

Key Clinical Performance Objectives

Cheat Sheet for PCC Documentation and Data Entry for CRS Version 17.0
Last Updated September 2016

Data Entry Best Practices to Meet Measures

Recommended use for this material: Each facility should:

1. Identify their three or four key clinical problem areas.
2. Review the attached information.
3. Customize the provider documentation and data entry instructions, if necessary.
4. Train staff on appropriate documentation.
5. Post the applicable pages of the Cheat Sheet in exam rooms.

This document is to provide information to both providers and to data entry on the most appropriate way to document key clinical procedures in the Resource and Patient Management System (RPMS). It does not include all of the codes the Clinical Reporting System (CRS) checks when determining if a performance measure is met. To review that information, view the CRS short version logic at:

http://www.ihs.gov/crs/includes/themes/newihstheme/display_objects/documents/crsv16/GPRAMeasuresV161.pdf

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

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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 in PCC: <ul style="list-style-type: none"> • Date received • Location • Results 	Diabetes Prevalence Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: 250.00-250.93 or ICD-10: E10.*-E13.* Provider Narrative: Modifier: Cause of DX:

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Diabetes: Glycemic Control	<p>Active Clinical Patients DX with diabetes and with an A1c:</p> <ul style="list-style-type: none"> • Less than (<) 8 (Good Glycemic Control) 	<p>Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Standard PCC data entry:</p> <p>A1c Lab Test</p> <p><i>Mnemonic LAB enter</i></p> <p>Enter Lab Test Type: [Enter site's defined A1c Lab Test]</p> <p>Results: [Enter Results]</p> <p>Units:</p> <p>Abnormal:</p> <p>Site: [Blood, Plasma]</p> <p>Historical A1c Lab Test</p> <p><i>Mnemonic HLAB enter</i></p> <p>Date of Historical Lab Test:</p> <p>Type:</p> <p>Location Name:</p> <p>Enter Lab Test: [Enter site's defined A1c Lab Test]</p> <p>Results:</p> <p>CPT Entry</p> <p><i>Mnemonic CPT enter</i></p> <p>Enter CPT: 83036, 83037, 3044F-3046F</p> <p>Quantity:</p> <p>Modifier:</p> <p>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"> • Less than (<) 140/90 (mean systolic less than (<) 140, mean diastolic less than (<) 90) 	<p>Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Standard PCC data entry:</p> <p>Blood Pressure Data Entry</p> <p>Value: [Enter as Systolic/Diastolic (e.g., 140/90)]</p> <p>Select Qualifier:</p> <p>Date/Time Vitals Taken:</p>

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<p>Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes</p>	<p>Active Clinical Patients DX with diabetes age 40 - 75 or age 21 and older with documented CVD or LDL greater than or equal to (\geq)190 who have statin therapy.</p>	<p>Standard PCC documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Dosage 	<p>Standard PCC data entry: Statin Therapy Medication <i>Mnemonic RX enter</i> Select Medication: [Enter Statin Therapy Prescribed Medication] Outside Drug Name (Optional): [Enter any additional name for the drug] SIG Quantity: Day Prescribed: Event Date&Time: Ordering Provider:</p> <p>Historical Statin Therapy Medication <i>Mnemonic HRX enter</i> Date of Historical Medication: Type: Location Name: Enter Medication: [Enter Statin Therapy Prescribed Medication] Name of Non-Table Drug: SIG: Days Prescribed: Date Discontinued: Date Dispensed (If Known): Outside Provider Name:</p>

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Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes (cont.)			<p>Statin Therapy CPT Mnemonic CPT enter Enter CPT Code: 4013F Quantity: Modifier: Modifier 2:</p>
Diabetes: Nephropathy Assessment	<p>Active Clinical Patients DX with diabetes with a Nephropathy assessment:</p> <ul style="list-style-type: none"> • Estimated GFR with result during the Report Period • Urine Albumin-to-Creatinine Ratio during the Report Period • End Stage Renal Disease diagnosis/treatment 	<p>Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Standard PCC data entry: 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>Urine Albumin-to-Creatinine Ratio CPT Mnemonic CPT enter Enter CPT: 82043 AND 82570 Quantity: Modifier: Modifier 2:</p>

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Diabetes: Nephropathy Assessment (cont.)			<p>ESRD CPT <i>Mnemonic CPT enter</i> Enter CPT: 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G9231, S2065 or S9339 Quantity: Modifier: Modifier 2:</p> <p>ESRD POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: 585.6, V42.0, V45.11, V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2 Provider Narrative: Modifier: Cause of DX:</p> <p>ESRD Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: ICD-9: 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>

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Diabetic Retinopathy	<p>Patients with diabetes and no bilateral blindness 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 in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Exams:</p> <ul style="list-style-type: none"> • Diabetic Retinal Exam <ul style="list-style-type: none"> – Dilated retinal eye exam – Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist – Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos – Routine ophthalmological examination including refraction (new or existing patient) – Diabetic indicator; retinal eye exam, dilated, bilateral • Other Eye Exams <ul style="list-style-type: none"> – Non-DNKA (did not keep appointment) visits to ophthalmology or optometry clinics with an optometrist or ophthalmologist, or visits to formally validated tele-ophthalmology retinal evaluation clinics 	<p>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, 67039, 67040, 92002, 92004, 92012, 92014 Quantity: Modifier: Modifier 2:</p>

