

CMS 68: Documentation of Current Medications in the Medical Record

-18 yrs. and older, reported for EVERY encounter during the measurement period.

-The list includes ALL known medications/supplements and must contain name, dosage, frequency, and route

*Must complete medication reconciliation in 2 parts, the nurse completes and the provider completes in order to get a green check by medication reconciliation in the chart

Click Document Medication by HX – Review Medications & Click document medication history

The screenshot shows a software interface for documenting medication history. At the top, there are navigation options: 'Add', 'External Rx History', 'No Check', and 'Patient Pharmacy'. Below these are checkboxes for 'Medication History' (checked), 'No Known Home Medications', 'Unable To Obtain Information', and 'Use Last Compliance'. On the right, there are 'Reconciliation Status' buttons: 'Med History', 'Admission', and 'Discharge'. The main area is titled 'Document Medication by Hx' and contains a table with columns: 'Order Name', 'Status', 'Details', 'Last Dose Date/Time', 'Information Source', 'Compliance', and 'Compliance Comments'. A blue banner across the table reads: 'Medication history has not yet been documented. Please document the medication history for this patient encounter.' The table lists two medications under the 'Home Medications' section: amoxicillin (amoxicillin 400 mg/5 mL oral liquid) and cetirizine (cetirizine 1 mg/mL oral syrup). Both are listed as 'Prescribed'. At the bottom, there are buttons for 'Details', 'Missing Forward Detail', 'Leave Med History Incomplete - Finish Later', 'Document History', and 'Cancel'.

| Order Name | Status | Details | Last Dose Date/Time | Information Source | Compliance | Compliance Comments |
|--|------------|---|---------------------|--------------------|------------|---------------------|
| Home Medications | | | | | | |
| Medication history has not yet been documented. Please document the medication history for this patient encounter. | | | | | | |
| amoxicillin (amoxicillin 400 mg/5 mL oral liquid) | Prescribed | 800 mg q 10 mL, Oral, every 12 hr. # 200 mL, 0 Refill(s), Pharmacy: North Century Pharmacy, 10427, on, 11/... | | | | |
| cetirizine (cetirizine 1 mg/mL oral syrup) | Prescribed | 2.5 mg q 2.5 mL, Oral, Daily, PRN as needed for allergy symptoms, # 75 mL, 0 Refill(s), Start Date: 11/16/22 L... | | | | |

CMS 69: Preventative Care and Screening: BMI Screening and Follow up

-18 yrs. and older, with a BMI documented at current visit or one within the last 12 months AND a BMI outside of normal parameters (**Normal 18 yrs. older BMI => 18.5 and < 25 kg/m²**)

-Exclusion for measure includes a diagnosis of pregnancy during the measurement period or is patient has a palliative care procedure order

*Enter Height & Weight in form. If patient falls out of normal range, go to Health Status section and select options from the "Patient Counseled" box as appropriate

1. Navigate to the Vitals & Measurements section of the Clinical Summary.

PowerForm Ad Hoc Charting folder location:

- Acute/Ambulatory: Additional Assessments
- ED: ED Forms

2. Fill out Weight and Height within the Summary Tab of the form.

The screenshot shows the 'Measurements' section of a clinical form. The 'Weight' field is set to 112 kg and the 'Height / Length' field is set to 154 cm. A red box highlights these two fields. Other fields include 'Weight (lb)' at 246 lb and 'Height / Length (in)' at 72 in. The 'Detailed Decree' field shows 33.08 kg/m² and 2.35 m².

3. If patient falls outside the normal range, place an Intervention.

4. An intervention can be placed by navigating to the Health Status section of the Comprehensive/Quick Intake Form.

The screenshot shows the 'Health Status' section of a clinical form. The 'Patient Counseled' section is highlighted with a red box. It contains three checkboxes: 'Nutrition', 'Physical activity', and 'Elevated BMI'. The 'Allergies Verified', 'Meds Verified', and 'History Verified' sections each have 'Yes' and 'No' radio buttons. The 'Immunizations Current' section has 'Yes', 'No', 'None received', 'Unknown', and 'Other' radio buttons.

5. For additional interventions, see Interventions section within Data Elements below and the Alternative Documentation Methods section.

CMS 122: Diabetes: Hemoglobin A1C Poor Control

- between 18-75 yrs. old with a visit during the measurement period
- active problem or diagnosis of Diabetes.
- HgbA1C > 9.0 during the measurement period
- *if no A1C is interfaced in from our lab, one can be manually entered on POC lab section

Document HgbA1c result

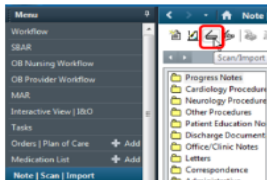
The screenshot shows a patient record for a female patient, 68 years old, with a diagnosis of Diabetes. The patient's information includes: Sex: Female, Birth Sex: Female, FIN: 600243376, Allergies: codeine, MRN: 14919, Admitted: 1/16/2023 14:17, and Loc: TJ Health Pavilion Clinics / Discharged Admitted. The form for documenting the HgbA1c result includes fields for: *Test site: TJPV POC; *Orderable: Hemoglobin A1c POCT; *Specimen type: Blood; *Performed date/time: **/**; *Performed ID: (blank); and *Ordering physician: Maloy, Brad M MD. A 'Results' table with columns for Procedure, Result, and Flags is also visible.

