2020 CQM Job Guide – EPIC

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Childhood Immunizations

Applies to: Family Practice and PEDs

Denominator: All patients who will turn 2 years of age in the current calendar year.

To meet the measure: All patient should have all 24 or 25 IZ's before turning 2 years of age: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1 VZV (Varicella), 4 Pneumococcal conjugate, 1 HepA, 2 or 3 Rotavirus (RV), and 2 influenza.

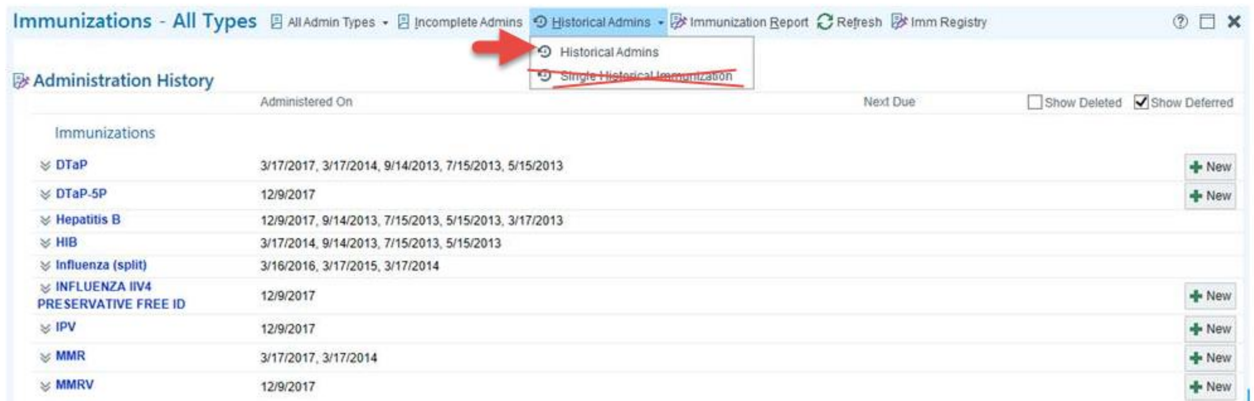
Notes:

•Patients under the catch-up schedule who do not need clinically all 24 or 25 IZ's will never meet the measure. To prevent the number of patients in this scenario, MA's should always schedule an applicable IZ follow up appointment based on CDC guidelines

MA/LVN workflow notes:

MA needs to add all historical IZ's (check CAIR, yellow IZ Card, etc.) Please note:

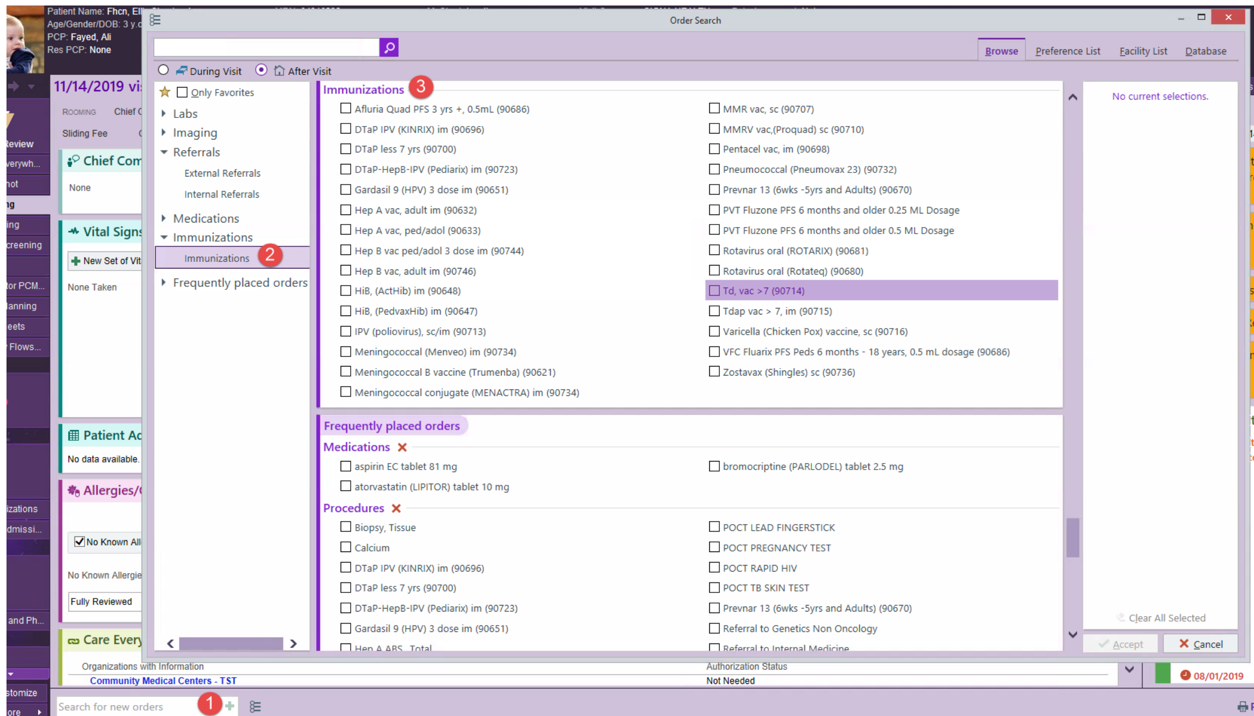
- In Chart Review or during the Visit: Go to the Immunizations Section
- Click on Historical Admins from the toolbar
- Enter dates next to the Immunizations that were given historically, then click Accept when completed
- Never use Single Historical Immunization to document a historical immunization



When MA/LVN/Provider have to administer new vaccines, please note:

- Check for the Health Maintenance Alerts as a reference to know what may be needed. Use the CAIR Routing Slip as a reference.
- Order Immunization, and once administered document required fields of administration, making sure to complete the VIS and VFC fields.

- The progress note needs to include documentation of who verified the immunization (MA/LVN will document this into their Note using the ‘FHCN MA ITEMS PERFORMED smart text’ provider can free-text.)



Immunizations - All Types | All Admin Types | Incomplete Admins | Historical Admins | Immunization Report | Refresh | Imm Registry

Administered Immunization

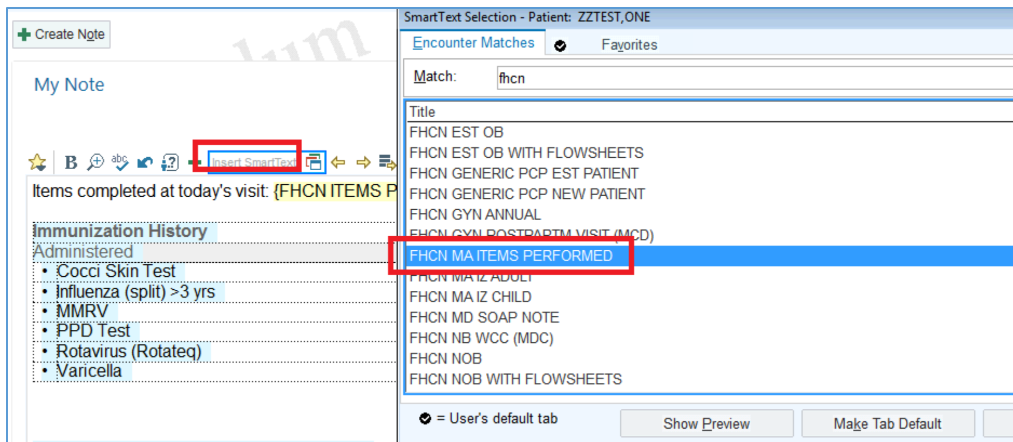
Name:	HepA			Given	
Date:	1/30/2019	Time:	15:17	Given by:	ACANTHITE, CHRIS-FHNURSE
Lot #:	5465165189	Dose:	0.5 mL	VIS date:	7/20/2016
Mfg:	GlaxoSmithKline	Site:	Left vastus lateralis	Comment:	
NDC:	0006-4831-01	Route:	Intramuscular	Location:	
Product:		External:			
Expires:	5/31/2019	Next due:			

Is this vaccine sponsored by the state as part of a VFC program?

