KEY CLINICAL PERFORMANCE OBJECTIVES
"Cheat Sheet" for PCC Documentation and Data Entry for CRS Version 7.0
Last Updated April 11, 2007

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 RPMS. It does not include all of the codes 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/misc/links_gateway/download.cfm?doc_id=10625&app_dir_id=4&doc_file=CRS_2007_v7.0_National_GPRA_Report_Performance_Measures_Definitions_and_Logic-11_09_06.pdf

Performance Measure	Standard	Provider Documentation	Data Entry
Depression Screening	Adult patients 18 years of age and older should be screened for depression *at least annually*. (Source: United States Preventive Services Task Force)	**Medical Providers:** EXAM—Depression Screening Negative Positive - further evaluation indicated Refused - patient declined exam/screen Unable to screen	Standard PCC data entry: *Mnemonic* ***EX***: 36 or DEP SCR (AUM Patch 9 (released 8/26/05); AUPN patch 15 (released 9/13/05) N Negative/Normal P Positive/Abnormal Refusals *Mnemonic*: ***REF*** Exam Exam Value: **DEP SCR (or 36)** Date Refused: Unable to Screen: *mnemonic* ***UAS*** (PCC Data Entry patch 7) Exam Exam Value: **DEP SCR (or 36)** Date Refused:

Performance Measure	Standard	Provider Documentation	Data Entry
Depression Screening (cont'd)		**Behavioral Health Providers:** Enter BHS problem code 14.1 or narrative "Screening for Depression."* **Note:** BHS problem code 14.1 maps to ICD-9 V79.0. * Depression Screening Exam Code #36 to be added in upcoming patches to RPMS behavioral health applications (BHS v3.0 and BH GUI/Patient Chart). **Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).** <u>Patient Health Questionnaire (PHQ-2 Scaled Version)</u> Over the past 2 weeks, how often have you been bothered by any of the following problems? 1. Little interest or pleasure in doing things 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 2. Feeling down, depressed, or hopeless 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	Standard BHS data entry: Enter BHS problem code 14.1 or narrative "Screening for Depression." **Note:** BHS problem code 14.1 maps to ICD-9 V79.0 (Special Screening for Mental Disorders and Developmental Handicaps, Depression).

Performance Measure	Standard	Provider Documentation	Data Entry
Depression Screening (cont'd)		PHQ-2 Scaled Version (cont'd) **Total Possible PHQ-2 Score:** Range: 0-6 **0-2:** Negative Depression Screening Exam Code Result: NEGATIVE **3-6:** Positive; further evaluation indicated Depression Screening Exam Code Result: POSITIVE The patient may decline the screen or "Refuse to answer" Depression Screening Exam Code Result: REFUSED **Provider should note the screening tool used was the PHQ-2 Scaled in the COMMENT section of the Exam Code.**	

Performance Measure	Standard	Provider Documentation	Data Entry
Domestic (Intimate Partner) Violence Screening (DV/IPV)	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)	**Medical and Behavioral Health Providers:** EXAM—DV (or IPV) Screening Negative - denies being a current or past victim of DV Present - admits being current victim of DV Past - denies being a current victim, but admits being a past victim of DV Refused - patient declined exam/screen Unable to screen	Exam *Mnemonic* ***EX***: 34 or INTIMATE PARTNER VIOLENCE SCREEN (AUM 4.1 patch 1; AUPN patch 11) N Negative PR Present PA Past Refusals *Mnemonic*: ***REF*** Exam Exam Value: **INT (or 34)** Date Refused: Unable to Screen: *mnemonic* ***UAS*** (PCC Data Entry patch 7) Exam Exam Value: **INT (or 34)** Date Refused:

