

KEY CLINICAL PERFORMANCE OBJECTIVES

“Cheat Sheet” for PCC Documentation and Data Entry for CRS Version 12.0

Last Updated January 2012

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; and (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 Resource and Patient Management System (RPMS). It does not include all of the codes the Clinical Reporting System (CRS) checks for when determining if a performance measure is met. To review that information, view the CRS short version logic at:

<http://www.ihs.gov/CIO/CRS/documents/crsv12/GPRA%20PART%20Measures%20V12.pdf>

Note: GPRA measures do not include refusals.

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes Prevalence NOTE: This is not a GPRA measure; however, it is used in determining patients that have been diagnosed with diabetes.		Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC: Date received Location Results	Standard PCC data entry: Diabetes Prevalence Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: 250.00-250.93 Provider Narrative: Modifier: Cause of DX:
Diabetes: Glycemic Control	Active Clinical Patients DX with diabetes and with an A1c: <ul style="list-style-type: none"> > 9.5 (Poor Glycemic Control) < 7 (Ideal Glycemic Control) 	Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC: Date received Location Results	Standard PCC data entry: A1c Lab Test <i>Mnemonic LAB enter</i> Enter Lab Test Type: [Enter site’s defined A1c Lab Test] Results: [Enter Results] Units: Abnormal: Site: [Blood, Plasma]

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes: Glycemic Control (cont)			<p>Historical A1c Lab Test <i>Mnemonic HLAB enter</i> Date of Historical Lab Test: Type: Location Name: Enter Lab Test: [Enter site's defined A1c Lab Test] Results:</p> <p>CPT Entry <i>Mnemonic CPT enter</i> Enter CPT: 83036, 83037, 3044F-3046F Quantity: Modifier: Modifier 2:</p>
Diabetes: Blood Pressure Control	<p>Active Clinical Patients DX with diabetes and with controlled Blood Pressure:</p> <ul style="list-style-type: none"> • < 130/80 (mean systolic < 130, mean diastolic < 80) 	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received Location Results</p>	<p>Standard PCC data entry:</p> <p>Blood Pressure Data Entry <i>Mnemonic BP enter</i> Value: [Enter as Systolic/Diastolic (e.g., 130/80)] Select Qualifier: Date/Time Vitals Taken:</p>
Diabetes: LDL Assessment	<p>Active Clinical Patients DX with diabetes and a completed LDL test.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received Location Results</p>	<p>Standard PCC data entry:</p> <p>LDL (Calculated) (REF)* Lab Test *REF–Reference Lab <i>Mnemonic LAB enter</i> Enter Lab Test Type: [Enter site's defined LDL Reference Lab Test]</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes: LDL Assessment (cont)			<p>Results: [Enter Results] Units: Abnormal: Site: [Blood, Serum]</p> <p>LDL (Calculated) Lab Test <i>Mnemonic LAB enter</i> Enter Lab Test Type: [Enter site's defined LDL Lab Test] Results: [Enter Results] Units: Abnormal: Site: [Blood]</p> <p>Historical LDL Lab Test <i>Mnemonic HLAB enter</i> Date of Historical Lab Test: Type: Location Name: Enter Lab Test: [Enter site's defined LDL Reference Lab Test or LDL Lab Test] Results:</p> <p>LDL CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes: Nephropathy Assessment	Active Clinical Patients DX with diabetes with a Nephropathy assessment: <ul style="list-style-type: none"> • Estimated GFR with result during the Report Period • Quantitative Urinary Protein Assessment during the Report Period • End Stage Renal Disease diagnosis/treatment 	Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC: <p>Date received</p> <p>Location</p> <p>Results</p>	Standard PCC data entry: <p>Estimated GFR Lab Test <i>Mnemonic LAB enter</i> Enter Lab Test Type: [Enter site's defined Est GFR Lab Test] Results: [Enter Results] Units: Abnormal: Site: [Blood]</p> <p>Historical GFR Lab Test <i>Mnemonic HLAB enter</i> Date of Historical Lab Test: Type: Location Name: Enter Lab Test: [Enter site's defined Est GFR Lab Test] Results:</p> <p>Quantitative Urinary Protein Assessment CPT <i>Mnemonic CPT enter</i> Enter CPT: 82042, 82043, 84156 Quantity: Modifier: Modifier 2:</p> <p>ESRD CPT <i>Mnemonic CPT enter</i></p>

