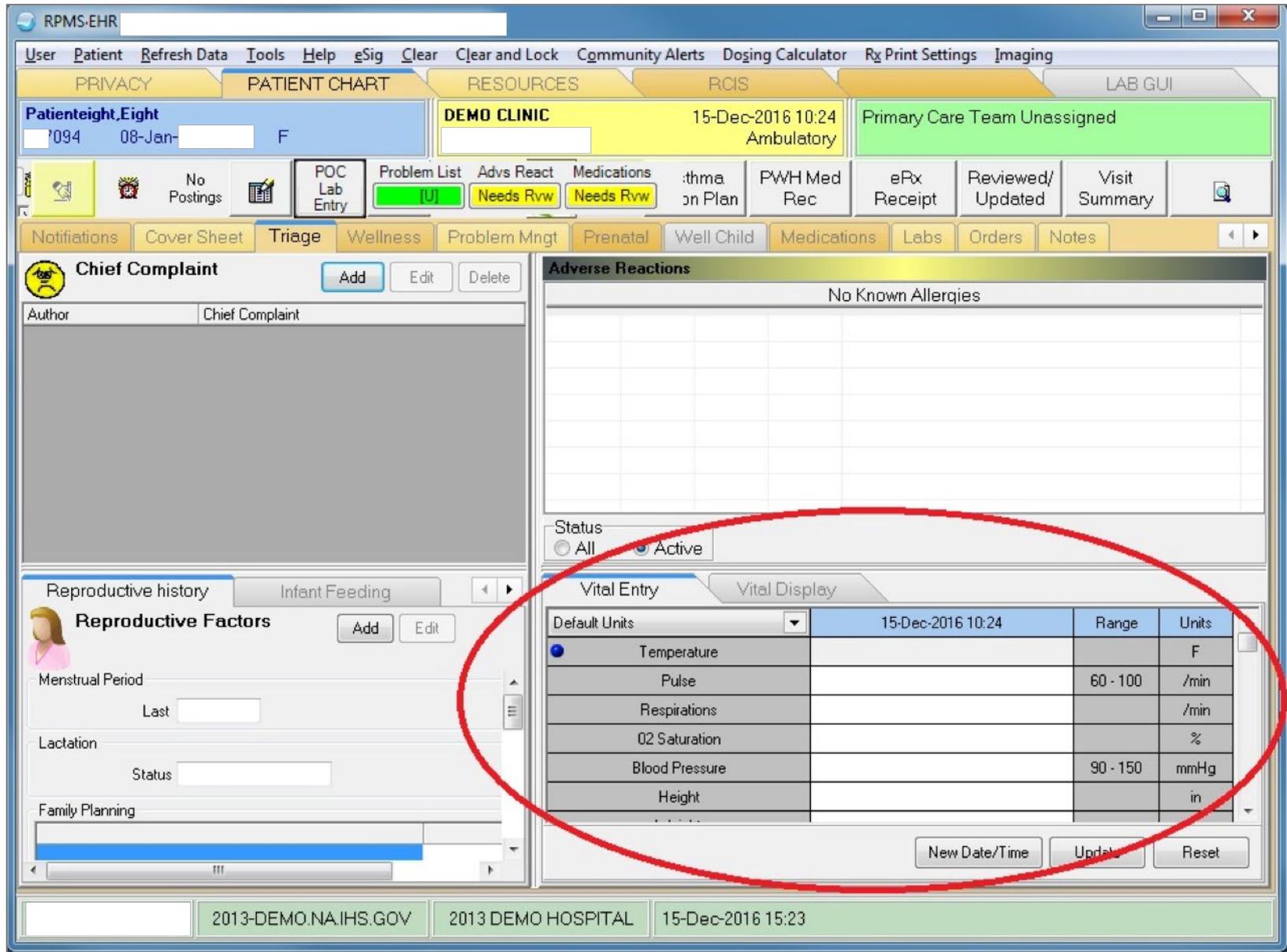
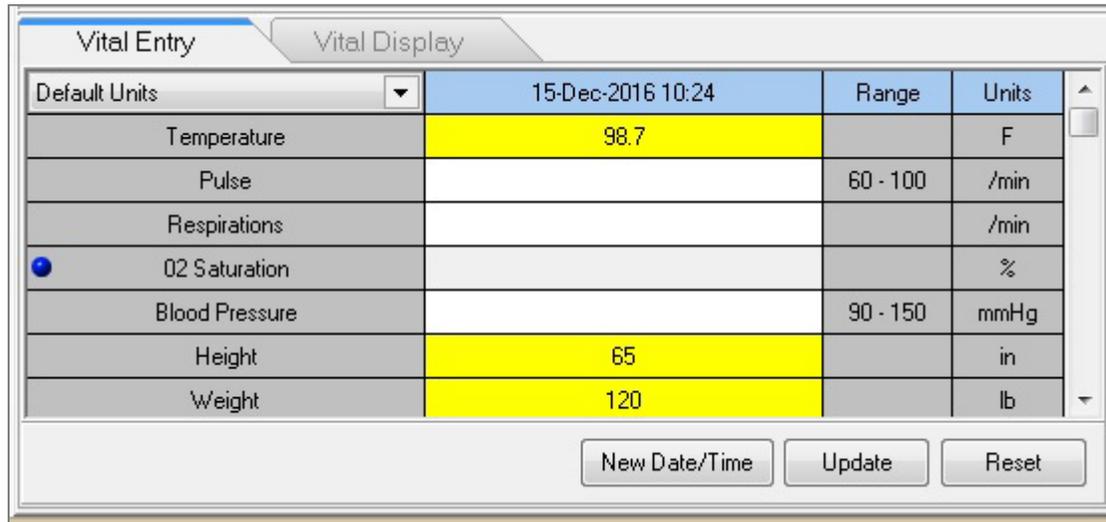


Figure 46: **Vitals** component

To enter Vital Measurements:



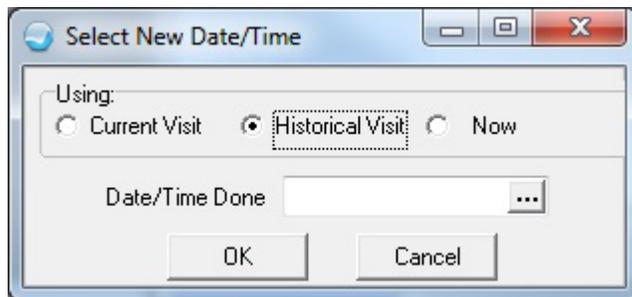
The screenshot shows a software window titled "Vital Entry" with a "Vital Display" tab. It contains a table with the following data:

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

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

Figure 47: Entering a Vital Measurement

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



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

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

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

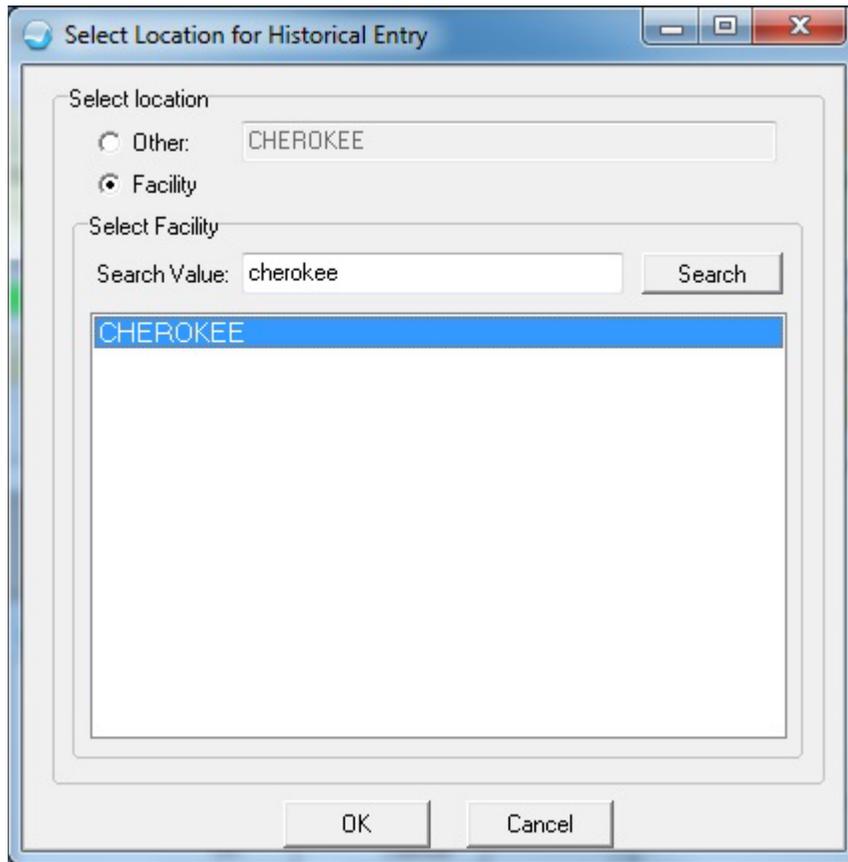


Figure 49: Choosing the historical location

- 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) redisplay.