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Diabetic Retinopathy (cont.)			<p>Other Eye Exam POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: V72.0 Provider Narrative: Modifier: Cause of 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 in 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: Exam Type: 30 Result: Comments: Encounter Provider:</p>

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Access to Dental Service (cont.)			<p>Dental Exam (ADA code) <i>Mnemonic ADA enter</i> Dental Service Code: 0000, 0190, 0191 Type: No. Of Units: Operative Site:</p> <p>Historical Dental Exam (ADA code) <i>Mnemonic HADA enter</i> Date of Historical ADA: Type: Location Name: ADA Code: 0000, 0190 Units:</p> <p>Dental Exam CPT <i>Mnemonic CPT enter</i> Enter CPT: D0190, D0191 Quantity: Modifier: Modifier 2:</p> <p>Dental Exam POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: V72.2; ICD-10: Z01.20, Z01.21 Provider Narrative: Modifier: Cause of DX:</p>

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Dental Sealants	<p>Patients should have one or more intact dental sealants.</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 in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Standard PCC data entry:</p> <p>Dental Sealants (ADA) <i>Mnemonic ADA enter</i> Dental Service Code: 1351, 1352, 1353 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, D1352, D1353 Quantity: Modifier: Modifier 2:</p>

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Topical Fluoride	<p>Patients should have one or more topical fluoride applications.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Standard PCC data entry:</p> <p>Topical Fluoride (ADA code) <i>Mnemonic ADA enter</i> Dental Service Code: 1206, 1208, 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: 1206, 1208, 5986 Units:</p> <p>Topical Fluoride CPT <i>Mnemonic CPT enter</i> Enter CPT: D1206, D1208, D5986, 99188 Quantity: Modifier: Modifier 2:</p> <p>Topical Fluoride POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: V07.31 Provider Narrative: Modifier: Cause of DX:</p>

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Influenza	<p>All patients ages 6 months and older should have an annual influenza (flu) shot.</p> <p>Refusals should be documented. Note: Only Not Medically Indicated (NMI) 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 in 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> <p>Immunization Package of "Egg Allergy" or "Anaphylaxis"</p> <p>NMI Refusal</p>	<p>Standard PCC data entry:</p> <p>Influenza Vaccine</p> <p><i>Mnemonic IM enter</i></p> <p>Select Immunization Name: 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166 (other options are 111, 15, 16, 88)</p> <p>Lot:</p> <p>VFC Eligibility:</p> <p>Historical Influenza Vaccine</p> <p><i>Mnemonic HIM enter</i></p> <p>Date of Historical Immunization:</p> <p>Type:</p> <p>Location:</p> <p>Immunization Type: 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166 (other options are 111, 15, 16, 88)</p> <p>Series:</p> <p>Influenza Vaccine POV</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: ICD-9: *V04.81, *V06.6</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>* NOT documented with 90663, 90664, 90666-90668, 90470, G9141, G9142</p>

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Influenza (cont.)			<p>Influenza Vaccine CPT <i>Mnemonic CPT enter</i> Enter CPT: 90630, 90654-90662, 90672, 90673, 90685-90688, G0008 Quantity: Modifier: Modifier 2:</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>

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<p>Adult Immunizations</p>	<p>All adults ages 65 and older will have a pneumococcal vaccine. All adult (18 and older) diabetic patients are strongly recommended to have a pneumococcal vaccine. Refusals should be documented. Note: Only NMI 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 in 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: Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal</p>	<p>Standard PCC data entry:</p> <p>Pneumococcal Vaccine <i>Mnemonic IM enter</i> Select Immunization Name: 33, 100, 109, 133, 152 Lot: VFC Eligibility:</p> <p>Historical Pneumococcal Vaccine <i>Mnemonic HIM enter</i> Date of Historical Immunization: Type: Location: Immunization Type: 33, 100, 109, 133, 152 Series:</p> <p>Pneumococcal Vaccine POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: V06.6, V03.82 Provider Narrative: Modifier: Cause of DX:</p> <p>Pneumococcal Vaccine CPT <i>Mnemonic CPT enter</i> Enter CPT: 90669, 90670, 90732, G0009, G9279 Quantity: Modifier: Modifier 2:</p>

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Adult Immunizations			<p>NMI Refusal of Pneumococcal <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 Pneumococcal (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>