CMS 125: Breast Cancer Screening

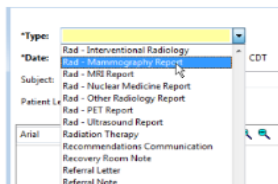
- Female patients 50-74 yrs. old with visit during measurement period
- exclusions: Bilateral mastectomy before or during the measurement period or 2 unilateral mastectomies on two different dates of service before or during the measurement period
- *results may be obtained via interface or scanned in using note type "**Mammography report**" Sign document. Please change the DOS to the report date.

Lab results may be obtained via a lab or hub interface. If this is not an option, or enabled, the workflow for manual entry is listed below.

1. Navigate to the Note/Scan/Import section



2. Scan in report using the note type "Rad - Mammography Report", "Mammography Report" or "Radiology MA" (domain dependent).



3. Sign Document

Measure 130: Colorectal Screen

Patient Population: 50-75 years of age

Goal: Annual FOBT ~OR~ Cologuard every 3 years ~OR~ Colonoscopy every 10 years

Cologuard and Colonoscopy results will be imported with the following

DOC types: Outside Cologuard and Colonoscopy

Document Occult Blood result on POC Result Entry form below:

| | | | | |
|-------------------------|--|-------------------|--------|--------------------|
| | | Sex: Female | | FIN: 600243376 |
| | | Birth Sex: Female | | Allergies: codeine |
| | | | | Age: 68 years |
| * Test site: | | Results | | |
| TJPAV POC | | Procedure | Result | Flags |
| * Orderable: | | | | |
| Occult Blood Fecal POCT | | | | |
| * Specimen type: | | | | |
| Stool | | | | |
| * Performed date/time: | | | | |
| **/**/**** | | | | |
| * Performed ID: | | | | |
| | | | | |
| * Ordering physician: | | | | |
| Mallory, Brad M MD | | | | |

CMS 139: Falls: Screening for Future Fall Risk

- 65 yrs. and older for MIPS. Complete on all patients for Joint Commission requirements
- every visit during measurement period

Fall Risk Assessment - Complete Conley Fall Risk Questions

ALL QUESTIONS MUST BE ANSWERED to calculate a score!

| Conley Fall Risk Scale | |
|--|---|
| History | |
| History of Falling in Last 3 Months, Including Since Admission | |
| <input type="radio"/> Yes | Yes response scores 2 |
| <input checked="" type="radio"/> No | |
| Observation | |
| Impaired Judgment/Lack of Safety Awareness | Agitation |
| <input type="radio"/> Yes | <input type="radio"/> Yes |
| <input checked="" type="radio"/> No | <input checked="" type="radio"/> No |
| Yes response scores 3 | Yes response scores 2 |
| Impaired Gait, Shuffle, Wide Base, Unsteady Walk | |
| <input type="radio"/> Yes | |
| <input checked="" type="radio"/> No | |
| Yes response scores 1 | |
| Direct Questions (Do You...) | |
| Ever Experience Dizziness or Vertigo | Ever Wet or Soil Yourself on Way to Bathroom |
| <input type="radio"/> Yes | <input type="radio"/> Yes |
| <input checked="" type="radio"/> No | <input checked="" type="radio"/> No |
| Yes response scores 1 | Yes response scores 1 |
| Fall Risk Score | |
| Fall Risk Score | A score greater than or equal to 2 will automatically enter a fall risk protocol order. |
| 0 | |

CMS 155: Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents

-between 3-17 yrs. old with an outpatient visit.

-exclusion if patient has an active problem or diagnosis of pregnancy during the measurement period

*Fill out Height and Weight, go to Health Status tab and check appropriate boxes under the “patient counseled” section

Measurement 1

1. Navigate to the Vitals & Measurements section of the Clinical Summary.

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3. Fill out Weight and Height within the Summary Tab of the form.

The screenshot shows the 'Measurements' section of a clinical summary form. The 'Weight' field is filled with '112' and 'kg', and the 'Height / Length' field is filled with '54' and 'cm'. A red box highlights these two fields.

Measurement 2 & 3

4. Open the Health Status Tab

5. Under the Patient Counseled Box, check off the appropriate boxes.

The screenshot shows the 'Health Status' section of a clinical summary form. The 'Patient Counseled' section is highlighted with a red box and contains three checkboxes: 'Nutrition', 'Physical activity', and 'Elevated BMI'. The 'Allergies Verified' section has 'Yes' selected.

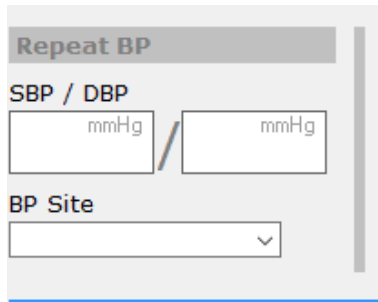
CMS 165: Controlling High Blood Pressure

-Between 18-65 yrs. old

-encounter during the measurement period AND a diagnosis of Hypertension

-Exclusion include patients with diagnosis or problem Pregnancy, End Stage Renal Disease (ESRD), or Chronic Kidney Disease Stage 5

*obtain BP with every visit, if elevated (<140/90) then 2nd BP entered in “more vitals” tab



The image shows a screenshot of a medical form titled "Repeat BP". It contains two input fields for "SBP / DBP" in "mmHg" units, separated by a slash. Below these is a dropdown menu labeled "BP Site".

- Patient must have a reading below 140/90 to MET this measure.