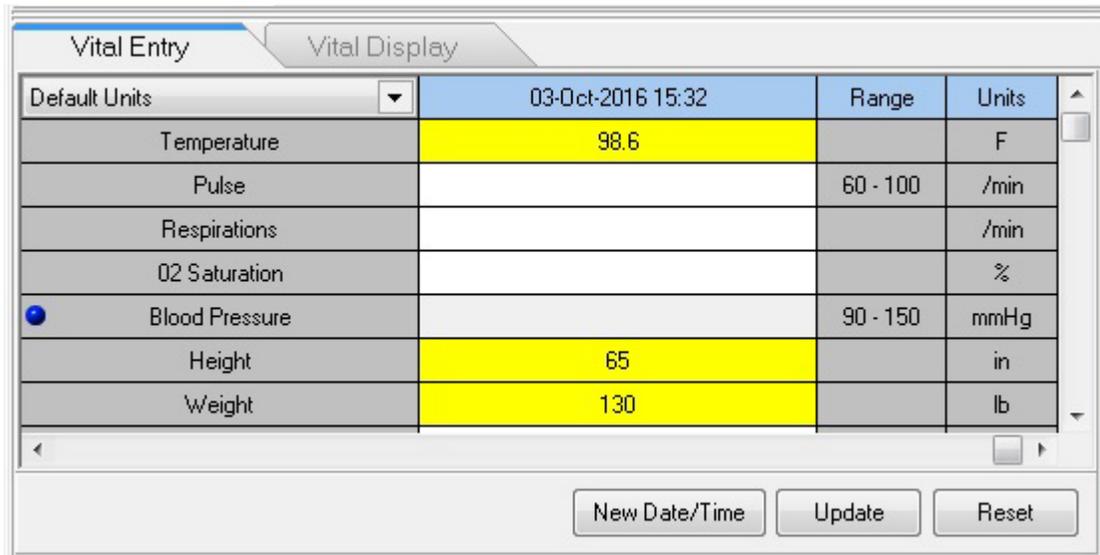


Figure 51: Entering Vital Measurements

Lab Tests

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

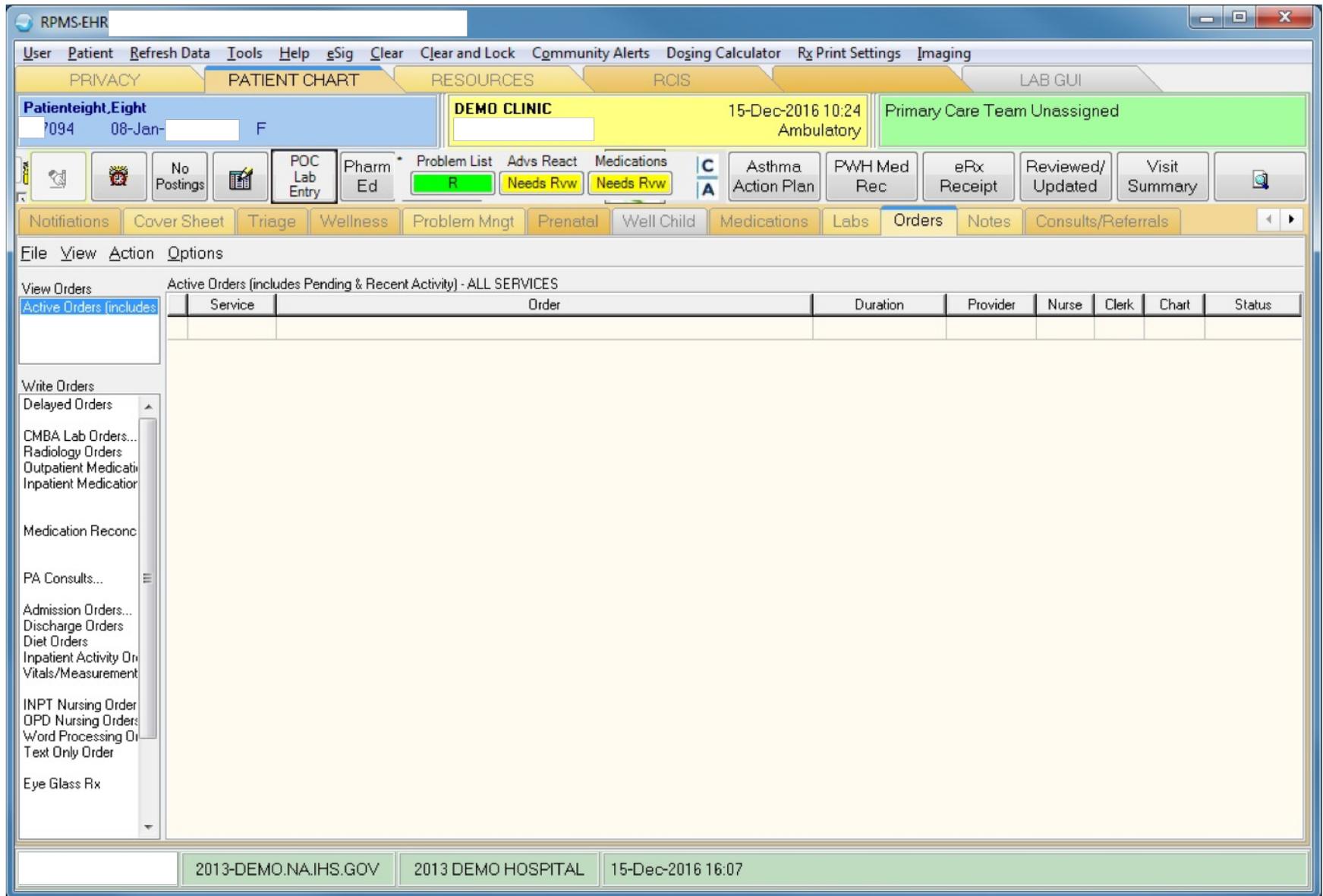


Figure 52: **Orders** component

To enter a Lab test:

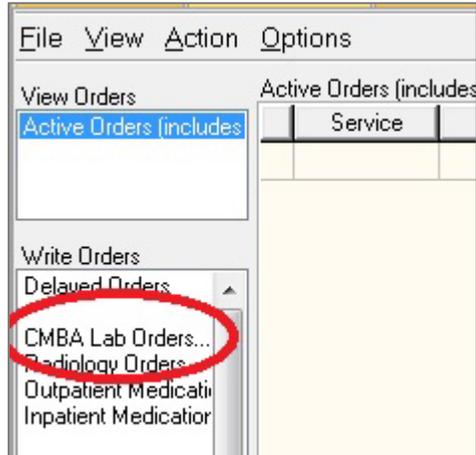


Figure 53: Entering a Lab test

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.