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Childhood Immunizations	<p>Children age 19–35 months will be up-to-date for all ACIP recommended immunizations.</p> <p>This is the 4313*314 combo:</p> <p>4 DTaP 3 IPV 1 MMR 3 Hepatitis B 3 or 4 Hib 1 Varicella 4 Pneumococcal</p> <p>Refusals should be documented.</p> <p>Note: Only NMI 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 in PCC:</p> <ul style="list-style-type: none"> • IZ type • Date received • Location <p>Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization</p> <p>Contraindications should be documented and are counted toward the GPRA Measure.</p> <p>Contraindications include Immunization Package of "Anaphylaxis" for all childhood immunizations. The following additional contraindications are also counted:</p> <ul style="list-style-type: none"> • IPV: Immunization Package: "Neomycin Allergy." • OPV: Immunization Package: "Immune Deficiency." • MMR: Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy." • Varicella: Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy." • Pneumococcal: Immunization Package: "Anaphylaxis" 	<p>Standard PCC data entry: Childhood Immunizations</p> <p><i>Mnemonic IM enter</i></p> <p>Select Immunization Name: DTaP: 20, 50, 102, 106, 107, 110, 120, 130, 146; DTP: 1, 22, 102; Tdap: 115; DT: 28; Td: 9, 113, 138, 139; 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; Pneumococcal: 33, 100, 109, 133, 152</p> <p>Lot: VFC Eligibility:</p>

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Childhood Immunizations (cont.)		<p>Dosage and types of immunization definitions:</p> <p>4 doses of DTaP:</p> <ul style="list-style-type: none"> • 4 DTaP/DTP/Tdap • 1 DTaP/DTP/Tdap and 3 DT/Td • 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus • 4 DT and 4 Acellular Pertussis • 4 Td and 4 Acellular Pertussis • 4 each of Diphtheria, Tetanus, and Acellular Pertussis <p>3 doses of IPV:</p> <ul style="list-style-type: none"> • 3 OPV • 3 IPV • Combination of OPV and IPV totaling three doses <p>1 dose of MMR:</p> <ul style="list-style-type: none"> • MMR • 1 M/R and 1 Mumps • 1 R/M and 1 Measles • 1 each of Measles, Mumps, and Rubella <p>3 doses of Hepatitis B</p> <ul style="list-style-type: none"> • 3 doses of Hep B <p>3 or 4 doses of HIB, depending on the vaccine administered</p> <p>1 dose of Varicella</p> <p>4 doses of Pneumococcal</p>	<p>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: DTaP: 20, 50, 102, 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; Pneumococcal: 33, 100, 109, 133, 152</p> <p>Series:</p>

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Childhood Immunizations (cont.)		<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 GPRA communities will not be affected.</p>	<p>Childhood Immunizations POV</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: DTaP: ICD-9: V06.1; DTP: ICD-9: V06.1, V06.2, V06.3; DT: ICD-9: V06.5; Td: ICD-9: V06.5; Diphtheria: ICD-9: V03.5; Tetanus: ICD-9: V03.7; Acellular Pertussis: ICD-9: V03.6; IPV: ICD-9: V04.0, V06.3; IPV (evidence of disease): ICD-9: 730.70-730.79, ICD-10: M89.6*; MMR: ICD-9: V06.4; Measles: ICD-9: V04.2; Measles (evidence of disease): ICD-9: 055*, ICD-10: B05.*; Mumps: ICD-9: V04.6; Mumps (evidence of disease): ICD-9: 072*, ICD-10: B26.*; Rubella: ICD-9: V04.3; Rubella (evidence of disease): ICD-9: 056*, 771.0, ICD-10: B06.*; Hepatitis B (evidence of disease): ICD-9: V02.61, 070.2, 070.3, ICD-10: B16.*, B19.1*, Z22.51; Hib: ICD-9: V03.81; Varicella: ICD-9: V05.4; Varicella (evidence of disease): ICD-9: 052*, 053*, ICD-10: B01.*-B02.*; Pneumococcal: ICD-9: V06.6, V03.82</p>

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Childhood Immunizations (cont.)			<p>Childhood Immunizations CPT <i>Mnemonic CPT enter</i> Enter CPT: DTaP: 90696, 90698, 90700, 90721, 90723; DTP: 90701, 90720; Tdap: 90715; DT: 90702; Td: 90714, 90718; Diphtheria: 90719; Tetanus: 90703; OPV: 90712; IPV: 90696, 90698, 90713, 90723; MMR: 90707, 90710; M/R: 90708; Measles: 90705; Mumps: 90704; Rubella: 90706; Hepatitis B: 90636, 90723, 90740, 90743-90748, G0010; HIB: 90645-90648, 90698, 90720-90721, 90748; Varicella: 90710, 90716; Pneumococcal: 90669, 90670, 90732, G0009, G9279 Quantity: Modifier: Modifier 2:</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: Provider Who Documented: Comment:</p>

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Childhood Immunizations (cont.)			<p>Immunization Package Contraindication Childhood Immunizations (Assumes you are in the IMM Pkg for Single Patient Record for your site)</p> <p>Select Action: C (Contraindications)</p> <p>Select Action: A (Add Contraindication)</p> <p>Vaccine: [See codes above]</p> <p>Reason: [See Contraindications section under the Provider Documentation column]</p> <p>Date Noted:</p> <p>Command: Save</p> <p>Select Action: Quit</p>