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention)	Pregnant women should be screened for alcohol use at least on their first visit; education and follow-up provided as appropriate Women of childbearing age should be screened at least annually	**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.** **Medical Providers:** EXAM—Alcohol Screening Negative Positive Refused - patient declined exam/screen Unable to screen **Behavioral Health Providers:** Enter BHS problem code 29.1 or narrative "Screening for Alcoholism."* **Note:** BHS problem code 29.1 maps to ICD-9 V79.1. * Alcohol Screening Exam Code #35 to be added in upcoming patches to RPMS behavioral health applications (BHS v3.0 and BH GUI/Patient Chart). **Note: Recommended Brief Screening Tool: SASQ (below).**	Standard PCC data entry: *Mnemonic* ***EX***: 35 (AUM Patch 9 (released 8/26/05); AUPN patch 15 (released 9/13/05) N Negative/Normal P Positive/Abnormal SASQ (enter in Comments section) Refusals *Mnemonic*: ***REF*** Exam Exam Value: **35** Date Refused: Unable to Screen: *mnemonic* ***UAS*** (PCC Data Entry patch 7) Exam Exam Value: **35** Date Refused: Standard BHS data entry: Enter BHS problem code 29.1 or narrative "Screening for Alcoholism." **Note:** BHS problem code 29.1 maps to ICD-9 V79.1 (Screening for Alcoholism).

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont'd)		Single Alcohol Screening Question (SASQ) For Women: When was the last time you had more than 4 drinks in one day? For Men: When was the last time you had more than 5 drinks in one day? Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen Alcohol Screening Exam Code Result: POSITIVE The patient may decline the screen or "Refuse to answer" Alcohol Screening Exam Code Result: REFUSED **Provider should note the screening tool used was the SASQ.**	

Performance Measure	Standard	Provider Documentation	Data Entry
Alcohol Screening (FAS Prevention) (cont'd)		**All Providers: Use the CAGE questionnaire**: 1. Have you ever felt the need to **Cut** down on your drinking? 2. Have people **Annoyed** you by criticizing your drinking? 3. Have you ever felt bad or **Guilty** about your drinking? 4. 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? Based on how many YES answers were received, document Health Factor on PCC: HF – CAGE 0/4 (all No answers) HF – CAGE 1/4 HF – CAGE 2/4 HF – CAGE 3/4 HF – CAGE 4/4 Optional values: Level/Severity: Mild, Moderate, or 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"	*Under mnemonic **HF**, enter:* CAGE 0/4 (all No answers) CAGE 1/4 CAGE 2/4 CAGE 3/4 CAGE 4/4 Level/Severity Provider Quantity

Performance Measure	Standard	Provider Documentation	Data Entry
Obesity Assessment (Calculate BMI [Body Mass Index])	Children (through age 18) should have both height and weight taken on the same day at least annually (at every visit is recommended) Adults 19-50, height and weight at least every 5 years, not on same day Adults over 50, height and weight taken every 2 years	Standard PCC documentation To document Refusals on PCC: Write "Refused" in Height or Weight boxes at upper right	Standard PCC data entry Refusals: *mnemonic* ***REF*** Measurements Measurement Type: **HT** or **WT** Date Refused:

Performance Measure	Standard	Provider Documentation	Data Entry
Childhood Immunizations	Children age 19-35 months will be up-to-date for all ACIP recommended immunizations This is the 43133 combo: 4 DTaP 3 IPV 1 MMR 3 Hib 3 Hepatitis B	Standard PCC documentation for immunizations performed at the facility Ask about off-site IZ and *record historical information* on PCC: IZ type Date received Location To document Refusals on PCC: Write "Refused [shot type" in POV section OR "Refused" in appropriate Order box at right **IMPORTANT NOTE:** The GPRA denominator is all User Population patients who are active in the Immunization Package. This means you must be using the Immunization Package and maintaining the active/inactive status field in order to have patients in your denominator for this GPRA measure. Immunization package v8.1 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 8.1. Children already in the Register or residing outside of the GPRA communities will not be affected. **For sites running the RPMS Electronic Health Record GUI:** The Immunization component in the released version of EHR is not compatible with Immunization version 8.1. A compatible EHR Immunization component is presently being tested. Sites running EHR should consider delaying the installation of Immunization v8.1 until the corresponding GUI component is released.	Standard PCC data entry For historical, use *mnemonic* ***HIM*** Date Type Location of Encounter Immunization Type(s) and Series Refusals: *mnemonic* ***REF*** Immunization Immunization Value: Date Refused (can be month and year only)