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetes: Nephropathy Assessment (cont)			<p>Enter CPT: 36145, 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, G0257, G0308-G0327, G0392, G0393, or S9339</p> <p>Quantity: Modifier: Modifier 2:</p> <p>ESRD POV <i>Mnemonic PPV enter</i> Purpose of Visit: 585.5, 585.6, V42.0, V45.11, V45.12, or V56.* Provider Narrative: Modifier: Cause of DX:</p> <p>ESRD Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6* Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX (ESRD)]</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Diabetic Retinopathy</p>	<p>Patients with diabetes 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 GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Exams:</p> <p>Diabetic Retinal Exam</p> <p>Dilated retinal eye exam</p> <p>Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist</p> <p>Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos</p> <p>Routine ophthalmological examination including refraction (new or existing patient)</p> <p>Diabetic indicator; retinal eye exam, dilated, bilateral</p> <p>Other Eye Exams</p> <p>Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or validated tele-ophthalmology retinal evaluation clinics</p> <p>non-DNKA visits to an optometrist or ophthalmologist</p>	<p>Standard PCC data entry:</p> <p>Diabetic Retinopathy Exam <i>Mnemonic EX enter</i> Select Exam: 03 Result: [Enter Results] Comments: Provider Performing Exam:</p> <p>Historical Retinopathy Exam: <i>Mnemonic HEX enter</i> Date of Historical Exam: Type: Location Name: Exam Type: 03 Result Comments Encounter Provider</p> <p>Retinal Exam CPT <i>Mnemonic CPT enter</i> Enter CPT: 2022F, 2024F, 2026F, S0620, S0621, S3000 Quantity: Modifier: Modifier 2:</p> <p>Other Eye Exam CPT <i>Mnemonic CPT enter</i> Enter CPT: 67028, 67038, 67039, 67040, 92002, 92004, 92012, 92014 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetic Retinopathy (cont)			<p>Other Eye Exam POV <i>Mnemonic PPV enter</i> Purpose of Visit: V72.0 Provider Narrative: Modifier: Cause of DX:</p> <p>Other Eye Exam Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 95.02 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>Other Eye Exam Clinic <i>Mnemonic CL enter</i> Clinic: A2, 17, 18, 64 Was this an appointment or walk in?:</p>
Access to Dental Service	<p>Patients should have annual dental exams.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <ul style="list-style-type: none"> Date received Location Results 	<p>Standard PCC data entry</p> <p>Dental Exam <i>Mnemonic EX enter</i> Select Exam: 30 Result: [Enter Results] Comments: Provider Performing Exam:</p> <p>Historical Dental Exam <i>Mnemonic HEX enter</i> Date of Historical Exam: Type: Location Name:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Access to Dental Service (cont)			Exam Type: 30 Result: Comments: Encounter Provider: Dental Exam (ADA code) <i>Mnemonic ADA enter</i> Dental Service Code: 0000, 0190 Type: No. Of Units: Operative Site: Historical Dental Exam (ADA code) <i>Mnemonic HADA enter</i> Date of Historical ADA: Type: Location Name: ADA Code: 0000, 0190 Units: Dental Exam POV <i>Mnemonic PPV enter</i> Purpose of Visit: V72.2 Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Dental Sealants</p>	<p>A maximum of two sealants per tooth are counted toward the GPRA measure.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p>	<p>Standard PCC data entry</p> <p>Dental Sealants (ADA) <i>Mnemonic ADA enter</i> Dental Service Code: 1351 Type: No. Of Units: Operative Site:</p> <p>Historical Dental Sealants <i>Mnemonic HADA enter</i> Date of Historical ADA: Type: Location Name: ADA Code: 1351 Units:</p> <p>Dental Sealants CPT <i>Mnemonic CPT enter</i> Enter CPT: D1351 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Topical Fluoride</p>	<p>A maximum of four topical fluoride application are counted toward the GPRA measure.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p>	<p>Standard PCC data entry</p> <p>Topical Fluoride (ADA code) <i>Mnemonic ADA enter</i> Dental Service Code: 1203, 1204, 1206, 5986 Type: No. Of Units: Operative Site:</p> <p>Historical Fluoride (ADA code) <i>Mnemonic HADA enter</i> Date of Historical ADA: Type: Location Name: ADA Code: 1203, 1204, 1206, 5986 Units:</p> <p>Topical Flouride CPT <i>Mnemonic CPT enter</i> Enter CPT: D1203, D1204, D1206, D5986 Quantity: Modifier: Modifier 2:</p> <p>Topical Flouride POV <i>Mnemonic PPV enter</i> Purpose of Visit: V07.31 Provider Narrative: Modifier: Cause of DX:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Adult Immunizations: Influenza</p>	<p>All adults ages 65 and older should have an annual Influenza (flu) shot.</p> <p>Adults 55-64 are strongly recommended to have annual Influenza (flu) shot.</p> <p>All adult (18 and older) diabetic patients are strongly recommended to have annual Influenza (flu) shot.</p> <p>Refusals should be documented. Note: Only NMI (Not Medically Indicated) refusals are counted toward the GPRA Measure.</p>	<p>Standard PCC documentation for immunizations performed at the facility, Ask about off-site tests and record historical information on PCC:</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> <ul style="list-style-type: none"> Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal 	<p>Standard PCC data entry</p> <p>Influenza Vaccine <i>Mnemonic IM enter</i> Select Immunization Name: 140, 141 or 144 (other options are 111, 15, 16, 88) Lot: VFC Eligibility:</p> <p>Historical Influenza Vaccine <i>Mnemonic HIM enter</i> Date of Historical Immunization: Type: Location: Immunization Type: 88 (other options are 111, 15, 16) Series:</p> <p>Influenza Vaccine POV <i>Mnemonic PPV enter</i> Purpose of Visit: *V04.81, *V06.6 Provider Narrative: Modifier: Cause of DX:</p> <p>* NOT documented with 90663, 90664, 90666-90668, 90470, G9141, G9142</p> <p>Influenza Vaccine CPT <i>Mnemonic CPT enter</i> Enter CPT: 90654-90662, G0008, G8108 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Adult Immunizations: Influenza (cont)</p>			<p>Influenza Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 99.52 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>NMI Refusal of Influenza <i>Mnemonic NMI enter</i> Patient Refusals For Service/NMI Refusal Type: Immunization Immunization Value: [See codes above] Date Refused: Provider Who Documented: Comment:</p> <p>Immunization Package Contraindication Influenza (Assumes you are in the IMM Pkg for Single Patient Record for your site) Select Action: C (Contraindications) Select Action: A (Add Contraindication) Vaccine: [See codes above] Reason: Egg Allergy, Anaphylaxis Date Noted: Command: Save Select Action: Quit</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Adult Immunizations: Pneumovax</p>	<p>All adults ages 65 and older will have a pneumovax.</p> <p>All adult (18 and older) diabetic patients are strongly recommended to have a pneumovax.</p> <p>Refusals should be documented. Note: Only NMI (Not Medically Indicated) refusals are counted toward the GPRA Measure.</p>	<p>Standard PCC documentation for immunizations performed at the facility, Ask about off-site tests and record historical information on PCC:</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> <ul style="list-style-type: none"> Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal 	<p>Standard PCC data entry</p> <p>Pneumovax Vaccine <i>Mnemonic IM enter</i> Select Immunization Name: 33, 100, 109, 133 Lot: VFC Eligibility:</p> <p>Historical Pneumovax Vaccine <i>Mnemonic HIM enter</i> Date of Historical Immunization: Type: Location: Immunization Type: 33, 100, 109, 133 Series:</p> <p>Pneumovax Vaccine POV <i>Mnemonic PPV enter</i> Purpose of Visit: V06.6, V03.82 Provider Narrative: Modifier: Cause of DX:</p> <p>Pneumovax Vaccine CPT <i>Mnemonic CPT enter</i> Enter CPT: 90669, 90670, 90732, G0009, G8115 Quantity: Modifier: Modifier 2:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Adult Immunizations: Pneumovax (cont)</p>			<p>Pneumovax Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 99.55 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>NMI Refusal of Pneumovax <i>Mnemonic NMI enter</i> Patient Refusals For Service/NMI Refusal Type: Immunization Immunization Value: [See codes above] Date Refused: Provider Who Documented: Comment:</p> <p>Immunization Package Contraindication Pneumovax (Assumes you are in the IMM Pkg for Single Patient Record for your site) Select Action: C (Contraindications) Select Action: A (Add Contraindication) Vaccine: [See codes above] Reason: Egg Allergy, Anaphylaxis Date Noted: Command: Save Select Action: Quit</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Immunizations	<p>Children age 19-35 months will be up-to-date for all ACIP recommended immunizations.</p> <p>This is the 4313314 combo:</p> <p>4 DTaP</p> <p>3 IPV</p> <p>1 MMR</p> <p>3 Hepatitis B</p> <p>3 Hib</p> <p>1 Varicella</p> <p>4 Pneumococcal</p> <p>Refusals should be documented.</p> <p>Note: Only NMI (Not Medically Indicated) refusals are counted toward the GPRA Measure.</p>	<p>Standard PCC documentation for immunizations performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>IZ type</p> <p>Date received</p> <p>Location</p> <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> <p>IPV:</p> <p>Immunization Package: "Neomycin Allergy."</p> <p>MMR:</p> <p>Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</p> <p>Varicella:</p> <p>Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</p> <p>Dosage and types of immunization definitions:</p> <p>4 doses of DTaP:</p> <p>4 DTaP/DTP/Tdap</p> <p>1 DTaP/DTP/Tdap and 3 DT/Td</p> <p>1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus</p>	<p>Standard PCC data entry</p> <p>Childhood Immunizations</p> <p><i>Mnemonic IM enter</i></p> <p>Select Immunization Name:</p> <p><i>DTaP: 20, 50, 106, 107, 110, 120, 130, 146; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113; Tetanus: 35, 112; Acellular Pertussis: 11; OPV: 2, 89; IPV: 10, 89, 110, 120, 130, 146; MMR: 3, 94; M/R: 4; R/M: 38 ; Measles: 5; Mumps: 7; Rubella: 6; Hepatitis B: 8, 42-45, 51, 102, 104, 110, 146; HIB: 17, 22, 46-49, 50, 51, 102, 120, 146; Varicella: 21, 94</i></p> <p>Lot:</p> <p>VFC Eligibility:</p> <p>Historical Childhood Immunizations</p> <p><i>Mnemonic HIM enter</i></p> <p>Date of Historical Immunization:</p> <p>Type:</p> <p>Location:</p> <p>Immunization Type: <i>DTaP: 20, 50, 106, 107, 110, 120, 130; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113; Tetanus: 35, 112; Acellular Pertussis: 11; OPV: 2, 89; IPV: 10, 89, 110, 120, 130; MMR: 3, 94; M/R: 4; R/M: 38 ; Measles: 5; Mumps: 7; Rubella: 6; Hepatitis B: 8, 42-45, 51, 102, 104, 110; HIB: 17, 22, 46-49, 50, 51, 102, 120; Varicella: 21, 94</i></p> <p>Series:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Childhood Immunizations (cont)</p>		<p>4 DT and 4 Acellular Pertussis</p> <p>4 Td and 4 Acellular Pertussis</p> <p>4 each of Diphtheria, Tetanus, and Acellular Pertussis</p> <p>3 doses of IPV:</p> <p>3 OPV</p> <p>3 IPV</p> <p>Combination of OPV & IPV totaling 3 doses</p> <p>1 dose of MMR:</p> <p>MMR</p> <p>1 M/R and 1 Mumps</p> <p>1 R/M and 1 Measles</p> <p>1 each of Measles, Mumps, and Rubella</p> <p>3 doses of Hepatitis B</p> <p>3 doses of Hep B</p> <p>3 doses of HIB</p> <p>1 dose of Varicella</p> <p>IMPORTANT NOTE:</p> <p>The GPRA denominator is all User Population patients who are active in the Immunization Package. This means you must be using the Immunization Package and maintaining the active/inactive status field in order to have patients in your denominator for this GPRA measure. Immunization package v8.4 offers a scan function that searches the RPMS Patient Database for children who are less than 36 months old and reside in GPRA communities for the facility and automatically enters them into the Register with a status of Active. Sites can run this scan at any time, and should run it upon loading 8.4. Children already in the Register or residing outside of the</p>	<p>Childhood Immunizations POV</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: DTaP: V06.1; DTP: V06.1, V06.2, V06.3; DT: V06.5; Td: V06.5; Diphtheria: V03.5; Tetanus: V03.7; Acellular Pertussis: V03.6; OPV contraindication: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; IPV: V04.0, V06.3; IPV (evidence of disease): 730.70-730.79; MMR: V06.4; Measles: V04.2; Measles (evidence of disease): 055*; Mumps: V04.6; Mumps (evidence of disease): 072*; Rubella: V04.3; Rubella (evidence of disease): 056*, 771.0; Hepatitis B (evidence of disease): V02.61, 070.2, 070.3; HIB: V03.81; Varicella: V05.4; Varicella (evidence of disease): 052*, 053*; Varicella contraindication: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Childhood Immunizations CPT</p> <p><i>Mnemonic CPT enter</i></p> <p>Enter CPT: DTaP: 90696, 90698, 90700, 90721, 90723; DTP: 90701, 90720; Tdap: 90715; DT: 90702; Td: 90714, 90718; Diphtheria: 90719; Tetanus:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Immunizations (cont)		GPRA communities will not be affected.	<p> 90703; OPV: 90712; IPV: 90696, 90698, 90713, 90723; MMR: 90707, 90710; M/R: 90708; Measles: 90705; Mumps: 90704; Rubella: 90706; Hepatitis B: 90636, 90723, 90740, 90743-90748, G0010; HIB: 90645-90648, 90698, 90720-90721, 90748; Varicella: 90710, 90716 Quantity: Modifier: Modifier 2: </p> <p> Childhood Immunizations Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: DTP: 99.39; Diphtheria: 99.36; Tetanus: 99.38; IPV: 99.41; MMR: 99.48; MMR contraindication: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; Measles: 99.45; Mumps: 99.46; Rubella: 99.47; Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] </p> <p> NMI Refusal of Childhood Immunizations <i>Mnemonic NMI enter</i> Patient Refusals For Service/NMI Refusal Type: Immunization Immunization Value: [See codes above] Date Refused: </p>