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<p>Cancer Screening: Pap Smear Rates</p>	<p>Women ages 24-64 should have a Pap Smear every 3 years, or if patient is 30 to 64 years of age, either a Pap Smear documented in the past 3 years, or a Pap Smear and an HPV DNA documented in the past 5 years.</p> <p>Note: Refusals of any above test are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Data entry through Women’s Health program or standard PCC data entry for tests performed at the facility.</p> <p>Pap Smear V Lab <i>Mnemonic LAB enter</i> Enter Lab Test Type: Pap Smear Results: [Enter Results] Units: Abnormal: Site:</p> <p>Pap Smear POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: V72.32, V76.2, 795.0*; ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4 Provider Narrative: Modifier: Cause of DX:</p> <p>Pap Smear CPT <i>Mnemonic CPT enter</i> Enter CPT: 88141-88154, 88160-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 Quantity: Modifier: Modifier 2:</p>

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Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Cancer Screening: Pap Smear Rates (cont.)			<p>Historical Pap Smear <i>Mnemonic HPAP enter</i> Date Historical Pap Smear: Type of Visit: Location Name: Enter Outside Location: [(if "Other" was entered for Location Name:)] Select V Lab Test: Pap Smear Results: [Enter Results]</p> <p>HPV V Lab <i>Mnemonic LAB enter</i> Enter Lab Test Type: HPV Results: [Enter Results] Units: Abnormal: Site:</p> <p>HPV POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: V73.81, 079.4, 796.75, 795.05, 795.15, 796.79, 795.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51 Provider Narrative: Modifier: Cause of DX:</p> <p>HPV CPT <i>Mnemonic CPT enter</i> Enter CPT: 87623-87625 Quantity: Modifier:</p> <p>Modifier 2:</p>
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Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
<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 in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Telephone visit with patient Verbal or written lab report Patient's next visit</p>	<p>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>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Cancer Screening: Mammogram Rates (cont.)			<p>Mammogram POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: V76.11, V76.12, 793.80, 793.81, 793.89; ICD-10: R92.0, R92.1, R92.8, Z12.31 Provider Narrative: Modifier: Cause of DX:</p> <p>Mammogram CPT <i>Mnemonic CPT enter</i> Enter CPT: 77053-77059, G0206; G0204, G0202 Quantity: Modifier: Modifier 2:</p> <p>Mammogram Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: ICD-9: 87.36, 87.37; ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Colorectal Cancer Screening	<p>Adults ages 50–75 should be screened for CRC (HEDIS).</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 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, or provider).</p> <p>Guaiac cards returned by patients to providers should be sent to Lab for processing.</p> <p>Ask and record historical information in PCC:</p> <ul style="list-style-type: none"> Date received Location Results <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</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: ICD-9: 153.*, 154.0, 154.1, 197.5, V10.05; ICD-10: C18.*, C19, C20, C78.5, Z85.030, Z85.038</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Total Colectomy CPT</p> <p><i>Mnemonic CPT enter</i></p> <p>Enter CPT: 44150-44151, 44155-44158, 44210-44212</p> <p>Quantity:</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>Total Colectomy Procedure</p> <p><i>Mnemonic IOP enter</i></p> <p>Operation/Procedure: ICD-9: 45.8*; ICD-10: 0DTE*ZZ</p> <p>Provider Narrative:</p> <p>Operating Provider:</p> <p>Diagnosis: [Enter appropriate DX]</p> <p>FOBT or FIT CPT</p> <p><i>Mnemonic CPT enter</i></p> <p>Enter CPT: 82270, 82274, G0328</p> <p>Quantity:</p> <p>Modifier:</p> <p>Modifier 2:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Colorectal Cancer Screening (cont.)			<p>Flexible Sigmoidoscopy CPT <i>Mnemonic CPT enter</i> Enter CPT: 45330-45345, G0104 Quantity: Modifier: Modifier 2:</p> <p>Flexible Sigmoidoscopy Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: ICD-9: 45.24; ICD-10: 0DJD8ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p> <p>Colon Screening CPT <i>Mnemonic CPT enter</i> Enter CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, G0105, G0121, G9252, G9253 Quantity: Modifier: Modifier 2:</p> <p>Colon Screening Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; ICD-10: (see logic manual for codes) Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Colorectal Cancer Screening (cont.)			<p>Historical CRC</p> <p><i>Mnemonic [from the following list] enter:</i></p> <p>HCOL - Historical Colonoscopy HFOB - Historical FOBT (Guaiac) HSIG - Historical Sigmoidoscopy HBE - Historical Barium Enema</p> <p>Date: Type: Location of Encounter: Quantity:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
<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 in 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–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Previous (Former) Smoker [or -Smokeless] (quit greater than (>) 6 months) • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 6 months) • HF–Smoker in Home • HF–Ceremonial Use Only • HF–Exp to ETS (Second Hand Smoke) • HF–Smoke Free Home <p>Note: If your site uses other expressions (e.g., "Chew" instead of "Smokeless," "Past" instead of "Previous"), be sure Data Entry staff knows how to "translate"</p> <p>Tobacco Patient Education Codes:</p> <ul style="list-style-type: none"> • Codes will contain "TO-", "-TO", "-SHS" 	<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>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
<p>Tobacco Use and Exposure Assessment (cont.)</p>		<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>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 Education (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p> <p>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:</p> <p>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:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Use and Exposure Assessment (cont.)			<p>Smokeless Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Current Smokeless or Cessation-Smokeless Level/Severity: Provider: Quantity:</p> <p>ETS Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Exp to ETS Level/Severity: Provider: Quantity:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Cessation	<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 or quit tobacco use.</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 in 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–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Cessation-Smoker [or -Smokeless] (quit or actively trying less than (<) 6 months) <p>Tobacco Patient Education Codes:</p> <ul style="list-style-type: none"> • Codes will contain "TO-", "-TO", "-SHS" <p>Prescribe Tobacco Cessation Aids:</p> <ul style="list-style-type: none"> • Predefined Site-Populated Smoking Cessation Meds • Meds containing: <ul style="list-style-type: none"> - “Nicotine Patch” - “Nicotine Polacrilex” - “Nicotine Inhaler” - “Nicotine Nasal Spray” 	<p>Standard PCC data entry</p> <p>Tobacco Cessation 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 Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Tobacco Cessation PED - Diagnosis</p> <p><i>Mnemonic PED enter</i></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 Education (Minutes):</p> <p>Comment</p> <p>Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)]</p> <p>Goal Comment:</p> <p>Provider’s Narrative:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Cessation (cont.)		