Not VFC Eligible | VFC Eligible - Medicaid/Medicare | VFC Eligible - Under Insured | VFC Eligible - Uninsured | Yes - Amer Indian/Alaskan Native State Specific Eligible | Yes - State Specific Eligible | Yes - Local Specific Eligible | Not Eligible - Under Insured | Unknown

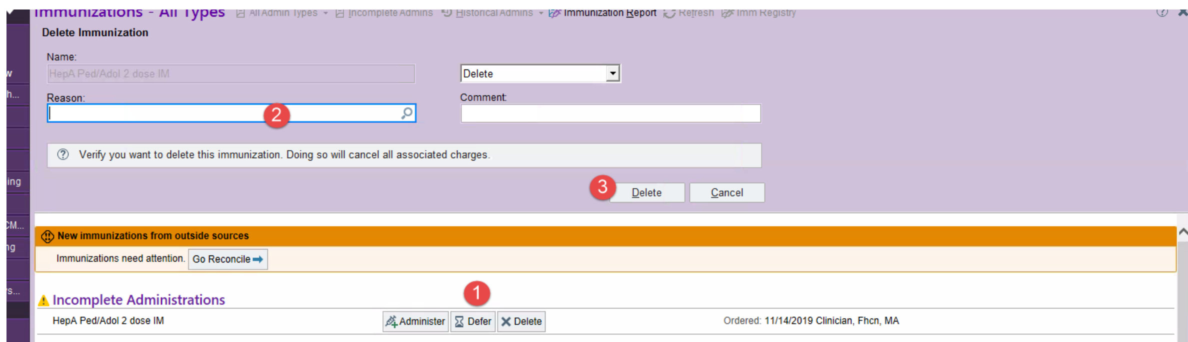
VIS FORM Given Date: 12/24/2018

Accept as Incomplete | Accept | Cancel



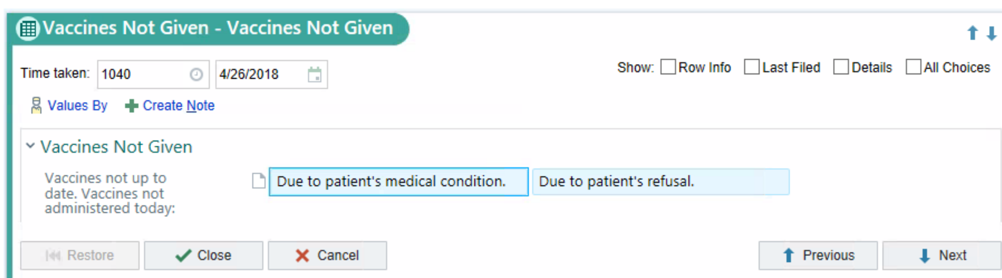
If IZ was not given, even though it was due:

- Provider/MA needs to cancel order if not yet signed, or, MA will Delete Immunization and enter deletion Reason and Comments as needed



- MA/Provider needs to go to the Screening Tab → to the Vaccines Not Given section to document the reason the vaccine was not given
- Select Close to save

Note: The documentation of a reason for not administering the vaccine/s will not exclude the patient from NOT meeting the numerator of the measure.



Exclusions:

- Allergy to applicable IZ's to be documented as structured allergies
- Patient under palliative care (aka Hospice); workflow is as follows:
    - Go to FYI flag (can be found in More button in lower left corner in the Encounter or in the Registration screen) → Choose New Flag: Palliative Care

Adult Weight Screening & Follow Up (18+)

Applies to: Family Practice, Internal Medicine, OBGYN, Behavioral Health, Nutrition, Dental, and other specialties

Denominator: All Patients 18+

To meet the measure: All patients 18+ with BMI recorded in Vitals, and the BMI is above 25 or below 18.5 kg/m^2 the patient needs to receive education on Nutrition & Physical Activity every 12 months. Education given needs to be documented via a structured field.

To document BMI:

- MA needs to record Height and weight at EVERY visit using the Vitals Screen and click on close once complete
- Note: the BMI does not show in red if it is out of range for adults

Vital Signs

3/22/18 15:19 | New Set of Vitals

Taken on: 3/22/2018 15:19 Orthostatics

BP:
Site:
Position:
Cuff size:
Pulse:
Temp:
Source:

Weight:
Height:
Resp:
SpO2:
PF (best):

Pain score:
Location:
Educated?
Comment:

Tobacco Use
Never Assessed — Smokeless: Unknown
Ready to quit? Yes No
Counseling given? Yes No
Mark as Reviewed — Never reviewed — Edit Tobacco Use

Restore | Close

Vital Signs

New Set of Vitals — Flowsheets

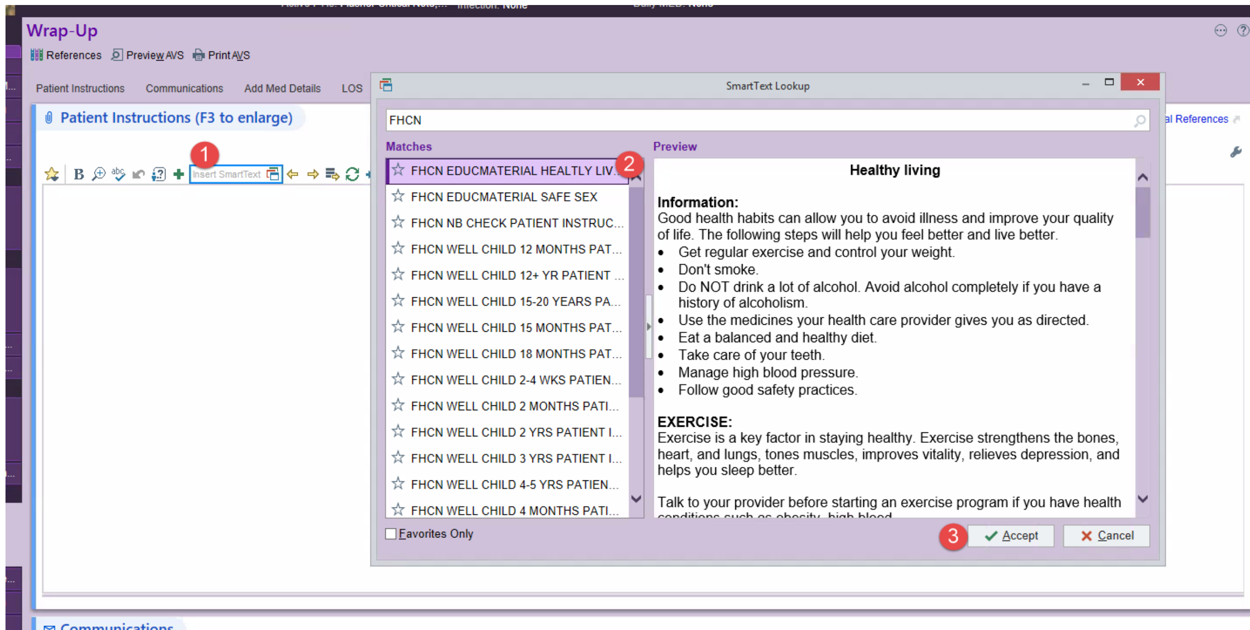
	11/14/19 18:16
BP	110/64 !
BP Location	Right arm
Patient Position	Supine
BP Cuff Size	Small
Pulse	64 !
Resp	17 !
Temp	36.6 C (97.9 F)
Temp src	Tympanic
Weight	45.4 kg (100 lb)
Height	34" (86.4 cm)
Pain Score	0 - No pain