Performance Measure	Standard	Provider Documentation	Data Entry
Adult Immunization: Flu Vaccine	All adults ages 65 and older should have an annual flu shot Adults 55-64 are strongly recommended to have annual flu shot All adult (18 and older) diabetic patients are strongly recommended to have annual flu shot Refusals should be documented.	Standard PCC documentation for immunizations performed at the facility Ask about off-site IZ and *record historical information* on PCC: IZ type Date received Location To document Refusals on PCC: Write "Refused Flu Shot" in POV section OR "Refused" in Influenza Order box at right	Standard PCC data entry For historical, use *mnemonic* ***HIM*** Date Type Location Immunization Type: **88 Inf Virus Vaccine NOS (other options are 111 Inf Virus Vac Intranasal; 15 Inf Virus Vac SV; or 16 Inf Virus Vac WV)** Refusals: *mnemonic* ***REF*** Immunization Immunization Value: Date Refused
Adult Immunization: Pneumococcal Vaccine	All adults ages 65 and older will have a pneumovax All adult (18 and older) diabetic patients are strongly recommended to have a pneumovax Refusals should be documented.	Standard PCC documentation for immunizations performed at the facility Ask about off-site IZ and *record historical information* on PCC: IZ type Date received Location To document Refusals on PCC: Write "Refused Pneumovax" in POV section OR "Refused" in Pneumo Vax Order box at right	Standard PCC data entry For historical, use mnemonic ***HIM*** Date Type Location Immunization Type: **33 Pneumo Polysac Vac (other options are 100 Pneumo Conj Vacc, or 109 Pneumo NOS)** Refusals: *mnemonic* ***REF*** Immunization Immunization Value: Date Refused

Performance Measure	Standard	Provider Documentation	Data Entry
Colorectal Cancer Screening	Adults ages 50 and older should be screened for CRC (USPTF). For GPRA, IHS counts any of the following: 1. Annual fecal occult blood test (FOBT) 2. Flexible sigmoidoscopy or double contrast barium enema every 5 years 3. Colonoscopy every 10 years. 4. Refusal of any above test during the past year.	Standard PCC 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* on PCC: date received and location Telephone visit with patient Verbal or written lab report Patient's next visit Discuss with Data Entry staff and ensure they know where refusals are documented on the PCC form.	Standard PCC data entry process for procedures, Lab or Radiology *Mnemonics for Historical:* ***HBE*** Historical Barium Enema ***HCOL*** Historical Colonoscopy ***HFOB*** Historical FOBT (Guaiac) ***HSIG*** Historical Sigmoidoscopy Date Type Location of Encounter *Mnemonics for Refusals:* <u>Refusal of FOBT-Lab:</u> Refusals Mnemonic: ***REF*** Refusal Type: Lab Lab Test: Fecal Occult Blood Date Refused: <u>Refusal of FOBT-CPT:</u> *Requires AUT Version 98.1, Patch 19 (AUT*98.1*19), released 06/08/06* Refusals Mnemonic: ***REF*** Refusal Type: CPT CPT: 82270, 82274, or G0107 Date Refused:

Performance Measure	Standard	Provider Documentation	Data Entry
Colorectal Cancer Screening (cont'd)			<u>Refusal of Flex Sig-Procedure:</u> *Requires AUT Version 98.1, Patch 19 (AUT*98.1*19), released 06/08/06* Refusals Mnemonic: ***REF*** Refusal Type: ICD Operation/Procedure ICD-9 Procedure: 45.24 or 45.42 Date Refused: <u>Refusal of Flex Sig-CPT:</u> *Requires AUT Version 98.1, Patch 19 (AUT*98.1*19), released 06/08/06* Refusals Mnemonic: ***REF*** Refusal Type: CPT CPT: 45330-45345, or G0104 Date Refused: <u>Refusal of DCBE-Radiology:</u> Refusals Mnemonic: ***REF*** Refusal Type: Radiology Exam CPT or Exam Name: 74280, G0106, or G0120 Date Refused: <u>Refusal of Colonoscopy-Procedure:</u> *Requires AUT Version 98.1, Patch 19 (AUT*98.1*19), released 06/08/06* Refusals Mnemonic: ***REF*** Refusal Type: ICD Operation/Procedure ICD-9 Procedure: 45.22, 45.23, 45.25, or 45.43 Date Refused:

Performance Measure	Standard	Provider Documentation	Data Entry
Colorectal Cancer Screening (cont'd)			Refusal of Colonoscopy-CPT: *Requires AUT Version 98.1, Patch 19 (AUT*98.1*19), released 06/08/06* Refusals Mnemonic: ***REF*** Refusal Type: CPT CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, or G0121 Date Refused:
Pap Smear	Women ages 18-64 should have a Pap Smear every 3 years (HEDIS). Refusals should 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 To document Refusals on PCC: Write "Refused Pap Smear" in POV section OR "Refused" in Pap Order box at right	Data entry through Women's Health program or standard PCC data entry for tests performed at the facility Historical Pap Mnemonic: ***HPAP*** Date Type of Visit Location Name Enter Outside Location (if entered "Other" for Location Name) Results Refusals Mnemonic: ***REF*** Lab Test Value: Pap Smear Date Refused:

Performance Measure	Standard	Provider Documentation	Data Entry
Mammogram	Women ages 50-69 should have a mammogram every 2 years Refusals should be documented.	Standard PCC documentation for Radiology performed at the facility Ask and *record historical information* on PCC: date received and location Telephone visit with patient Verbal or written lab report Patient's next visit To document Refusals on PCC: Write "Refused Mammogram" in POV section OR "Refused" in Mammogram Order box at right	Data entry through Women's Health program or standard PCC data entry for tests performed at the facility Historical *Mnemonic**: HRAD*** Date Type of Visit Location Name Enter Outside Location (if "Other" was entered for Location Name) Radiology Exam: 76090, 76091, or 76092 Impression Abnormal Refusals Mnemonic: ***REF*** Mammogram RAD/NUC MED Procedures Value (CPT): 76090, 76091, or 76092 Date Refused

Performance Measure	Standard	Provider Documentation	Data Entry
Diabetic Retinopathy	Patients with diabetes will have a qualified* retinal examination in the past 12 months *Qualified retinal exam: The following methods are qualifying for this measure: • Dilated retinal evaluation by an optometrist or ophthalmologist • Standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist • Any photographic method formally validated to ETDRS, e.g. JVN, Inoveon, EyeTel, etc.	EXAM—DM Eye Exam To document Refusals on PCC: Write "Refused DM Eye Exam" in POV section	*Under mnemonic **EX** enter* DIABETIC EYE EXAM Refusals Mnemonic: ***REF*** Exam Exam Value: **03** Date Refused:

Performance Measure	Standard	Provider Documentation	Data Entry
Tobacco Use and Exposure Assessment	Ask all patients age five and over about tobacco use *at least annually*	Document on designated Health Factors section of form: HF—Non-Tobacco User HF—Smoker HF—Smokeless HF – Smoker & Smokeless HF – Previous Smoker [or Smokeless] (quit > 6 months) HF – Cessation Smoker [or Smokeless] (quit or actively trying < 6 months) HF – Smoker in Home HF – Ceremonial HF – Exp to ETS (Second Hand Smoke) HF – Smoke Free Home NOTE: if your site uses other expressions (e.g.," Chew" instead of "Smokeless;" "Past" instead of "Previous"), be sure Data Entry staff know how to "translate" Optional values: Level/Severity: Mild, Moderate, or Severe Quantity: e.g., # of cigarettes smoked daily Ensure you update the patient's health factors as they enter a cessation program and eventually become non-tobacco users. Patients who 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."	*Under mnemonic **HF** enter* NON-TOBACCO USER CURRENT SMOKER CURRENT SMOKELESS CURRENT SMOKER & SMOKELESS PREVIOUS SMOKER PREVIOUS SMOKELESS CESSATION SMOKER [or SMOKELESS] SMOKER IN HOME CEREMONIAL EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE SMOKE FREE HOME Level/Severity Provider Quantity