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Immunizations (cont)			Provider Who Documented: Comment: Immunization Package Contraindication Childhood Immunizations (Assumes you are in the IMM Pkg for Single Patient Record for your site) Select Action: C (Contraindications) Select Action: A (Add Contraindication) Vaccine: [See codes above] Reason: [See Contraindications section under the Provider Documentation column] Date Noted: Command: Save Select Action: Quit
Cancer Screening: Pap Smear Rates	Women ages 21-64 should have a Pap Smear every 3 years. Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.	Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC: Date received Location Results	Data entry through Women’s Health program or standard PCC data entry for tests performed at the facility. Pap Smear V Lab <i>Mnemonic LAB enter</i> Enter Lab Test Type: Pap Smear Results: [Enter Results] Units: Abnormal: Site: Pap Smear POV <i>Mnemonic PPV enter</i>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Cancer Screening: Pap Smear Rates (cont)</p>			<p>Purpose of Visit: V67.01, V76.2, V72.32, V72.3, V76.47, 795.0*, 795.10-16, 795.19</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Pap Smear CPT <i>Mnemonic CPT enter</i> Enter CPT: 88141-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091</p> <p>Quantity:</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>Pap Smear Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 91.46</p> <p>Provider Narrative:</p> <p>Operating Provider:</p> <p>Diagnosis: [Enter appropriate DX]</p> <p>Historical Pap Smear <i>Mnemonic HPAP enter</i> Date Historical Pap Smear:</p> <p>Type of Visit:</p> <p>Location Name:</p> <p>Enter Outside Location: [(if "Other" was entered for Location Name:)]</p> <p>Select V Lab Test: Pap Smear Results: [Enter Results]</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Cancer Screening: Mammogram Rates</p>	<p>Women ages 52-64 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 PCC documentation for Radiology performed at the facility, Ask and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Telephone visit with patient</p> <p>Verbal or written lab report</p> <p>Patient’s next visit</p>	<p>Data entry through Women’s Health program or standard PCC data entry for tests performed at the facility</p> <p>Mammogram Radiology Procedure</p> <p><i>Mnemonic RAD enter</i></p> <p>Enter Radiology Procedure: 77053-77059, G0206; G0204, G0202</p> <p>Impression: [Enter Results]</p> <p>Abnormal:</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>Historical Mammogram Radiology</p> <p><i>Mnemonic HRAD enter</i></p> <p>Date of Historical Radiology Exam:</p> <p>Type:</p> <p>Location Name:</p> <p>Enter Outside Location: [(if “Other” was entered for Location Name:)]</p> <p>Radiology Exam: 77053-77059,G0206; G0204, G0202</p> <p>Impression:</p> <p>Abnormal:</p> <p>Mammogram POV</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: V76.11, V76.12, 793.80, 793.81, 793.89</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Cancer Screening: Mammogram Rates (cont)			Provider Narrative: Modifier: Cause of DX: Mammogram CPT <i>Mnemonic CPT enter</i> Enter CPT: 77053-77059, G0206; G0204, G0202 Quantity: Modifier: Modifier 2: Mammogram Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 87.36, 87.37 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Colorectal Cancer Screening</p>	<p>Adults ages 50 -75 should be screened for CRC (USPTF).</p> <p>For GPRA, IHS counts any of the following:</p> <ul style="list-style-type: none"> • Annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT) • Flexible sigmoidoscopy or double contrast barium enema 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 PCC documentation for procedures performed at the facility (Radiology, Lab, Provider).</p> <p>Guaiac cards returned by patients to providers should be sent to Lab for processing.</p> <p>Ask and record historical information on PCC:</p> <p style="padding-left: 20px;">Date received</p> <p style="padding-left: 20px;">Location</p> <p style="padding-left: 20px;">Results</p> <p>Telephone visit with patient</p> <p>Verbal or written lab report</p> <p>Patient’s next visit</p>	<p>Standard PCC data entry process for procedures, Lab or Radiology</p> <p>Colorectal Cancer POV <i>Mnemonic PPV enter</i> Purpose of Visit: 153.*, 154.0, 154.1, 197.5, V10.05 Provider Narrative: Modifier: Cause of DX:</p> <p>Colorectal Cancer CPT <i>Mnemonic CPT enter</i> Enter CPT: G0213-G0215, G0231 Quantity: Modifier: Modifier 2:</p> <p>Total Colectomy CPT <i>Mnemonic CPT enter</i> Enter CPT: 44150-44151, 44155-44158, 44210-44212 Quantity: Modifier: Modifier 2:</p> <p>FOBT or FIT CPT <i>Mnemonic CPT enter</i> Enter CPT: 82270, 82274, G0328 Quantity: Modifier: Modifier 2:</p> <p>Flexible Sigmoidoscopy CPT <i>Mnemonic CPT enter</i> Enter CPT: 45330-45345, G0104</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Colorectal Cancer Screening (cont)			<p>Quantity: Modifier: Modifier 2:</p> <p>Flexible Sigmoidoscopy Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 45.24 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>DBE CPT <i>Mnemonic CPT enter</i> Enter CPT: 74280, G0106, G0120 Quantity: Modifier: Modifier 2:</p> <p>DBE Radiology Procedure <i>Mnemonic RAD enter</i> Enter Radiology Procedure: 74280, G0106, G0120 Impression: [Enter Results] Abnormal: Modifier: Modifier 2:</p> <p>Colonoscopy POV <i>Mnemonic PPV enter</i> Purpose of Visit: V76.51 Provider Narrative: Modifier: Cause of DX:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Colorectal Cancer Screening (cont)			<p>Colon Screening CPT <i>Mnemonic CPT enter</i> Enter CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121 Quantity: Modifier: Modifier 2:</p> <p>Colon Screening Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: 45.22, 45.23, 45.25, 45.42, 45.43 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>Historical CRC HCOL - Historical Colonoscopy HFOB - Historical FOBT (Guaiac) HSIG - Historical Sigmoidoscopy HBE - Historical Barium Enema <i>Mnemonics for [Historical CRC Mnemonic above] enter:</i> Date: Type: Location of Encounter: Quantity:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<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 PCC documentation for tests performed at the facility, Ask and record historical information on PCC:</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 Smoker, status unknown HF–Current Smokeless HF–Previous (Former) Smoker [or -Smokeless] (quit > 6 months) HF–Cessation-Smoker [or -Smokeless] (quit or actively trying < 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" 	<p>Standard PCC data entry</p> <p>Tobacco Screening Health Factor</p> <p><i>Mnemonic HF enter</i></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>Historical Tobacco Health Factor</p> <p><i>Mnemonic HHF enter</i></p> <p>Date Historical Health Factor:</p> <p>Type of Visit:</p> <p>Location Name:</p> <p>Enter 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</p> <p><i>Mnemonic PED enter</i></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 Educ (Minutes):</p> <p>Comment</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Use and Exposure Assessment (cont)		<p>NOTE: Ensure you update the patient’s health factors as they enter a cessation program and eventually become non-tobacco users. Patients who are in a tobacco cessation program should have their health factor changed from “Smoker” or “Smokeless” to “Cessation-Smoker” or “Cessation-Smokeless” until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to “Previous Smoker” or “Previous Smokeless.”</p>	<p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Tobacco Users Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Current Smoker (every day, some day, or status unknown), Current Smokeless, Cessation-Smoker, Cessation-Smokeless Level/Severity: Provider: Quantity: Smokers Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Current Smoker (every day, some day, or status unknown), or Cessation-Smoker Level/Severity: Provider: Quantity: Smokeless Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Current Smokeless or Cessation-Smokeless Level/Severity: Provider: Quantity:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Use and Exposure Assessment (cont)			ETS Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Exp to ETS Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Tobacco Cessation</p>	<p>Active Clinical patients identified as current tobacco users prior to report period and who have received tobacco cessation counseling or a Rx for smoking cessation aid.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask and record historical information on PCC:</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 Last documented Tobacco related POV Last documented Tobacco related CPT <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 Smoker, status unknown HF–Current Smokeless HF–Cessation-Smoker [or -Smokeless] (quit or actively trying < 6 months) <p>Tobacco Patient Education Codes:</p> <ul style="list-style-type: none"> Codes will contain "TO-", "-TO", "-SHS" 	<p>Standard PCC data entry</p> <p>Tobacco Cessation PED - Topic Mnemonic PED enter</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 Educ (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 Cessation PED - Diagnosis Mnemonic PED enter</p> <p>Select ICD Diagnosis Code Number: 649.00-649.04</p> <p>Category:</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Educ (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>