Age Percentiles	
BP	98 % / 96 % !
Weight	>99 %
Height	2 %
BMI	>99 %
Other Vitals	
BMI	60.82 kg/m^2
BSA	1.04 m^2
LMP	3/20/2019
Menstrual status:	Pregnant
EDD	12/25/2019
OB/Gyn status reviewed	Never reviewed
Tobacco	
Smoking Status	Never Assessed
Smokeless Status	Unknown
Reviewed	Never reviewed

Patient Addtl Vitals

To provide applicable education material to the patient:

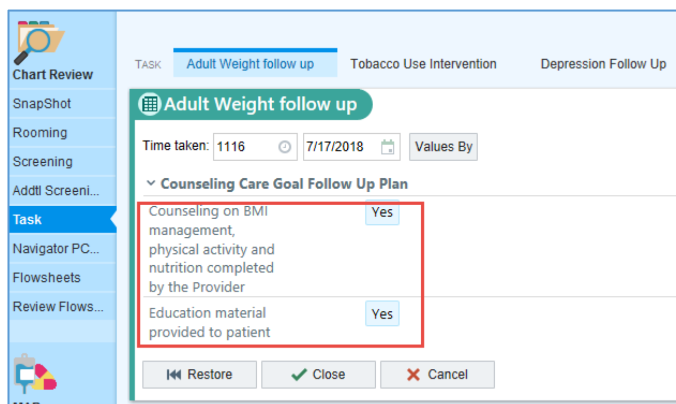
1. Preprinted material is given to patients as needed
2. Use the Letters activity and select the FHCN EDUCMATERIAL HEALTHY LIVING, print it out and save to the patient chart. Give the patient the printed copy.
3. Add Patient Education using Smart Text to Patient Instruction in Wrap Up to add education material to the After Visit Summary



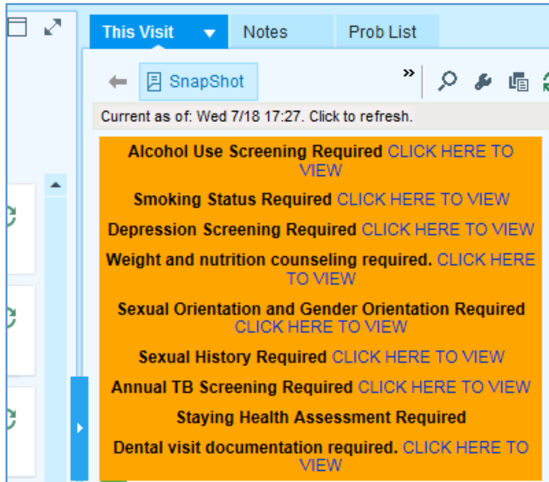
Provider Note: the provider will discuss/counsel with the patient as applicable

To document Education Material when given via structured field:

- MA or Provider- Go to the TASK Activities Bar, select Adult Weight Follow up
- Click on YES "Counseling on BMI management, physical activity and nutrition completed by Provider"
- As applicable, click on YES , on "Education material was provided to patient"

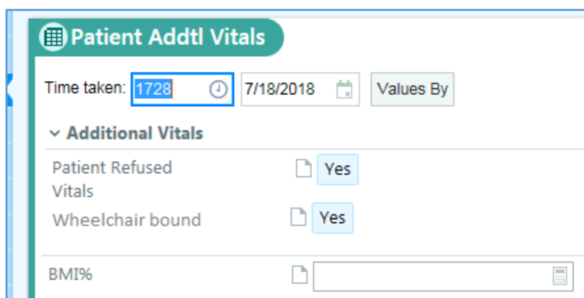


When completing this task, the Health Reminder (in Orange) in the Snapshot Screen will be removed. This reminder will display again every calendar year.



Exclusions:

- Pregnant patient
- Refused/Wheelchair bound documented in the Patient Addlt Vitals Screen
- Patient under palliative care (aka Hospice); workflow is as follows:
    - Go to FYI flag (can be found in More button in lower left corner in the Encounter or in the Registration screen) → Choose New Flag: Palliative Care
- Patients 65+ with mental illnesses, confusion, dementia, or nutritional deficiency whom weight reduction would complicate underlying medical conditions documented in Medical History or as a diagnosis in the problem list.



Weight Assessment/Counseling for Children: (2-17)

Applies to: Family Practice, PEDs, Dental, Behavioral Health, and Nutrition

Denominator: All patients 2-17 years old

To meet the measure: MA needs record height and weight in vitals for all patients 2-17 for EVERY visit. The percentile must be manually input in the Patient Addlt Vitals section. Education material must be provided. Education given needs to be documented via a structured field.

To document BMI Percentile:

- MA needs to record Height and weight at EVERY visit using the Vitals Screen and click on close
- To retrieve the BMI %, use the completed closed Vital Signs section
- Then, go to the Patient Addt Vitals and enter the BMI Percentile. Click close to save

Vital Signs

New Set of Vitals

Flowsheets

	11/14/19 18:16
BP	110/64 !
BP Location	Right arm
Patient Position	Supine
BP Cuff Size	Small
Pulse	64 !
Resp	17 !
Temp	36.6 C (97.9 F)
Temp src	Tympanic
Weight	45.4 kg (100 lb)
Height	34" (86.4 cm)
Pain Score	0 - No pain

Age Percentiles	
BP	98 % / 96 % !
Weight	>99 %
Height	2 %
BMI	>99 %
Other Vitals	
BMI	60.82 kg/m²
BSA	1.04 m²
LMP	3/20/2019
Menstrual status:	Pregnant
EDD	12/25/2019
OB/Gyn status reviewed	Never reviewed
Tobacco	
Smoking Status	Never Assessed
Smokeless Status	Unknown
Reviewed	Never reviewed

Patient Addtl Vitals

Patient Addtl Vitals

Time taken: 1728 7/18/2018 Values By

Additional Vitals

Patient Refused Vitals	Yes
Wheelchair bound	Yes
BMI%	

To provide applicable education material to the patient:

1. Preprinted material is given to patients as needed
2. Use the Letters activity and select the FHCN EDUCMATERIAL HEALTHY LIVING, print it out and save to the patient chart. Give the patient the printed copy.
3. Add Patient Education using Smart Text to Patient Instruction in Wrap Up to add education material to the After Visit Summary

Provider Note: Provider will discuss/counsel with the patient as applicable

MA/Provider- To document Education Material when given via structured field:

- Go to the TASK Activities Bar, select Counseling Nutrition & Physical Activity (2-17)
- Click on YES on “Counseling on physical activity and nutrition completed by the Provider””
- As applicable, click on YES , on “Education material was provided to patient”

Counseling Nutrition & Physical Activity (2-17)
Time taken: 1734 7/18/2018 Values By
Preventive Medicine Counseling
Counseling on physical activity and nutrition completed by the Provider Yes No
Education material provided to patient Yes
Restore Close Cancel

When completing this task, the Health Reminder (in Orange) in the Snapshot Screen will be removed. This reminder will display again every calendar year.

Exclusions:

- Pregnancy
- Patient under palliative care (aka Hospice); workflow is as follows:
    - Go to FYI flag (can be found in More button in lower left corner in the Encounter or in the Registration screen) → Choose New Flag: Palliative Care

Tobacco Use Assessment & Cessation Intervention

Applies to: Family Practice, Internal Medicine, OBGYN, Dental, Behavioral Health, Nutrition, and other specialties

Denominator: All patients 18+ years old

To meet measure: All patients 18+ of age need to have Tobacco Use screening completed. If the patient is a current smoker, patient needs to be counseled on the dangers of tobacco use and urged to quit. Documentation on tobacco counseling needs to be documented via a structured field.