<p>Note: Ensure you update the patient's health factors as they enter a cessation program and eventually become nontobacco 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>Tobacco Cessation Clinic <i>Mnemonic CL enter</i> Clinic: 94 Was this an appointment or walk in?: Tobacco Cessation Dental (ADA) Mnemonic ADA enter 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 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 Quantity: Day Prescribed: Event Date&Time: Ordering Provider:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Cessation (cont.)			<p>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:</p> <p>Tobacco Cessation Prescription CPT <i>Mnemonic CPT enter</i> Enter CPT Code: 4001F Quantity Modifier: Modifier 2:</p> <p>Quit Tobacco Health Factor <i>Mnemonic HF enter</i> Select V Health Factor: Previous Smoker, Previous Smokeless Level/Severity: Provider: Quantity:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Cessation (cont.)			<p>Quit Tobacco POV</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: ICD-9: 305.13, V15.82; ICD-10: F17.2*1, Z87.891</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening	<p>Adult patients' ages 12 through 75 should be screened for alcohol use at least annually.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Alcohol screening may be documented with either an exam code or the CAGE health factor in PCC.</p> <p>Medical Providers: EXAM—Alcohol Screening</p> <ul style="list-style-type: none"> • Negative—Patient's screening exam does not indicate risky alcohol use. • Positive—Patient's screening exam indicates potential risky alcohol use. • Refused—Patient declined exam/screen • Unable to screen - Provider unable to screen <p>Note: Recommended Brief Screening Tool: SASQ (below). <i>Single Alcohol Screening Question (SASQ)</i></p> <p><i>For Women:</i></p> <ul style="list-style-type: none"> • When was the last time you had more than 4 drinks in one day? <p><i>For Men:</i></p> <ul style="list-style-type: none"> • When was the last time you had more than 5 drinks in one day? 	<p>Standard PCC data entry Alcohol Screening Exam <i>Mnemonic EX enter</i> Select Exam: 35, ALC Result: A—Abnormal N—Normal/Negative PR—Resent PAP—Present and Past PA—Past PO—Positive Comments: SASQ Provider Performing Exam:</p> <p>Historical Alcohol Screen Exam <i>Mnemonic HEX enter</i> Date of Historical Exam: Type: Location Name: Exam Type: 35, ALC Result: Comments: Encounter Provider:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening (cont.)		<p>Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen:</p> <ul style="list-style-type: none"> Alcohol Screening Exam Code Result: Positive <p>The patient may decline the screen or “Refuse to answer”:</p> <ul style="list-style-type: none"> Alcohol Screening Exam Code Result: Refused <p>The provider is unable to conduct the screen:</p> <ul style="list-style-type: none"> Alcohol Screening Exam Code Result: Unable To Screen <p>Note: Provider should note the screening tool used was the SASQ at the Comment Mnemonic for the Exam code.</p> <p>All Providers: Use the CAGE questionnaire:</p> <p>Have you ever felt the need to Cut down on your drinking?</p> <p>Have people Annoyed you by criticizing your drinking?</p> <p>Have you ever felt bad or Guilty about your drinking?</p> <p>Have you ever needed an Eye-opener the first thing in the morning to steady your nerves or get rid of a hangover?</p> <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 in PCC:</p> <ul style="list-style-type: none"> HF-CAGE 0/4 (all No answers) HF-CAGE 1/4 HF-CAGE 2/4 HF-CAGE 3/4 HF-CAGE 4/4 	<p>Cage Health Factor <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> <p>Level/Severity:</p> <p>Provider:</p> <p>Quantity:</p> <p>Alcohol Screening POV <i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: ICD-9: V11.3, V79.1</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Standard BHS data entry</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 (Screening for Alcoholism).</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening (cont.)		<p>Optional values:</p> <ul style="list-style-type: none"> • Level/Severity: Minimal, Moderate, or Heavy/Severe • Quantity: # of drinks daily OR T (Tolerance) -- # drinks to get high (e.g. T-4) • Comment: used to capture other relevant clinical info e.g. "Non-drinker" <p>Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-"</p> <p>AUDIT Measurements:</p> <ul style="list-style-type: none"> • Zone I: Score 0–7 Low risk drinking or abstinence • Zone II: Score 8–15 Alcohol use in excess of low-risk guidelines • Zone III: Score 16–19 Harmful and hazardous drinking • Zone IV: Score 20–40 Referral to Specialist for Diagnostic Evaluation and Treatment <p>AUDIT-C Measurements: How often do you have a drink containing alcohol?</p> <ul style="list-style-type: none"> • (0) Never (Skip to Questions 9-10) • (1) Monthly or less • (2) 2 to 4 times a month • (3) 2 to 3 times a week • (4) 4 or more times a week 	<p>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: ICD-9: 303.*, 305.0*, 291.*, 357.5*; ICD-10: F10.1*, F10.20, F10.220-F10.29, F10.920-F10.982, F10.99, G62.1 Provider Narrative: Modifier: Cause of DX: Alcohol-Related Diagnosis BHS POV data entry Enter BHS POV 10, 27, 29 Enter BHS problem code 10, 12.1, 14.2, 17.1, 18.1, 20.1, 22.1</p> <p>Alcohol-Related Procedure <i>Mnemonic IOP enter</i> Operation/Procedure: ICD-9: 94.46, 94.53, 94.61-94.63, 94.67-94.69 Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening (cont.)		<p>How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <ul style="list-style-type: none"> • (0) 1 or 2 • (1) 3 or 4 • (2) 5 or 6 • (3) 7, 8, or 9 • (4) 10 or more <p>How often do you have 6 or more drinks on one occasion?</p> <ul style="list-style-type: none"> • (0) Never • (1) Less than monthly • (2) Monthly • (3) Weekly • (4) Daily or almost daily <p>The AUDIT-C (the first three AUDIT questions which focus on alcohol consumption) is scored on a scale of 0–12 (scores of 0 reflect no alcohol use).</p> <ul style="list-style-type: none"> • In men, a score of 4 or more is considered positive • In women, a score of 3 or more is considered positive. <p>A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence.</p>	<p>Alcohol-Related PED - Topic <i>Mnemonic PED enter</i> Enter Education Topic: [Enter Alcohol-Related Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p> <p>Alcohol-Related PED - Diagnosis <i>Mnemonic PED enter</i> Select ICD Diagnosis Code Number: V11.3, V79.1, 303.*, 305.0*, 291.* or 357.5* Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening (cont.)		<p>CRAFFT Measurements:</p> <ul style="list-style-type: none"> • C–Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? • R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? • A–Do you ever use alcohol/drugs while you are by yourself, ALONE? • F–Do you ever FORGET things you did while using alcohol or drugs? • F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? • T–Have you gotten into TROUBLE while you were using alcohol or drugs? <p>Total CRAFFT score (Range: 0–6). A positive answer to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated.</p> <p>Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<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> Patient Refusals For Service: Exam Exam Value: 35, ALC Date Refused: Provider Who Documented: Comment:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