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Cessation (cont)		<p>Prescribe Tobacco Cessation Aids: Predefined Site-Populated Smoking Cessation Meds</p> <p>Meds containing:</p> <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 enter a cessation program and eventually become non-tobacco users. Patients who are in a tobacco cessation program should have their health factor changed from “Smoker” or “Smokeless” to “Cessation-Smoker” or “Cessation-Smokeless” until they have stopped using tobacco for 6 months. After 6 months, their health factor can be changed to “Previous Smoker” or “Previous Smokeless.”</p>	<p>Goal Comment: Provider’s Narrative:</p> <p>Tobacco Cessation Clinic <i>Mnemonic CL enter</i> Clinic: 94 Was this an appointment or walk in?:</p> <p>Tobacco Cessation Dental (ADA) <i>Mnemonic ADA enter</i> Select V Dental Service Code: 1320 No. Of Units: Operative Site:</p> <p>Tobacco Cessation CPT <i>Mnemonic CPT enter</i> Enter CPT Code: D1320, 99406, 99407, 4000F, G8402 or G8453 Quantity Modifier: Modifier 2:</p> <p>Tobacco Cessation Medication <i>Mnemonic RX enter</i> Select Medication: [Enter Tobacco Cessation Prescribed Medication] Outside Drug Name (Optional): [Enter any additional name for the drug] SIG</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Cessation (cont)			Quantity: Day Prescribed: Event Date&Time: Ordering Provider: Historical Tobacco Cessation Medication <i>Mnemonic HRX enter</i> Date of Historical Medication: Type: Location Name: Enter Medication: [Enter Tobacco Cessation Prescribed Medication] Name of Non-Table Drug: SIG: Days Prescribed: Date Discontinued: Date Dispensed (If Known): Outside Provider Name: Tobacco Cessation Prescription CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 4001F Quantity Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Alcohol Screening (FAS Prevention)</p>	<p>Pregnant women should be screened for alcohol use at least on their first visit; education and follow-up provided as appropriate.</p> <p>Women of childbearing age should be screened at least annually.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Alcohol screening may be documented with either an exam code or the CAGE health factor in PCC or BHS. BHS problem codes can also currently be used.</p> <p>Medical Providers:</p> <p>EXAM—Alcohol Screening</p> <p>Negative—Patient’s screening exam does not indicate risky alcohol use.</p> <p>Positive—Patient’s screening exam indicates potential risky alcohol use.</p> <p>Refused—Patient declined exam/screen</p> <p>Unable to screen - Provider unable to screen</p> <p>Behavioral Health Providers:</p> <p>Enter BHS problem code 29.1 or narrative “Screening for Alcoholism.”*</p> <p>Note: BHS problem code 29.1 maps to ICD-9 V79.1.</p> <p>Note: Recommended Brief Screening Tool: SASQ (below).</p> <p><i>Single Alcohol Screening Question (SASQ)</i></p> <p><i>For Women:</i></p> <p>When was the last time you had more than 4 drinks in one day?</p> <p><i>For Men:</i></p> <p>When was the last time you had more than 5 drinks in one day?</p>	<p>Standard PCC data entry</p> <p>Alcohol Screening Exam</p> <p><i>Mnemonic EX enter</i></p> <p>Select Exam: 35, ALC</p> <p>Result:</p> <p>A—Abnormal</p> <p>N—Normal/Negative</p> <p>PR—Resent</p> <p>PAP—Present and Past</p> <p>PA—Past</p> <p>PO—Positive</p> <p>Comments: SASQ</p> <p>Provider Performing Exam:</p> <p>Historical Alcohol Screen Exam</p> <p><i>Mnemonic HEX enter</i></p> <p>Date of Historical Exam:</p> <p>Type:</p> <p>Location Name:</p> <p>Exam Type: 35, ALC</p> <p>Result:</p> <p>Comments:</p> <p>Encounter Provider:</p> <p>Cage Health Factor</p> <p><i>Mnemonic HF enter</i></p> <p>Select Health Factor: CAGE</p> <p>1 CAGE 0/4 (all No answers)</p> <p>2 CAGE 1/4</p> <p>3 CAGE 2/4</p> <p>4 CAGE 3/4</p> <p>5 CAGE 4/4</p> <p>Choose 1-5: [Number from above]</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		<p>Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen:</p> <p style="padding-left: 40px;">Alcohol Screening Exam Code Result: Positive</p> <p>The patient may decline the screen or “Refuse to answer”:</p> <p style="padding-left: 40px;">Alcohol Screening Exam Code Result: Refused</p> <p>The provider is unable to conduct the screen:</p> <p style="padding-left: 40px;">Alcohol Screening Exam Code Result: Unable To Screen</p> <p>Note: Provider should note the screening tool used was the SASQ at the <i>Comment</i> Mnemonic for the Exam code.</p> <p>All Providers: Use the CAGE questionnaire:</p> <ul style="list-style-type: none"> • 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? <p>Tolerance: How many drinks does it take you to get high?</p> <p>Based on how many YES answers were received, document Health Factor on PCC:</p> <p style="padding-left: 40px;">HF-CAGE 0/4 (all No answers)</p> <p style="padding-left: 40px;">HF-CAGE 1/4</p> <p style="padding-left: 40px;">HF-CAGE 2/4</p> <p style="padding-left: 40px;">HF-CAGE 3/4</p>	<p>Level/Severity: Provider: Quantity:</p> <p>Alcohol Screening POV <i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: V11.3, V79.1 Provider Narrative: Modifier: Cause of DX:</p> <p>Standard BHS data entry Enter BHS problem code *29.1 or narrative: “Screening for Alcoholism.”</p> <p>*Note: BHS problem code 29.1 maps to ICD-9 V79.1 (Screening for Alcoholism).</p> <p>Alcohol Screening CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 99408, 99409, G0396, G0397, H0049, H0050 Quantity: Modifier: Modifier 2:</p> <p>Alcohol-Related Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: 303.*, 305.0*, 291.*, 357.5* Provider Narrative: Modifier: Cause of DX:</p> <p>Alcohol-Related Diagnosis BHS POV data entry</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		<p>HF-CAGE 4/4</p> <p>Optional values: Level/Severity: Minimal, Moderate, or Heavy/Severe</p> <p>Quantity: # of drinks daily OR T (Tolerance) -- # drinks to get high (e.g. T-4)</p> <p>Comment: used to capture other relevant clinical info e.g. "Non-drinker"</p> <p>Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-"</p> <p>AUDIT Measurements:</p> <p>Zone I: Score 0–7 Low risk drinking or abstinence</p> <p>Zone II: Score 8–15 Alcohol use in excess of low-risk guidelines</p> <p>Zone III: Score 16–19 Harmful and hazardous drinking</p> <p>Zone IV: Score 20–40 Referral to Specialist for Diagnostic Evaluation and Treatment</p> <p>AUDIT-C Measurements:</p> <p>How often do you have a drink containing alcohol?</p> <p>(0) Never (Skip to Questions 9-10)</p> <p>(1) Monthly or less</p> <p>(2) 2 to 4 times a month</p> <p>(3) 2 to 3 times a week</p> <p>(4) 4 or more times a week</p> <p>How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2</p> <p>(1) 3 or 4</p>	<p>Enter BHS problem code 10, 27, 29</p> <p>Alcohol-Related Procedure <i>Mnemonic IOP enter</i></p> <p>Operation/Procedure: 94.46, 94.53, 94.61-94.63, 94.67-94.69</p> <p>Provider Narrative:</p> <p>Operating Provider:</p> <p>Diagnosis: [Enter appropriate DX]</p> <p>Alcohol-Related PED - Topic <i>Mnemonic PED enter</i></p> <p>Enter Education Topic: [Enter Alcohol-Related Education Code (See the Provider Documentation column)]</p> <p>Readiness to Learn:</p> <p>Level of Understanding:</p> <p>Provider:</p> <p>Length of Educ (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>Alcohol-Related PED - Diagnosis <i>Mnemonic PED enter</i></p> <p>Select ICD Diagnosis Code Number: V11.3, V79.1, 303.*, 305.0*, 291.* or 357.5*</p> <p>Category:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		<p>(2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more</p> <p>How often do you have six or more drinks on one occasion?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <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> <p>In men, a score of 4 or more is considered positive In women, a score of 3 or more is considered positive.</p> <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> <p>C–Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?</p> <p>R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?</p> <p>A–Do you ever use alcohol/drugs while you are by yourself, ALONE?</p> <p>F–Do you ever FORGET things you did while using alcohol or drugs?</p> <p>F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?</p>	<p>Readiness to Learn: Level of Understanding: Provider: Length of Educ (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 Screen AUDIT Measurement <i>Mnemonic AUDT enter</i> Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken:</p> <p>Alcohol Screen AUDIT-C Measurement <i>Mnemonic AUDC enter</i> Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken:</p> <p>Alcohol Screen CRAFFT Measurement <i>Mnemonic CRFT enter</i> Value: [Enter 0-6] Select Qualifier: Date/Time Vitals Taken:</p> <p>Unable to Perform Alcohol Screen <i>Mnemonic UAS enter</i></p>