To document Tobacco Screening:

- In the Rooming Activity, select History. Scroll down to the Social History section and complete the Tobacco related questions

Notes:

- DO NOT document "Tobacco Use" in vitals section. NOTE: documenting from Vital Signs will not count towards the measure
- The Tobacco Section of the Social History needs to be completed every 12 months
- If the patient is a non-smoker, the Orange Health Reminder will be automatically removed
- If the patient is a smoker or former smoker, counseling on tobacco should be documented in the record.

How to provide applicable education material to the patient:

1. Preprinted material is given to patients as needed
2. Use the Letters activity and select the FHCN EDUCMATERIAL HEALTHY LIVING, print it out and save to the patient chart. Give the patient the printed copy.

3. Add Patient Education using Smart Text to Patient Instruction in Wrap Up to add education material to the After Visit Summary

Provider Note: the provider will discuss/counsel with the patient as applicable

MA/Provider- To document tobacco via structured field:

- Go to the TASK Activity, and select Tobacco Use Intervention
- Document YES on “Counseling on dangers of tobacco completed by the Provider”
- As applicable, click on YES , on “Education material was provided to patient”

Click on Close to save

Exclusions:

- None

Screening for Clinical Depression & Follow-up Plan:

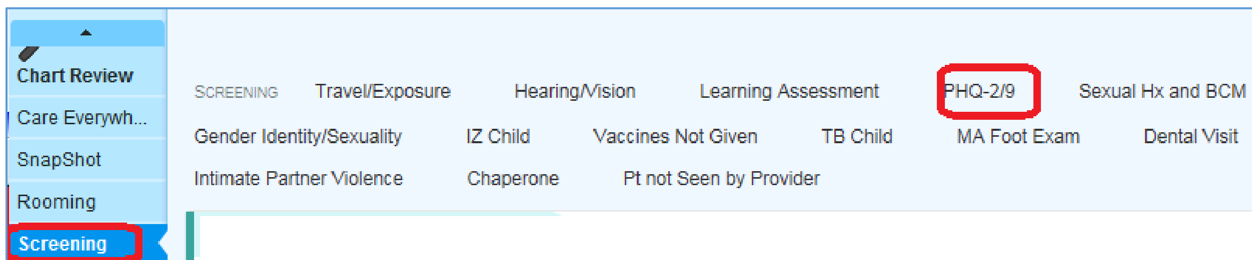
Applies to: Family Practice, Internal Medicine, PEDs, OBGYN, Dental, Behavioral Health, and Nutrition

Denominator: Patients 12 or older

To meet this measure: Conduct the PHQ-2/9 in the screening section annually. If patient tests PHQ2/9 total score of 1 or more, then follow up clinically as applicable (e.g. make an appt, provider counseling, etc.). Follow up on Depression when patient scores 1 or more; this needs to be documented via a structured field.

To document the Depression Score:

- Go to the Screening Activity and select the PHQ2/9 Form
- Document the answers to all questions. The form will automatically reflect the Total score
- Click on Close to save the form.

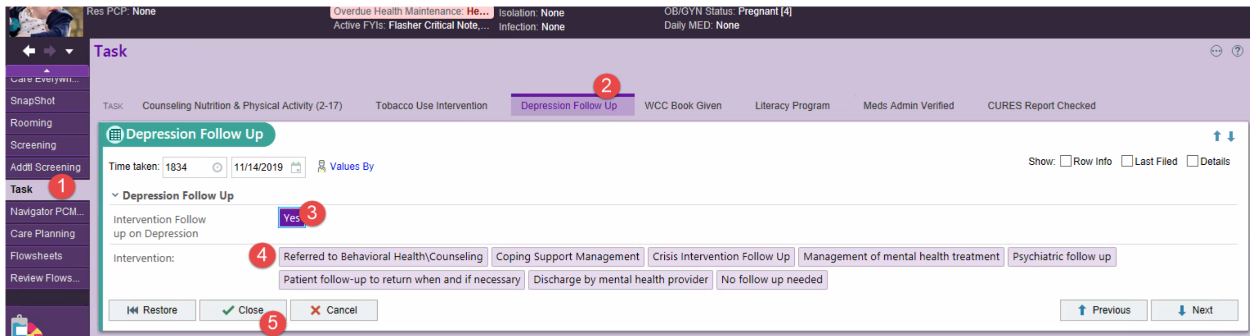


- If the Score is ZERO, the Orange Health Reminder will be automatically removed
- If the Score is 1 or more, the Depression Follow up must be completed.

Provider- To document Depression Follow up via structured field:

- If the Score is 1 or more, go to the TASK Activity, and select Depression Follow up
- Document YES on “Intervention Follow up on Depression” done
- Select applicable “Intervention” option
- Click on Close to save

The Orange Health Reminder will be automatically removed



Exclusions:

- Patients with a diagnosis of bipolar disorder or depression documented in the problem list
- Patients who refused the answer the PHQ2/9 Questionnaire (document within PHQ2/9)

PHQ-2/9 - PHQ-9 - Patient Health Questionnaire

Time taken: 0929 7/11/2018

Values By Create Note

Patient Refusal

Patient Refused Yes

Over the last 2 weeks how often have you been bothered by any of the followi

1. Little interest or pleasure in doing things 0-Not at all 1-Several days

2. Feeling down, depressed, or hopeless 0-Not at all 1-Several days

3. Trouble falling or staying asleep, or sleeping too much 0-Not all all 1-Several days

Cervical Cancer Screening

Applies to: Family Practice, Internal Medicine, and OBGYN

Denominator: All female patients 23-64

To meet the measure: Patients 23-29 need a Pap Smear resulted within the current Calendar Year or within the last 2 calendar years. Patients 30-64 need a pap smear with HPV co-testing resulted within the current calendar year or within the last 4 calendar years. Workflow to meet the measure is as follows:

Note:

- Provider needs to order applicable lab; MA team to follow up until the lab is resulted
- MA needs to schedule appointment for a Pap Smear if this is not done during the visit

Outside Documents: If patient had pap performed outside FHCN, the MA should ask the patient to bring the paper pap results to the clinic.

- The Paper pap results should be forwarded to the Health Record Department, who will perform the applicable steps to have the Lab Result count for the CQM
- Steps cannot be completed unless physical copy of cervical cancer screening report is scanned into record

Exclusions:

- Patients who have had a hysterectomy with no residual cervix – documented in the Surgical History tab
- Patient under palliative care (aka Hospice); workflow is as follows:
    - Go to FYI flag (can be found in More button in lower left corner in the Encounter or in the Registration screen) → Choose New Flag: Palliative Care

Once Final result of these orders is in the chart, it will fulfil the Cervical Cancer Screening:

	Completing Procedure, LOS, E/M Code	Code Type
1	CYTOLOGY, THINPREP PAP SMEAR [LAB35455Q]	Custom
2	THIN PREP PAP AND HPV II [LAB15003Q]	Custom
3	SUREPAP/CT [LAB47493Q]	Custom
4	SUREPATH FOCALPOINT-GS PAP [LAB18810Q]	Custom
5	SUREPATH FOCALPOINT-GS PAP AND C. TRACHOMATIS, N. GONORRHOEAE [LAB18816Q]	Custom
6	SUREPATH FOCALPOINT-GS PAP AND HR HPV DNA WITH RFX TO GENOTYPES 16,18 [LAB18829Q]	Custom
7	SUREPATH FOCALPOINT-GS PAP AND HR HPV DNA, CT/GC [LAB18828Q]	Custom
8	SUREPATH (REFL) [LAB701331Q]	Custom
9	SUREPATH FOCALPOINT-GS PAP W/REFLEX [LAB18811Q]	Custom
10	SUREPATH FOCALPOINT-GS PAP WITH REFLEX TO HR HPV DNA, CT/GC [LAB18817Q]	Custom
11	SUREPATH FOCALPOINT-GS PAP AND HR HPV DNA [LAB18813Q]	Custom
12	THINPREP(R) PAP TEST AND HPV RNA, HIGH RISK E6/E7, TMA [LAB90931Q]	Custom
13	THINPREP-TIS W/RFL HPV RNA, E6/E7 [LAB90934Q]	Custom
14	THINPREP TIS PAP REFLEX HPV MRNA E6/E7, CHLAMYDIA/N.GONORRE [LAB91912Q]	Custom
15	THINPREP PAP TEST WITH IMAGER AND HPV RNA, HIGH RISK, E6/E7 [LAB90933Q]	Custom
16	THINPREP TIS PAP AND HPV MRNA E6/E7 REFLEX HPV 16,18/45 [LAB91414Q]	Custom
17	THINPREP TIS PAP AND HPV MRNA E6/E7, CHLAMYDIA/N.GONORRHOEAE [LAB91339Q]	Custom
18	SUREPATH® PAP (REFL) HPV MRNA E6/E7 [LAB39634Q]	Custom
19	N. GONORRHOEAE DNA,SDA, PAP VIAL [LAB17617Q]	Custom
20	PAP - NO REFLEX [LAB304006]	Custom
21	PAP - NO REFLEX W/ GC CT [LAB304007]	Custom
22	PAP - REFLEX IF ASCUS [LAB304010]	Custom
23	PAP - REFLEX IF ASCUS W/ GC CT [LAB304011]	Custom
24	PAP - REFLEX IF ASCUS W/ VAGINITIS [LAB304012]	Custom
25	PAP - REFLEX IF ASCUS W/ GC CT AND VAGINITIS [LAB304013]	Custom
26	PAP - REFLEX IF ASCUS AND ABOVE [LAB304014]	Custom
27	PAP - REFLEX IF ASCUS AND ABOVE W/ GC CT [LAB304015]	Custom
28	PAP - REFLEX IF ASCUS AND ABOVE W/ VAGINITIS [LAB304016]	Custom
29	PAP - REFLEX IF ASCUS AND ABOVE W/ GC CT AND VAGINITIS [LAB304017]	Custom
30	PAP - HPV CO-TEST [LAB304018]	Custom
31	PAP - HPV CO-TEST W/ GC CT [LAB304019]	Custom
32	PAP - NO REFLEX W/ TRICHOMONAS AND GC CT [LAB304022]	Custom
33	PAP - NO REFLEX W/ TRICHOMONAS AND VAGINITIS [LAB304023]	Custom
34	PAP - NO REFLEX W/ TRICHOMONAS, GC CT AND VAGINITIS [LAB304024]	Custom
35	PAP - REFLEX IF ASCUS W/ TRICHOMONAS [LAB304025]	Custom
36	PAP - REFLEX IF ASCUS W/ TRICHOMONAS AND GC CT [LAB304026]	Custom
37	PAP - REFLEX IF ASCUS W/ TRICHOMONAS AND VAGINITIS [LAB304027]	Custom
38	PAP - REFLEX IF ASCUS W/ TRICHOMONAS, GC CT AND VAGINITIS [LAB304028]	Custom
39	PAP - REFLEX IF ASCUS AND ABOVE W/ TRICHOMONAS [LAB304029]	Custom
40	PAP - REFLEX IF ASCUS AND ABOVE W/ TRICHOMONAS AND GC CT [LAB304030]	Custom
41	PAP - REFLEX IF ASCUS AND ABOVE W/ TRICHOMONAS AND VAGINITIS [LAB304031]	Custom
42	PAP - REFLEX IF ASCUS AND ABOVE W/ TRICHOMONAS AND VAGINITIS AND GC CT [LAB304032]	Custom
43	PAP - HPV CO-TEST W/ TRICHOMONAS [LAB304033]	Custom
44	PAP - HPV CO-TEST W/ TRICHOMONAS AND GC CT [LAB304034]	Custom
45	PAP - HPV CO-TEST W/ TRICHOMONAS AND VAGINITIS [LAB304035]	Custom
46	PAP - HPV CO-TEST W/ TRICHOMONAS AND VAGINITIS AND GC CT [LAB304036]	Custom
47	PAP - NO REFLEX W/ TRICHOMONAS [LAB304052]	Custom
48	CYTOLOGY, GYN [LAB5]	Custom
49	SUREPATH PAP AND HPV MRNA E6/E7 [LAB15095Q]	Custom
50	THINPREP TIS PAP AND HR HPV DNA, C. TRACHOMATIS AND N. GONORRHOEAE [LAB92092Q]	Custom
51	THINPREP-TIS [LAB58315Q]	Custom
52	PAP SMEAR - AMB REF LAB ONLY [POC304103]	Custom

Diabetes HbA1c (Poor Control)

Applies to: Family Practice and Internal Medicine

Denominator: Patients 18-75 years of age with diabetes diagnosis code(s) used in a claim, or displaying active in the problem list (e.g. E10-, E11-, E024-)

To meet the measure: Patients most recent HbA1c resulted in the calendar year with a value of <9% resulted in the calendar year.

The CQM (Clinical Quality Measure) will record in the numerator all patients with a HbA1C resulted in the measurement year with >9% or no test. Having a lower score is better.

Notes:

- If patients (age 18-75) have no HbA1c resulted in the calendar year or the HbA1c is 9% or higher in the most recent lab result, follow up & treat; schedule appointment, order the HbA1c when applicable, monitor until the HbA1c is back under control (<8% MA can order via approved CQM guidelines)

Exclusions:

- Gestational diabetes (O99.81) as active in the Problem List
- Steroid induced diabetes (E16.4, E16.8) as active in the Problem List
- Polycystic ovaries (E28.2) as active in the Problem List
- Patient under palliative care (aka Hospice); workflow is as follows:
    - Go to FYI flag (can be found in More button in lower left corner in the Encounter or in the Registration screen) → Choose New Flag: Palliative Care

Hemoglobin A1C
Status: Final result (Resulted: 4/20/2018)
Component Results
Component
Resulted
Hemoglobin A1C
9.2
04/20/2018 00:00
Encounter
View Encounter

Hypertension

Applies to: Family Practice and Internal Medicine

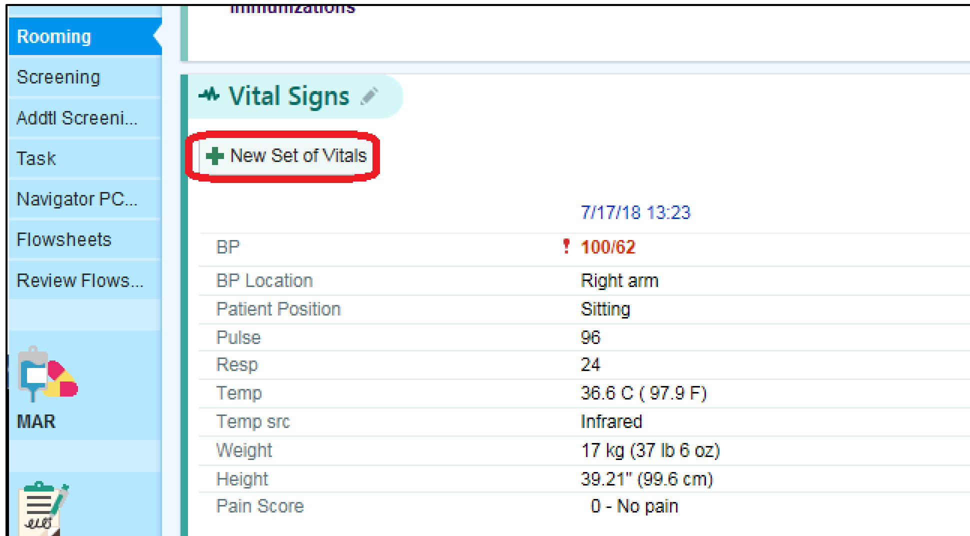
Denominator: All patients 18-85 years of age with the hypertension diagnosis code(s) used in a claim or active in the problem list