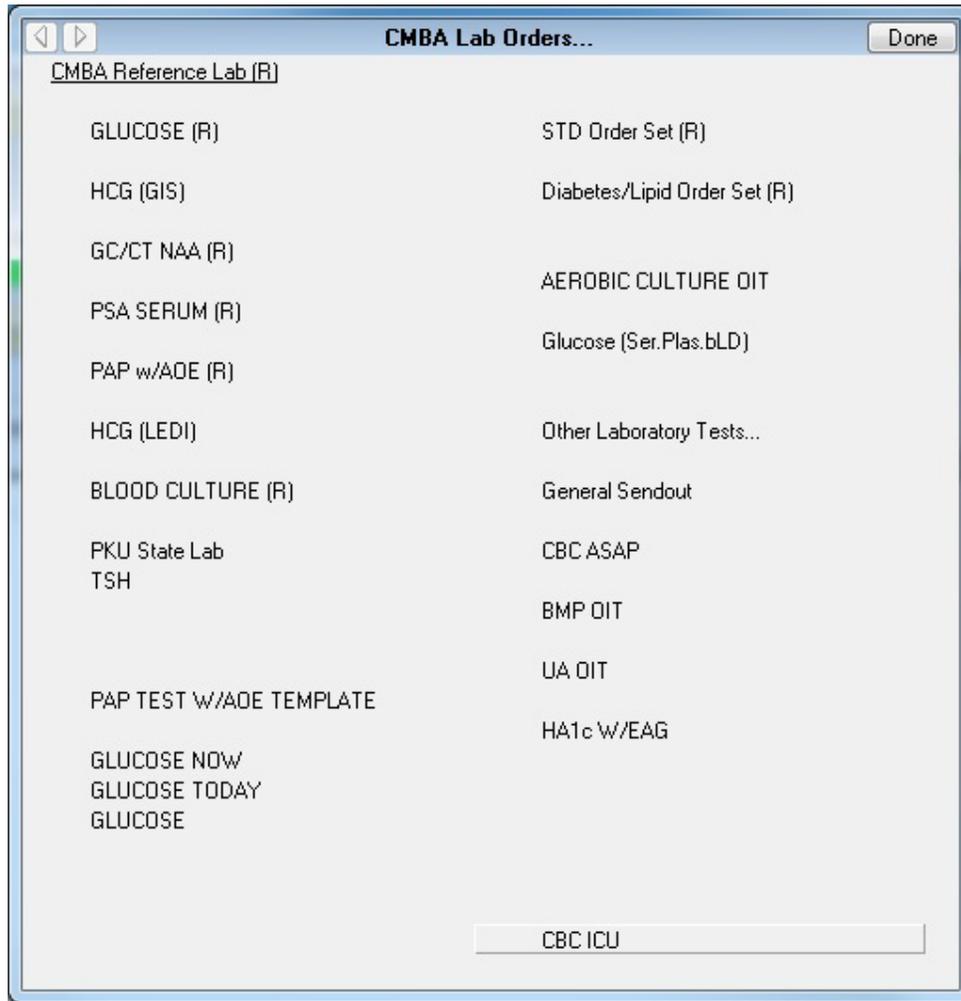


Figure 54: **Lab Orders...** dialog

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

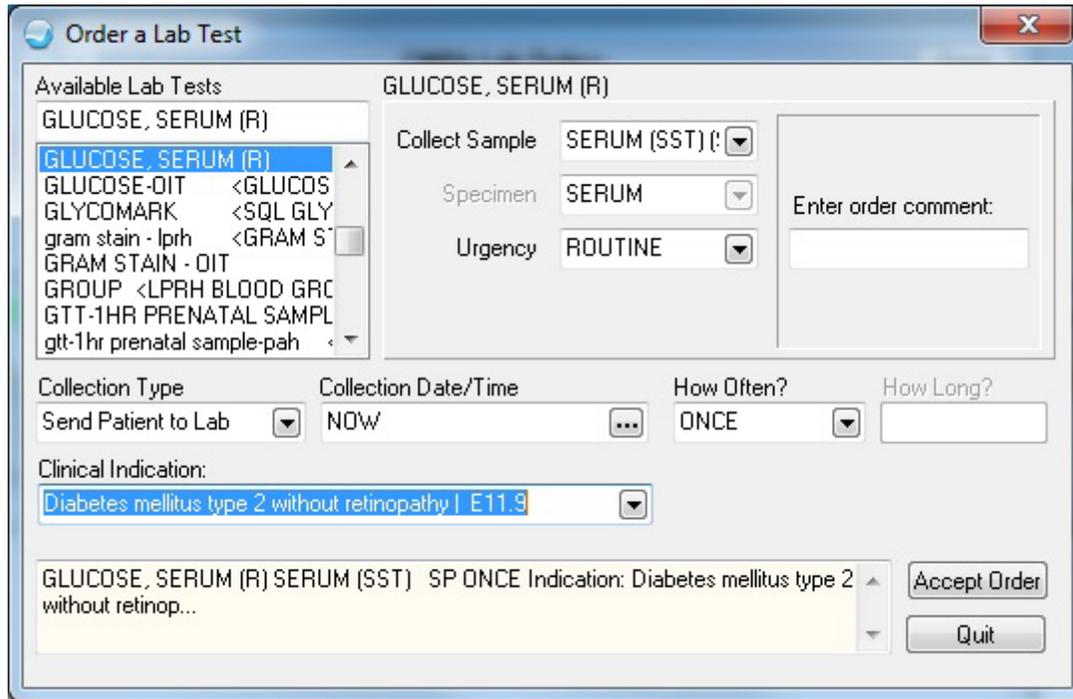


Figure 55: Order a Lab Test dialog

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).

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

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).

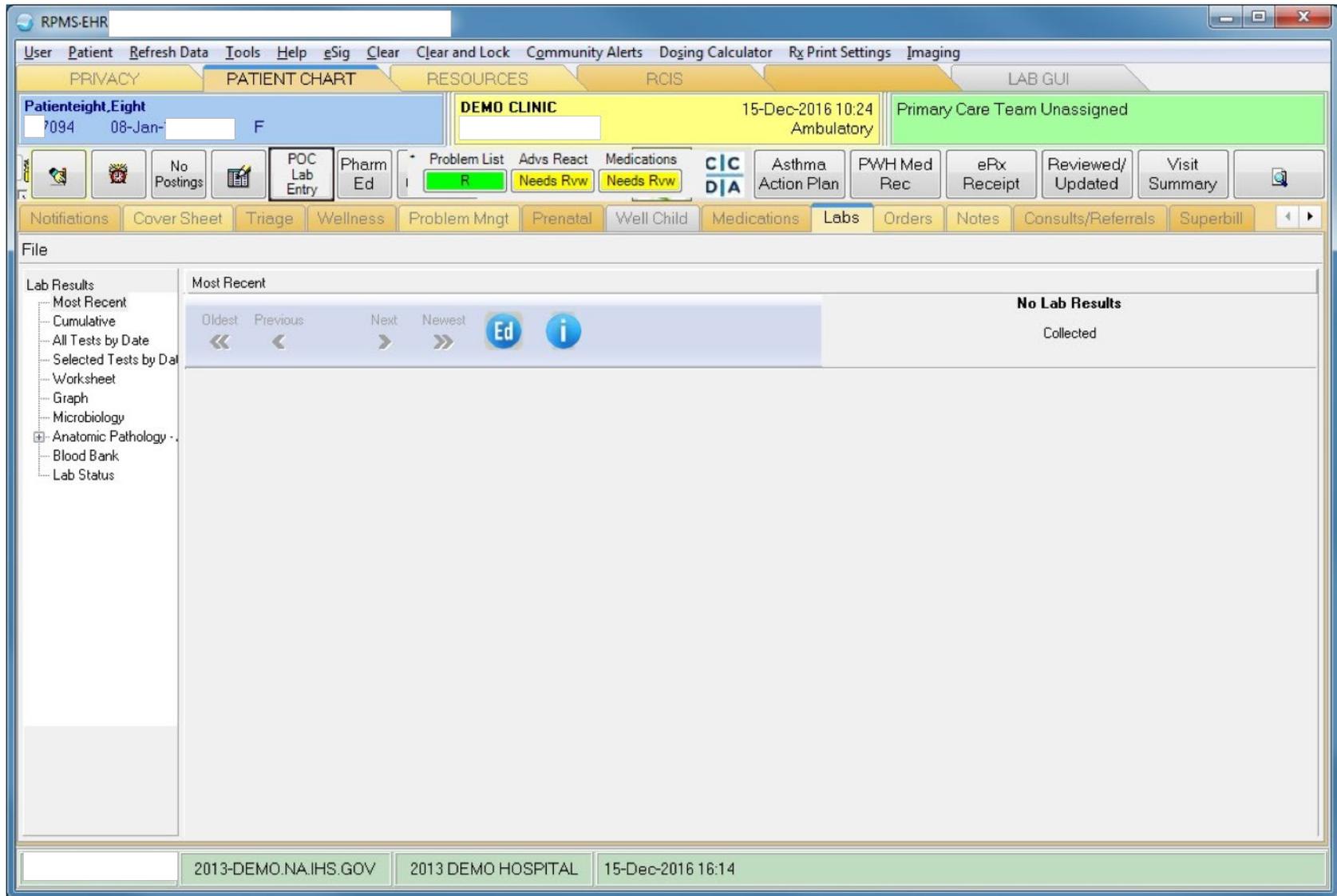


Figure 57: Viewing the lab results

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:

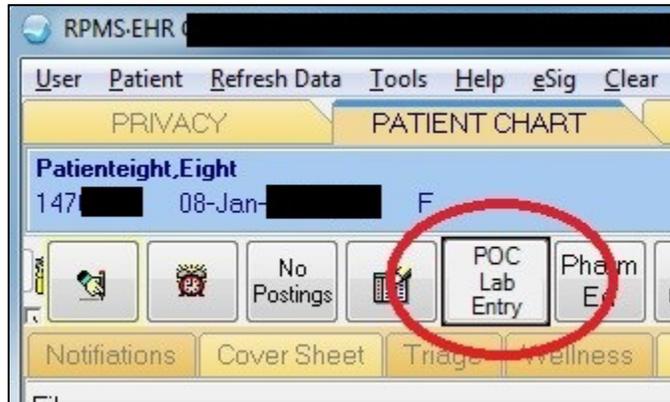


Figure 58: Entering a Point of Care Lab test

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.

Lab Point of Care Data Entry Form

Patient: PATIENT, CRSAE Hospital Location: 01 GENERAL

Ordering Provider: [REDACTED] Nature of Order/Change: WRITTEN

Test: GLUCOSE Sample Type: BLOOD

Collection Date and Time: 08/23/2010 09:55 AM Sign or Symptom: 714.0 Rheumatoid Arthritis

Comment/Lab Description:

[Text Area] Add Canned Comment

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

Save Cancel

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).

The screenshot displays the 'Medications' component within the RPMS-EHR system. The interface is organized into several sections:

- Header/Menu:** Includes 'User', 'Patient', 'Refresh Data', 'Tools', 'Help', 'eSig', 'Clear', 'Clear and Lock', 'Community Alerts', 'Dosing Calculator', 'Rx Print Settings', and 'Imaging'.
- Navigation Tabs:** 'PRIVACY', 'PATIENT CHART', 'RESOURCES', 'RCIS', and 'LAB GUI'.
- Patient Information:** Patient name 'Patienteight, Eight', ID '7094', birth date '08-Jan-', gender 'F', location 'DEMO CLINIC', visit date '15-Dec-2016 10:24 Ambulatory', and 'Primary Care Team Unassigned'.
- Toolbars:**
 - Top toolbar: 'No Postings', 'POC Lab Entry', 'Problem List', 'Advs React', 'Medications', 'Asthma Action Plan', 'PWH Med Rec', 'eRx Receipt', 'Reviewed/Updated', 'Visit Summary'.
 - Secondary toolbar: 'Notifications', 'Cover Sheet', 'Triage', 'Wellness', 'Problem Mngt', 'Prenatal', 'Well Child', 'Medications', 'Labs', 'Orders', 'Notes'.
- Main Action Area:** 'File', 'View', 'Action' menu and buttons for 'Active Only', 'Chronic Only', '90 days', 'Print...', 'Print New Items', 'Process...', 'New...', 'Check', 'Ed', and 'i'.
- Medication Tables:**
 - Outpatient Medications:** Columns include Action, Chronic, Outpatient Medications, Status, Process, Issued, Last Filled, Expires, Refills Remaining, Rx #, and Provider.
 - Non-CRSU Meds-Outside Rx, OTC:** Columns include Action, Status, and Start Date.
 - Inpatient Medications:** Columns include Action, Status, and Stop Date.
- Footer:** '2013-DEMO.NA.IHS.GOV', '2013 DEMO HOSPITAL', and '15-Dec-2016 15:42'.

Figure 60: Medications component

To enter a prescription for a medication:

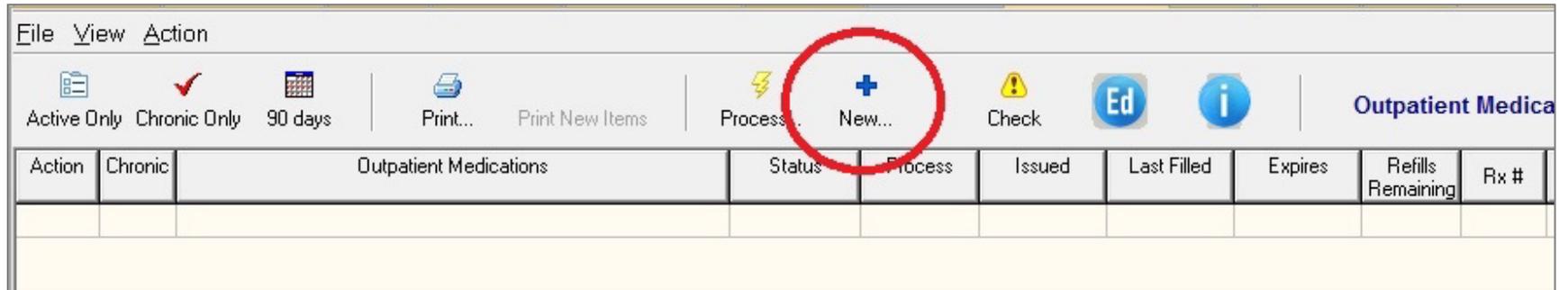


Figure 61: Entering a patient medication

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

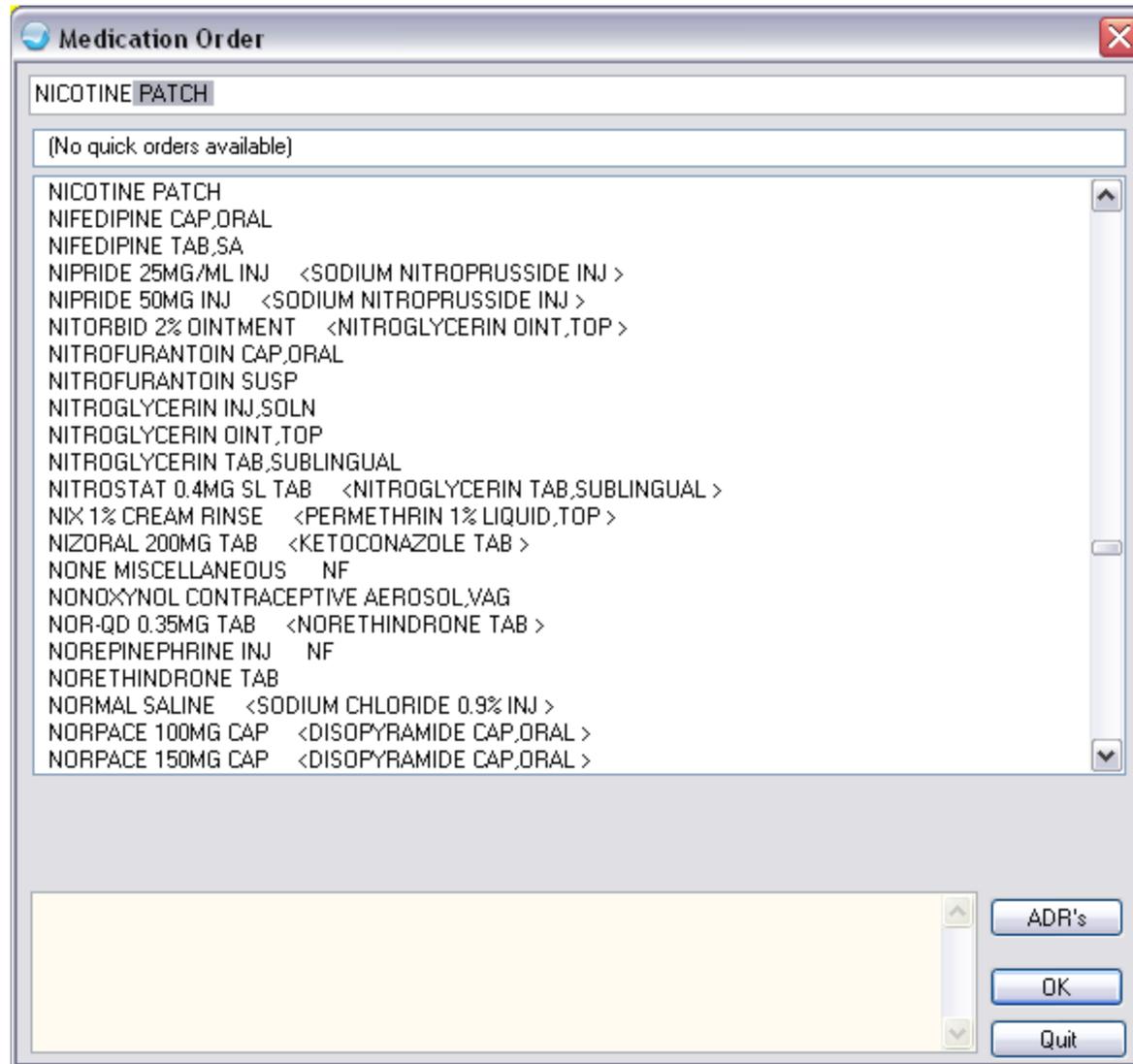


Figure 62: Medication Order dialog

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

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

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

Figure 63: Entering additional medication information

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

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

Figure 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).