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont)		<p>T–Have you gotten into TROUBLE while you were using alcohol or drugs?</p> <p>Total CRAFFT score (Range: 0–6). Positive answers to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated.</p>	<p>Patient Refusals For Service: Exam Exam Value: 35, ALC Date Refused: Provider Who Documented: Comment:</p>
Intimate Partner (Domestic) Violence Screening (IPV/DV)	<p>Adult females should be screened for domestic violence at <i>new encounter and at least annually Prenatal once each trimester</i> (Source: Family Violence Prevention Fund National Consensus Guidelines) Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask and <i>record historical information</i> on PCC:</p> <p>Date received Location Results</p> <p>Medical and Behavioral Health Providers: EXAM—IPV/DV Screening</p> <p>Negative – Denies being a current or past victim of IPV/DV</p> <p>Past – Denies being a current victim, but discloses being a past victim of IPV/DV</p> <p>Present – Discloses current IPV/DV</p> <p>Present and Past – Discloses past victimization and current IPV/DV victimization</p> <p>Refused – Patient declined exam/screen</p> <p>Unable to screen – Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.)</p> <p>IPV/DV Patient Education Codes: Codes will contain "DV-" or "-DV"</p>	<p>Standard PCC data entry</p> <p>IPV/DV Screening Exam <i>Mnemonic EX enter</i> Select Exam: 34, INT Result: A–Abnormal N–Normal/Negative PR–Resent PAP–Present and Past PA–Past PO–Positive Comments: Provider Performing Exam:</p> <p>Historical IPV/DV Screen Exam <i>Mnemonic HEX enter</i> Date of Historical Exam: Type: Location Name: Exam Type: 34, INT Result: Comments: Encounter Provider:</p> <p>Standard BHS data entry Enter BHS problem code Narrative “IPV/DV exam”</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont)			<p>IPV/DV Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: 995.80-83, 995.85, V15.41, V15.42, V15.49, V61.11 (IPV/DV Counseling) Provider Narrative: Modifier: Cause of DX:</p> <p>IPV/DV Diagnosis BHS POV data entry Enter BHS problem code 43.*, 44.*</p> <p>IPV/DV–Topic <i>Mnemonic PED enter</i> Enter Education Topic: [Enter IPV/DV Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Educ (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 <i>Mnemonic PED enter</i> Select ICD Diagnosis Code Number: 995.80-83, 995.85, V15.41, V15.42, V15.49</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont)			Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (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: Unable to Screen for IPV/DV <i>Mnemonic UAS enter</i> Patient Refusals For Service: Exam Select Exam: 34 or INT Date Refused: Provider Who Documented: Comment:

Performance Measure	Standard	Provider Documentation	Data Entry
Depression Screening	<p>Adult patients 18 years of age and older should be screened for depression at least annually.</p> <p>(Source: United States Preventive Services Task Force)</p> <p>Note: Refusals are NOT counted toward the GPRA measure, but should be documented.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Medical Providers:</p> <p>EXAM—Depression Screening</p> <p>Normal/Negative – Denies symptoms of depression</p> <p>Abnormal/Positive – Further evaluation indicated</p> <p>Refused – Patient declined exam/screen</p> <p>Unable to screen – Provider unable to screen</p> <p>Note: Refusals are not counted toward the GPRA measure, but should be documented.</p> <p>Behavioral Health Providers:</p> <p>Enter BHS problem code 14.1 or narrative “Screening for Depression.”</p> <p>Note: BHS problem code 14.1 maps to ICD-9 V79.0.</p> <p>Mood Disorders:</p> <p>Two or more visits with POV related to:</p> <p>Major Depressive Disorder</p> <p>Dysthymic Disorder</p> <p>Depressive Disorder NOS</p> <p>Bipolar I or II Disorder</p> <p>Cyclothymic Disorder</p> <p>Bipolar Disorder NOS</p>	<p>Standard PCC data entry</p> <p>Depression Screening Exam</p> <p><i>Mnemonic EX enter</i></p> <p>Select Exam: 36, DEP</p> <p>Result:</p> <p>A–Abnormal</p> <p>N–Normal/Negative</p> <p>PR–Resent</p> <p>PAP–Present and Past</p> <p>PA–Past</p> <p>PO–Positive</p> <p>Comments: PHQ-2 Scaled, PHQ9</p> <p>Provider Performing Exam:</p> <p>Historical Depression Screen Exam</p> <p><i>Mnemonic HEX enter</i></p> <p>Date of Historical Exam:</p> <p>Type:</p> <p>Location Name:</p> <p>Exam Type: 36, DEP</p> <p>Result:</p> <p>Comments: PHQ-2 Scaled, PHQ9 (If Known)</p> <p>Encounter Provider:</p> <p>Depression Screen Diagnosis POV</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: V79.0</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p>

Performance Measure	Standard	Provider Documentation	Data Entry																
<p>Depression Screening (cont)</p>		<p>Mood Disorder Due to a General Medical Condition Substance-induced Mood Disorder Mood Disorder NOS</p> <p>Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</p> <p><i>Patient Health Questionnaire (PHQ-2 Scaled Version)</i></p> <p>Over the past 2 weeks, how often have you been bothered by any of the following problems?</p> <p>Little interest or pleasure in doing things</p> <table border="0"> <tr> <td>a. Not at all</td> <td>Value: 0</td> </tr> <tr> <td>b. Several days</td> <td>Value: 1</td> </tr> <tr> <td>c. More than half the days</td> <td>Value: 2</td> </tr> <tr> <td>d. Nearly every day</td> <td>Value: 3</td> </tr> </table> <p>Feeling down, depressed, or hopeless</p> <table border="0"> <tr> <td>a. Not at all</td> <td>Value: 0</td> </tr> <tr> <td>b. Several days</td> <td>Value: 1</td> </tr> <tr> <td>c. More than half the days</td> <td>Value: 2</td> </tr> <tr> <td>d. Nearly every day</td> <td>Value: 3</td> </tr> </table> <p><i>PHQ-2 Scaled Version (cont'd)</i></p> <p>Total Possible PHQ-2 Score: Range: 0-6</p> <p>0-2: Negative Depression Screening Exam: Code Result: Normal or Negative</p> <p>3-6: Positive; further evaluation indicated Depression Screening Exam Code Result: Abnormal or Positive</p> <p>The patient may decline the screen or “Refuse to answer” Depression Screening Exam Code Result: Refused</p>	a. Not at all	Value: 0	b. Several days	Value: 1	c. More than half the days	Value: 2	d. Nearly every day	Value: 3	a. Not at all	Value: 0	b. Several days	Value: 1	c. More than half the days	Value: 2	d. Nearly every day	Value: 3	<p>Depression Screening CPT <i>Mnemonic CPT enter</i> Enter CPT: 1220F Quantity: Modifier: Modifier 2:</p> <p>Standard BHS POV data entry Enter BHS problem code *14.1 or narrative: “Screening for Depression.”</p> <p>*Note: BHS problem code 14.1 maps to ICD-9 V79.0 (Special Screening for Mental Disorders and Developmental Handicaps, Depression).</p> <p>Unable to Screen for Depression <i>Mnemonic UAS enter</i> Patient Refusals For Service: Exam Exam Value: 36, DEP Date Refused: Provider Who Documented: Comment:</p> <p>Mood Disorder Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311 Provider Narrative: Modifier: Cause of DX:</p>
a. Not at all	Value: 0																		
b. Several days	Value: 1																		
c. More than half the days	Value: 2																		
d. Nearly every day	Value: 3																		
a. Not at all	Value: 0																		
b. Several days	Value: 1																		
c. More than half the days	Value: 2																		
d. Nearly every day	Value: 3																		

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Depression Screening (cont)</p>		<p>The provider is unable to conduct the Screen Depression Screening Exam Code Result: Unable To Screen</p> <p>Provider should note the screening tool used was the PHQ-2 Scaled at the <i>Comment</i> Mnemonic for the Exam Code.</p> <p><i>PHQ9 Questionnaire Screening Tool</i></p> <p>Little interest or pleasure in doing things?</p> <p>a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3</p> <p>Feeling down, depressed, or hopeless?</p> <p>a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3</p> <p>Trouble falling or staying asleep, or sleeping too much?</p> <p>a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3</p> <p>Feeling tired or having little energy?</p> <p>a. Not at all Value: 0 b. Several days Value: 1 c. More than half the days Value: 2 d. Nearly every day Value: 3</p>	<p>Standard BHS Mood Disorder POV data entry Enter BHS problem code: 14, 15</p>

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

Performance Measure	Standard	Provider Documentation	Data Entry
Depression Screening (cont)		<p>Thoughts that you would be better off dead, or of hurting yourself in some way?</p> <p>a. Not at all Value: 0</p> <p>b. Several days Value: 1</p> <p>c. More than half the days Value: 2</p> <p>d. Nearly every day Value: 3</p> <p><i>PHQ9 Questionnaire (Cont'd)</i></p> <p>Total Possible PHQ-2 Score: Range: 0-27</p> <p>0-4 Negative/None Depression Screening Exam: Code Result: None</p> <p>5-9 Mild Depression Screening Exam: Code Result: Mild depression</p> <p>10-14 Moderate Depression Screening Exam: Code Result: Moderate depression</p> <p>15-19 Moderately Severe Depression Screening Exam: Code Result: Moderately Severe depression</p> <p>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 <i>Comment</i> Mnemonic for the Exam Code.</p>	