To meet the measure: Patients need to have last BP <140 and <90 at the most recent visit/encounter within the calendar year

Notes:

- Blood Pressure is collected during every visit
- Providers will review the patients' blood pressure, if patients have BP <140 and <90 then patient will meet numerator
- MA/Provider will complete a New Blood Pressure intake as applicable during the visit
- If BP is still >140 or >90, Provider will treat as applicable. The MA needs to schedule a follow up appointment for BP check, this should be scheduled in the providers schedule within 2 weeks

Vital Signs
3/22/18 15:19 | New Set of Vitals
Taken on: 3/22/2018 15:19 | Orthostatics
BP: | Weight: | Pain score:
Site: | Height: | Location:
Position: | Resp: | Educated?
Cuff size: | SpO2: | Comment:
Pulse: | PF (best):
Temp:
Source:
Tobacco Use
Never Assessed | Smokeless: Unknown
Ready to quit? Yes No
Counseling given? Yes No
Mark as Reviewed | Never reviewed | Edit Tobacco Use
Restore | Close



Exclusions:

- Pregnancy
- Diagnosis of end of stage renal disease, dialysis or renal transplant
- Patient under palliative care (aka Hospice); workflow is as follows:
    - Go to FYI flag (can be found in More button in lower left corner in the Encounter or in the Registration screen) → Choose New Flag: Palliative Care

Chlamydia

Applies to: Family Practice, Internal Medicine, PEDs, and OBGYN

Denominator: All female patients 10-25 years old of age, who are sexually active or unknown if sexually active

To meet the measure: Female patients with Chlamydia test resulted in the calendar year

Workflow:

- In the Screening ACTIVITY, the MA/NHC → Select the Sexual Hx and BCM Form → Document if the patient is Sexually Active for every patient over 10 years of age (screenshot below)
- MA/Provider/NHC need to order the chlamydia test and follow up until the lab test is resulted.

Notes:

- If the female patient has a visit in the CY and does not have sexual activity documented in the last 12 months, the patient will be included in the denominator

External Record flow:

- If patient had Chlamydia Screening outside FHCN, the MA should ask the patient bring the paper chlamydia results to the clinic. The paper Chlamydia results should be forwarded to the Health Record Department, who will perform the applicable steps to meet the measure.

Asthma Medication Ratio

Applies to: Family Practice, Internal Medicine, and PEDs

Denominator: Patients 5-64 years of age with persistent asthma in a claim during the calendar year or displaying active in the problem list

To meet the measure: Patients need to have a ratio of controller medications to total asthma medications of 0.50 or greater

How to document medications:

- MA/Provider should document applicable medications currently taken by the patient into the Home Medications of the Rooming tab
- MA/Provider should review the Outside Medication Reconciliation section and add them to the record as applicable as taken
- Provider will prescribe or refill as applicable ***while keeping in mind the required ratio***
- Providers need to always maintain problem list updated. E.g. resolving persistent asthma diagnosis if the patient if the condition has changed.

Note: Staff can use the Asthma Survey in the Addtl Screening Activity as a reference tool

Exclusions:

- Patients who are allergic to asthma medications. MA needs to document Rx Allergies using the Rx Button
- The following diagnosis codes: E84.0, E84.11, E84.19, E84.8, E84.9, J43.0, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.0, J44.1, J44.9, J44.9, J44.9, J68.4, J96.00, J96.01, J96.02, J96.20, J96.21, J96.22, J98.2, J98.3

Well Child Visits 3-6

Applies to: Family Practice and PEDs

Denominator: Children who turn 3-6 years of age in measurement year

To meet the measure: Patients must have a well child check in the calendar year:

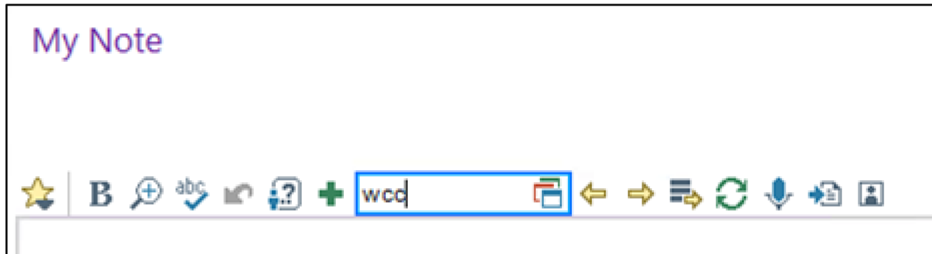
- defined as a physical exam including a health and developmental history and health education/anticipatory guidance,
- and have applicable LOS: 99392, 99393, 99382, 99383
- and have Counseling on Nutrition and Physical Activity documented

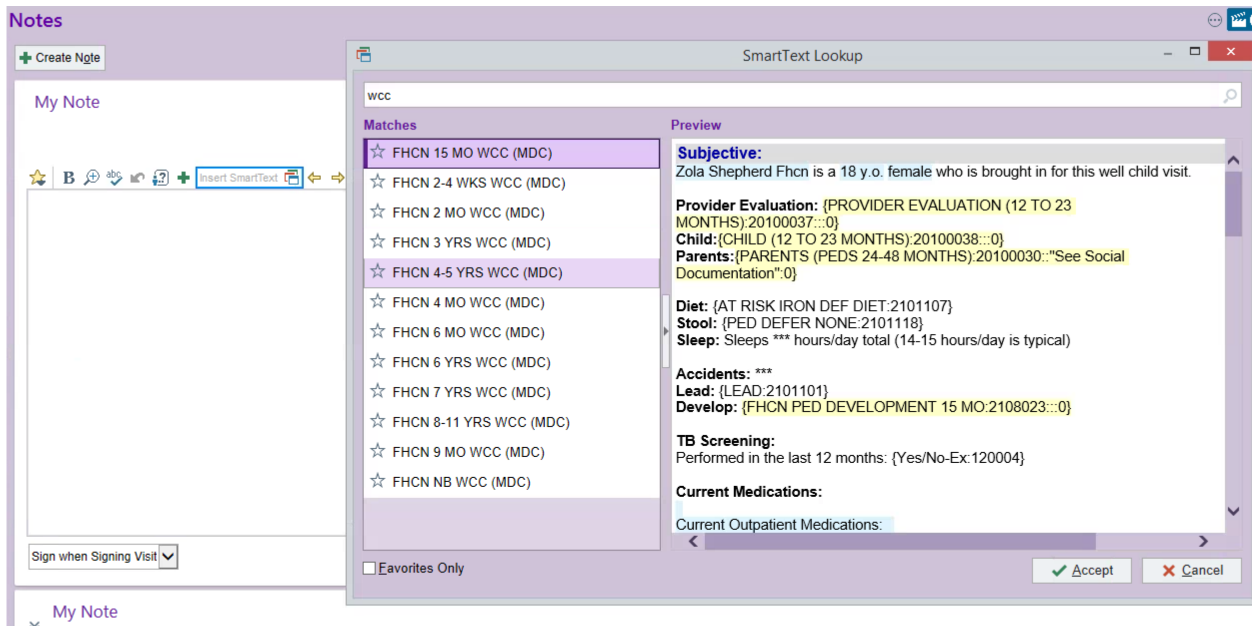
Workflow Notes:

1. MA's have to document Vitals. BMI is a requirement for this measure
2. MA needs to document/update histories: medical history, surgical, family, social, etc. as applicable

3. MA needs to access the TASK Activity and document with YES that "Counseling on physical activity and nutrition was completed by the Provider"

4. Provider, when documenting his/her note, needs to use the SMART TEXT functionality to include required documentation
   - Type FHCN into the SMART TEXT field and hit ENTER
   - The Smart Text Lookup window will open.
   - Select the applicable Match and click on Accept





5. Provider needs to use the F2 function KEY to go to each of the required sections of the Note
   a. You can right-Click on different **SMARTPHRASES** to see a **SMARTLIST dropdown** of options display
   b. Select the applicable items on the **SMARTLIST and** right-click to add them to the note
   c. Document as applicable on any section with three asterisk ***
   d. If you need to **edit a SMARTPHRASE**, go back to the **SMARTPHRASE** and right-click, then select RESELECT THIS SMARTLIST section. Select applicable items and right-click to add them to the note
   e. Ensure you select applicable anticipatory guidance topics discussed with the parent

Provider Evaluation: recent minor problems: colds
Parents: See Social Documentation

Diet: prematurity
Stool: none
Sleep: Sleeps 222 hours/day total (14-15 hours/day is typica

Accidents: 222
Lead: no risk noted, will have lead level tested (recommende
Develop: {FHCN PED DEVELOPMENT 3 YRS:21080026}

knows name, age and sex
talks in sentences
stands on one foot for 3 seconds
throws ball
washes hands
imitates vertical line
***

Diet: prematurity
Stool: none
Sleep: Sleeps *** hours/day total (14-15 hours/day is typical)

Accidents: ***

Recent Medical History
No past medical history

Allergies/intolerance:

Reselect This SmartList's Selections
Reselect All SmartList Selections
Delete SmartList
Make Selected Text Editable

cant changes","no hospitalizations, emergency room visits, antibiotics, accidents

6. Provider needs to document in the Wrap Up Section the LOS
   a. Type 993 into the LOS Field and click on ENTER
   b. You will see a menu of LOS options.
   c. Select the Well Child Visit code applicable for the visit

Wrap-Up
References Preview AVS Print AVS
Patient Instructions Communications Add Med Details LOS Charge Capture Follow-up After Visit Summary

Level of Service
N1 N2 N3 N4
E1 E2 E3 E4
No Charge
LOS: 993
Modifiers: May be added after LOS is selected
Auth prov:

Charge Capture
Service Date Service Provider
11/14/2019
Diagnoses: Encounter for routine child health examinat
Search for new charge Add

Level of Service

Code	Code Type	Description
99394	CPT(R)	PREVENTIVE VISIT,EST,12-17
99395	CPT(R)	PREVENTIVE VISIT,EST,18-39
99396	CPT(R)	PREVENTIVE VISIT,EST,40-64
99397	CPT(R)	PREVENTIVE VISIT,EST,65 & OVER
99392	CPT(R)	PREVENTIVE VISIT,EST,AGE 1-4
99393	CPT(R)	PREVENTIVE VISIT,EST,AGE5-11
99384	CPT(R)	PREVENTIVE VISIT,NEW,12-17
99385	CPT(R)	PREVENTIVE VISIT,NEW,18-39
99386	CPT(R)	PREVENTIVE VISIT,NEW,40-64
99387	CPT(R)	PREVENTIVE VISIT,NEW,65 & OVER
99382	CPT(R)	PREVENTIVE VISIT,NEW,AGE 1-4
99383	CPT(R)	PREVENTIVE VISIT,NEW,AGE5-11

Accept Cancel

Adolescent Well-Care Visit

Applies to: Family Practice and PEDs

Denominator: Patients who are 12 – 21 years of age as of December 31st of the calendar year

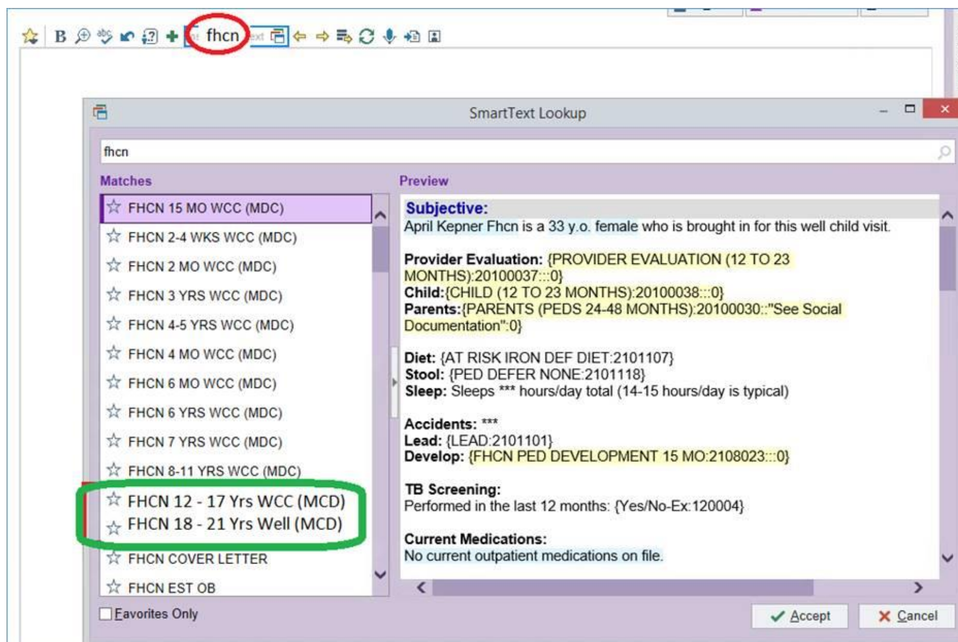
To meet the measure: Patients must have an Adolescent Well-Care Visit in the measurement year

- defined as a physical exam including a health and developmental history and health education/anticipatory guidance,
- and have applicable LOS: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395

Workflow Notes:

1. MA's have to document Vitals, and needs to document/update histories: medical history, surgical, family, social, etc. as applicable

2. Provider, when documenting his/her note, needs to use the SMART TEXT functionality to include required documentation
    - Type FHCN into the SMART TEXT field and hit ENTER
    - The Smart Text Lookup window will open.
    - Select the applicable Match and click on Accept



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    b. Select the applicable items on the **SMARTLIST and** right-click to add them to the note
    c. Document as applicable on any section with three asterisk ***

d. If you need to **edit a SMARTPHRASE**, go back to the **SMARTPHRASE** and right-click, then select RESELECT THIS SMARTLIST section. Select applicable items and right-click to add them to the note
e. Ensure you select applicable anticipatory guidance topics discussed with the parent

4. Provider needs to document in the Wrap Up Section the LOS
   a. Type 993 into the LOS Field and click on ENTER
   b. You will see a menu of LOS options.
   c. Select the Well Visit code applicable for the visit

Post-Partum Care

Applies to: OB/GYN

Denominator: Prenatal patients who delivered a live birth from October 8th of the previous measurement year to October 7th of the current measurement year

To meet the measure: Patients need a postpartum visit between 7 – 84 days after delivery that contains any the following:

1. Pelvic exam
2. OR Evaluation of BP, Weight and notation on Breast feeding (yes or no)
3. OR Notation of “PP care” , “PP check” (this means we could use visit types)
4. OR Perineal of cesarean wound check visit
5. OR Screening for depression, anxiety, tobacco use, mental health disorders, drug use
6. OR glucose screening for women with gestational diabetes
   OR documentation of infant care, family planning, resumption of physical activity, etc.