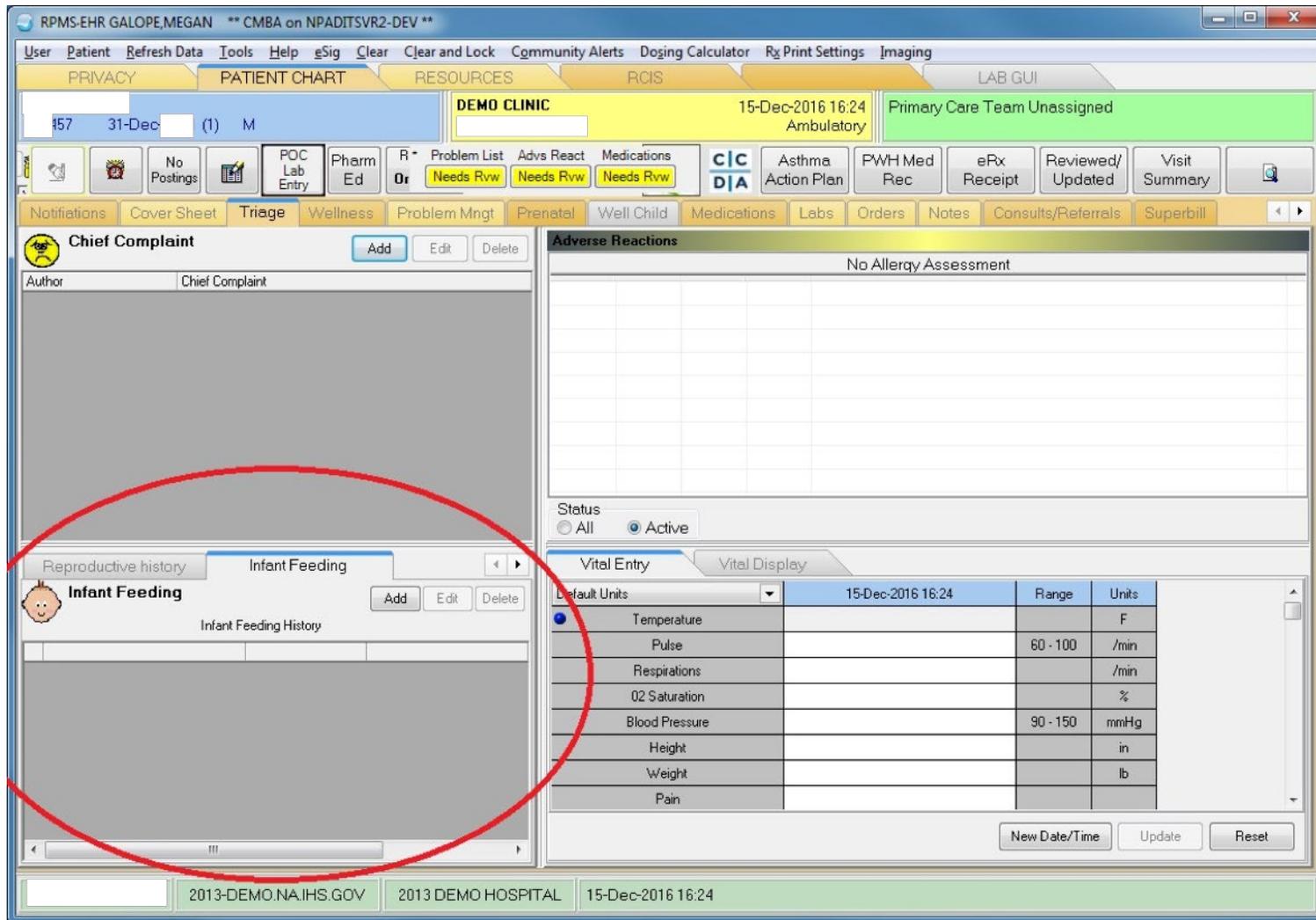


Figure 65: Infant Feeding component

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.

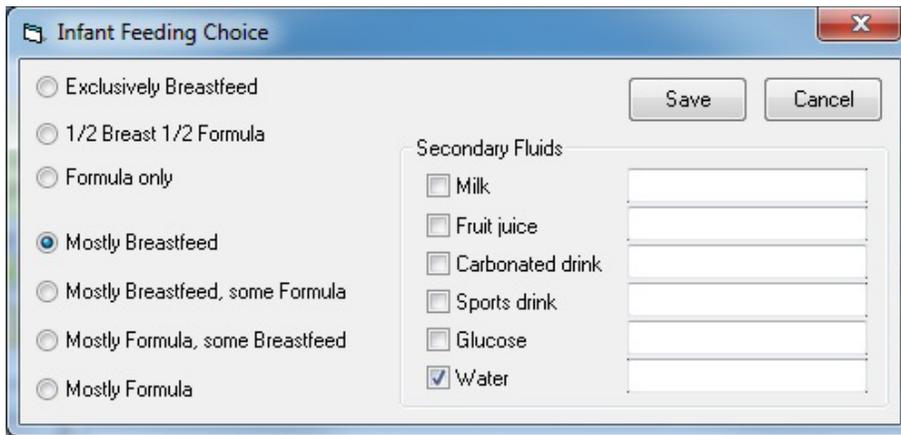


Figure 67: Selecting an Infant Feeding choice

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).

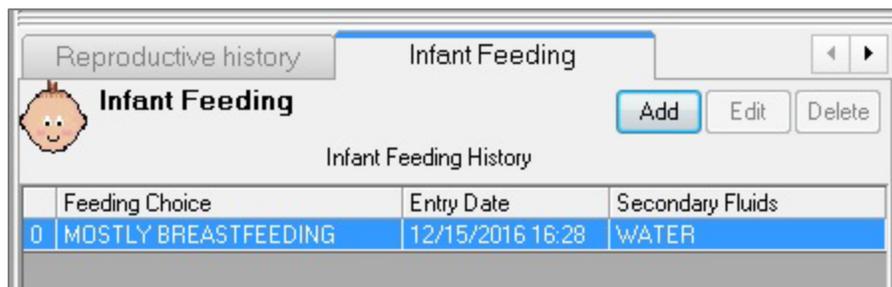


Figure 68: Example of a newly added Infant Feeding choice

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).

The screenshot displays the RPMS-EHR interface for patient 'Patienteight.Eight'. The 'Wellness' tab is active, and the 'Education' component is selected. The Education table is highlighted with a red circle. Below it, the 'Exams' and 'Health Factors' sections are visible.