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Obesity Assessment (Calculate BMI [Body Mass Index])</p> <p>NOTE: This is not a GPRA measure; however, it's displayed in GPRA report for reducing the incidence of obesity. The information is included here is to inform providers and data entry staff of how to collect, document, and enter the data.</p>	<p>Children (through age 18) must have both height and weight taken on the same day at least annually (at every visit is recommended).</p> <p>Adults 19-50, height and weight at least every 5 years, not required to be on same day.</p> <p>Adults over 50, height and weight taken every 2 years, not required to be on same day.</p>	<p>Standard PCC documentation Obtain Height and Weight during visit and record information on PCC:</p> <p>Height</p> <p>Weight</p> <p>Date Recorded</p> <p>BMI is calculated using NHANES II.</p> <p>Obese is defined as:</p> <p>BMI of 30 or more for adults 19 and older.</p> <p>For ages 2-18, definitions based on standard tables.</p> <p>To document Refusals on PCC:</p> <p>Use the REF Mnemonic</p> <p>Refusals include:</p> <p>REF (refused)</p> <p>NMI (not medically indicated)</p> <p>UAS (unable to screen) and must be documented during the past year.</p> <p>For ages 18 and under, both the height and weight must be refused on the same visit at any time during the past year.</p> <p>For ages 19 and older, the height and weight must be refused during the past year and are not required to be on the same visit.</p> <p>Patients whose BMI either is greater or less than the Data Check Limit range shown in the BMI Standard Reference Data Table in PCC will not be included in the report counts for Overweight or Obese.</p>	<p>Standard PCC data entry:</p> <p>Height Measurement</p> <p><i>Mnemonic HT enter</i></p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Estimated</p> <p>Date/Time Vitals Taken:</p> <p>Weight Measurement</p> <p><i>Mnemonic WT enter</i></p> <p>Value:</p> <p>Select Qualifier:</p> <p>Actual</p> <p>Bed</p> <p>Chair</p> <p>Dry</p> <p>Estimated</p> <p>Standing</p> <p>Date/Time Vitals Taken:</p> <p>Historical Height and Weight Measurement (May be used for ages 19 and older)</p> <p><i>Mnemonic HMSR enter</i></p> <p>Enter Date Historical Measurement:</p> <p>Type:</p> <p>Location:</p> <p>Select Measurement: HT, WT</p> <p>Value:</p> <p>Refusal of Height</p> <p><i>Mnemonic REF enter</i></p> <p>Patient Refusals For Service:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Obesity Assessment (Calculate BMI [Body Mass Index]) (cont)</p>			<p>Measurements Measurement Type: HT Date Refused: Provider Who Documented: Comment:</p> <p>Refusal of Weight <i>Mnemonic REF enter</i> Patient Refusals For Service:</p> <p>Measurements Measurement Type: WT Date Refused: Provider Who Documented: Comment:</p> <p>Unable to Screen for Height <i>Mnemonic UAS enter</i> Patient Refusals For Service:</p> <p>Measurements Enter Measurement Type: HT Date Refused/Not Indicated: Provider Who Documented: Comment:</p> <p>Unable to Screen for Weight <i>Mnemonic UAS enter</i> Patient Refusals For Service:</p> <p>Measurements Enter Measurement Type: WT Date Refused/Not Indicated: Provider Who Documented: Comment:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<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 => 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 PCC documentation Obtain Height and Weight during visit and record information on PCC: Height Weight Date Recorded</p> <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>Patients whose BMI either is greater or less than the Data Check Limit range shown below will not be included in the report counts for Overweight or Obese.</p>	<p>Standard PCC data entry</p> <p>Height Measurement <i>Mnemonic HT enter</i> Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken:</p> <p>Weight Measurement <i>Mnemonic WT enter</i> Value: Select Qualifier: Actual Bed Chair Dry Estimated Standing Date/Time Vitals Taken:</p>

Performance Measure	Standard	Provider Documentation						Data Entry
Childhood Weight Control (cont)		Low-High		BMI >= 85	BMI >= 95	Data Check Limits		
		Ages	Sex	Over Weight	Obese	BMI >	BMI <	
		2-2	M	17.7	18.7	36.8	7.2	
			F	17.5	18.6	37.0	7.1	
		3-3	M	17.1	18.0	35.6	7.1	
			F	17.0	18.1	35.4	6.8	
		4-4	M	16.8	17.8	36.2	7.0	
	F	16.7	18.1	36.0	6.9			
5-5	M	16.9	18.1	36.0	6.9			
	F	16.9	18.5	39.2	6.8			
Comprehensive CVD-Related Assessment	<p>Active Clinical Patients ages 22 and older diagnosed with Ischemic Heart Disease (IHD) prior to the Report Period, AND at least 2 visits during the Report Period, AND 2 IHD-related visits ever who had the following tests documented:</p> <ul style="list-style-type: none"> • Blood Pressure • LDL Assessment • Tobacco Use Assessment • BMI Calculated • Lifestyle Counseling <p>Note: This does NOT include depression screening and does NOT include refusals of BMI.</p>	<p>Standard PCC documentation for tests performed at the facility, Ask about off-site tests and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>Note: See related individual measures above for recording historical information.</p> <p>Blood Pressure Control</p> <p>LDL Assessment</p> <p>Tobacco Use and Assessment</p> <p>BMI (Obesity)</p> <p>Tobacco Use Health Factors:</p> <p>HF–Current Smoker, every day</p> <p>HF–Current Smoker, some day</p> <p>HF–Current Smoker, status unknown</p> <p>HF–Current Smokeless</p> <p>HF–Previous (Former) Smoker [or -Smokeless] (quit > 6 months)</p>						<p>Standard PCC data entry</p> <p>IHD Diagnosis POV (Prior to the report period)</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: 410.0-412.*, 414.0-414.9, 428.* 429.2</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Blood Pressure Data Entry</p> <p><i>Mnemonic BP enter</i></p> <p>Value: [Enter as Systolic/Diastolic (e.g., 130/80)]</p> <p>Select Qualifier:</p> <p>Date/Time Vitals Taken:</p> <p>LDL (Calculated) (REF)* Lab Test</p> <p><i>Mnemonic LAB enter</i></p> <p>Enter Lab Test Type: LDL</p> <p>Results:</p> <p>Units:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Comprehensive CVD-Related Assessment (cont)</p>	<p>Note: Refusals of any or all of the above are not counted toward the GPRA measure, but should still be documented.</p>	<p>HF–Cessation-Smoker [or -Smokeless] (quit or actively trying < 6 months)</p> <p>HF–Smoker in Home</p> <p>HF–Ceremonial Use Only</p> <p>HF–Exp to ETS (Second Hand Smoke)</p> <p>HF–Smoke Free HomeNOTE: 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: Codes will contain "TO-", "-TO", "-SHS"</p> <p>BMI is calculated using NHANES II. Adults 19–50, height and weight at least every 5 years, not required to be on same day. Adults over 50, height and weight taken every 2 years, not required to be on same day.</p> <p>Nutrition, dietary surveillance and counseling Patient Education Codes: Codes will contain "-N" (Nutrition) or "-MNT"</p> <p>Exercise Patient Education Codes: Codes will contain “-EX”</p> <p>Lifestyle Patient Education Codes: Codes will contain “-LA”</p> <p>Other Related Nutrition and Exercise Patient Educations Codes: Codes will contain “-OBS” (Obesity)</p> <p>Lifestyle Counseling includes: Lifestyle adaptation counseling Medical nutrition therapy Nutrition counseling Exercise counseling</p>	<p>Abnormal: Site: [Blood, Serum] *REF – Reference Lab LDL (Calculated) Lab Test <i>Mnemonic LAB enter</i> Enter Lab Test Type: LDL Results: Units: Abnormal: Site: [Blood] LDL CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F Quantity : Modifier: Modifier 2: Tobacco Use Assessment <i>Mnemonic HF enter</i> Select V Health Factor: [Enter HF (See the Provider Documentation column)] Level/Severity: Provider: Quantity: Tobacco Use Dental (ADA) <i>Mnemonic ADA enter</i> Select V Dental Service Code: 1320 No. Of Units: Operative Site:</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Comprehensive CVD-Related Assessment (cont)		Other lifestyle education	<p> Tobacco Screening CPT <i>Mnemonic CPT enter</i> Enter CPT Code: D1320, 99406, 99407, 1034F, 1035F, 1036F, 1000, G8455, G8456, G8457, G8402, G8453 Quantity Modifier: Modifier 2: </p> <p> Tobacco Related Diagnoses POV <i>Mnemonic PPV enter</i> Purpose of Visit: 305.1, 649.00-649.04, V15.82 Provider Narrative: Modifier: Cause of DX: </p> <p> Tobacco Screening PED - Topic <i>Mnemonic PED enter</i> Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Educ (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>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Comprehensive CVD-Related Assessment (cont)</p>			<p>Tobacco Screening PED - Diagnosis <i>Mnemonic PED enter</i> Select ICD Diagnosis Code Number: 305.1, 649.00-649.04, V15.82 Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (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>BMI Data Entry Height Measurement <i>Mnemonic HT enter</i> Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken:</p> <p>Weight Measurement <i>Mnemonic WT enter</i> Value: Select Qualifier: Actual Bed</p>

Performance Measure	Standard	Provider Documentation	Data Entry
Comprehensive CVD-Related Assessment (cont)			Chair Dry Estimated Standing Date/Time Vitals Taken: Lifestyle Counseling Data Entry Medical Nutrition Therapy CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 97802-97804, G0270, G0271 Quantity: Modifier: Modifier 2: Medical Nutrition Therapy Clinic <i>Mnemonic CL enter</i> Clinic: 67, 36 Was this an appointment or walk in?: Nutrition Education POV <i>Mnemonic PPV enter</i> Purpose of Visit: V65.3 Provider Narrative: Modifier: Cause of DX: Nutrition/Exercise/Lifestyle Adaption PED - Topic <i>Mnemonic PED enter</i> Enter Education Topic: [Enter Nutrition/Exercise/Lifestyle Adaption Patient Education Code (See the Provider Documentation column)]