<p>Screening, Brief Intervention, and Referral to Treatment (SBIRT)</p>	<p>Active Clinical Plus BH patients age 9 through 75 who screened positive for risky or harmful alcohol use should receive a Brief Negotiated Interview (BNI) or Brief Intervention (BI) within 7 days of the positive screen.</p>	<p>Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>BNI/BI CPT <i>Mnemonic CPT enter</i> Enter CPT Code: G0396, G0397, H0050, 96150-96155 Quantity Modifier: Modifier 2:</p> <p>BNI/BI PED - Topic <i>Mnemonic PED enter</i> Enter Education Topic: AOD-BNI Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
<p>Intimate Partner (Domestic) Violence Screening (IPV/DV)</p>	<p>Adult females should be screened for domestic violence at new encounter and at least annually Prenatal once each trimester (Source: Family Violence Prevention Fund National Consensus Guidelines) Note: Refusals are 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 in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Medical and Behavioral Health Providers: EXAM—IPV/DV Screening</p> <ul style="list-style-type: none"> • Negative—Denies being a current or past victim of IPV/DV • Past—Denies being a current victim, but discloses being a past victim of IPV/DV • Present—Discloses current IPV/DV • Present and Past—Discloses past victimization and current IPV/DV victimization • Refused—Patient declined exam/screen • Unable to screen—Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.) <p>IPV/DV Patient Education Codes:</p> <ul style="list-style-type: none"> • Codes will contain "DV-" or "-DV" 	<p>Standard PCC data entry 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: Standard BHS data entry Enter BHS problem code Narrative “IPV/DV exam”</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont.)			<p>IPV/DV Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: 995.80-83, 995.85, V15.41, V15.42, V15.49; ICD-10: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, Z91.410; IPV/DV Counseling: ICD-9: V61.11; ICD-10: Z69.11 Provider Narrative: Modifier: Cause of DX: 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 Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont.)			<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>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
<p>Depression Screening</p>	<p>All patients 12 years of age and older should be screened for depression at least annually. (Source: United States Preventive Services Task Force) Note: Refusals are 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 in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results <p>Medical Providers: EXAM—Depression Screening</p> <ul style="list-style-type: none"> • Normal/Negative—Denies symptoms of depression • Abnormal/Positive—Further evaluation indicated • Refused—Patient declined exam/screen • Unable to screen—Provider unable to screen <p>Note: Refusals are not counted toward the GPRA measure, but should be documented.</p> <p>Behavioral Health Providers: 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: Two or more visits with POV related to:</p> <ul style="list-style-type: none"> • Major Depressive Disorder • Dysthymic Disorder • Depressive Disorder NOS • Bipolar I or II Disorder • Cyclothymic Disorder • Bipolar Disorder NOS • Mood Disorder Due to a General Medical Condition • Mood Disorder NOS 	<p>Standard PCC data entry Depression Screening Exam <i>Mnemonic EX enter</i> Select Exam: 36, DEP Result:</p> <ul style="list-style-type: none"> • A—Abnormal • N—Normal/Negative • PR—Resent • PAP—Present and Past • PA—Past • PO—Positive <p>Comments: PHQ-2 Scaled, PHQ9, PHQT Provider Performing Exam:</p> <p>Historical Depression Screen Exam <i>Mnemonic HEX enter</i> Date of Historical Exam: Type: Location Name: Exam Type: 36, DEP Result: Comments: PHQ-2 Scaled, PHQ9 (If Known), PHQT Encounter Provider:</p> <p>Depression Screen Diagnosis POV <i>Mnemonic PPV enter</i> Purpose of Visit: ICD-9: V79.0 Provider Narrative: Modifier: Cause of DX:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		<p>Note: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below).</p> <p>Patient Health Questionnaire (PHQ-2 Scaled Version)</p> <p>Over the past two weeks, how often have you been bothered by any of the following problems?</p> <p>Little interest or pleasure in doing things</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>Feeling down, depressed, or hopeless</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>PHQ-2 Scaled Version (continued)</p> <p>Total Possible PHQ-2 Score: Range: 0-6</p> <ul style="list-style-type: none"> • 0-2: Negative Depression Screening Exam: <ul style="list-style-type: none"> - Code Result: Normal or Negative • 3-6: Positive; further evaluation indicated Depression Screening Exam <ul style="list-style-type: none"> - Code Result: Abnormal or Positive <p>The patient may decline the screen or “Refuse to answer” Depression Screening Exam</p> <ul style="list-style-type: none"> • Code Result: Refused <p>The provider is unable to conduct the Screen Depression Screening Exam</p> <ul style="list-style-type: none"> • Code Result: Unable To Screen <p>Provider should Note the screening tool used was the PHQ-2 Scaled at the Comment Mnemonic for the Exam Code.</p>	<p>Depression Screening CPT <i>Mnemonic CPT enter</i></p> <p>Enter CPT: 1220F, 3725F, G0444</p> <p>Quantity:</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>Standard BHS POV data entry</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 (Special Screening for Mental Disorders and Developmental Handicaps, Depression).</p> <p>Unable to Screen for Depression <i>Mnemonic UAS enter</i></p> <p>Patient Refusals For Service: Exam</p> <p>Exam Value: 36, DEP</p> <p>Date Refused:</p> <p>Provider Who Documented:</p> <p>Comment:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		<p>PHQ9 Questionnaire Screening Tool</p> <p>Little interest or pleasure in doing things?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>Feeling down, depressed, or hopeless?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>Trouble falling or staying asleep, or sleeping too much?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>Feeling tired or having little energy?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 <p>Poor appetite or overeating?</p> <ul style="list-style-type: none"> • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 	<p>Mood Disorder Diagnosis POV</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: ICD-9: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311; ICD-10: F06.31-F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0-F31.71, F31.73, F31.75, F31.77, F31.81-F31.9, F32.*-F39</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>Standard BHS Mood Disorder POV data entry</p> <p>Enter BHS problem code: 14, 15</p>