Visit Date	Education Topic	Comprehensi	Status	Objectives	Comment	Provider	Length	Type	Location

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

Visit Date	Health Factor	Category	Comment
12/15/2016	Current Smoker, Every Day	Tobacco	

2013-DEMO.NA.IHS.GOV 2013 DEMO HOSPITAL 15-Dec-2016 16:31

Figure 69: **Education** component

To enter Patient Education:

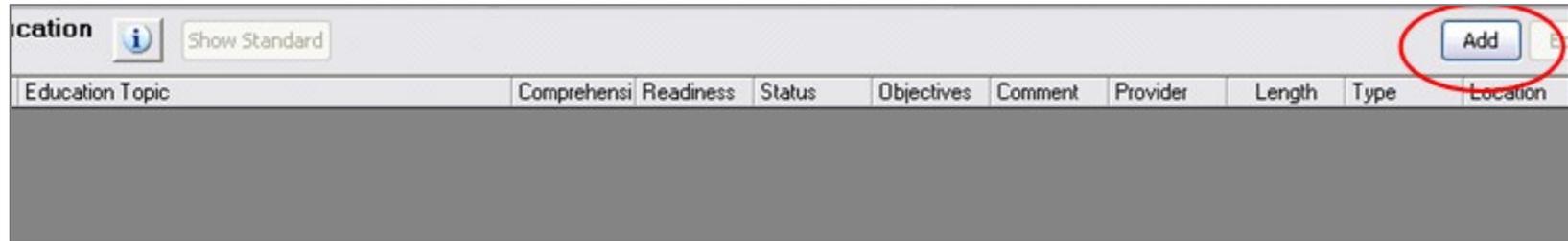


Figure 70: Entering Patient Education

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

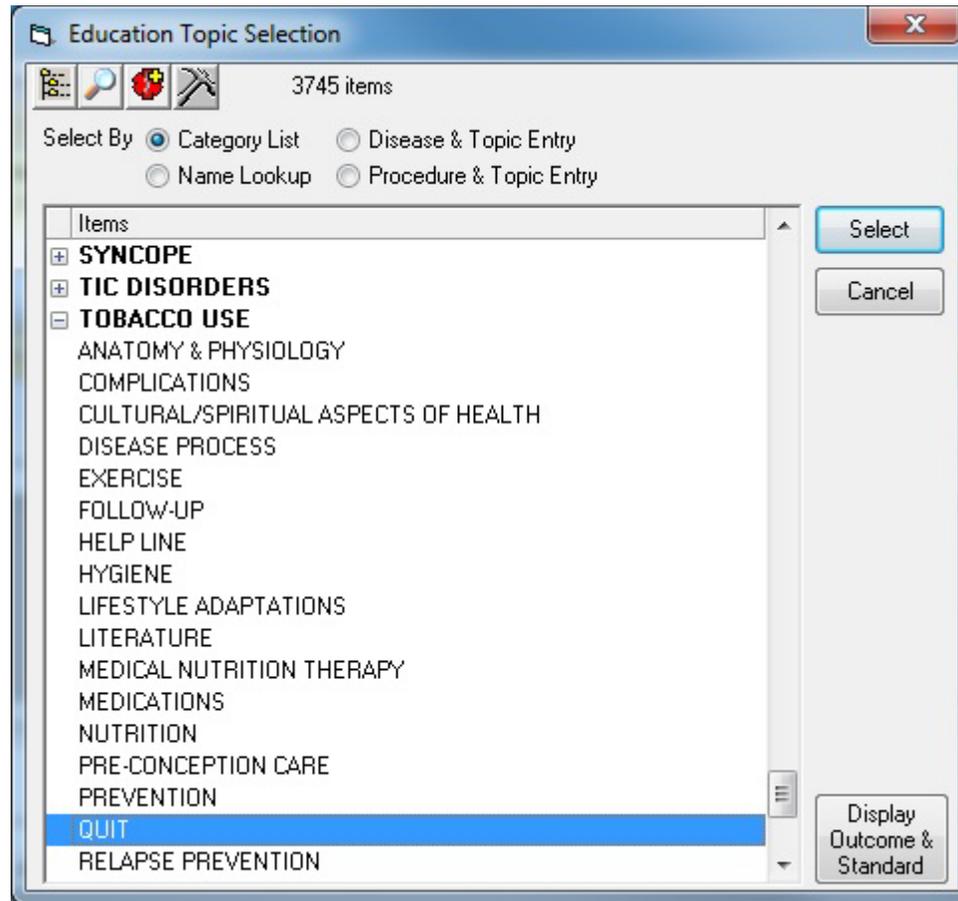


Figure 71: Selecting the education

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:

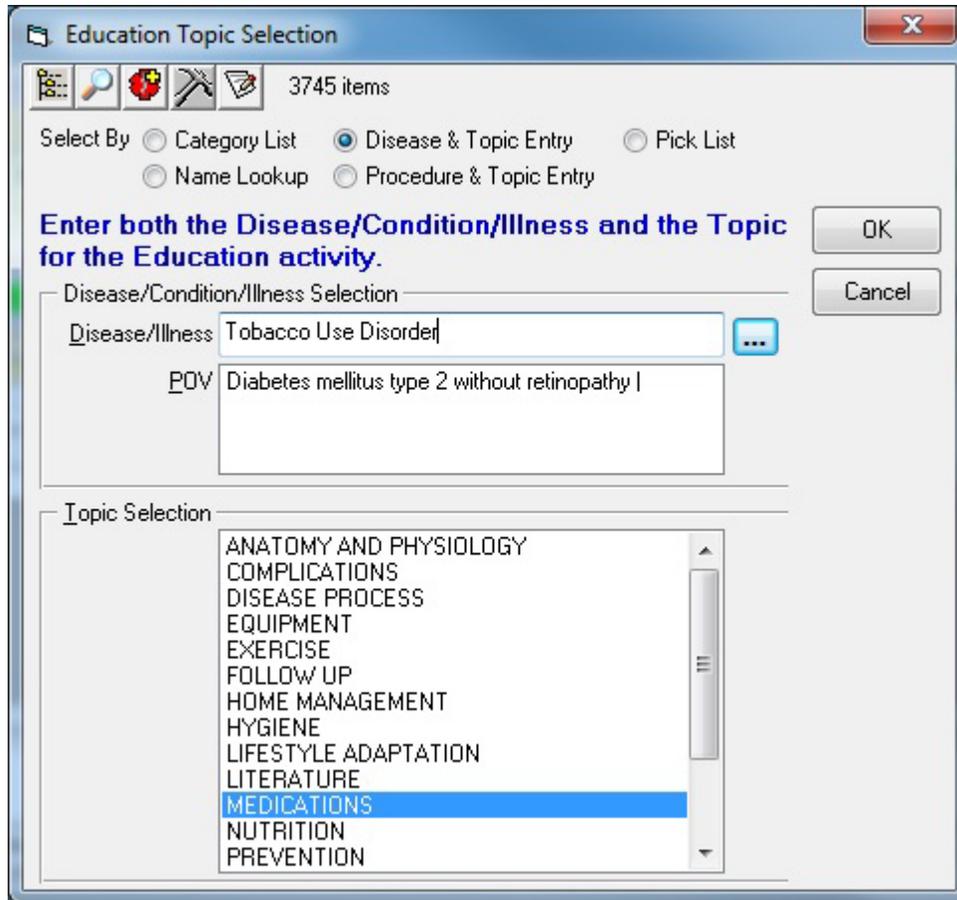


Figure 72: Entering Patient Education by disease

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.

The screenshot shows a software dialog box titled "Add Patient Education Event". The dialog is divided into two main sections. The left section contains several input fields and radio buttons: "Education Topic" is set to "Tobacco Use-Quit" with "(Tobacco Use)" below it; "Type of Training" has "Individual" selected; "Comprehension Level" is set to "GOOD"; "Length" is "10 (min)"; "Comment" is an empty text box; "Provided By" is an empty text box; "Readiness to Learn" is set to "RECEPTIVE"; and "Status/Outcome" has three radio buttons: "Goal Set", "Goal Met", and "Goal Not Met", with "Goal Set" selected. The right section contains a vertical stack of controls: an "Add" button, a "Cancel" button, a "Historical" checkbox (unchecked), a "Display Outcome & Standard" button, and a "Patient's Learning Health Factors" button. Below the "Patient's Learning Health Factors" button is an empty text box.

Figure 73: Add Patient Education Event dialog

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

The screenshot shows a software window titled "Add Patient Education Event". The window is divided into two main sections. The left section contains the following fields and controls:

- Education Topic:** A text box containing "Tobacco Use-Quit" with "(Tobacco Use)" below it.
- Type of Training:** Radio buttons for "Individual" (selected) and "Group".
- Comprehension Level:** A dropdown menu showing "GOOD".
- Length:** A text box with "10" and "(min)" next to it.
- Comment:** An empty text area.
- Provided By:** An empty text box.
- Readiness to Learn:** A dropdown menu.
- Status/Outcome:** Radio buttons for "Goal Set", "Goal Met", and "Goal Not Met".
- Historical:** A section containing:
 - Event Date:** A text box with "11/29/2016".
 - Location:** A text box with "CHEROKEE".
 - Radio buttons for "IHS/Tribal Facility" (selected) and "Other".