Workflow for the patient to meet the Numerator

1. The patient needs to have a Post-Partum Visit 7-84 days after the delivery
2. The Post-Partum Visit will meet the requirement on any of the below scenarios

A) The provider needs to document any of these diagnosis that are common in a Postpartum-Encounter
   - Z01.411- gyn exam- normal
   - Z01.419 gyn with abnormal findings
   - Z01.42 pap smear
   - Z30.430- IUD
   - Z39.1 care for lactating mother
   - Z39.2 encounter for routine postpartum follow up.

B) AND/OR The provider will educate the patient, complete the PPD Scale in the Additional Screening Tab and will use the dot phrase .FHCN Postpartum, which will display the below information

Active FYIs: Flasher Critical Note Visit Coverage:... Pain Agreement: Expired on 9/2...

Chart Review
Care Everywh...
SnapShot
Rooming
Screening
Addtl Screening
Task
Navigator PCM...
Care Planning
Flowsheets
Review Flows...
MAR
Plan
Immunizations
Hosp Admissi...
Notes
History and Ph...
Wrap-Up

Addtl Screening

ADDTL SCREENING Asthma Survey Alcohol Misuse/Abuse (Audit C) GAD-7 PPD Scale 24hr Recall Glucose Monitoring
Add'l Questions Nutrition Screen Group Notes

PPD Scale - Postpartum Depression Scale

Time taken: 1955 11/26/2019 Show: Row Info Last Filed Details All Choices

Values By Create Note

In the past 7 days:

Question	Choices
I have been able to laugh and see the funny side of things	0=As much as I always could; 1=Not quite so much now; 2=Definitely not so much now; 3=Not at all
I have looked forward with enjoyment to things	0=As much as I ever did; 1=Rather less than I used to; 2=Definitely less than I used to; 3=Hardly at all
I have blamed myself unnecessarily when things went wrong	3=Yes, most of the time; 2=Yes, some of the time; 1=Not very often; 0=No, never
I have been anxious or worried for no good reason	0=No, not at all; 1=Hardly ever; 2=Yes, sometimes; 3=Yes, very often
I have felt scared or panicky for no good reason	3=Yes, quite a lot; 2=Yes, sometimes; 1=No, not much; 0=No, not at all
I haven't been able to cope lately	3=Yes, most of the time I haven't been able to cope; 2=Yes, sometimes I haven't been coping as well as usual; 1=No, most of the time I have coped quite well; 0=No, I have been coping as well as ever
I have been so unhappy that I have had difficulty sleeping	3=Yes, most of the time; 2=Yes, sometimes; 1=Not very often; 0=Not at all
I have felt sad or miserable	3=Yes, most of the time; 2=Yes, quite often; 1=Not very often

My Note
11:47

Edit

Expand All Collapse All

Plan General:

Post Partum Breast Feeding evaluation completed
Post partum education provided
Post partum depression screening completed
Family Contraceptive Planning education provided
Blood Pressure evaluated and Weight noted
Patient reported breast feeding: {YES/NO:21079}.

Vitals

Vitals:

	11/19/19 1146
BP:	120/77
BP Location:	Right arm
Patient Position:	Sitting
BP Cuff Size:	1
Pulse:	67
Resp:	18
Temp:	35.6 °C (96 °F)
Weight:	78 kg (172 lb)
Height:	56" (142.2 cm)

B) AND/OR: The appointment visit type was :
   a. POST PARTUM 2 WEEK
   b. POST PARTUM 6 WEEK
   c. POSTPARTUM

C) AND/OR: If the patient had gestational diabetes, the patient will also meet the numerator if the patient has a glucose screening test completed.

D) AND/OR: If the patient has a Cervical Cancer Lab test ordered and resulted within 7-84 days of the delivery.

Breast Cancer Screening

Applies to: Family Practice, Internal Medicine, OB/GYN

Denominator: Women 52-74 years of age

To meet the measure: Patients who had a mammogram anytime on or between October 1st two years prior to the measurement year and December 31st of the measurement year (i.e.: For CY 2018 patient needs a mammogram between October 1st 2016 and December 31st 2018).

Workflow

The provider will review the Health Maintenance Alert window to identify If the Annual Mammogram is completed and shows as due in the future, or if it displays under Current Care Gaps as overdue.

- The provider will order the applicable mammogram following established workflows (generate referral Order)
- The Referral Staff/MA will follow up as applicable to ensure the mammogram is completed
- Most Mammogram orders are performed at CMC.
- Once the mammogram report is FINAL RESULT in Epic, it will be sent to the Ordering Provider's inBasket for review.
- Simultaneously , the Health Maintenance Alert for Mammogram will update as complete
- If the mammogram is performed at a non CMC Site, obtain the Mammo report, send it to the Health Records department at FHCN for them to upload it into Epic to fulfill the Health Maintenance alert and CQM Requirements

CSN: None | MyChart: Active | Attend Prov: None
Allergies: Penicillins, Codeine, I... | My Sticky Note:... | OB/GYN Status: Postmenopausa...
Overdue Health Maintenance: He... | Specialty Com... | Daily MED: None
Visit Coverage:... | Pain Agreement: Not on File

Health Maintenance

Address Topic | Remove Override | Document Past Immunization | Edit Modifiers | Report | Update HM | Guidelines

New data from outside sources

Allergies and Medications need attention. Go Reconcile

Topic	Due Date	Frequency	Date Completed
Current Care Gaps			
HIV SCREEN	Overdue since 10/11/1977	Once	
COLON CANCER SCREENING ANNUAL FOBT/FOBI	Overdue since 10/11/2012	1 year(s)	
ZOSTER,RECOMBINANT (SHINGRIX) 50yrs+ (1 of 2)	Overdue since 10/11/2012	Imm Details	
INFLUENZA	Overdue since 8/1/2019	1 year(s)	9/17/2018
Upcoming			
AMB ANNUAL MAMMOGRAM	Next due on 2/1/2020	1 year(s)	2/1/2019
AMB CERVICAL PAP 31-65	Next due on 11/29/2020	3 year(s)	11/29/2017
TD (ADULT)	Next due on 11/6/2024	10 year(s)	11/6/2014
PNEUMOCOCCAL: 65+ YEARS (1 of 2 - PCV13)	Next due on 10/11/2027	Imm Details	9/17/2018

Once Final result of these orders is in the chart, it will fulfil the Breast Cancer Screening:

	Completing Procedure, LOS, E/M Code	Code Type
1	MAMM DIGITAL DIAGNOSTIC LEFT [IMG588]	Custom
2	MAMM DIGITAL DIAGNOSTIC RIGHT [IMG589]	Custom
3	MAMM DIGITAL DIAGNOSTIC BILATERAL [IMG600]	Custom
4	MAMM DIGITAL SCREENING BILATERAL [IMG605]	Custom
5	MAMM TOMOSYNTHESIS DIAGNOSTIC BILATERAL [IMG3041301]	Custom
6	MAMM TOMOSYNTHESIS DIAGNOSTIC RIGHT [IMG3041302]	Custom
7	MAMM TOMOSYNTHESIS DIAGNOSTIC LEFT [IMG3041303]	Custom
8	MAMM TOMOSYNTHESIS W SCREENING BILATERAL [IMG3041304]	Custom
9	MAMM TOMOSYNTHESIS SCREENING RIGHT [IMG3041305]	Custom
10	MAMM TOMOSYNTHESIS SCREENING LEFT [IMG3041306]	Custom
11	MAMM DIGITAL SCREENING LEFT [IMG3041242]	Custom
12	MAMM DIGITAL SCREENING RIGHT [IMG3041243]	Custom
13	MAMM TOMOSYNTHESIS BILATERAL [IMG3041307]	Custom

Technical Exclusion to get data into the CQM report

- If the patient has surgical History of Mastectomy documented in the Surgical History, the Health Maintenance Alert will not display. In this scenario, even if the Mammogram Order has been resulted, it will not be reflected in the CQM report.