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		<p>Total Possible PHQ-2 Score: Range: 0–27:</p> <ul style="list-style-type: none"> • 0-4 Negative/None Depression Screening Exam: Code Result: None • 5-9 Mild Depression Screening Exam: Code Result: Mild depression • 10-14 Moderate Depression Screening Exam: Code Result: Moderate depression • 15-19 Moderately Severe Depression Screening Exam: Code Result: Moderately Severe depression • 20-27 Severe Depression Screening Exam: Code Result: Severe depression <p>Provider should Note the screening tool used was the PHQ9 Scaled at the Comment Mnemonic for the Exam Code.</p>	

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
<p>Antidepressant Medication Management</p>	<p>Patients 18 years of age and older with new episodes of depression should fill a sufficient number of separate prescriptions/refills of antidepressant medication for continuous treatment of at least 84 days (12 weeks) (APT) and 180 days (6 months) (CONPT).</p>	<p>Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Dosage 	<p>Standard PCC data entry: Antidepressant Medication <i>Mnemonic RX enter</i> Select Medication: [Enter Antidepressant Prescribed Medication] Outside Drug Name (Optional): [Enter any additional name for the drug] SIG Quantity: Day Prescribed: Event Date&Time: Ordering Provider:</p> <p>Historical Antidepressant Medication <i>Mnemonic HRX enter</i> Date of Historical Medication: Type: Location Name: Enter Medication: [Enter Antidepressant Prescribed Medication] Name of Non-Table Drug: SIG: Days Prescribed: Date Discontinued: Date Dispensed (If Known): Outside Provider Name:</p>