Performance Measure	Standard	Provider Documentation	Data Entry
Comprehensive CVD-Related Assessment (cont)			Readiness to Learn: Level of Understanding: Provider: Length of Educ (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: Nutrition/Exercise/Lifestyle Adaption PED - Diagnosis <i>Mnemonic PED enter</i> Select ICD Diagnosis Code Number: V65.3 (Nutrition), V65.41 (Exercise), 278.00 or 278.01 (Obesity) Category: Readiness to Learn: Level of Understanding: Provider: Length of Educ (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:

Performance Measure	Standard	Provider Documentation	Data Entry
<p>HIV Screening</p>	<p>Pregnant women should be tested for HIV at least on their first visit; 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 PCC documentation for tests performed at the facility, Ask and record historical information on PCC:</p> <p>Date received</p> <p>Location</p> <p>Results</p> <p>NOTE: The timeframe for screening for the pregnant patients denominator is anytime during the past 20 months.</p> <p>Pregnant patients are any patients with at least 2 non-pharmacy only visits with a pregnancy POV code with no recorded abortion or miscarriage in this timeframe.</p>	<p>Standard PCC data entry</p> <p>HIV Screen CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 86689, 86701-86703, 87390, 87391, 87534-87539</p> <p>Quantity: Modifier: Modifier 2:</p> <p>HIV Diagnoses POV <i>Mnemonic PPV enter</i> Purpose of Visit: 042, 079.53, V08, 795.71</p> <p>Provider Narrative: Modifier: Cause of DX:</p> <p>HIV Lab Test <i>Mnemonic LAB enter</i> Enter Lab Test Type: [Enter site's defined HIV Screen Lab Test] Results: [Enter Results (e.g., Negative, Positive, Indeterminant)] Units: Abnormal: Site: [Blood, Serum]</p> <p>Historical HIV Screen <i>Mnemonic HLAB enter</i> Date of Historical Lab Test: Type: Location Name: Enter Lab Test:</p>

Performance Measure	Standard	Provider Documentation	Data Entry																																																								
HIV Screening (cont)			Results:																																																								
<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.</p> <p>The information is included here to inform providers and data entry staff of how to collect, document, and enter the data.</p>	<p><i>All providers should assess the feeding practices of all newborns through age 1 year at all well-child visits.</i></p>	<p>The following grid is designed to be used on PCC and PCC+. It was successfully field tested at Phoenix Indian Medical Center (PIMC) for pediatric clinic visits. See the next page for definitions of each feeding choice.</p> <table border="1" data-bbox="919 402 1373 948"> <tr> <td colspan="4">Feeding Choice (today) X</td> </tr> <tr> <td colspan="2">Exclusive Breastfeeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">Mostly Breastfeeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">½ Breastfeeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">½ Formula feeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">Mostly Formula feeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">Formula only feeding</td> <td colspan="2"></td> </tr> <tr> <td colspan="4">One time data fields</td> </tr> <tr> <td colspan="4">Mom's name</td> </tr> <tr> <td colspan="4">Or chart#</td> </tr> <tr> <td>Birth order</td> <td></td> <td>Birth wt.</td> <td></td> </tr> <tr> <td colspan="2">started formula</td> <td colspan="2">___wks/mth</td> </tr> <tr> <td colspan="2">stopped breastfeeding</td> <td colspan="2">___wks/mth</td> </tr> <tr> <td colspan="2">started solids</td> <td colspan="2">___wks/mth</td> </tr> </table> <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>	Feeding Choice (today) X				Exclusive Breastfeeding				Mostly Breastfeeding				½ Breastfeeding				½ Formula feeding				Mostly Formula feeding				Formula only feeding				One time data fields				Mom's name				Or chart#				Birth order		Birth wt.		started formula		___wks/mth		stopped breastfeeding		___wks/mth		started solids		___wks/mth		<p>Standard PCC data entry</p> <p>Infant Breastfeeding</p> <p><i>Mnemonic IF enter</i></p> <p>Enter Feeding Choice:</p> <ol style="list-style-type: none"> 1 Exclusive Breastfeeding 2 Mostly Breastfeeding 3 1/2 & 1/2 Breast and Formula 4 Mostly Formula 5 Formula Only
Feeding Choice (today) X																																																											
Exclusive Breastfeeding																																																											
Mostly Breastfeeding																																																											
½ Breastfeeding																																																											
½ Formula feeding																																																											
Mostly Formula feeding																																																											
Formula only feeding																																																											
One time data fields																																																											
Mom's name																																																											
Or chart#																																																											
Birth order		Birth wt.																																																									
started formula		___wks/mth																																																									
stopped breastfeeding		___wks/mth																																																									
started solids		___wks/mth																																																									

Performance Measure	Standard	Provider Documentation	Data Entry
Breastfeeding Rates (cont)		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.	
Patient Education Measures (Patient Education Report) NOTE: This is not a GPRA measure; however, the information is being provided because there are several GPRA measures that do include patient education as meeting the numerator (e.g. alcohol screening). Providers and data entry staff need to know they need to collect and enter ALL components of patient education.	N/A	<i>All providers should document all 5 patient education elements and elements #6-7 below if a goal was set for the patient:</i> 1. Education Topic/Diagnosis 2. Readiness to Learn 3. Level of Understanding (see below) 4. Initials of Who Taught 5. Time spent (in minutes) 6. Goal Not Set, Goal Set, Goal Met, Goal Not Met 7. Text relating to the goal or its status Readiness to Learn: Distraction Eager To Learn Intoxication Not Ready Pain Receptive Severity of Illness Unreceptive	Standard PCC data entry Patient Education Topic <i>Mnemonic PED enter</i> Topic: [Enter Topic] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider: Length of Educ (minutes): Comment: Goal Code: GS, GM, GNM, GNS Goal Comment: Patient Education Diagnosis <i>Mnemonic PED enter</i> Select ICD Diagnosis Code Number: Category: [Enter Category] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider: Length of Educ (Minutes): Comment:

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Patient Education Measures (Patient Education Report) (cont)</p>		<p>Levels of Understanding: P–Poor F–Fair G–Good GR–Group-No Assessment R–Refused</p> <p>Goal codes: GS–Goal Set GM–Goal Met GNM–Goal Not Met GNS–Goal Not Set</p> <p>An example of how this would look on the PCC form for Topic is:</p> <p>DM-N-E-G-DU-15 MIN-GS-Patient will eat more fruits and vegetables and less sugar: DM-N = Diabetes Mellitus -Nutrition (Topic) E = Eager to Learn (Readiness to Learn) G = Good (Level of Understanding) DU = Initials of Provider 15 MIN = 15 minutes spent providing education to the patient (Time Spent) GS = A goal was set Patient will... = The goal set for the patient</p> <p>Diagnosis Categories: Anatomy and Physiology Complications Disease Process Equipment Exercise</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>

Performance Measure	Standard	Provider Documentation	Data Entry
<p>Patient Education Measures (Patient Education Report) (cont)</p>		<p>Follow-up Home Management Hygiene Lifestyle Adaptation Literature Medical Nutrition Therapy Medications Nutrition Prevention Procedures Safety Tests Treatment</p> <p>An example of how this would look on the PCC form for Diagnosis is:</p> <p>V65.3-N-E-G-DU-15 MIN-GS-Patient will eat more fruits and vegetables and less sugar:</p> <p>V65.3 = Dietary Surveil/Counsel (Diagnosis) N = Nutrition (Category) E = Eager to Learn (Readiness to Learn) G = Good (Level of Understanding) DU = Initials of Provider 15 MIN = 15 minutes spent providing education to the patient (Time Spent) GS = A goal was set Patient will... = The goal set for the patient</p>	