The right section of the window contains the following controls:

- Add:** A blue button.
- Cancel:** A grey button.
- Historical:** A checked checkbox.
- Display Outcome & Standard:** A button.
- Patient's Learning Health Factors:** A button.

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.

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

Figure 75: Example of a newly added Patient Education

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

Integrated Problem Maintenance - Add Problem

Problem ID **TST-2** Priority Pregnancy Related Use as POV Primary Save Cancel

* **SNOMED CT** ... Get SCT Pick list

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

* Required Field

Provider Text

Date of Onset ...

Qualifiers Severity: Clinical Course
 Severity Clinical Course Episodicities

Is Injury

Comments Add Delete

Narrative	Date	Author

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

Goal Notes	Care Plans	Visit Instructions	Care Planning Activities

Figure 76: Entering the Patient Education

- 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.

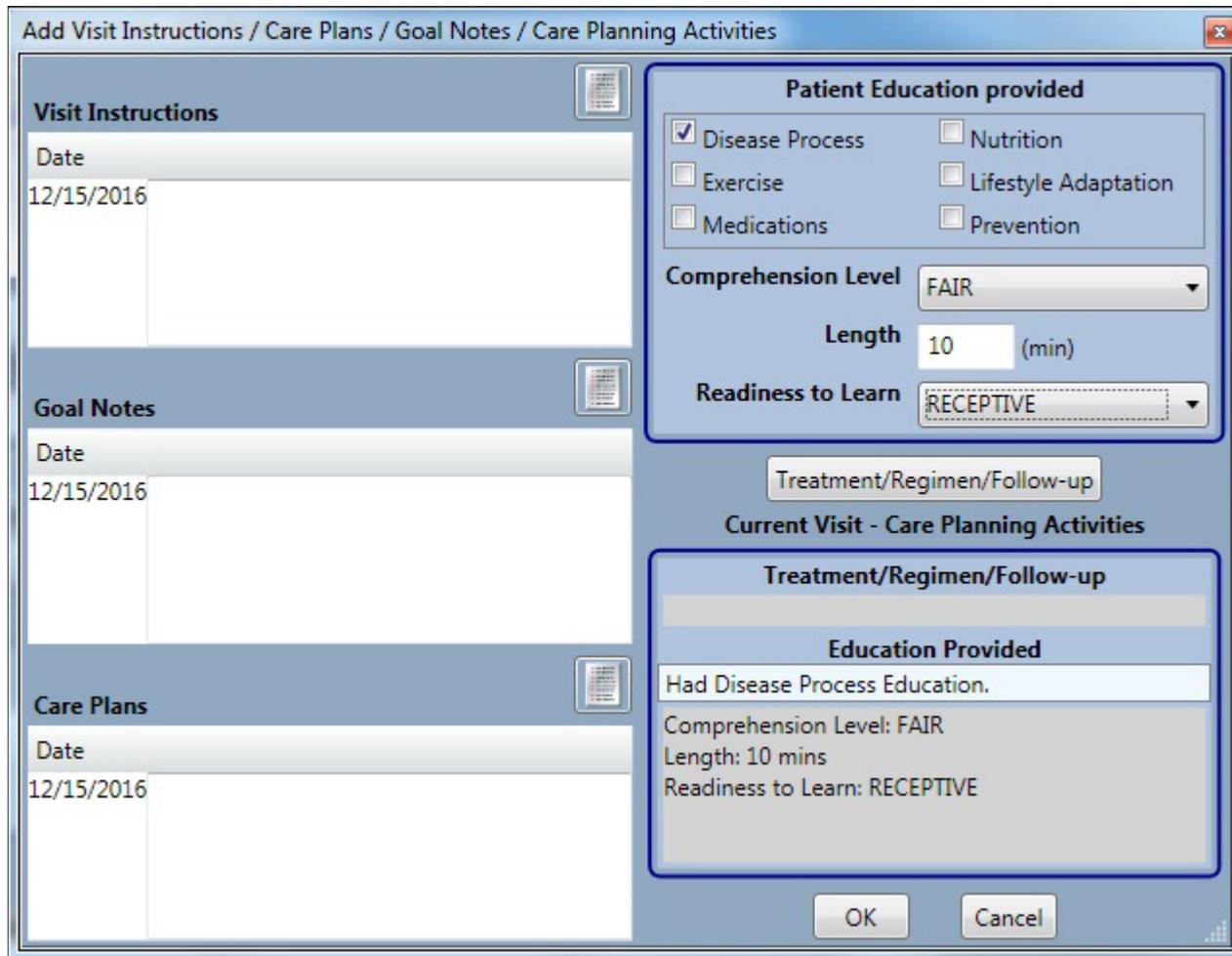


Figure 77: **Add Visit Instruction/Care Plans/Goal Activities** dialog

- 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.

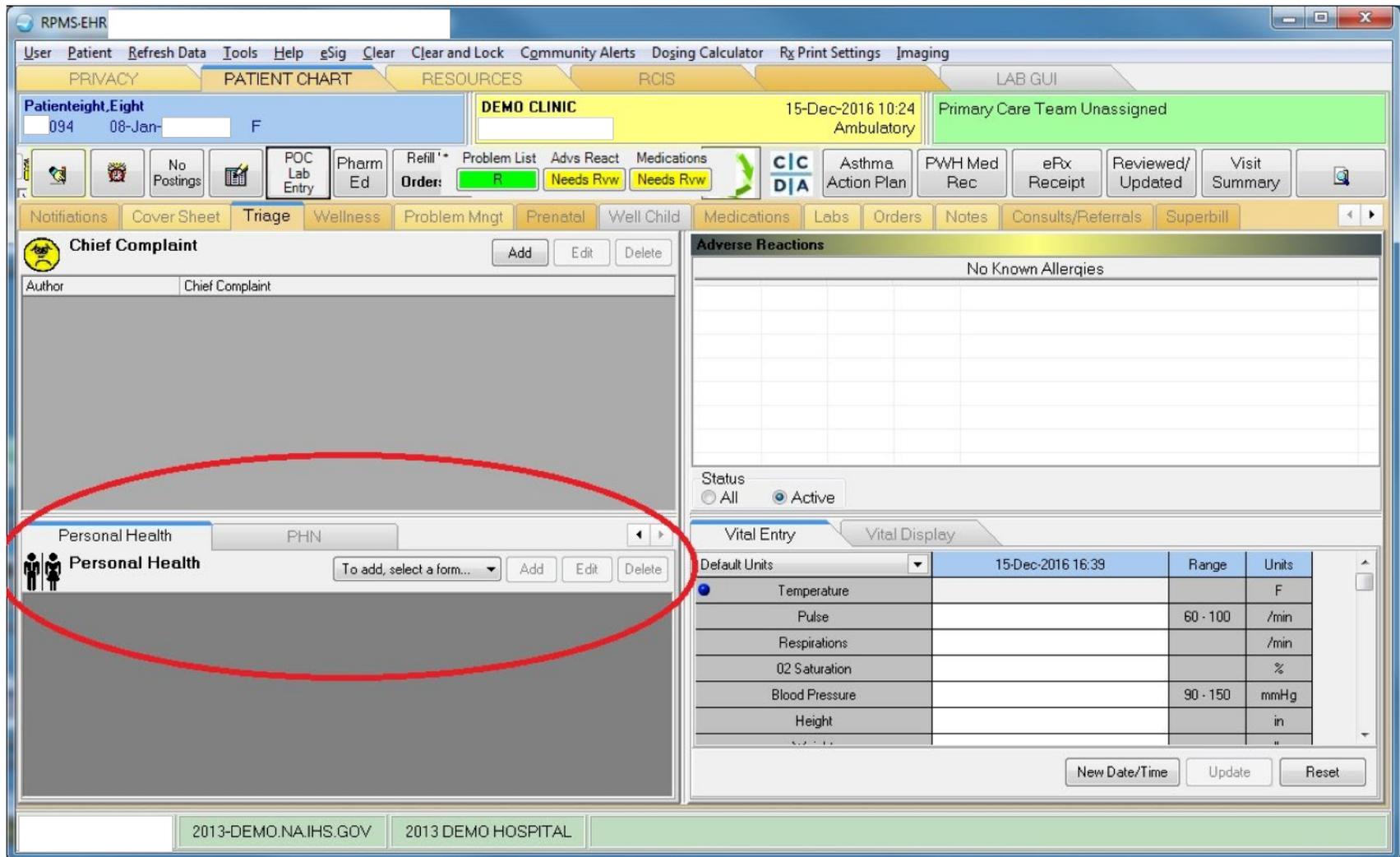


Figure 78: **Personal Health** component

To enter a Refusal:

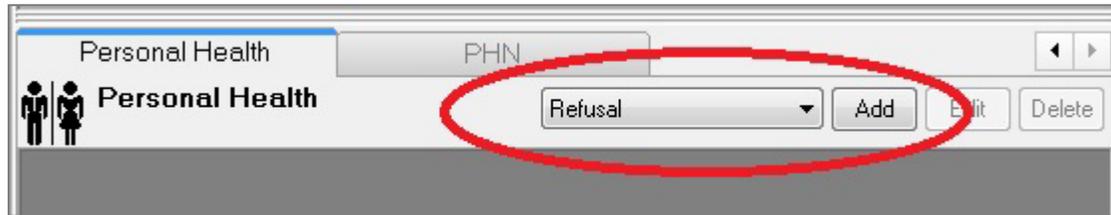


Figure 79: Entering a Refusal

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

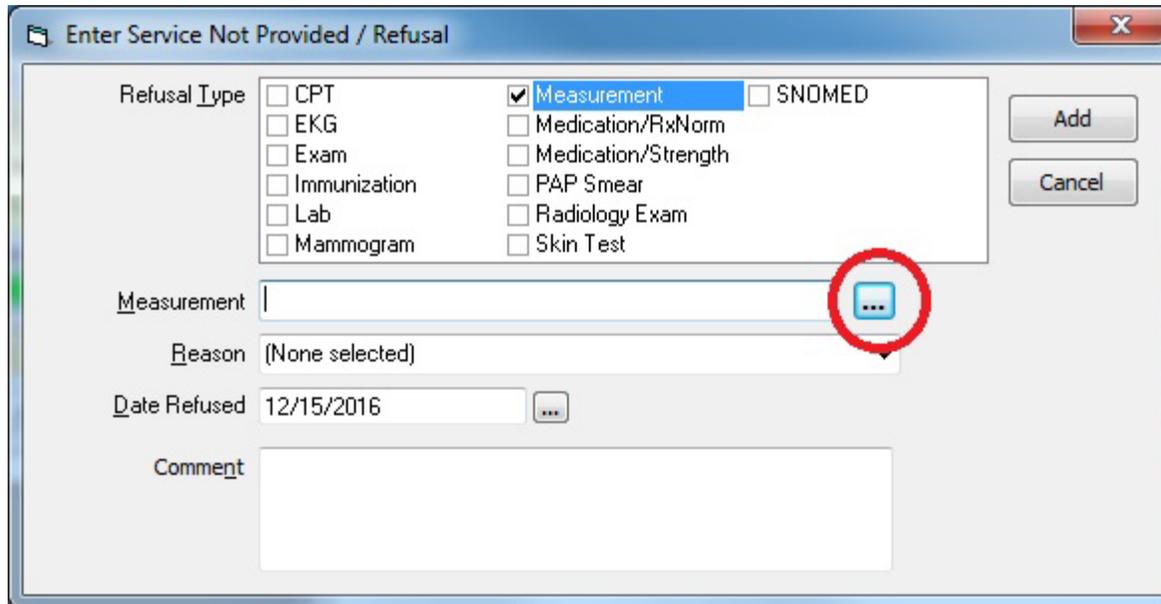


Figure 80: Selecting the Refusal Type

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

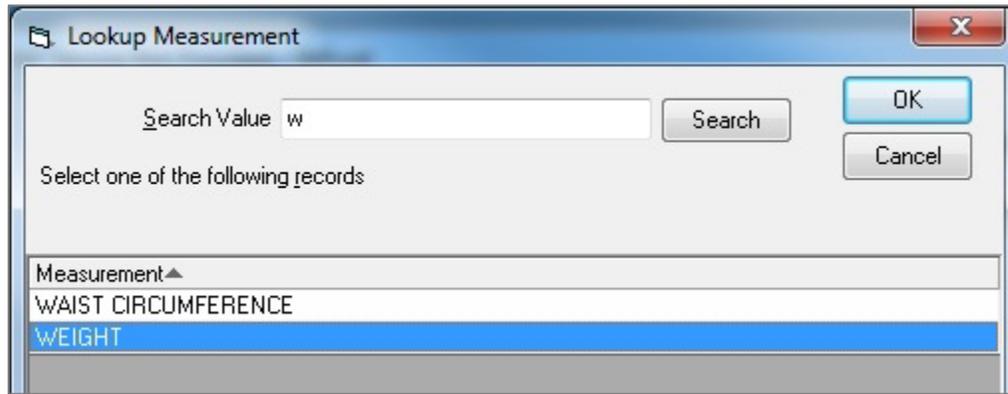


Figure 81: **Lookup Measurement** dialog

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.

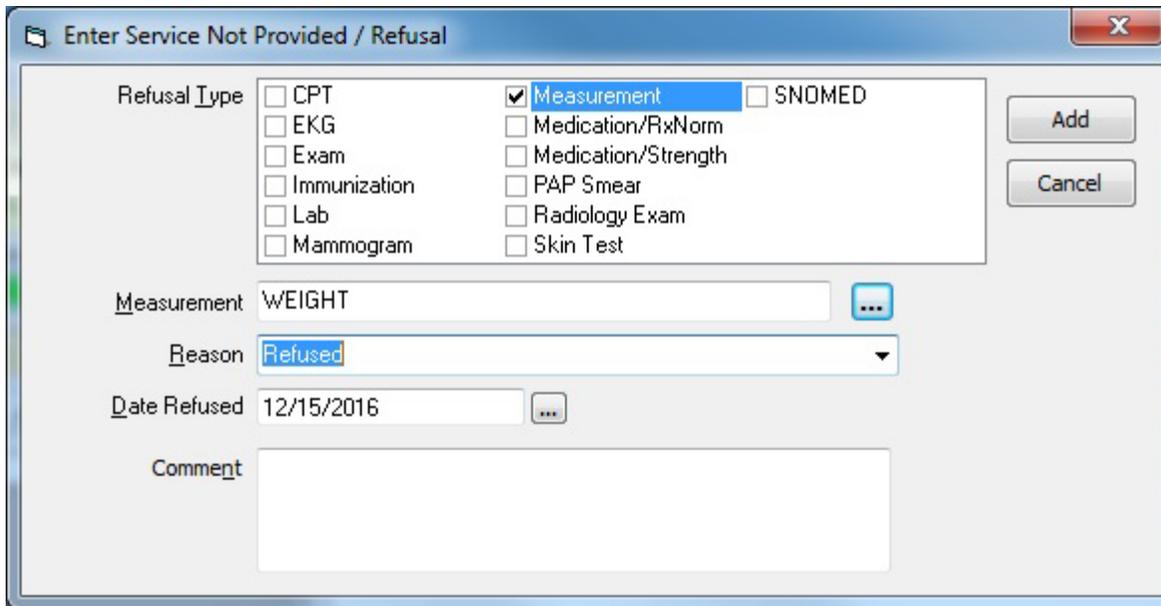


Figure 82: Entering a comment

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

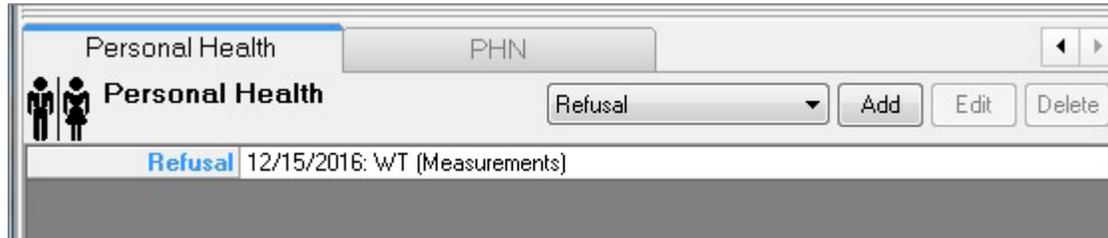


Figure 83: Example of a newly added Refusal

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