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
<p>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</p>	<p>Active Clinical Patients age 40 -75 DX with diabetes or age 21 and older with documented CVD or LDL greater than or equal to (\geq) 190 who have statin therapy.</p>	<p>Standard PCC documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Dosage 	<p>Standard PCC data entry: Statin Therapy Medication <i>Mnemonic RX enter</i> Select Medication: [Enter Statin Therapy Prescribed Medication] Outside Drug Name (Optional): [Enter any additional name for the drug] SIG Quantity: Day Prescribed: Event Date&Time: Ordering Provider:</p> <p>Historical Statin Therapy Medication <i>Mnemonic HRX enter</i> Date of Historical Medication: Type: Location Name: Enter Medication: [Enter Statin Therapy Prescribed Medication] Name of Non-Table Drug: SIG: Days Prescribed: Date Discontinued: Date Dispersed (If Known): Outside Provider Name:</p>

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (cont.)			Statin Therapy CPT Mnemonic CPT enter Enter CPT Code: 4013F Quantity: Modifier: Modifier 2:

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
HIV Screening	<p>Patients should be tested for HIV at least once; education and follow-up provided as appropriate.</p> <p>Note: Refusals are not counted toward the GPRA measure, but should still be documented.</p>	<p>Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC:</p> <ul style="list-style-type: none"> • Date received • Location • Results 	<p>Standard PCC data entry</p> <p>HIV Screen CPT</p> <p><i>Mnemonic CPT enter</i></p> <p>Enter CPT Code: 86689, 86701-86703, 87390, 87391, 87534-39</p> <p>Quantity:</p> <p>Modifier:</p> <p>Modifier 2:</p> <p>HIV Diagnoses POV</p> <p><i>Mnemonic PPV enter</i></p> <p>Purpose of Visit: ICD-9: 042, 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711-O98.73</p> <p>Provider Narrative:</p> <p>Modifier:</p> <p>Cause of DX:</p> <p>HIV Lab Test</p> <p><i>Mnemonic LAB enter</i></p> <p>Enter Lab Test Type: [Enter site's defined HIV Screen Lab Test]</p> <p>Results: [Enter Results (e.g., Negative, Positive, Indeterminant)]</p> <p>Units:</p> <p>Abnormal:</p> <p>Site: [Blood, Serum]</p> <p>Historical HIV Screen</p> <p><i>Mnemonic HLAB enter</i></p> <p>Date of Historical Lab Test:</p> <p>Type:</p> <p>Location Name:</p> <p>Enter Lab Test:</p> <p>Results:</p>
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Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC																																																
<p>Breastfeeding Rates The information is included here to inform providers and data entry staff of how to collect, document, and enter the data.</p>	<p>All providers should assess the feeding practices of all newborns through age 1 year at all well-child visits.</p>	<p>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" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr style="background-color: #d3d3d3;"> <th colspan="4" style="text-align: center;">Feeding Choice (today) X</th> </tr> </thead> <tbody> <tr> <td style="width: 50%;">Exclusive Breastfeeding</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 30%;"></td> </tr> <tr> <td>Mostly Breastfeeding</td> <td></td> <td></td> <td></td> </tr> <tr> <td>½ Breastfeeding ½ Formula feeding</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mostly Formula feeding</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Formula only feeding</td> <td></td> <td></td> <td></td> </tr> <tr style="background-color: #d3d3d3;"> <th colspan="4" style="text-align: center;">One time data fields</th> </tr> <tr> <td colspan="4">Mom's name or chart#</td> </tr> <tr> <td style="width: 25%;">Birth order</td> <td style="width: 25%;"></td> <td style="width: 25%;">Birth wt.</td> <td style="width: 25%;"></td> </tr> <tr> <td>started formula</td> <td></td> <td>___ wks/mth</td> <td></td> </tr> <tr> <td>stopped breastfeeding</td> <td></td> <td>___ wks/mth</td> <td></td> </tr> <tr> <td>started solids</td> <td></td> <td>___ wks/mth</td> <td></td> </tr> </tbody> </table> <p>Exclusive Breastfeeding. Breastfed or expressed breast milk only, no formula Mostly Breastfeeding. Mostly breastfed or expressed breast milk, with some formula feeding (1X per week or more, but less than half the time formula feeding.) ½ Breastfeeding, ½ Formula Feeding. Half the time breastfeeding/expressed breast milk, half formula feeding Mostly Formula. The baby is mostly formula fed, but breastfeeds at least once a week Formula Only. Baby receives only formula</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 Infant Breastfeeding <i>Mnemonic IF enter</i> 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
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Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
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.	

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

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

Key Clinical Performance Objectives

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Patient Education Measures (Patient Education Report) (cont.)		<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>	