Performance Measure	Standard	Provider Documentation	Data Entry
Prenatal HIV Testing	Pregnant women should be tested for HIV at least on their first visit; education and follow-up provided as appropriate	Standard PCC documentation for tests performed at the facility To document Refusals on PCC: Write "Refused HIV test" in POV section	Standard PCC data entry for tests performed at the facility Historical Mnemonic: ***HLAB*** Date of Test: Name of Lab Test: Results: Refusals Mnemonic: ***REF*** Lab Test Value: Date Refused:
Medication Education	Patients receiving medications should be educated about appropriate use and potential risks	**Provider and/or pharmacist should document all 5 patient education elements:** Disease State - Education Topic – Level of Understanding – Who Taught – Time spent (in minutes) Level of Understanding = G (Good), F (Fair), P (Poor), Group (Not Assessed), R (Refused)	*Mnemonic **PED**:* Education Topic Any patient education containing "M-" or "-M" DMC-IN (Diabetes medicine - Insulin) FP-DPO, FP-OC, FP-TD ASM-NEB, ASM-MDI PL-NEB, PL-MDI Provider Level of Understanding: G, F, P, Group, R (Refused) Length of Education (minutes)

Performance Measure	Standard	Provider Documentation	Data Entry
Dental Measures: - Access to Dental Services (Annual Dental Exam) - Topical Fluoride - Dental Sealants		Standard PCC documentation for tests performed at the facility Ask about off-site tests and *record historical information* on PCC: Date received Location	Standard PCC data entry ***Historical Dental Exam (exam code):*** For historical, use *mnemonic* ***HEX*** Date Type and Location Name or Choose Existing Visit if visits exists on that date Exam Type: 30 (Dental Exam) ***Historical Dental Exam (ADA code):*** For historical, use *mnemonic* ***HADA*** Date Type and Location Name or Choose Existing Visit if visit exists on that date ADA Code: 0000 or 0190 Units ***Refusal of Dental Exam (ADA code):*** Requires AUT Version 98.1, Patch 19 (AUT*98.1*19), released 06/08/06 Refusals *Mnemonic*: ***REF*** ADA Code ADA Code Value: 0000 or 0190 Date Refused:

Performance Measure	Standard	Provider Documentation	Data Entry
Dental Measures (cont'd)		Standard PCC documentation for tests performed at the facility Ask about off-site tests and *record historical information* on PCC: Date received Location	***Historical Sealants:*** For historical, use *mnemonic* ***HADA*** Date Type and Location Name OR Choose Existing Visit if visit exists on that date ADA Code: 1351 Units ***Refusal of Sealant (ADA code):*** Requires AUT Version 98.1, Patch 19 (AUT*98.1*19), released 06/08/06 Refusals *Mnemonic*: ***REF*** ADA Code ADA Code Value: 1351 Date Refused: ***Historical Topical Fluoride:*** For historical, use *mnemonic* ***HADA*** Date Type and Location Name OR Choose Existing Visit if visit exists on that date ADA Code: 1201, 1203, 1204, or 1205 Units

Performance Measure	Standard	Provider Documentation	Data Entry
Dental Measures (cont'd)			***Refusal of Topical Fluoride (ADA code):*** Requires AUT Version 98.1, Patch 19 (AUT*98.1*19), released 06/08/06 Refusals *Mnemonic*: ***REF*** ADA Code ADA Code Value: 1201, 1203, 1204, or 1205 Date Refused:

Performance Measure	Standard	Provider Documentation	Data Entry
Breastfeeding Rates **NOTE:** This is not a GPRA measure; however, it will be used in conjunction with the Childhood Weight Control measure for reducing the incidence of childhood obesity. The information is included here to inform providers and data entry staff of how to collect, document, and enter the data.	<u>All providers</u> should assess the feeding practices of all newborns through age 1 year at all well-child visits.	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.	Standard PCC data entry: *Mnemonic* ***IF*** (Infant Feeding Choice) (Data entry patch 8 apcd0200.08k, released October 19, 2005) Feeding Choice Value: 1 (EXCLUSIVE BREASTFEEDING 2 (MOSTLY BREASTFEEDING) 3 (1/2 & 1/2 BREAST AND FORMULA) 4 MOSTLY FORMULA 5 FORMULA ONLY

Feeding Choice (today) X			
Breastfeeding only			
Mostly Breastfeeding			
½ Breastfeeding ½ Formula feeding			
Mostly Formula feeding			
Formula feeding only			
<u>One time data fields</u>			
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'd)		**Breastfeeding Only** - Formula supplementing less than 3 times per week (<3x per week) **Mostly Breastfeeding** - Formula supplementing 3 or more times per week (≥3x per week) but otherwise mostly breastfeeding **½ Breastfeeding, ½ Formula Feeding** - Half the time breastfeeding, half formula feeding **Mostly Formula** - The baby is mostly formula fed, but breastfeeds at least once a week **Formula Only** - Baby receives only formula The additional one-time data fields, e.g., birth weight, formula started, and breast stopped, may also be collected and may be entered using the data entry *mnemonic* **PIF.** However, this information is not used or counted in the CRS logic for Breastfeeding Rates.	

Performance Measure	Standard	Provider Documentation	Data Entry
Fall Risk Assessment in Elders **NOTE:** This is not a GPRA measure; however, the information is included here to inform providers and data entry staff of the new exam code and how to collect, document, and enter the data.	All patients 65 and older should be screened annually for falls.	EXAM — Fall Risk A Abnormal N Normal/Negative PA Past PR Present To document Refusals on PCC: Write "Refused Fall Risk Exam" in POV section	AUT Version 98.1, Patch 19 (AUT*98.1*19), released 06/08/06 *Under mnemonic **EX** enter* V Exam: 37 (FALL RISK) Result: A (Abnormal) N (Normal/Negative) PA (Past) PR (Present) Refusals Mnemonic: ***REF*** Exam Exam Value: 37 Date Refused:

Performance Measure	Standard	Provider Documentation	Data Entry
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. domestic violence screening, alcohol screening). Providers and data entry staff need to know they need to collect and enter ALL components of patient education.	N/A	**All providers should document all 5 patient education elements and elements #6-7 below if a goal was set for the patient:** 1. Disease State 2. Education Topic 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 Level of Understanding = G (Good), F (Fair), P (Poor), Gp (Group assessment), R (Refused) An example of how this would look on the PCC form is: **DM-N-G-SSK-15 MIN-GS-Patient will eat more fruits and vegetables and less sugar.** Where, **DM**= Diabetes Mellitus (Disease State) **N**=Nutrition (Education Topic) **G**= Good (Level of Understanding) **SSK**=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	*Mnemonic **PED**:* Topic *(includes both Disease State and Education Topic)* Goal (Objectives Met) *(if a goal was set, not set, met, or not met, enter the text relating to the goal)* Level of Understanding: G, F, P, Gp (Group), R (Refused) Individual/Group: I, G Length of Educ (minutes) Provider Status (Behavior Code): GNS, GS, GM, GNM *(use GNS if a goal was not set, GS if a goal was set on this visit, GM if a goal was met as of this visit, GNM if a goal was not met as of this visit)*